Education sector responses to HIV and AIDS:

Learning from good practices in Africa

This document is based on the background paper prepared for and the proceedings of the Africa regional workshop organised jointly by the Commonwealth Secretariat and ADEA, and hosted by HSRC, on 12–14 September 2006 in Johannesburg, South Africa

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COMMONWEALTH SECRETARIAT

ASSOCIATION FOR THE DEVELOPMENT OF EDUCATION IN AFRICA/ ASSOCIATION POUR LE DÉVELOPPEMENT DE L'ÉDUCATION EN AFRIQUE

HUMAN SCIENCES RESEARCH COUNCIL

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Published by the Commonwealth Secretariat

Designed by Wayzgoose
Printed by the Printing Section, Commonwealth Secretariat

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Acknowledgements

The authors wish to thank Dr Jyotsna Jha from the Social Transformation Programmes Division of the Commonwealth Secretariat for initiating the idea of the workshop and the background paper. We also wish to acknowledge her support, comments on various drafts of the final paper and her contribution over the course of the initiative. Financial support was provided by the Commonwealth Secretariat and the Association for the Development of Education in Africa (ADEA). We also thank Mr Virgilio Juvane of ADEA for his support and contribution.

We wish to acknowledge the support and encouragement of Dr Olive Shisana, the President of the South African Human Sciences Research Council (HSRC) and HSRC sponsorship in the form of staff time, bags, gifts and the gala dinner. Nico Jacobs, Florence Phalatse and Boitumelo Molomo are thanked for administrative and logistical assistance.

Thanks to all the speakers who fulfilled their briefs, and without whose input the workshop would not have been so successful, and the country participants for responding so enthusiastically to requests and for participating in the workshop.

We have greatly benefited from the inputs and contribution of Professor M. Kelly from Zambia.

Abbreviations and Acronyms

ADEA	Association for the Development of Education in Africa
AIC	AIDS Information Centre
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-retrovirals
CBO	Community-based organisation
CCEM	Conference of Commonwealth Education Ministers
DHS	Demographic and Health Surveys
EDC	Education Development Centre
EFA	Education for All
EI	Education International
ELRC	Education Labour Relations Council
EMIS	Education Management Information Centre
FBO	Faith-based organisation
FTI	Fast Track Initiative
GCE	Global Campaign for Education
GEEI	Gender Equality in Education Index
GITA	Greater Involvement of Teachers living with AIDS
GRS	Global Readiness Survey
HIV	Human Immunodeficiency Virus
HR	Human Resources
HSRC	Human Sciences Research Council
IEC	Information, Education and Communication
IIEP	International Institute for Educational Planning
KENEPOTE	Kenya Network of Positive Teachers
LSE	Life Skills Education
MDGs	Millennium Development Goals
MOE	Ministry of Education
MTT	Mobile Task Team
NGO	Non-governmental organisation
OOSY	Out-of-school youth
OVC	Orphans and vulnerable children
PIASCY	Presidential Initiative on AIDS Strategy for Communication to Youth
PMTCT	Prevention of mother-to-child transmission
SACA	State Action Committee on AIDS (Nigeria)
SADC	Southern African Development Community
SADTU	South African Democratic Teachers' Union
STIs	Sexually Transmitted Infections
UNAIDS	United Nations Programme on AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UWI	University of West Indies
VCT	Voluntary counselling and testing
WHO	World Health Organisation

Executive Summary

Globally, the HIV and AIDS epidemic remains a major public health, social, economic and development challenge. The Commonwealth Heads of Government have reaffirmed their commitment to combating HIV and AIDS, malaria and other communicable diseases in recognition of the human devastation caused by HIV and AIDS and the threat it poses to sustainable development. In the Commonwealth Sierra Leone mid-term review of the 15th Conference of Commonwealth Education Ministers (CCEM) held in 2005, African education ministers expressed interest in learning about good practices regarding education sector responses to HIV and AIDS in Africa.

Education is one of the sectors worst affected by the pandemic. On the one hand, HIV and AIDS have affected educator supply because of the relatively high sero-prevalence found among teachers. On the other, it has made millions of children orphans, thereby increasing the responsibility of schools and teachers.

This document summarises the key issues regarding HIV and AIDS and the education sector and is based primarily on a review of published literature and the findings of the regional workshop organised by the Commonwealth Secretariat and the Association for the Development of Education in Africa (ADEA) from 12 to 14 September 2006 at the Airport Grand Hotel in Johannesburg, South Africa. The workshop was attended by 40 delegates, and its focus was on 'Good Practices in Education Sector Responses to HIV and AIDS in Africa'.

The main aim of the workshop was to provide a forum for the sharing, presentation and review of HIV and AIDS good practice education sector responses in Africa. Speakers included technical experts and government officials, and presentations varied from overall education sector responses to specific country and programme experiences.

Section 1 of this report briefly reviews HIV and AIDS and the need for an accelerated response. Sub-Saharan Africa remains the worst-affected region in the world, with the highest prevalence in Southern African (between 15–35%). Across the region, the rate of new HIV infections peaked in the late 1990s and some countries have shown declines, notably Kenya, Zimbabwe, Uganda and urban areas of Burkina Faso. Women have become the face of the epidemic in Africa, and around 59% of all adults living with HIV in sub-Saharan Africa are women. HIV and AIDS are directly affecting millions of children, adolescents and young people. There are many hopeful signs of progress in the fight against the epidemic and the Commonwealth Secretariat and ADEA focus on good practices and learning from experience has the potential to galvanise support and impress upon all that every action counts.

Section 2 focuses on HIV and AIDS and education sector responses. HIV and AIDS represent a direct threat to achieving the goal of 'Education for All'. The epidemic affects the supply and demand for primary and secondary schooling, especially in high HIV prevalence countries. At the same time, education remains one of the most effective interventions against the epidemic, leading to some describing education as a 'social vaccine against HIV and AIDS'. The Global Campaign for Education (GCE) has calculated that around 700,000 annual cases of HIV in young adults could be prevented if all children received a complete primary education and that the economic impact of HIV and AIDS could be greatly reduced. Therefore, countries face an urgent need to strengthen their education systems as a key strategy for escaping the grip of HIV and AIDS.

Good practice in the education sector must include strategies for HIV prevention and/or reduction, providing social support for affected educators and learners and protecting the sector's capacity to provide quality education provision. The kind of education needed in a world with HIV and AIDS must go beyond incorporating HIV and AIDS in the curriculum and move towards constructing a new system based on the four pillars of learning. These are learning to know, learning to do, learning to live together and learning to be.

Different strategies and programmes have been implemented in the education sector by international organisations and individual countries, although not all of these have been systematically documented. At national level, some countries have taken steps to address the impact of HIV and AIDS on the education sector and to adapt systems to respond to the epidemic. The Global Readiness Survey (GRS) found that all countries reported dedicated staff at the national Ministry of Education, progress with mainstreaming HIV and AIDS and progress with the development of education sector HIV and AIDS strategic plans and policies. However much more remains to be done.

Section 3 highlights the evidence on mass campaigns for HIV and AIDS prevention, education and advocacy. Mass media campaigns have been conducted in most sub-Saharan African countries, but many have not been formally evaluated. Evaluations of the mass campaigns have yielded mixed results, because of the diversity of interventions and populations studied. It is difficult to ascertain whether positive effects associated with the interventions are directly attributable to the interventions, as those who participate in interventions are sometimes self-selected and may differ in important ways from those who do not participate.

Section 4 summarises the evidence on girls, gender and education. Educating girls and women is critical in turning around the AIDS epidemic in Africa, leading to the assertion that education is key to building 'girl power'. Education also has intergenerational benefits, with more highly educated adults having a positive bearing on young women's condom use. More education also empowers boys and men to practise safer sex, thus reducing their own, and their partner's, risk of infection. Strategies for expanding girls' access to education are highlighted, and include the inclusion of gender and power dynamics in comprehensive sex health education; fostering gender equality; promoting positive role models and challenging negative gender stereotyping; expansion of the fast track initiative (FTI); and the removal of bottlenecks and macroeconomic constraints in order to expand access to primary and secondary schooling.

Section 5 focuses on HIV and AIDS education in schools. School-based programmes are important in reaching the great majority of children and young people, while also having an impact at community level. These programmes are able to influence attitudes and beliefs at an early stage of life. School programmes also have the benefits of equipping staff with teaching and learning tools. As teachers are often role models for their communities, schools may be the only place where adolescents can obtain accurate information on reproductive health. There are innovative school-based programmes in Commonwealth African countries, and these are highlighted.

In many countries, life skills programmes have been introduced within the education sector as part of the school curriculum. Life skills education (LSE) is a methodology that develops the ability of children and young people to reason, and helps them develop agency and social competence for action. However, implementation is not uniform across geographical areas and often depends on adequate resources and trained teachers.

Despite the importance and implementation of school-based programmes, there is a paucity of studies that evaluate them. In addition, variation in the content, duration and intensity of the interventions, together with differences in evaluation design and instruments, mean that it is difficult make comparisons across countries or even sub-regions. However, studies have demonstrated that school-based programmes have positive effects on knowledge, attitudes and communication about sexuality and sexual health.

Characteristics of effective curricula-based programmes are highlighted and include specific elements regarding the process, content and implementation of the curriculum.

Section 6 reviews programmes for out-of-school young people, as school-based programmes provide a partial response to the problem and do not reach out-of-school youth. A recent *World Development Report* suggests that developing countries which invest in better education, healthcare and job training for their young people between the ages of 12 and 24 years of age could produce surging economic growth and sharply reduced poverty. Most education sectors in Africa do not have special programmes designed for or targeted at out-of-school youth. This group is assumed to be covered by the health ministry, multi-media or non-governmental organisations (NGOs). Experiences shared by workshop participants on youth out-of-school initiatives are presented, as are the proposed World Health Organisation (WHO) and partners' 'Go' interventions that are proposed for widespread implementation.

Section 7 focuses on teachers who are infected or affected by HIV and AIDS. Teachers are central pillars of the education system, and their survival and well-being is essential for the sustainability of the system. However, HIV and AIDS have the potential to erode the gains made in education over the last few decades. Globally, teachers are confronted by the impact of HIV and AIDS. The challenges teachers face in sub-Saharan Africa include increasing workloads caused by absenteeism, sick leave and the deaths of colleagues, the need to take care of sick relatives and the provision of assistance to infected and affected pupils.

Most education ministries have paid less attention to teachers' programmes on HIV and AIDS. Most have policies, but do not have action plans or resources to implement them in supporting infected and affected educators. In many countries, programmes designed to give support and care to educators have just started or do not exist. Good practice examples are shared, as well as the leadership role played in some instances by teaching unions or special interest groups.

Section 8 briefly reviews community responses, care and support. The crisis of orphans and vulnerable children (OVC) will persist for decades, even with the expansion of prevention and treatment programmes. OVC are at higher risk of HIV infection, as they face numerous material, emotional and social problems.

Data from 20 sub-Saharan African countries show that children aged 10 to 14 years who have lost one or both parents are less likely to be in school than their non-orphaned peers: hence orphanhood has a negative impact on education. Female OVC are more at risk than boys. Comprehensive programmes in the ministries of education are only available in 29% of countries and school feeding seems to be the most frequent programme response to the problem of OVC.

Section 9 summarises the inputs, deliberations and discussions at the three-day workshop.

The conclusion highlights the overall key issues emerging from the review and workshop. There is increased recognition of the importance of HIV and AIDS in the education sector. At the same time, the sector has played an impor-

tant role in improving HIV-related knowledge, practices and attitudes, has contributed to reduced HIV prevalence rates and is an important source of support for orphans and affected children. Education sector policies and strategic plans have been compiled in most countries. NGOs have tended to take the lead in intersectoral programme implementation and trade unions have played an active role in the implementation of programmes for teachers.

There are many pockets of excellence in all countries, but implementation is not widespread. Implementation tends to be weak, with geographical disparity within countries; it is mostly focused on schoolchildren and is only just beginning to focus on teachers. There is less focus on other education sector staff and parents have largely been left out of the loop. There is limited knowledge about the impact of programmes on socio-cultural issues and country progress on programmes aimed at the girl-child is difficult to determine. There is inadequate focus and attention on the higher education and pre-school sectors, out-of-school youth and the monitoring and evaluation of programmes.

Effective life skills programmes are not implemented uniformly and condoms remain controversial despite evidence that they reduce risk. The review and workshop also highlighted the apparent numerous overlapping initiatives from international organisations.

The analysis shows that there is no scope for complacency and that programme implementation must be geared to achieve maximum impact. Much work still needs to be done, particularly in scaling up effective programmes, in caring for infected and affected teachers and in recognising the duality between the education sector and communities affected by the epidemic.

Recommendations emanating from the workshop represent the consensus view of delegates and are summarised below.

Teaching and Learning Materials

- ADEA and the Commonwealth Secretariat should facilitate and encourage the sharing of teaching and learning materials that already exist in different regions in Africa.
- Countries should be encouraged to learn from one another and be proactive in seeking or providing existing materials as well as learning about practices in Africa and elsewhere.

Approach to curriculum development

- The curriculum should be based on a broader country approach/framework which includes *inter alia* an emphasis on human rights, empowerment and sustainable development; social support, focusing on the most vulnerable groups; a protective and safe environment; and a teaching and learning environment for HIV and AIDS impact mitigation
- There is a need to recognise and draw on existing frameworks and/or initiatives, e.g. Decade of Education for Sustainable Development documents and other relevant materials.

Training of teachers

- Where relevant, countries should immediately review their teacher development programmes so as to incorporate life skills and HIV and AIDS, and commence training without delay.
- Every teacher should be competent in life skills and HIV and AIDS education by 2015.

- Life skills and HIV and AIDS must be integrated into the pre-service teacher development programmes.
- Implement comprehensive programmes of in-service training and support by 2010.
- Review and/or evaluate approaches to training of teachers.
- Ensure dissemination of information on good practices to all countries.
- Capacity building of all education sector staff.
- Countries are encouraged to draw on existing good practices, e.g teachers caring for teachers and support groups such as the South African teaching unions and the Kenya Network of Positive Teachers (KENEPOTE).
- Advocacy and lobbying: trade unions and organisations representing teachers' interests (e.g. those living with HIV) need to be part of all strategic planning, meetings and implementation.
- ADEA is encouraged to share its research expertise and make it available and accessible to all levels of the education sector.
- Support for teachers to reach Education for All goals by 2015.

Role of education sector with regard to young people out of school

- It is important for the education sector to identify vulnerable young people before they 'drop out' and to take remedial steps.
- There must be improved collaboration and/or coordination of the Ministry of Education and relevant ministries and other organisations or partners that deal with youth programmes (e.g. youth and health).
- Work with partners/stakeholders in the identification and re-integration of out-of-school young people.
- Provide approaches which include content and methodology for out-of-school young people to improve information, skills and access to services.

Community responses and orphans and vulnerable children

- There is a need to advocate for increased public sector funding for OVC.
- Sensitisation and involvement of parents, communities and teachers.
- The use of existing mechanisms to lobby and intensify advocacy for in-country public (ministries) and civil society (including private sector) co-operation and co-ordination, so that there is improved protection, access and retention of OVC in the education system.

General recommendations relate to monitoring and evaluation, and to sustainability and other education sector issues that need to be taken forward. The latter include conditions of employment and appropriate incentives both for training and working in rural areas; pre-school, higher education and other education sector staff HIV and AIDS initiatives; addressing stigma and discrimination; and improved coordination and collaboration across ministries with community-based organisations (CBOs), non-governmental organisations (NGOs) and faith-based organisations (FBOs).

Introduction

Globally, the HIV and AIDS epidemic remains a major public health, social, economic and development challenge. Sub-Saharan Africa continues to be disproportionately affected (UNAIDS, 2006). HIV and AIDS threaten the achievement of key developmental goals, especially in Africa. These include the Dakar Framework for Action on Education for All; the Millennium Development Goals (MDGs) and the Declaration of Commitment of the United Nations General Assembly Special Session (UNGASS) on HIV and AIDS. With regard to the goal on 'Education for All', UNESCO estimates that 55 nations are unlikely to reach universal primary enrolment by 2015 and 28 of these countries are among the 45 most AIDS-affected countries (UNESCO, 2005a).

The 2006 UNAIDS Report shows that important progress has been made in national responses to the challenge of AIDS, including in leadership, increases in funding, HIV prevention and access to anti-retroviral treatment. However, AIDS remains an exceptional threat and a number of significant challenges remain. These include the need for improved planning, sustained leadership, scaling up prevention, care of orphaned and vulnerable children and treatment coverage, reliable long-term funding for the response to AIDS response and systems to implement plans, civil society involvement and, specifically, the involvement of people living with HIV (UNAIDS, 2006).

The Commonwealth Heads of Government reaffirmed their commitment to combating HIV and AIDS, malaria and other communicable diseases in recognition of the human devastation caused by HIV and AIDS and the threat to sustainable development. Many face particular difficulty in responding to HIV and AIDS and other major diseases, and in reaching the goal of universal access to prevention, treatment, care and support for those living with HIV and AIDS by 2010. They urged the Secretariat to continue to assist countries with prevention measures and strengthen all other sectors that contribute to the reduction of the spread of HIV and AIDS within their countries. In the Commonwealth Sierra Leone mid-term review of 15 CCEM in 2005, African education ministers expressed interest in learning about good practices regarding the education sector's response to HIV and AIDS in Africa. Furthermore, the Commonwealth Secretariat noted the importance of analysing successes and failures, or situations where they had been a lack of action, in order to draw key lessons for member states as well as for others in the region.

At the Sierra Leone mid-term review meeting, the ADEA Secretariat presented its strategy to support African Ministries of Education in addressing HIV and AIDS issues. The ADEA strategy emphasises the potential role of teachers and schools in mitigating the epidemic's impact on educational systems.

Education is one of the sectors worst affected by the pandemic. On the one hand, HIV and AIDS have affected educator supply because of the relatively high seroprevalence found among teachers (UNESCO, 2005a). On the other, it has made millions of children orphans, thereby increasing the responsibility of schools and teachers. Some Southern Africa countries are experiencing a reversal in educational attainment trends as a result of the epidemic. However, education remains one of the most effective approaches to prevent HIV transmission and to mitigate the impact of the epidemic. There is increasingly clear evidence that access to schools for children and adolescents ranks among the most cost-effective means of HIV prevention, as it assists in keeping them free of infection

and helps them to avoid risk (UNICEF, 2005). Early training also promotes healthy and protective lifestyles. Educational institutions branch out further into communities and reach more young people than any other government-supported institutions. Moreover, quality education influences not only the acquisition of knowledge but the development of constructive attitudes, skills and behaviours needed to develop appropriate personal and societal responses to the epidemic (Kelly, 2006; Coombe, 2003; Bennell, 2003; World Bank, 2002; UNESCO, 2005).

In order to promote the sharing of experiences and consolidate a report on good practices in education sector responses to HIV and AIDS in Africa, the Commonwealth Secretariat and the ADEA Working Group on the Teaching Profession organised a joint regional workshop in September 2006 through the South African Human Sciences Research Council (HSRC).

This paper summarises the key issues regarding HIV and AIDS and the education sector and is based primarily on a review of published literature and the regional workshop held on 12–14 September 2006. The document is not intended to provide a comprehensive overview or scientific analysis of all education sector experiences or activities. Rather, its aim is to draw on available knowledge and experience, to highlight lessons learned and to assist the Commonwealth Secretariat and ADEA in enhancing their policy and programming activities in the education sector.

It appears that there are many descriptive programmes and activities, but few examples of HIV and AIDS education programmes or initiatives that have been rigorously evaluated and point to clear evidence-based action or programmes. The document is divided into the following sections:

- HIV and AIDS and the need for an accelerated response
- HIV and AIDS and education sector responses
- Mass campaigns for HIV and AIDS prevention, education and advocacy
- Girls, gender and education
- Education in schools
- Out-of-school youth
- Teachers infected and affected and the role of teachers in impact mitigation
- Community responses, care and support
- Summary of workshop proceedings

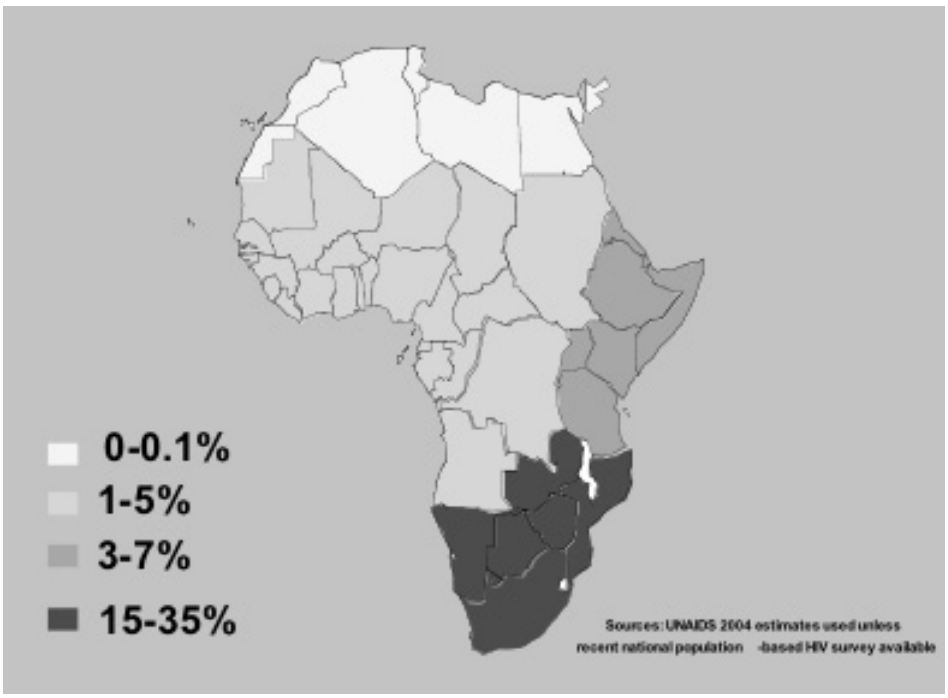
Each section begins with a brief background of key issues under consideration, followed by a summary and/or good practice highlights. Inputs from workshop speakers and participants have been incorporated in the various sections where they are relevant. A summary of the three-day workshop inputs, deliberations and conclusions are contained in Section 9. The recommendations emanating from the workshop are contained in the concluding section.

1 Overview of HIV and AIDS in Africa

Understanding the heterogeneity of HIV and AIDS

Understanding the heterogeneity of HIV is critical to developing appropriate strategies that are context specific (Wilson, 2006). Figure 1 shows HIV prevalence rates for different parts of Africa.

Figure 1. The heterogeneous nature of HIV in Africa



- Sub-Saharan Africa remains the worst-affected region in the world, with the highest prevalence in Southern African (between 15–35%). Across the region, rates of new HIV infections peaked in the late 1990s and some countries have shown declines, notably Kenya, Zimbabwe, Uganda and urban areas of Burkina Faso. HIV prevalence appears to be levelling off (i.e. the number of new infections is roughly matching the number of people who are dying of AIDS) but at very high levels in southern Africa (UNAIDS, 2006).
- At the end of 2005, 64% of all people living with HIV, or 24.5 million individuals, lived in sub-Saharan Africa.
- In 2005, an estimated 2.7 million people in the region became newly infected with HIV and 2 million adults and children died of AIDS.
- Women have become the face of the epidemic in Africa, and around 59% of all adults living with HIV in sub-Saharan Africa are women.
- HIV and AIDS are directly affecting millions of children, adolescents and young people. In 2005, the region was home to 2 million children under 15

years of age living with HIV. Almost 90% of the total number of children living with HIV live in sub-Saharan Africa and fewer than one in ten of these children are being reached by basic support services.

- The limited coverage and uptake of prevention of mother-to-child transmission (PMTCT) services means that many children born to HIV-infected mothers are infected with HIV around the time of birth. The majority of these children die before they have the opportunity to start school. The educational performance of those few children who are started on anti-retroviral treatment at an early age, and who survive long enough to enter the schooling system, is relatively poor due to absenteeism. Many children infected with HIV at birth die before reaching the age of 10 (UNICEF et al., 2002).
- Children under 15 account for one in seven new HIV infections globally and a young person aged 15–24 contracts HIV every 15 seconds (UNICEF, 2005).
- In sub-Saharan Africa, an estimated 8.6 million youth are living with HIV, of whom two-thirds are female. Economic, social and cultural factors contribute to sub-Saharan African youths' vulnerability to HIV and AIDS (UNAIDS, 2006).
- Children under 15 account for one in six AIDS-related deaths and a child under 15 dies of an AIDS-related illness every minute of every day (UNICEF, 2005).
- An estimated 12 million children under the age of 17 (just under 10% of children) living in sub-Saharan Africa have lost one or both parents to AIDS.
- Schools are becoming dysfunctional, losing their teachers due to illness and death. Even children who are spared a family bereavement often lose their teachers and classmates, their neighbours and role models to HIV and AIDS (UNICEF, 2005).
- In several sub-Saharan African countries, the HIV pandemic has dramatically reduced the number of teachers. According to UNAIDS estimates, in 2001 as many as 1 million children in sub-Saharan Africa lost their teachers to AIDS. This has secondary effects on youth, as the limited availability of teachers reduces access to education, particularly in rural areas, aggravating the cycle of low educational attainment and high rates of HIV infection among young people (UNAIDS/UNESCO, 2005).

Box 1. Hopeful signs

- HIV and AIDS remain a significant threat to development and there is no room for complacency.
- Progress has been made in country AIDS responses, and there is greater leadership, increases in funding and improvements in HIV prevention and access to anti-retroviral treatment.
- In April 2006 the United Nations, together with the African Union, declared a 'Year of Acceleration of HIV Prevention'.
- The Southern Africa region, through the Southern Africa Development Community (SADC) Secretariat organised an 'Expert Think-Tank Meeting' on HIV prevention in May 2006.
- Commonwealth education ministries requested practical examples of best practices in education sector responses to HIV and AIDS.
- The 2006 Toronto international AIDS conference highlighted the need for accelerated delivery and action.
- The Commonwealth Secretariat and ADEA focus on good practices and learning from experience has potential to galvanise support and impress upon policy implementers that every action counts and that it cannot be business as usual.

2 HIV and AIDS and Education Sector Responses

Why focus on the education sector?

'Education is the most powerful weapon you can use to change the world' (Nelson Mandela, Global Campaign for Education (GCE), 2004), and 'is a basic instrument for eradicating poverty, constructing citizenship and improving people's ability to control their own futures' (Social Watch, n.d.). The GCE has calculated that around 700,000 annual cases of HIV in young adults could be prevented if all children received a complete primary education and that the economic impact of HIV and AIDS could be greatly reduced (GCE, 2004).

There is broad consensus on the actual and likely impacts of the epidemic on the education sector (Kelly, 2000; Coombe, 2003; Bennell, 2003). HIV and AIDS represent a direct threat to reaching the goal of 'Education for All', while lack of schooling contributes to the further spread of the epidemic (Education International, 2006). The 2002 UNAIDS interagency working group on 'AIDS, Schools and Education' notes that the attainment of the MDGs for education 'cannot be achieved without urgent attention to HIV/AIDS' (UNAIDS, 2002). Kelly has argued that HIV and AIDS have swamped education with a wide range of problems, while Coombe has warned about a collapse of education systems, unless there is both a comprehensive sector understanding and response (Coombe and Kelly, 2000).

HIV and AIDS are a systemic problem for the education sector and hence require a systemic response (Kelly, 2006). The epidemic affects the supply and demand for primary and secondary schooling, especially in countries where there is a high prevalence of HIV. On the supply side, infected teachers will eventually become chronically ill, with increased absenteeism, lower morale and productivity. Teacher deaths due to AIDS-related illnesses are projected to increase rapidly over the next 10 to 15 years (Cohen, 2002; Bennell, 2003). A study in Zimbabwe found that 19% of male teachers and almost 29% of female teachers were living with HIV.

A South African education sector study found a sero-prevalence of 12.7% among teachers and significant gender, racial and geographical differences (Shisana et al., 2005). The study also revealed that there were gaps in knowledge with regard to HIV transmission and that multiple and intergenerational sexual partnerships, low condom use, migration and mobility are key drivers of the epidemic in the South African education sector.

On the demand side, children orphaned or otherwise made vulnerable by AIDS may not attend school because they have to look after the household, care for younger siblings or because they cannot afford the fees (UNICEF, 2005). HIV and AIDS are significant obstacles to children achieving universal access to primary education by 2015, with a decline in school enrolment as one of the most visible effects of the epidemic (UNICEF, 2005).

HIV and AIDS weaken the quality of training and education mainly because trained teachers are lost, student–teacher contact is reduced with inexperienced and under-qualified teachers taking over before they are ready, and class sizes

increase. A teacher's illness or death is more devastating in rural areas where schools are dependent on only one or two teachers. In Kenya, Uganda, Swaziland, Zambia and Zimbabwe, the epidemic is expected to contribute significantly to future shortages of primary teachers. In Swaziland, for example, an additional 7000 teachers will need to be trained by 2020 to compensate for AIDS deaths (Whiteside et al., 2003). UNAIDS has estimated a net additional cost of US$1 billion per year as a result of the impact of AIDS, i.e. the loss and absenteeism of teachers and incentives to keep orphans and vulnerable children in school (UNAIDS, 2002).

Box 2. Overview of challenges and threats posed by the epidemic to the education sector

HIV and AIDS and the Classroom Environment

- Teachers and students under severe psychological and physical stress
- Interference of discriminatory practices in the teaching–learning processes
- Teachers ill-prepared to cope with rapidly changing learning and learners' conditions
- Access to and knowledge of coping mechanisms scarce and poorly focused and organised.

Impact on the School Environment

- Disruption in management of teaching personnel and overall organisation of schools due to death and absenteeism of teachers, discrimination and stigmatisation
- School managers (principals) ill-prepared to face new challenges, including pressure from communities regarding perceived insecure working conditions

Impact on Teachers

- Teacher absenteeism due to attending funerals, market days and/or moonlighting for extra income
- Teacher illness and death
  - in all countries, learning is adversely affected when a teacher dies.
  - in a few countries, even neighbouring schools are affected by deaths

Immediate Community Environment under HIV and AIDS

- Climate of suspicion straining relationships between schools and communities
- Integration of teachers in communities compromised
- School Management Committees, when they exist, are busy settling conflicts
- Parents and community leaders ill-informed about, and unprepared to cope with, HIV and AIDS

Source: H. Boukary, *HIV and AIDS in Africa: the education system and the need for an accelerated response*, presented at regional workshop, 12–14 September 2006.

Many children from AIDS-affected families drop out of school because of inability to afford school fees. Children who are infected with HIV are more likely to drop out of school. In addition, children who drop out of school, but who are not already infected with HIV, are more likely to become infected.

Although evidence about the connection between level of education and HIV prevalence is not straightforward, there is generally an inverse relationship between the level of education and the disease burden for most infectious diseases (Vandemoortele and Delamonica, 2000; Kelly, 2006). Education levels are strongly predictive of better knowledge, safer behaviour and reduced HIV infection rates; education has been described as 'the single most effective preventive weapon against HIV and AIDS' (UNAIDS, 2002; World Bank, 2002).

Education improves health outcomes, and educated people are generally healthier than those who are uneducated (Pritchett and Summers, 1995), even when they have similar incomes, because education:

- Equips people to understand, evaluate and apply facts;
- Increases the ability to acquire and use health-related information and services (World Bank, 1993; WHO, 2003);
- Gives greater bargaining power in household decisions and personal relationships. This is particularly important for women, as it often translates into increased allocation of household resources to child health, schooling and nutrition (Thomas, 1990; Herz and Sperling, 2005);
- Improves social status.

The Global Campaign for Education has argued that in countries with high or fast-growing epidemics, 'getting every child into school is essential to stop AIDS destroying the fragile stock of human capital on which poor people's livelihoods – and developing countries' economic futures – depend' (GCE, 2004). While universal primary education is not a substitute for expanded HIV and AIDS treatment and prevention, they are complementary and both are urgently necessary to win the fight against the disease (GCE, 2004).

In countries where school fees have been abolished, school drop-out rates have been reduced (Global Coalition on Women and AIDS, 2005; UNICEF, 2005). Eliminating school fees and providing children with access to basic education gives them better options for earning a living once they leave school. Keeping young people in school, particularly girls, dramatically lowers their vulnerability to HIV.

The longer children remain in school, the better their income earning potential and the greater their power to make decisions affecting their sexual lives. Higher educational levels are also correlated with delayed sexual debut, fewer sexual partners, and higher rates of condom use. In a recent analysis of eight sub-Saharan African countries, women with eight or more years of schooling were up to 87% less likely to have sex before the age of 18, compared to women with no schooling (Gupta and Mahy, 2003). A study among 15–18-year-old girls in Zimbabwe found that those enrolled in school were more than five times less likely to be HIV-positive than those who had dropped out (UNICEF, 2004). A study in Swaziland found that 30% of in-school youth were sexually active, compared to 70% of out-of-school youth, while studies in Zambia have found lower levels of HIV infection among better educated people (UNAIDS, 2004, Whiteside et al., 2003)

Surveys in Malawi, Uganda and Zambia have shown a strong link between

higher education and fewer sexual partners (Wambe et al., 2004). However, in sub-Saharan Africa many youth leave school before completing secondary school. Overall primary school enrolment is less than 60%, and only 20% of appropriately aged children are enrolled in secondary school. Education can help adolescents avoid HIV, but in many countries fewer than 20% of women aged 15–19 years old and fewer than 30% of men of this age have more than a primary school education (Alan Guttmacher Institute, 2004). Youth infected or affected by HIV frequently have their schooling disrupted (World Bank, 2003). Having limited schooling and marketable skills, many HIV-affected youth resort to transactional sex as a means of survival, placing them at high risk of becoming infected with HIV.

The education sector has a central role in the multisectoral response to HIV and AIDS in Africa (World Bank, 2002; Patel et al., 2003). It is regarded as a key defence against the spread of HIV, especially through the empowerment of young women and girls, its ability to reach children and young people, and its contribution to knowledge, attitudes, skills and behaviour. In an analysis of 32 Demographic and Health Surveys (DHS) conducted since the 1990s, it was found that nearly one in every two illiterate women is ignorant about basic HIV/AIDS, which is about five times higher than that for women with post-primary education. Compared to women with post-primary schooling, illiterate women are three times more likely to think that a healthy-looking person cannot be seropositive; four times more likely to believe that there is no way to avoid AIDS; and three times more likely to be unaware that the HIV virus can be transmitted from mother to child (Vandemoortele and Delamonica, 2000).

Box 3. Education as a determinant of health outcomes: the example of HIV and AIDS

- Education levels are strongly predictive of better knowledge, safer behaviour and, most importantly, reduced infection rates.
- Education has been described as a 'social vaccine' against HIV/AIDS.
- Young people's risk of contracting HIV in Uganda appears to halve when they have a complete primary school education, even without specific AIDS education.
- Schooling reduces HIV risk as it increases knowledge of the disease and is correlated with changes in sexual behaviour.
- Literate women are four times more likely to know the main ways to avoid AIDS.
- Better educated girls delay sexual activity longer and are more likely to require their partners to use condoms.
- Education also accelerates behaviour change among young men, making them more receptive to prevention messages.

Source: Adapted from People's Health Movement, *Global Health Watch: An Alternative World Health Report*, 2005

Despite the impact of the epidemic on the education sector, Kelly has noted that it is also important to acknowledge the achievements of the sector in the fight

against the epidemic. These achievements include improved HIV-related knowledge, practices and attitudes; contribution to reduced HIV prevalence rates and serving as a bastion of support for orphans and affected children. In addition, there is evidence that education levels related positively to constructive prevention practices and less stigmatising attitudes towards those who are HIV-positive (Kelly, 2006).

A study found that young people who lived in a household with a more educated adult were more likely to use condoms than those living with less educated adults (Hargreaves and Boler, 2006). Hence the education sector has, and will continue to have, inter-generational positive impacts on poverty and health (Kelly, 2006).

Countries face an urgent need, therefore, to strengthen their education systems as a key strategy for escaping the grip of HIV and AIDS itself (World Bank, 2002; UNESCO, 2005).

Box 4. Summary: the education sector and HIV and AIDS

- The epidemic affects the supply and demand for primary and secondary schooling, especially in high HIV prevalence countries
- HIV and AIDS represents a direct threat to reaching 'Education for All' and MDGs for education
- Lack of schooling contributes to the further spread of the epidemic
- Education remains one of the most effective approaches to prevent HIV transmission and to mitigate the impact of the epidemic
- Early training also promotes healthy and protective lifestyles
- Educational institutions branch out further into communities and reach more young people than any other government-supported institutions
- Keeping young people in school, particularly girls:
  - dramatically lowers HIV vulnerability
  - improves their income earning potential and choices regarding their sexual lives
  - correlates positively with delayed sexual debut, fewer sexual partners, and higher rates of condom use
- Education has inter-generational positive impacts on poverty and health
- Strong evidence to support the widespread implementation of effective school-based interventions to increase knowledge and reduce sexual risk behaviour
- Schooling restores structure, brings stability in chaos, and offers hope to orphans and vulnerable children

What has been done in the education sector in Commonwealth African countries regarding HIV and AIDS?

Good practice in the education sector must include strategies for HIV prevention and/or reduction; providing social support for affected educators and learners; and protecting the sector's capacity to provide quality education provision (Coombe, 2003; UNAIDS, 2005; UNESCO, 2005). Kelly has proposed that the

kind of education needed in a world with HIV and AIDS must go beyond incorporating HIV and AIDS in the curriculum and move towards constructing a new system based on the four pillars of learning: these are learning to know, to do, to live together and to be. This is illustrated in Figure 2 and summarised below.

Figure 2. The Four Pillars of Learning

Source: Kelly, 'Education and AIDS: Are We Too Optimistic?', paper presented to regional workshop, 12–14 September 2006.

- ***Learning to know:*** communicates comprehensive and accurate information about the disease
- ***Learning to do:*** fosters the acquisition of psychosocial, health, nutrition and other skills that improve ability to protect oneself against infection
- ***Learning to live together:*** promotes a caring, compassionate, rights-based, gender-sensitive, non-judgmental approach to every person
- ***Learning to be:*** supports the development of life-affirming attitudes, skills and value systems that help learners make responsible life choices, resist negative pressures and minimise harmful behaviours

Different strategies and programmes have been implemented in the education sector by international organisations and individual countries, although not all of these have been systematically documented. At national level, some countries have taken steps to address the impact of HIV and AIDS on the education sector and to adapt systems to respond to the epidemic (UNESCO, 2006). Table 1 shows the results of the Global Readiness Survey on selected high level indicators for Commonwealth countries in Africa (UNAIDS, 2006; UNESCO, 2006), while Figures 3–5 present learning experiences from Zambia, Nigeria and South Africa.

Table 1. Selected educator sector results from the Global Readiness Survey for Commonwealth African countries, 2004

Country	Education system	MOE structures	Enabling environment	HIV and AIDS mainstreaming
1. Botswana	■ Single education ministry ○ No comment on total enrolment	✗ No dedicated committee or management unit responsible for co-ordination ✓ Dedicated staff for HIV/AIDS at the national MOE ✓ Regional structures for implementation	✓ Admissions and fees regulations for schools and other educational institutions ✓ Specific HIV/AIDS policy ✓ HIV/AIDS workplace policy ✗ Review of other rules and regulations to manage HIV and AIDS impact/implications	✓ Education sector HIV/AIDS strategic plan ✓ HIV/AIDS in district level plans
2. Ghana	■ Single education ministry ■ Growing total enrolment responsible for	✓ Dedicated committee or management unit schools and other co-ordination ✓ Dedicated staff for HIV/AIDS at the national MOE ✓ Regional structures for implementation	✓ Admissions and fees regulations for educational institutions ✢ Specific HIV/AIDS policy ✓ HIV/AIDS workplace policy ○ Review of other rules and regulations to manage HIV and AIDS impact/implications	✓ Education sector HIV/AIDS strategic plan ✓ HIV/AIDS in district level plans
3. Kenya	■ Single education ministry ■ Growing total enrolment	✓ Dedicated committee or management unit responsible for co-ordination ✓ Dedicated staff for HIV/AIDS at the national MOE ✓ Regional structures for implementation	✓ Admissions and fees regulations for schools and other educational institutions ✓ Specific HIV/AIDS policy ✓ HIV/AIDS workplace policy ✓ Review of other rules and regulations to manage HIV and AIDS impact/implications	✓ Education sector HIV/AIDS strategic plan ✓ HIV/AIDS in district level plans
4. Lesotho	■ Single education ministry ■ Growing total enrolment	✓ Dedicated committee or management unit responsible for co-ordination ✓ Dedicated staff for HIV/AIDS at the national MOE ✗ Regional structures for implementation	✗ Regulations for schools and other educational institutions in terms of admissions and fees ✢ Specific HIV/AIDS policy ✢ HIV/AIDS workplace policy ○ Review of other rules and regulations to manage HIV and AIDS impact/implications	✓ Education sector HIV/AIDS strategic plan ✓ HIV/AIDS considered in district level plans
5. Malawi	■ Single education ministry ■ Stable total enrolment	✓ Dedicated committee or management unit responsible for co-ordination ✓ Dedicated staff for HIV/AIDS at the national MOE ✓ Regional structures for implementation	✓ Admissions and fees regulations for schools and other educational institutions ✢ Specific HIV/AIDS policy ✢ HIV/AIDS workplace policy ✓ Review of other rules and regulations to manage HIV and AIDS impact/ implications	✓ Education sector HIV/AIDS strategic plan ✗ HIV/AIDS in district level plans

Table 1 (continued)

Country	Education system	MOE structures	Enabling environment	HIV and AIDS mainstreaming
6. Mozambique	■ Two education ministries ■ Growing total enrolment	✓ Dedicated committee or management unit responsible for co-ordination ✓ Dedicated staff for HIV/AIDS at the national MOE ✓ Regional structures for implementation	✓ Regulations for schools and other educational institutions in terms of admissions and fees ✢ Specific HIV/AIDS policy ✢ HIV/AIDS workplace policy ✢ Review of other rules and regulations to manage HIV and AIDS impact/implications	✓ Education sector HIV/AIDS strategic plan ✗ HIV/AIDS considered in district level plans
7. Namibia	■ Two education ministries ■ Growing total enrolment	✓ Dedicated committee or management unit responsible for co-ordination ✓ Dedicated staff for HIV/AIDS at the national MOE ✓ Regional structures for implementation	✓ Admissions and fees regulations for schools and other educational institutions ✓ Specific HIV/AIDS policy ✓ Workplace policy relating to HIV/AIDS ✗ Review of other rules and regulations to manage HIV and AIDS impact/implications	✓ Education sector HIV/AIDS strategic plan ✓ HIV/AIDS considered in district level plans
8. Nigeria	■ Single education ministry ■ Growing total enrolment	✓ Dedicated committee or management unit responsible for co-ordination ✓ Dedicated staff for HIV/AIDS at the national MOE ✓ Regional structures for implementation	✓ Admissions and fees regulations for schools and other educational institutions ✢ Specific HIV/AIDS policy ✗ HIV/AIDS workplace policy ✗ Review of other rules and regulations to manage HIV and AIDS impact/implications	✓ Education sector HIV/AIDS strategic plan ✓ HIV/AIDS considered in district level plans
9. Sierra Leone	■ Single education ministry ■ Growing total enrolment	✓ Dedicated committee or management unit responsible for co-ordination ✓ Dedicated staff for HIV/AIDS at the national MOE ✗ Regional structures for implementation	✓ Admissions and fees regulations for schools and other educational institutions ✢ Specific HIV/AIDS policy ✗ HIV/AIDS workplace policy ✗ Review of other rules and regulations to manage HIV and AIDS impact/implications	✗ Education sector HIV/AIDS strategic plan ✓ HIV/AIDS considered in district level plans
10. South Africa	■ Single education ministry ■ Shrinking total enrolment	✓ Dedicated committee or management unit responsible for co-ordination ✓ Dedicated staff for HIV/AIDS at the national MOE ✓ Regional structures for implementation	✓ Regulations for schools and other educational institutions in terms of admissions and fees ✓ Specific HIV/AIDS policy ✓ HIV/AIDS workplace policy ✓ Review of other rules and regulations to manage HIV and AIDS impact/implications	✓ Education sector HIV/AIDS strategic plan ✓ HIV/AIDS considered in district level plans

Table 1 (continued)

Country	Education system	MOE structures	Enabling environment	HIV and AIDS mainstreaming
11. Swaziland	■ Single education ministry ■ Shrinking total enrolment	✓ Dedicated committee or management unit responsible for co-ordination ✓ Dedicated staff for HIV/AIDS at the national MOE ✓ Regional structures for implementation	✓ Regulations for schools and other educational institutions in terms of admissions and fees ✢ Specific HIV/AIDS policy ✢ HIV/AIDS workplace policy ✓ Review of other rules and regulations to manage HIV and AIDS impact/implications	✗ Education sector HIV/AIDS strategic plan ✗ HIV/AIDS considered in district level plans
12. Uganda	■ Single education ministry ■ Growing total enrolment	✓ Dedicated committee or management unit responsible for co-ordination ✓ Dedicated staff for HIV/AIDS at the national MOE ✓ Regional structures for implementation	✓ Regulations for schools and other educational institutions (e.g. admissions and fees) ✢ Specific HIV/AIDS policy ✢ HIV/AIDS workplace policy ✓ Review of other rules and regulations to manage HIV and AIDS impact/implications	✓ Education sector HIV/AIDS strategic plan ✓ HIV/AIDS considered in district level plans
13. United Republic of Tanzania	■ Two education ministries ■ Growing total enrolment	✓ Dedicated committee or management unit responsible for co-ordination ✓ Dedicated staff for HIV/AIDS at the national MOE ✓ Regional structures for implementation	✓ Admissions and fees regulations for schools and other educational institutions ✗ Specific HIV/AIDS policy ✗ HIV/AIDS workplace policy ✗ Review of other rules and regulations to manage HIV and AIDS impact/implications	✓ Education sector HIV/AIDS strategic plan ✓ HIV/AIDS considered in district level plans
14. Zambia	■ Single education ministry ■ Growing total enrolment	✓ Dedicated committee or management unit responsible for co-ordination ✓ Dedicated staff for HIV/AIDS at the national MOE ✓ Regional structures for implementation	○ Regulations for schools and other educational institutions in terms of admissions and fees ✢ Specific HIV/AIDS policy ✢ HIV/AIDS workplace policy ✓ Review of other rules and regulations to manage HIV and AIDS impact/implications	✓ Education sector HIV/AIDS strategic plan ✓ HIV/AIDS considered in district level plans

Source: Information in table extracted and adapted from UNAIDS Inter-agency Task team on Education, *Report on the education sector: Global HIV/AIDS readiness survey*, 2004. http://www.unesco.org

Key:

■ Statement of fact
✓ Yes/true response
✗ No/false response
✢ In process
○ No comment provided

Box 5. Summary of selected findings of the GRS

The GRS contains self-reported information on 14 of the 17 Commonwealth African countries (82%). As can be seen from the table:

- All countries reported having dedicated staff at the national ministry of education; dedicated committees or management units are in place in more than 90% of countries.
- Reported progress with mainstreaming of HIV and AIDS: 86% of countries indicated that they have an education sector HIV and AIDS strategic plan, and 78% indicated that they consider HIV and AIDS in district level plans;
- With regard to an enabling environment, 86% of countries have regulations in place for schools and other educational institutions in terms of admissions and fees. However, less than one third (29%) have a specific HIV and AIDS policy and only 36% have a workplace policy in place. Country responses indicated that 64% and 50% are in the process of developing specific HIV and AIDS and workplace policies, respectively.

Figure 3. Learning from Zambia

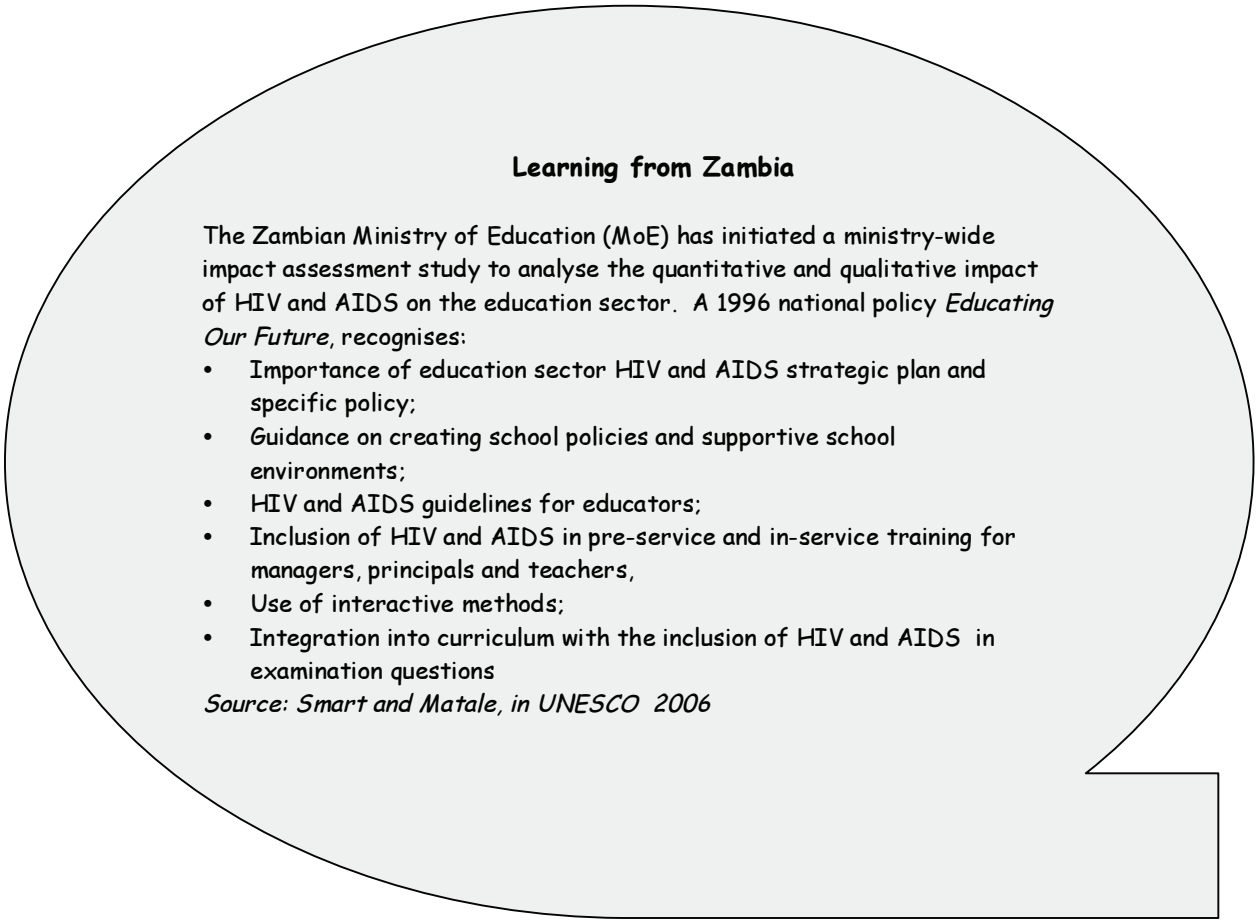


Figure 4. Learning from South Africa

Learning from South Africa

HIV and AIDS education sector strategic plan and policy in place and HIV and AIDS considered in district level plans.

The SA MOE hosted a workshop in July 2006 to review its HIV and AIDS and other health related programmes. It also wanted to get additional inputs on its draft framework for synergising "education, health and social development systems to promote *Health and Wellness*.

Challenges highlighted included: inadequate school health services, especially those in resource constrained settings, inadequate capacity to implement programmes, unacceptable levels of violence and insufficient involvement of stakeholders.

The revised framework intends to incorporate:

- Education for All (EFA) goals, Millennium Development Goal (MDG) and principles for Health Promoting Schools
- Dedicated and targeted interventions for special groups e.g. disabled pupils
- Improved monitoring and evaluation
- Inclusion of strategic partners e.g. teachers' unions, school governing bodies and the school community

Source: Information obtained at MOE workshop held in Kopanong, July 2006

Figure 5. Learning from Nigeria

Learning from Nigeria

- All states participated in the development of the National HIV and AIDS policy
- Prevention activities implemented includes sensitisation among staff and learners, awareness, anti-AIDS clubs in schools, peer education, school-based curriculum, guidance counsellors, written materials and teacher training on HIV and AIDS.
- One state has integrated HIV and AIDS into subjects like biology, integrated science and social studies.
- Access to education of orphans and vulnerable children requires attention as not much is being done

Challenges in the education sector implementation of HIV and AIDS activities include:-

- Inadequate funding (provided by the state government)
- Ministries of education do not know how to access funds from State Action Committee on AIDS (SACA)
- The non-inclusion of the HIV and AIDS desk officer into SACA
- Poor networking within the sector and between States
- Lack of incentives for staff of the education ministry to implement HIV and AIDS activities.

Reference: Federal Agencies (2005) ***Workshop document on Accelerating Education sector's response to HIV/AIDS in Nigeria*** *12 – 18th June 2005, Niepa Onondo, Nigeria*

3 Mass Campaigns for HIV and AIDS Prevention, Education and Advocacy

'Intensify and accelerate what works, and innovate to find effective ways to address the HIV problem within the education sector.' Z. Akiwumi, 2006

In 2005 African health ministers declared 2006 the 'Year for Accelerating Access to HIV Prevention'. In 2006 African leaders endorsed the *Brazzaville Commitment on Scaling up Towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Support by 2010*. In May 2006 the Southern Africa Development Community (SADC) Secretariat and UNAIDS organised an expert think-tank meeting on HIV prevention. Priority focus areas for HIV prevention identified include promotion of improved health-seeking behaviour and adoption of safe sex practices, especially by working with schools, trade unions, the trucking industry and migrants; the development of a multisectoral response within government and civil society; and improving access to male and female condoms, especially for 15–25-year-olds. Other important components of an HIV prevention strategy include management of sexually-transmitted infections (STIs), reduction of mother-to-child transmission, blood safety, post-exposure services and voluntary counselling and testing.

This section will comment on mass media approaches to HIV prevention among youth. A recent systematic review examined the effectiveness of mass media interventions from developing countries on changing HIV-related knowledge, attitudes and behaviours (Bertrand et al., 2006). Of the mass media interventions reviewed, published during the years 1990–2004, 12 were from countries in sub-Saharan Africa. Forms of intervention included TV campaigns, radio campaigns, educational theatre, educational comic books, one-on-one and small group information sessions, education and communication (IEC) campaigns, and the use of educational brochures, posters and billboards. Most of these campaigns targeted the general public or whole communities, and only a limited number focused exclusively on youth. These interventions and their evaluations are summarised in Table 2. The table also includes some mass campaigns that were not included in the systematic review.

Multimedia campaigns have the potential to influence positively knowledge, attitudes, self-efficacy, and to promote safer sexual behaviour. Most of the forms of educational entertainment (or 'edutainment') reviewed, including television, radio, drama, and comics were reported to be enjoyable and well received by the target audiences.

Television campaigns have had variable effects in different settings. It is difficult to evaluate the impact of the television component when it was part of a multimedia campaign. In Côte d'Ivoire exposure to a television campaign appeared to increase condom use (Shapiro et al., 2003), but among truck drivers in Burkina Faso, no such increase was observed (Tambashe et al., 2003).

Radio campaigns were associated with positive impacts on risk perception, self-efficacy, interpersonal communication and safer sexual behaviour in Tanzania (Vaughan et al., 2000), but did not appear to have much impact in Zambia (Yoder et al., 1996).

Box 6. Summary of mass campaigns and HIV and AIDS

- Mass media campaigns have been conducted in most sub-Saharan African countries, but many have not been formally evaluated.
- Knowledge of which mass media approaches work best for HIV prevention among youth is very limited.
- Evaluations of the mass campaigns have yielded mixed results, because of the diversity of the interventions and populations studied.
- It is difficult to ascertain whether positive effects associated with the interventions are directly attributable to the interventions, as those who participate in interventions are sometimes self-selected and may differ in important ways from those who do not participate.
- Other limitations of available evaluations of mass campaigns include a lack of information on the cost-effectiveness of different approaches and on the sustainability of positive intervention effects over time.

Educational drama has been associated with increased knowledge and risk perception (Skinner et al., 1991), and increased using of HIV testing and counselling services (Middelkoop et al., 2006) in two separate interventions in Cape Town, South Africa.

Educational comic books have been shown to be popular among youth in Gabon (Milleliri et al., 1999) and South Africa (Everett and Schaay, 1994), and have been shown to increase knowledge about HIV and AIDS and risk perception, but the impact of this medium on sexual risk behaviour has not been evaluated.

Sports campaigns have not been thoroughly evaluated, but are a potentially useful method of providing information about HIV and AIDS, and promoting safer behaviour among youth (CARE Lesotho, 1995).

Table 2. Summary of selected mass campaigns in African countries and their impact on HIV risk

Country, population Target group References	Description of interventions	Reach	Respondents and main results
Multimedia mass campaigns			
South Africa Students in Grades 8–12 Peltzer and Promtussananon, 2003	Intervention components included Soul City TV and radio programmes, health education booklets distributed in newspapers, and a national life skills programme for school children in Grades 8–12. TV programmes included a weekly drama for adults on health issues that provided basic information about HIV, and 'Soul buddyz', a children's programme.	>1/3 students exposed to Soul City media sources >10 times; 2/3 exposed >6 times. TV exposure higher in urban areas; radio exposure higher in rural areas.	Evaluated among 3150 high school students (mean age: 15.8 years, 56% female) Exposure to the Soul City life skills programme was associated with increased HIV knowledge, increased knowledge of condoms, increased HIV risk perception, delaying sex, and (among those who were already sexually active) condom use at last sex. Exposure was also associated with greater self-efficacy and more favourable attitudes towards PLWHAs.
South Africa Rural youth aged 15–24 years Peltzer and Philip, 2004	Intervention components included the Soul City radio, TV and life skills programme; community AIDS awareness forums; condom demonstration and distribution by peer educators; support groups for PLWHAs; and social care programmes.	Not reported	Evaluated among a representative community sample of rural youth aged 15–24 years. 421 participated at baseline and 416 participated in the follow-up evaluation 15 months later (mean age: 20.8 years, 55% female). Results showed a reduction in the number of sexual partners over a period of 15 months. Attitudes towards PLWHAs improved due to mass media and to a lesser extent through community interventions. Peer educators had an impact on HIV/AIDS knowledge, attitudes towards PLWHAs, exposure to magazine articles on HIV prevention, and exposure to radio messages on consistent condom use. In this sample of youth a reduction in the number of sexual partners seem to be more feasible than consistent condom use.
5 pilot sites in Zimbabwe Youth aged 10–24 years Kim et al., 2001	Six-month multimedia campaign targeting youth in five pilot sites. The campaign included posters, leaflets, newsletters, a radio programme, launch events, dramas, peer educators, a hotline, training family planning providers in clinics to be youth friendly, and the designation of youth friendly clinics. The radio programme consisted of weekly episodes of a 1-hour variety show, broadcast over 26 weeks. The drama component consisted of daily performances by theatre troupes for two months.	97% reported exposure to at least one campaign component; 61% to >3 components. Exposure to individual campaign components: posters: 92%, launch events: 87%, leaflets: 70%, dramas: 46%, hotline: 7%.	Evaluated among 1000 respondents from intervention communities and 400 from control communities. Respondents were aged 10–24 years and about 50% were female. Awareness of contraceptive methods increased in campaign areas, but general health knowledge changed little. As a result of the campaign, 80% of respondents had discussions about reproductive health. Young people in campaign areas were 2.5 times as likely as those in comparison sites to report saying no to sex, 4.7 times as likely to visit a health centre and 14.0 times as likely to visit a youth centre. Contraceptive use at last sex rose from 56% to 67% in campaign areas.
South Africa, Youth aged 15–24 years Pettifor, 2005	Exposure to national HIV prevention programmes was measured as part of a national survey of youth.	34% of respondents had participated in at least one loveLife programme.	1194 15–24 year olds. Youth who had participated in at least one loveLife programme were less likely to be infected with HIV (adjusted odds ratio 0.60 for women and 0.61 for men). However the researchers caution that the lower prevalence of HIV infection may not be attributable to participating in the loveLife programme.

Table 2 (continued)

Country, population Target group References	Description of interventions	Reach	Respondents and main results
Multimedia mass campaigns (continued)			
Burkina Faso Truck drivers along trucking routes in West Africa Tambashe et al., 2003	'Roulez Protégé', a mass media campaign targeting truck drivers along West African trucking routes. The intervention included use of television, radio, billboards, and group discussions.	Exposure among truck drivers reported to be 'high' .	Exposure to radio spots and group discussions was associated with increased discussion of AIDS among peers and with greater self-reported intention to use condoms in the future. Exposure to TV spots and billboards was not associated with increased discussion of AIDS or with greater intention to use condoms.
Television			
Côte d'Ivoire General population in three regions Shapiro et al., 2003	'SIDA dans la Cité' ('AIDS in the City'), a weekly television soap opera about AIDS. The intervention was designed to promote condom use and safer sexual behaviour.	65% of respondents had seen at least one episode, and 27% of male and 41% of female respondents had seen at least 10 episodes	Evaluation among 2150 respondents aged 15–49 years. TV series appealed to individuals with high risk behaviour. Exposure to 10 or more episodes was associated with a higher frequency of condom use at last sex, particularly among men.
Radio			
Tanzania General population Vaughan et al., 2000	Entertainment-education radio soap opera 'Twende na Wakati' ('Let's go with the Times'), broadcast twice a week for 30 minutes over a 6-year period. The radio programme emphasised four key themes: (i) STD treatment; (ii) condom use; (iii) AIDS is incurable and is transmitted through sexual contact; and (iv) dispelling false information about AIDS.	In 1994, 47% reported exposure. In 1997 reported exposure had increased to 58%.	Evaluated among 1940 in the intervention arm and 861 in the control arm. The age and sex of respondents was not reported. Exposure to the radio programme was associated with having fewer sexual partners among both men and women and increased condom use. The radio programme also appeared to increase self-perception of risk of contracting HIV; enhance self-efficacy for HIV prevention; and increase interpersonal communication about HIV and AIDS.
Northern Zambia General population Yoder et al., 1996	A 10-episode radio drama, performed in Bemba, broadcast weekly over a 9-month time period. Each episode lasted 30 minutes. The drama portrayed two families in Lusaka and their friends as they responded to the problems of rearing teenage children, maintaining friendships, making ends meet, having sexual relations, and learning about AIDS.	45% of respondents had listened to an episode but <1/3 were regular listeners.	Follow-up evaluation among 1682 respondents, mean age 25.9 years, about 50% female. Knowledge about HIV and AIDS increased substantially, and there was some reduction in risky behaviour, but these changes could not be attributed to the intervention.
Drama and theatre			
Cape Town, South Africa General population Skinner et al., 2001	'Puppets Against AIDS', a 20-minute educational street theatre performance, followed by a question and answer session to provide information about HIV and AIDS. The performance medium was inspired by the puppetry tradition of the Bambara, Bozo, and Yoruba cultures. The performance was designed to provide basic factual information about HIV, including modes of transmission and methods of prevention; to dispel misconceptions about HIV and AIDS; and to promote acceptance of PLWHAs.	Not reported. This intervention was carried out in communities throughout South Africa, and in other African countries, including Zimbabwe and Kenya, but the evaluation focused on people who had attended a performance in Cape Town during a 3-week period.	208 individuals who had attended a performance, median age 24 years, 53% female. Attending the show had a positive short-term impact on knowledge about HIV and AIDS and modes of transmission, risk perception, and knowledge of protective behaviour. Impact on behaviour not evaluated.

Table 2 (continued)

Country, population Target group References	Description of interventions	Reach	Respondents and main results
Drama and theatre (continued)			
Western Cape, South Africa A peri-urban community near Cape Town Middelkoop et al., 2006	A structured community-based education programme based on drama. The programme was designed to increase the use of HIV testing and counselling services. Young adults from the community received training in HIV/AIDS and drama and developed sketches addressing perceived barriers to VCT. 80 performances were held over 12 months.	Not reported	In the 12 months following the initiation of the intervention, there was a marked increase in the use of VCT services in the intervention community. The use of VCT services remained stable in two control communities.
Comic books			
Libreville and Lambarene, Gabon High school students Milleliri et al., 1999	High school students received a 15-minute classroom presentation on AIDS from a doctor followed by a question and answer session. They were an educational comic book about condom use to take home and read on their own.	728 of 964 students given the comic book reported having read it by the time of the follow-up evaluation 15–30 days later. The mean number of readers reported per comic book distributed was 7.5!	Evaluated among 771 students in 11 high schools, mean age 19 years, 55% male. Knowledge of modes of HIV transmission and the role of condoms as a method of prevention increased substantially.
South African youth Church groups, students, youth groups, civic associations, street children and out-of-school youth Everett and Schaay, 1994	A photo comic 'Roxy: Life, Love and Sex in the Nineties' designed to enhance awareness of the risk of HIV transmission through unsafe sex. The comic included condom use instructions with illustrations.	30,000 copies of the comic book were distributed.	A qualitative evaluation though 8 focus group discussions with students. Participants identified with the characters and situations portrayed in the comic. Effect of the intervention on condom use and sexual behaviour not reported.
Mass campaigns promoted through sport			
Lesotho General population, especially high school students CARE Lesotho, 1995	'Footballers Against AIDS' campaign. Footballers were recruited to speak to youth, fans and the general community about HIV and AIDS. Information, education and communication materials distributed at league football matches designated as HIV/AIDS awareness matches. An educational football theme comic book was developed. Educational videos, football health camps, interschool sporting competitions and extension of the campaign to other sports planned.	Not reported.	Athletes who participated in conducting the campaign reported to have changed their sexual behaviour as a result of participating in the programme. Impact on youth not reported.

Table 2 (continued)

Country, population Target group References	Description of interventions	Reach	Respondents and main results
Other small media or local campaigns			
18 rural parishes in Masaka District, Uganda General population Quigley et al., 2004	Information was disseminated through large and small group meetings, drama, video shows and group or one-to-one discussions with community educators. Information leaflets were distributed at each of the activities. Social marketing of condoms and voluntary HIV counselling and testing services were implemented in all the intervention communities.	81% of individuals in the intervention communities, and 9% in the comparison communities reported attending at least one intervention activity in the past year .	First follow-up included 1677 individuals from intervention communities and 1687 from control communities. Second follow-up included 1567 individuals from intervention communities and 1695 from control communities. Median age 33 years, 56% female. Attending at least one intervention activity was associated with a lower incidence of HIV infection (adjusted rate ratio 0.41 in women and 0.66 in men, but reported behaviour change was similar among those who did and did not attend any intervention activities.
East Moyo, rural Uganda General population, including Sudanese refugees Schopper et al., 1995	A district-wide HIV prevention campaign, focusing on information, education and communication (IEC), and condom promotion. Production and distribution of an information pamphlet entitled 'AIDS: be informed and protected' in English and Madi. Community educators held information sessions about HIV prevention and care, targeting the general public and groups such as the military, police, and traditional healers. Each session included the distribution of pamphlets, as well as condom demonstration and distribution.	Of 1744 individuals surveyed, 60% had attended an information session and 42% had received a pamphlet about AIDS.	1744 individuals in the follow-up evaluation, age 15 to 49 years, 50% female. Knowledge about HIV prevention improved substantially. Participation in the intervention was associated with increased knowledge about condoms, and increased condom use with casual sexual partners, although overall condom use remained low (3%). 50% of condom users had experienced difficulty with obtaining condoms. The intervention also increased the proportion of people who reported that they would be willing to take care of a family member with AIDS (from 60% to 77%).
Ghana Members of the army and national police Anonymous, 1992	Condom promotion campaign launched with an AIDS Awareness Day followed by social marketing of condoms by means of posters, bumper stickers, T-shirts, press packs, key chains, a video, and comic books in local pidgin English. Condoms sold at an affordable price in barracks, army shops and canteens.	Not reported.	Condom sales rose from 500 a month to 6000 to 7000 a month in less than 1 year.
Choma District, Zambia Rural village population Trykker et al., 1992	Theatre performances; health talks by clinic staff and community workers; and distribution of pamphlets and posters. The campaign focused on providing information about the transmission of HIV, and on condom promotion and distribution. Health workers, teachers and traditional healers also attended seminars about HIV and AIDS.	The theatre group gave 55 performances to 13000 villagers. Rural health centre staff and community health workers gave 250 talks to 14000 villagers.	494 individuals participated in the follow-up evaluation, age range 15 to 69 years (median age 28 years, 57% female). Exposure to the intervention was associated with an improved knowledge of modes of transmission of HIV.

Table 2 (continued)

Country, population Target group References	Description of interventions	Reach	Respondents and main results
Other small media or local campaigns (continued)			
Cameroon One urban community and one rural community Babalola, 2001	A community mobilisation campaign carried out by a non-governmental organisation working with community groups. Two influential members of each community were trained in community mobilisation, and these mobilisers recruited and trained additional community members. The intervention aimed to promote knowledge and use of family planning services; improved knowledge and attitudes about HIV and STIs; and increased use of health services.	Not reported.	The intervention had a positive effect on knowledge and practice of family planning and knowledge and attitudes about HIV and STIs in the rural community, but was not demonstrated to have a beneficial effect in the urban community.

Figure 6. Soul City edutainment programme: learning from Southern Africa

The Soul City edutainment programme in Southern Africa

- Soul city is a multi-media "edutainment" strategy which has been running since 1992
- The programme is operating in 9 Southern African countries: Botswana, Malawi, Mozambique, Lesotho, South Africa, Swaziland, Namibia, Zambia, and Zimbabwe and is aimed at empowering communities, especially youth.
- In each country, the programme is context and culture specific
- Combines radio, television, newspapers and magazines to impart messages and advocates on healthy public policy
- Evaluation of Soul City for instance, found that more than 70% of respondents were exposed to their programme.
- Most memorable message was those dealing with HIV and AIDS, safe sex, smoking
- Knowledge about transmission of HIV increased significantly

Source: Soul City website: www.soulcity.org.za and presentation made at the regional workshop, 2006

4 Girls, Gender and Education

Increased feminisation of the epidemic

'The HIV and AIDS epidemic is layered upon existing forms of social oppression and inequalities based on gender, age, race and ethnicity, class, sexual orientation and ability/disability' R. Mohlahlane,2006

Globally, more than half of the adults who are HIV-positive are women. In sub-Saharan Africa, women account for close to 60% of adults and about 75% of youth infected with HIV. Gender power imbalances and inter-generational sex, together with biological factors, are important in placing women and girls at higher risk than men and boys (UNAIDS, 2005; UNICEF, 2005; Global Coalition on Women and AIDS, 2005).

In several sub-Saharan African countries, young women experience their sexual debut at a younger age than their male counterparts and their sexual partners tend to be older. Young girls who begin sexual activity at a young age are especially vulnerable to HIV. In some countries, young girls have rates of HIV infection up to six times higher than boys of the same age group (WHO, 2006), and it has been estimated that two-thirds of newly-infected young people aged 15–19 years old are female (World Bank, 2003). Studies in several sub-Saharan countries on age differences between girls aged 15–19 and their sexual partners have shown a gap of six or more years (Luke and Kurz, 2002). Relationships between young women and older men are characterised by a power imbalance, making it difficult for women to negotiate safe sex.

Box 7. Why are women and girls more vulnerable to HIV and AIDS?

Biological factors

- Physiology of the female genital tract
- Presence of sexually transmitted infections
- Mother-to-child transmission of HIV

Social factors

- Traditional gender norms, e.g. men have multiple sexual partners
- Female ignorance of sexuality
- Girls' and boys' upbringing linked in gender specific ways to emotional and sexual needs
- Females more likely to have first sexual experience at insistence of older, male partner, who is more likely to have been exposed to HIV
- Women and girls subjected to abusive male behaviours, e.g. sexual assault
- Women do not have power to insist on condom use
- Myths, e.g. having sex with virgin; traditional practices, e.g. female circumcision

Economic and political factors

- Women work the longest for the least economic returns
- Denied equal participation in policy making
- Denied equal access to resources
- Women and girls suffer most the consequences of migration and armed conflict
- Low status, many women sold into sex work, placing them at higher risk of contracting HIV and AIDS.

Source: UNICEF, *HIV/AIDS Education: A gender perspective: Tips and tools*, UNICEF, New York.

There is growing evidence that sexually transmitted infections, including HIV and violence risk, are linked to early socialisation that promotes certain gender roles as the norm. These norms include support for men having multiple female partners and maintaining control over the behaviour of their partners. Thus, addressing gender norms, the societal messages that dictate what is appropriate or expected behaviour for males and females, is increasingly recognised as a critical strategy in preventing the spread of HIV (Global Coalition on Women and AIDS, 2006).

Knowledge and information and access to services are the first lines of defence for young people in order to enable them to make correct decisions in risky situations. The percentage of girls who have access to information is very low, as a only a small proportion of girls complete primary schooling in sub-Saharan Africa. The average 16-year-old girl in Africa has less than three years of schooling (Emmett et al., 2006). Women living with HIV or AIDS often experience greater stigma and discrimination than men because of gender inequality.

HIV prevention campaigns often fail to address the increased vulnerability of young women because they fail to deal with women's lack of power to determine their sexual relations (Hargreaves and Boler, 2006). In a recent review, Hargreaves and Boler have shown that educating girls and women is critical in turning around the AIDS epidemic in Africa, leading to their assertion that education is key to building 'girl power'. There are also intergenerational benefits of education, with more highly educated adults having a positive bearing on young women's condom use. More education empowers boys and men to practise safer sex, thus reducing their own, and their partners', risk of infection.

Box 8. The impact of girls' education on HIV and sexual behaviour

Formal education can influence vulnerability to HIV in five different ways:

- It exposes girls to HIV and AIDS education, which helps prevent HIV.
- It provides psychosocial benefits for young women, helping them to build their self-esteem and capacity to act on HIV prevention messages.
- It leads to better economic prospects, which in turn lead to lifestyle changes that can influence HIV vulnerability.
- It can influence the level of power within sexual relationships.
- It affects the social and sexual networks of girls.

Source: J. Hargreaves and T. Boler (2006). *Girl power: the impact of girls' education.*

However, when using the Gender Equality in Education Index (GEEI), Commonwealth countries in Africa face a major challenge in scaling up from small good practice initiatives and in meeting the MDGs by 2015 (see Table 3). The GEEI standard of 95% implies that a country has achieved the goal on primary education for all children and the goal on women's empowerment (Unterhalter et al., 2005).

Table 3. Percentage increase in GEEI 1993–2003 in Commonwealth countries in Africa and percentage gain needed to reach a GEEI of 95% by 2015

Country	% increase in GEEI 1993–2003	% increase in GEEI needed 2005–2015 to reach GEEI of 95%
Botswana	7	22
Cameroon	−55	533
Ghana	15	144
Kenya	−28	265
Lesotho	14	126
Malawi	30	265
Mauritius	−9	17
Mozambique	0	375
Namibia	16	32
Nigeria	−23	375
South Africa	3	44
Swaziland	−11	58
Uganda	125	76
Tanzania	18	144
Zambia	−14	164

Source: E. Unterhalter et al. (2005). *Scaling up: Developing an approach on measuring progress on girls' education in Commonwealth countries in Africa.*

Using female teachers as a strategy to attract girls to primary schools has been found to be statistically significant in several studies (Kane, 2004). In Botswana, a consistently positive relationship was found to exist between schools with a higher proportion of female teachers and improvements in girls' achievement levels, without negative effects on boys (Kane, 2004). However, Africa has the lowest proportion of female teachers in the world. The 2004 *Global Readiness Survey* found that 13 out of 14 Commonwealth African countries reported that they cover gender content in the life-skills programme. Little information is available on the implementation and/or effectiveness of these programmes. Strategies are 'either poorly documented or they are reasonably documented, but don't tell us much about how girls have fared' (Kane, 2004). The 2004 report of the UN girls' education initiative concluded that political commitment, rights-based equity-oriented environment, partnerships, careful monitoring and evaluation, and intensified human and other resources are among the main ingredients for scaling up good practices in girls' education (Miske, 2005).

More recently, the role of men and boys in addressing gender inequality has been highlighted. This includes men's role in nurturing social structures that are more supportive to women, well designed activities that aim to change men's socialisation and men becoming a force in challenging and recasting harmful stereotypes of masculinity, confronting violence against women and taking responsibility for HIV prevention (Global Coalition on Women and AIDS, 2006).

Box 9 summarises strategies for expanding girls' access to education.

Figures 7 and 8 present additional information on apparent effective strategies regarding girls' education in Africa.

Box 9. Recommendations to expand 'girl power'

How to expand 'girl power'

- Use prevention messages to address gender and power dynamics within sexual relationships.
- Provide comprehensive sexual health education with a special focus on HIV and family planning.
- Foster gender equality, promote positive role models and challenge negative gender stereotyping.
- Show zero tolerance towards sexual violence and towards teachers having sexual relationships with students.
- Respond to the problem of teenage pregnancy and include policies on how to encourage teenage mothers to complete education.
- Abolish all forms of school fees in primary education.
- Expand of the Fast Track Initiative (FTI) – a pledge made by the international community to make sure that all countries have sufficient resources to provide basic education.
- Remove macroeconomic constraints that prevent governments from expanding their spending on education.
- Remove the bottlenecks between completion of primary school and access to secondary school, particularly for girls.

Source: J. Hargreaves and T. Boler (2006). *Girl power: the impact of girls' education on HIV and sexual behaviour*, ActionAid International, 2006.

Figure 7. Girls' education in Africa: strategies that work

Girls' education in Africa:
Strategies that work

- Education can protect girls from HIV
- Multi-sectoral interventions: programmes addressing HIV and AIDS, school and inter-Ministry interventions together with various delivery mechanisms e.g. mass media, peer-based learning, theatre for development and multiple strategies for addressing school participation
- Multiple interventions: Flexible package of interventions in response to changes e.g. increase in girls enrolment associated with new buildings, improvement in water supply and sanitation, more female teachers and girls scholarship programme
- Gender neutral interventions e.g. early childhood development and improved geographical access to schools
- Educational quality improvements e.g. programmes outside the formal school system, bilingual programmes, local/female teachers, single sex schools or classes
- Addressing costs e.g. reducing household costs of school attendance
- Community participation. In the Gambia, community exercises were used to help create a national girls education plan. In Uganda, Kenya, participatory poverty assessments have included education issues

Source: Kane, E. Girls' education in Africa: What do we know about strategies that work? Africa region: The World Bank, 2004.

Figure 8. SARA: A role model for girls as they face HIV and AIDS in Africa

SARA: A role model for girls as they face HIV and AIDS in Africa

SARA communication initiative (SCI) is a multi-media initiative, consisting of 7 comic books and 5 animated films with three categories of uses:

- A communication strategy to enhance individual behaviours or social change in the community on issues related to HIV and AIDS, girl child education and child rights protection
- A national model for girls' development and other child rights issues
- A strategic framework to encourage integrated communication planning.

SCI is a complementary regional project designed to support and reinforce ongoing and future programme activities supported by Unicef and its partners. It is an example of an entertainment education strategy in order to convey education messages.

The main findings of the pilot episode in Eastern and Southern Africa were that the story and objectives are well understood and that the story not only describes the situation of girls in Africa, but offers realistic solutions.

Source: Unicef and Johns Hopkins University. SARA: A role model for girls as they face HIV and AIDS in Africa: a review of the SARA communication initiative for its introduction in Ghana, 2001.

5 Education in Schools

School-based programmes are important in reaching the great majority of children and young people, while also having an impact at the community level. These programmes are able to influence attitudes and beliefs at early stage of life. School programmes also have the benefits of equipping staff with teaching and learning tools. As teachers are often role models for their communities, schools may be the only place where adolescents can obtain accurate information on reproductive health (World Bank, 2002). School based programmes also cover issues around health education, aimed at helping children develop the knowledge, attitudes, values, and skills–including interpersonal skills, critical and creative thinking, decision-making and self awareness – needed to make sound health-related decisions (UNICEF, UNESCO, 2006).

Table 4. A bird's eye view of innovative school-based programmes

Country	Summary
Botswana	• Youth adult partnership and *Telling the Story* in Botswana
	• *Talk Back* programme, a live television programme, screened every day from 12–1 pm.
The Gambia	• School-based peer education programme started in 2001 and evaluated in 2004
Kenya	• The Primary School for Better Health clubs have been running for five years and are donor funded, while the secondary schools health clubs are also donor funded and have been in existence for two years.
Namibia	• *Window of Hope* programme started in 1998 for children between 9–14 years of age.
	• 'My future is my choice' designed for youth 15 years and older. Both these programmes were evaluated in 2003.
Swaziland	• Health clubs were started in 1999 in primary and secondary schools and are headed by teachers. The schools assist in peer education of out-of-school youth. Psychosocial programmes provided with assistance of health clubs.
Zambia	• Student partnership worldwide, running for four years and evaluated in 2005.

Source: Information provided by participants at September 2006 regional workshop.

In many countries, life skills programmes have been introduced within the education sector as part of the school curriculum. Life skills education involves interpersonal and psychosocial skills such as communication, assertiveness, negotiation, values analysis and clarification. LSE is a 'methodology that develops the ability of children and young people to reason, and helps them develop agency and social competence in order to act. It can be applied to a number of challenges facing children and young people, such as HIV and AIDS, but also issues of gender, violence and human rights (Hoffman, 2006).

Children and adolescents were more likely to abstain and delay first sex because of exposure to life skill programmes (Hubley, 2000) However, implementation is not uniform across geographical areas and depends on there being adequate resources and trained teachers. An evaluation of the South African Ministry of Education life-skills programme on HIV and AIDS prevention in KwaZulu-Natal province found a significant increase in student knowledge

about HIV/AIDS only, with no effects on safe sex practices or on measures of psychosocial determinants of these practices (James et al., 2006). However, a process evaluation among teachers showed selective or partial implementation of the programme in some schools. Life skills education is not value free and its success depends on striking an acceptable balance between the duty of the school to impart the knowledge and skills, the capacity of the learner and parental authority (Ngwenya, 2003). Furthermore, unclear strategies, poor design and evaluation of effectiveness and sustainability, and scaling up are challenges that must be addressed in any life skills programme (Hoffman, 2006).

The Zimbabwean experience of school-based intervention suggests that if teachers are properly trained, they can help adolescents acquire skills necessary for making responsible decisions about their sexual behaviour (Sherman and Bassett, 1999). The study also found that sexually active adolescents benefit from safe forums that allow for questions about sex to express their feelings and learn appropriate communication skills.

Condoms are an important means of preventing unwanted pregnancy and sexually transmitted infections (STIs), including HIV. However, the merits of providing condoms in schools have been widely debated. Many people are opposed to condoms being supplied in schools because they believe that these encourage early sex, while others have argued for condom use to protect against risks of STIs, HIV and unwanted pregnancy. However, in general, sub-Saharan studies found that negative attitudes towards condom use are often based on cultural factors, e.g. the desire for children, female sexual compliance and a negative attitude towards condom use (Peltzer, 2002; Campbell et al., 2005). Community resistance to teaching about condoms also has an influence on students' use of condoms (Kinsman et al., 1999).

Teachers are important to the implementation of these school-based programmes. Their proper training can result in a positive response for the students, teachers and the programme itself. A South African study of school-based programmes found that teacher training improved the implementation of HIV and AIDS education by raising awareness among pupils and teachers about HIV and AIDS problems and the importance of responding to these (Mathews et al., 2006).

Despite the importance of school-based programmes, there is a paucity of studies which evaluate them. In addition, variation in the content, duration and intensity of the interventions, together with differences in evaluation design and instruments, make it difficult to make comparisons across countries or even sub-regions (Kaaya et al., 2002). However, studies have demonstrated that school based programmes have positive effects on knowledge, attitudes and communication about sexuality and sexual health.

Evidence from case studies reveals that children enjoy peer-led HIV and AIDS sessions (small group discussion, drama group and so on) because they not only provide opportunities for discussion, but may capture the playground (Sherman and Bassett, 1999; Rugalema and Khanye, 2002). Table 6 presents information on selected indicators for Commonwealth countries on the curriculum and HIV and AIDS, and Figures 10 and 11 highlight experiences from Kenya and Uganda, respectively.

Figure 9. School-based HIV prevention programmes for African youth: learning from experience

School-based HIV prevention programmes for African youth: Learning from experience

- Review of HIV and AIDS risk reduction programmes for youth in Malawi, Namibia Nigeria, South Africa, Tanzania, Uganda and Zimbabwe.
- Programme objectives varied, with some targeting only knowledge, others attitudes, or behaviour change.
- Ten of the 11 studies that assessed knowledge reported significant. improvements. All seven that assessed attitudes reported some degree of positive attitudinal change to risk reduction.
- In one of the three studies that targeted sexual behaviours, sexual debut was delayed, and the number of sexual partners decreased.
- In one of the two that targeted condom use, condom use improved.
- Knowledge and attitudes are easiest to change, but behaviours more challenging.

Characteristics of the most successful programmes

- Preferably based on local context with explicit or implicit behaviour change, learning and community development theories evident in their design, implementation, and evaluation.
- Programmes targeting younger, primary school children have had greater success in influencing sexual behaviours compared with those targeting older, secondary school children.
- Easier to establish low-risk behaviours than to change existing behaviours
- Programmes must be prepared to cope with reluctance to include the topic of condoms.
- Special resource needs to be considered when planning programmes and evaluation in the resource poor settings found in much of sub-Saharan Africa.
- Teachers must be committed and properly trained, and challenges of teacher attrition and sexual harassment of students by teachers must be incorporated into the design.

Source: M. Gallant, E. Maticka-Tyndale / Social Science & Medicine 58 (2004) 1337–1351 1349

Table 5. Selected indicators for Commonwealth countries on the curriculum and HIV and AIDS

Country	HIV and AIDS and the Curriculum
1. Botswana	✓ Primary school life skills programme ✓ Secondary school life skills programme ✓ Gender content in the life skills programme ✓ Orientation programmes for teachers in school life skills and HIV/AIDS ✓ Orientation process for parents regarding life skills programmes in schools ✓ HIV and AIDS materials available to tertiary sector students ✓ HIV and AIDS and life skills integral components in the new teachers' curriculum ✓ Efforts for out-of-school youths in life skills and HIV and AIDS awareness
2. Ghana	✓ Primary school life skills programme ✓ Secondary school life skills programme ✓ Gender content in the life skills programme ✗ Orientation programmes for teachers in school life skills and HIV/AIDS ✢ Orientation process for parents regarding life skills programmes in schools ✓ HIV and AIDS materials available to tertiary sector students ✓ HIV and AIDS and life skills integral components in the new teachers' curriculum ✓ Efforts for out-of-school youths in life skills and HIV and AIDS awareness
3. Kenya	✓ Primary school life skills programme ✓ Secondary school life skills programme ✓ Gender content in the life skills programme ✢ Orientation programmes for teachers in school life skills and HIV and AIDS ✗ Orientation process for parents regarding life skills programmes in schools ✓ HIV and AIDS materials available to tertiary sector students ✓ HIV and AIDS and life skills integral components in the new teachers' curriculum ✗ Efforts for out-of-school youths in life skills and HIV and AIDS awareness
4. Lesotho	✗ Primary school life skills programme ✗ Secondary school life skills programme ✗ Gender content in the life skills programme ✢ Orientation programmes for teachers in school life skills and HIV and AIDS ✗ Orientation process for parents regarding life skills programmes in schools ✗ HIV and AIDS materials available to tertiary sector students ✓ HIV and AIDS and life skills integral components in the new teachers' curriculum ✓ Efforts for out of school youths in life skills and HIV and AIDS awareness
5. Malawi	✓ Primary school life skills programme ✓ Secondary school life skills programme ✓ Gender content in the life skills programme ✓ Orientation programmes for teachers in school life skills and HIV and AIDS ✢ Orientation process for parents regarding life skills programmes in schools ✓ HIV and AIDS materials available to tertiary sector students ✓ HIV and AIDS and life skills integral components in the new teachers' curriculum ✓ Efforts for out-of-school youths in life skills and HIV and AIDS awareness
6. Mozambique	✓ Primary school life skills programme ✓ Secondary school life skills programme ✓ Gender content in the life skills programme ✓ Orientation programmes for teachers in school life skills and HIV and AIDS ✢ Orientation process for parents regarding life skills programmes in schools ✓ HIV and AIDS materials available to tertiary sector students ✓ HIV and AIDS and life skills integral components in the new teachers' curriculum ✓ Efforts for out-of-school youths in life skills and HIV and AIDS awareness

Table 5 (continued)

Country	HIV and AIDS and the Curriculum
7. Namibia	✓ Primary school life skills programme ✓ Secondary school life skills programme ✓ Gender content in the life skills programme ✓ Orientation programmes for teachers in school life skills and HIV and AIDS ✓ Orientation process for parents regarding life skills programmes in schools ✓ HIV and AIDS materials available to tertiary sector students ✓ HIV and AIDS and life skills integral components in the new teachers' curriculum ✓ Efforts for out-of-school youths in life skills and HIV and AIDS awareness
8. Nigeria	✓ Primary school life skills programme ✓ Secondary school life skills programme ✓ Gender content in the life skills programme ✢ Orientation programmes for teachers in school life skills and HIV and AIDS ✗ Orientation process for parents regarding life skills programmes in schools ✓ HIV and AIDS materials available to tertiary sector students ✓ HIV and AIDS and life skills integral components in the new teachers' curriculum ✓ Efforts for out of school youths in life skills and HIV and AIDS awareness
9. Sierra Leone	✓ Primary school life skills programme ✓ Secondary school life skills programme ✓ Gender content in the life skills programme ✓ Orientation programmes for teachers in school life skills and HIV and AIDS ✗ Orientation process for parents regarding life skills programmes in schools ✗ HIV and AIDS materials available to tertiary sector students ✓ HIV and AIDS and life skills integral components in the new teachers' curriculum ✓ Efforts for out of school youths in life skills and HIV and AIDS awareness
10. South Africa	✓ Primary school life skills programme ✓ Secondary school life skills programme ✓ Gender content in the life skills programme ✓ Orientation programmes for teachers in school life skills and HIV and AIDS ✓ Orientation process for parents regarding life skills programmes in schools ✓ HIV and AIDS materials available to tertiary sector students ✓ HIV and AIDS and life skills integral components in the new teachers' curriculum ✓ Efforts for out of school youths in life skills and HIV and AIDS awareness
11. Swaziland	✓ Primary school life skills programme ✓ Secondary school life skills programme ✓ Gender content in the life skills programme ✓ Orientation programmes for teachers in school life skills and HIV and AIDS ✗ Orientation process for parents regarding life skills programmes in schools ✓ HIV and AIDS materials available to tertiary sector students ✓ HIV and AIDS and life skills integral components in the new teachers' curriculum ✗ Efforts for out-of-school youths in life skills and HIV and AIDS awareness
12. Uganda	✓ Primary school life skills programme ✗ Secondary school life skills programme ✓ Gender content in the life skills programme ✢ Orientation programmes for teachers in school life skills and HIV and AIDS ✗ Orientation process for parents regarding life skills programmes in schools ✗ HIV and AIDS materials available to tertiary sector students ✗ HIV and AIDS and life skills integral components in the new teachers' curriculum ✗ Efforts for out-of-school youths in life skills and HIV and AIDS awareness

Table 5 (continued)

Country	HIV and AIDS and the Curriculum
13. United Republic of Tanzania	✓ Primary school life skills programme ✓ Secondary school life skills programme ✓ Gender content in the life skills programme ✓ Orientation programmes for teachers in school life skills and HIV and AIDS ✗ Orientation process for parents regarding life skills programmes in schools ○ HIV and AIDS materials available to tertiary sector students ○ HIV and AIDS and life skills integral components in the new teachers' curriculum ○ Efforts for out-of-school youths in life skills and HIV and AIDS awareness
14. Zambia	✓ Primary school life skills programme ✗ Secondary school life skills programme ✓ Gender content in the life skills programme ✓ Orientation programmes for teachers in school life skills and HIV and AIDS ✓ Orientation process for parents regarding life skills programmes in schools ✗ HIV and AIDS materials available to tertiary sector students ✓ HIV and AIDS and life skills integral components in the new teachers' curriculum ✓ Efforts for out-of-school youths in life skills and HIV and AIDS awareness

Source: Information in table extracted and adapted from: UNAIDS Inter-agency Task Team on Education, *Report on the Education Sector Global HIV/AIDS Readiness Survey*, 2004. http://www.unesco.org.

Key:

■ Statement of fact
✓ Yes/true response
✗ No/false response
✢ In process
○ No comment provided

Box 10. Summary: school-based programmes

- In terms of life skills education, 100% of countries reported having a life skills programme in primary schools, while 79% have a programme in secondary schools
- Orientation programmes for teachers in school life skills and HIV/AIDS was affirmed by 64% of countries, yet 86% stated that HIV and AIDS and life skills are integral components of the new teachers' curriculum.
- Of concern is the fact that only 28.5% reported on the existence of an orientation process for parents regarding life skills programmes in schools

Source: Global Readiness Survey

Characteristics of effective curricula-based programmes

Process of developing the curriculum:

- Participatory and involvement of numerous stakeholders
- Use a logic model approach
- Assess relevant needs and assets of target groups
- Design activities consistent with community values
- Pilot test the programme

Content of the curriculum

- Create safe environment for youth to participate
- Focus on clear health goals
- Focus narrowly on specific behaviours leading to health goals
- Address multiple risks and protective behaviours
- Structurally sound teaching methods
- Activities and messages appropriate to youth culture, age and sexual experience
- Cover topics in logical sequence

Implementation of the curriculum

- Select educators with desired characteristics and train them
- Secure minimal support from authorities and community organisations
- Implement activities to recruit youth and overcome barriers to their involvement
- Implement the programme fully

Source: D. Kirby and L. Rolleri (2005). *Impact of sex and HIV education programs on sexual behaviours of youth in developing and developed countries*, FHI, USA.

Figure 10. Primary School Action for Better Health (PSABH): learning from Kenya

Primary school action for Better Health (PSABH)
Learning from Kenya

The project aims to being about positive changes in the sexual relationships of pupils in government primary schools in Kenya and to provide accurate information on prevention, to promote abstinence and to delay the onset of sexual activity

Main findings after 30 months implementation are:

- Lower sexual initiation among girls
- Fewer girls reporting they ever played sex
- More girls and boys reporting condom use when engaging in sexual intercourse
- More girls and boys who believe that no means NO
- Increasing likelihood that pupils receive a pass grade on knowledge tests
- Sustained implementation at school level
- Some fall off in pupil participation after 18 months

Source: Wildish, J, Gichuru M, Maticka-Tyndale, E. Experiences of working with government education systems: and HIV and AIDS intervention in primary schools in Kenya: Case study.
Poster presented at the 17th International AIDS conference, Toronto, Canada (Poster presentation WEE 0455; WEP0574)
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Figure 11. Learning from Uganda

Learning from Uganda

- School-based health education programme, for primary school children aged 13 to 14
- Implemented in 97 schools with more than 100 hours of total exposure
- Targeted abstinence, although this goal was shifted to rational decision-making about sexual activity
- Activities were infused and consisted of school health clubs, peer led and question boxes
- Community sensitisation and input
- Evaluation found that students in their last year of primary school who reported being sexually active dropped from 42.9 per cent in 1996 to 11.1 per cent two years later.
- Findings from the control group exposed only to the national health education curriculum showed no significant decline during the same period (Shuey et al, 1999).

Source: Shuey, D.A., Babishangire, B. B., Omiat, S., and Bagarukaya (1999) Increased sexual abstinence among in- school adolescents as a result of school health education in Soroti district, Uganda, Health education research, Vol 14 (3), pp 411 – 19

6 Out-of-School Youth

Stand-alone school-based prevention education programmes provide only a partial response to the problem and do not reach out-of-school youth (UNESCO, 2005). There are many barriers to attending school, including poverty and inability to pay school fees, work traditions which oblige children to supplement family resources, shortage of schools and teachers and discriminatory behaviours (e.g. towards AIDS orphans).

More than 115 million children have never been to school and many more, especially girls, drop out prematurely. In the most affected countries, the majority of 10–14 year olds are not in school (UNICEF, 2005). Out-of-school youth are very diverse, ranging from those in rural areas to marginalised groups such as orphans, street children, refugees and victims of trafficking. Furthermore, out-of-school youth are at higher risk of HIV infection. The reasons for this include lack of access to school structures, health services, unequal socio-economic status (e.g. early marriage or sexual pressure on young girls, norms of masculinity and drugs).

A recent *World Development Report* suggests that developing countries which invest in better education, healthcare and job training for their young people between the ages of 12 and 24 years of age could produce surging economic growth and sharply reduced poverty (World Bank, 2006).

The *Global Readiness Survey* shows that 71% of countries had made efforts to include out-of-school youth in life skills and HIV/AIDS awareness efforts (UNESCO, 2004). In most of the countries, these groups have been targeted by youth-to-youth school programmes delivered by trained volunteers, as peer influence is the single most powerful determinant of early sexual behaviour.

Most education sectors in Africa do not have special programmes designed for or targeting out-of-school youth. This group is mostly assumed to be covered by the health ministries, multi-media programmes or NGOs. The *World Development Report* suggests 'a youth lens' to develop policies affecting the five phases with the biggest long-term impact on human capital. These phases are: continuing to learn; starting to work; developing a healthy lifestyle; beginning a family; and exercising citizenship. It recommends that countries resolve three issues: better coordination and integration with national policy, stronger voice, and more evaluation (World Bank, 2006).

Figure 12 highlights experiences shared by workshop participants on out-of-school youth initiatives.

In conjunction with partners, WHO has published the first systematic review of what works in preventing HIV infection among young people in developing countries (WHO et al., 2006). Evidence from 80 studies were reviewed and classified. 'Go' interventions are proposed for immediate implementation and are highlighted in Box 11.

Figure 12. Sharing country experiences on out-of-school youth

Sharing best practices from countries

- Youth clubs in Kenya, Uganda, Swaziland and Cameroon. These focus on recreation activities e.g. soccer, netball, volleyball, boxing, drama groups, music. Gender issues, HIV and AIDS education are incorporated. The participating youth are also used as peer educators and behaviour change agents. These programmes are at a small scale.
- Kenya: Sex workers in slum areas programme focusing on prevention.
- The Ugandan Presidential Initiative on AIDS strategy for Communication to Youth (PIASCY)
- Cameroon: Income generating activities for rural and urban youth i.e. farming, hairdressing, baking and HIV education activities. These are funded by the Ministry of youth affairs when the youth initiates the activities.
- Kenya: Jua-Kali programme – provide market opportunities to youth for marketing their products. This programme is wide-spread in East Africa: Uganda, Tanzania and Zanzibar.

Barriers

- Limited resources
- Tend to be one (dynamic) person driven
- Donor-led in many instances
- Sustainability of the programme challenged due to mobility of the youth.

Success factors

- Active involvement of National Youth Councils (NYC) in the coordination of the youth out of school activities.
- Programmes have a better chance of success if youth-led and structured
- Use of young people, including HIV positive youth as educators.
- Using the youth that is economically empowered as resource persons for disempowered youth.

Source: Inputs obtained from workshop participants at regional workshop, 2006.

Box 11. 'Go' interventions ready for widespread implementation

In schools

- Curriculum-based interventions led by adults and with defined quality criteria

In health services

- Adolescent-friendly health service
- Trained providers
- Community supportive actions

Young people most at risk

- Provide information and services through static and outreach facilities

Mass media

- Interventions that are culturally sensitive and involve a range of media, e.g. radio, TV, print, etc.

Communities

- Interventions that are directed to young people and work through existing structures and organisations

Source: WHO and partners, 2006.

7 Teachers Infected or Affected by HIV and AIDS

Teachers are central pillars in the education system and their survival and well-being is essential for the sustainability of the system. However, HIV and AIDS have the potential to erode the gains made in education over the last few decades. Globally, teachers are confronted by the impact of HIV and AIDS. The challenges teachers face in sub-Saharan Africa include an increasing workload due to absenteeism, sick leave and deaths of colleagues, responsibility for the care of sick relatives and providing assistance to infected and affected pupils (Education International, 2006).

In some countries, a tenfold increase in teacher mortality and absenteeism due to HIV and AIDS has severely reduced both teaching time and quality. Permanent or temporary absenteeism of one teacher can have strong repercussions on up to 100 children (UNESCO, 2005).

Teachers and other key educational personnel are not easily replaced. For example, in South Africa the entire output of teacher training colleges will not be enough to make up for those lost to HIV and AIDS. When teachers are lost, schools fail and whole communities suffer. When ministries lose key staff, the whole education system suffers (UNESCO, 2005; Peltzer et al., 2005). In Zambia the ability of the education sector to reach every child and every rural area is being severely compromised by AIDS deaths, exacerbated by inadequate output from teacher training colleges to meet the needs of a growing system that continues to suffer considerable teacher mortality (Kelly, 2006).

The potential impacts of the epidemic encompass:

- Workplace issues related to training, recruitment, retention and protection, productivity, practices and procedures.
- Poor teacher morale and low job satisfaction because of the increased workload taken over from those who have died (Shisana, 2006).
- Operations of the education sector, including education and support.
- Policy planning and management (UNESCO, 2005; Peltzer et al., 2005).

HIV and AIDS have negative implications for the supply of educators through increased morbidity and mortality of educators. High levels of morbidity can lead to the extensive disruption of activities. Estimates suggest that the overall number of days lost through increased educator absenteeism result in a total of 18 months of working time (Bennell, 2003). Such repetitive absences reduce educators' contact time with learners, compromising continuity and quality, and may constitute a significant cost to the system in output terms (Mobile Task Team, 2003). For example, the highest negative productivity among educators was found in the province of KwaZulu-Natal, South Africa, which is the province with the highest HIV prevalence rate among educators (21.8%) (Shisana et al., 2005; Peltzer et al., 2005).

However, most education ministries have paid less attention to teachers' programmes on HIV and AIDS. Most have policies, but do not have action plans or resources to implement them and support infected and affected educators. In many countries, support and care for educators affected and infected by HIV and

AIDS have only just started or do not exist. A few good practice examples were shared, which include free anti-retroviral drugs for teachers in Zambia and teacher training programmes in Botswana, Kenya, Lesotho, Malawi and Swaziland. Many of these have not been in existence for a long period, and hence their effectiveness has not been evaluated.

Table 6 summarises the results of the GRS for Commonwealth African countries with regard to human resource adaptation and workplace programmes

Table 6. Summary results of the GRS for Commonwealth African countries, 2004

Indicator	Number of countries	Percentage
Human resources adaptation to the impacts of HIV/AIDS		
Amendment of human resource policies to HIV and AIDS vulnerability and susceptibility to HIV and AIDS (e.g. deployment of teachers away from their families)	2/14	14%
HIV and AIDS impact analysis on demand and supply of human resources in the education sector	6/14	43%
Guidelines for teachers on dealing with HIV and AIDS in schools	2/14	14%
Workplace HIV/AIDS programmes		
Ministry of Education HIV and AIDS awareness programme for all its employees:		
• At the national level?	11/14	79%
• At the district level?	10/14	71%
• For staff at education institutions?	8/14	57%
Guidelines for implementing universal precautions	1/14	7%
Policy of non-discrimination with regard to recruitment, advancement, continued employment and benefits for personnel affected by HIV/AIDS	13/14	93%
Enforced confidentiality of information about Ministry employees affected by HIV/AIDS	12/14	86%

As can be seen from the table, while more than 90% of countries reported on policies of non-discrimination, only 7% have guidelines for implementing universal precautions. Fourteen per cent of countries reported amendment of existing human resource policies and only 14% have developed guidelines for teachers. The results also show fragmentation and disjuncture within the education system as a whole, as a comprehensive response should surely include the people who have to implement the overall strategy and policy.

An encouraging development has been that teachers' unions have taken up the challenge of implementing HIV and AIDS programmes. The joint Education International (EI)/Education Development Centre (EDC)/WHO teacher training programme to prevent HIV infection and related discrimination through schools was launched in 2001 (van der Schaaf, 2006; Akiwumi, 2006). There are 15 participating countries in Africa (out of a total of 17). The programme is unique in the following ways:

- It emphasises skill- building rather than simply passing on information;
- It uses participatory learning methods;

- It uses a cascading approach, where thousands of teachers (union volunteers) train teachers who then train other teachers at province, district or school level.

The evaluation of the programme has found significant increases in teachers' HIV-related knowledge and teachers' confidence in their ability to apply and teach HIV prevention skills. HIV is now top of the unions' agenda and this has enhanced the status and morale of teachers and teachers' unions within communities (van der Schaaf, 2006).

In Tanzania, the Congress of Tanzanian Teachers Union (TTU) has adopted an HIV and AIDS policy, while in Kenya the Kenya Network of Positive Teachers (KENEPOTE) took the adopted policy further by reaching out to HIV-positive teachers to ensure mainstreaming of their concerns and change the attitudes of the employer (van der Schaaf, 2006; Boroswa, 2006). The Lesotho Teacher Association has been organising annual workshops on HIV and AIDS for its members. However, the coverage has been low and the content basic (Rugalema and Khanye, 2002). Following prevalence and impact assessment in 2005, the South African Democratic Teachers Union (SADTU) has undertaken to implement the recommendations of the survey. The programme is aimed at reducing the number of new infections among educators, including prevention of mother-to-child transmission, creating a supportive environment in the school workplace for people who are HIV-positive and for those living with AIDS, increasing the number of educators who access testing on a regular basis and putting in place supportive workplace environments and treatment through provision of ARVs in both public and private medical services (Mbetse, 2006). Figures 13, 14 and 15 highlight good practices shared by Education International, KENEPOTE and SADTU.

Figure 13. Learning from Education International: a global trade union federation

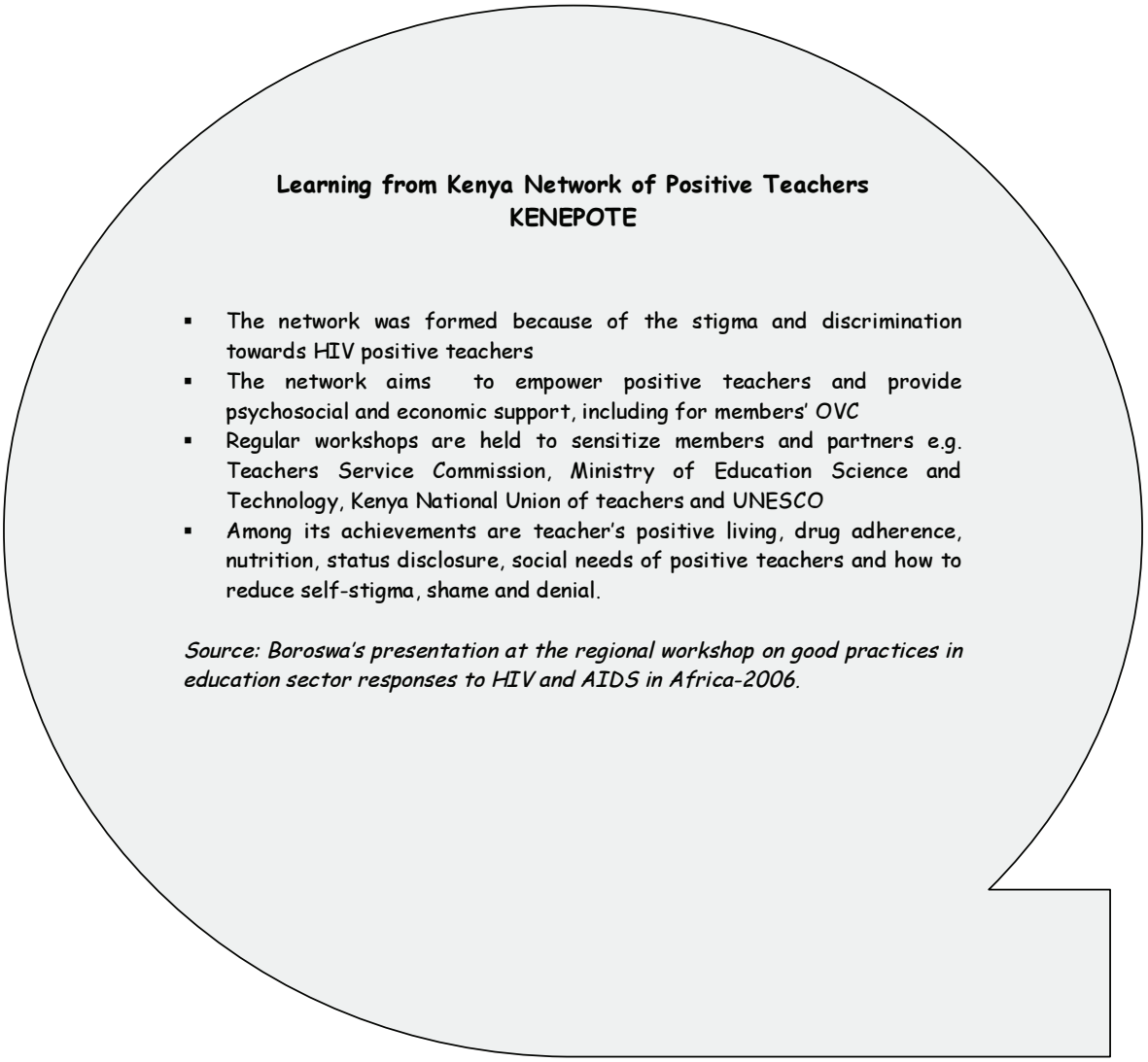
Education for all, HIV and AIDS

Learning from Education International: a global trade union federation

- Represents more than 29 million teachers and education sector workers with 348 member organisations operating in 166 countries, from pre-school to university.
- Within four years, teachers unions in 17 countries trained more than 133 000 teachers in 25 000 schools
- Its prevention programme focuses on knowledge, attitude and skills, to enable teachers to avoid HIV infection and fight AIDS-related stigma and discrimination.
- The programme and 'the teachers exercise book for HIV prevention' have increased knowledge about HIV and AIDS
- It has boosted confidence in participatory teaching methods
- Motivated teaches to modify their own behaviour
- Developed strong partnerships between unions, MOE, NGOs, civil society and academic institutions.

Source: Education International.. Education for All, HIV and AIDS, Brussels, EI, 2006

Figure 14. Learning from the Kenya Network of Positive Teachers



Learning from Kenya Network of Positive Teachers KENEPOTE

- The network was formed because of the stigma and discrimination towards HIV positive teachers
- The network aims to empower positive teachers and provide psychosocial and economic support, including for members' OVC
- Regular workshops are held to sensitize members and partners e.g. Teachers Service Commission, Ministry of Education Science and Technology, Kenya National Union of teachers and UNESCO
- Among its achievements are teacher's positive living, drug adherence, nutrition, status disclosure, social needs of positive teachers and how to reduce self-stigma, shame and denial.

Source: Boroswa's presentation at the regional workshop on good practices in education sector responses to HIV and AIDS in Africa-2006.

Figure 15. Learning from the South African Democratic Teachers Union

Learning from the South African Democratic Teacher's union (SADTU)

The programme aims to:

- Reduce the number of new infections among educators, including prevention of mother-to-child transmission,
- Facilitate the creation of a supportive workplace environment for people who are HIV positive and for those living with AIDS,
- Increase the number of educators accessing counselling and testing and support the provision of ARVs in both public and private medical services
- The programme has been implemented in government schools in three provinces, KwaZulu Natal, Mpumalanga and Eastern Cape, with plans to expand to six other SA provinces.

Source: Mbetse (2006) South Africa's educators living with and affected by HIV/AIDS: Prevention, care and treatment access. Paper presented at the consultative workshop on health and wellness, Benoni, SA

8 Community Responses, Care and Support

The crisis of orphans and vulnerable children will persist for decades, even with the expansion of prevention and treatment programmes (UNESCO, 2005).

The majority of orphans are being cared by grandparents, family members or through self-care in child-headed households (Letlape et al., 2005; Munyati et al., 2006; Jooste et al., 2006).

Orphans and vulnerable children are at higher risk for HIV infection, as they face numerous material, emotional and social problems (Skinner, 2006). They also face:

- Discrimination and stigma, as they are often shunned by society, lack affection and are left with few resources;
- Many of them drop out of school due to inability to pay school fees;
- They also often suffer from malnutrition and ill health and are in danger of exploitation and abuse (UNICEF).

Data from 20 sub-Saharan countries show that children aged 10–14 years old who have lost one or both parents are less likely to be in school than their non-orphaned peers. Hence this has a negative impact on education.

- In Kenya, Zambia and Tanzania orphans are less likely to be at the appropriate education level for their age;
- Lower school enrolment and completion rates among orphans and vulnerable children are caused and/or compounded by a number of factors relating to HIV and AIDS;
- Lack of affordable schooling: the sudden increase in poverty that can accompany the death of a parent or the onset of AIDS in a household often means that families cannot afford school-related costs;
- Family responsibilities: children, especially girls, are more relied upon to take care of siblings or sick family members;
- Family scepticism about the value of education: some families, particularly when facing the challenges of HIV and AIDS, doubt the usefulness and importance of education to their children's future;
- Poor quality education: the shortage of trained teachers and decreased teacher productivity due to HIV and AIDS, as well as larger class sizes due to teacher shortages and other factors, can reduce the quality of education;
- Stigma and trauma: the loss of a family member or caregiver, plus the stigma attached to being an 'AIDS orphan', causes severe emotional stress for children (UNICEF, 2005; UNESCO, 2005; UNAIDS, 2006).

Female OVC are more at risk than boys, for reasons already outlined. Table 7 summarises the results of the GRS for Commonwealth African countries with regard to responses relating to infected and affected children.

Table 7. Responses of Commonwealth Africa aimed at infected and affected children

Indicator	Number of countries	Percentage
Programme to address the needs of orphaned and vulnerable children in the education system	4/14	29%
School feeding scheme in place	10/14	71%
Counselling services, by trained counsellors, available at most or all schools at the following levels:		
At the primary level	5/14	36%
At the secondary level	6/14	43%

As can be seen from the table, comprehensive programmes in the Ministry of Education are only available in 29% of countries and school feeding seems to be the most frequent programme response to OVC.

Table 8. Sharing good practices on responses to OVC

Country	Brief description
Botswana	• Circles of support aim to strengthen school and community networks • Successfully piloted in 16 schools in order to ensure that OVC get support • Donor funded • Working in a co-ordinated fashion to provide optimum support to OVC • OVC live with guardians, in foster homes and efforts have been made to keep them in families
Lesotho	• Secondary education scholarships by World Bank and government and Global Fund, and other NGOs particularly Red Cross Society and World Vision • These organisations also support community programmes of home based care and food gardens • The office of the First Lady as well as government provide learning material and food to OVC and children with special needs • There is collaboration between UNICEF and EU to scale up the Red Cross and World Vision programmes
Namibia	• Christ Hope International has established two orphanages in Namibia, one centrally and one in the South. • First lady very involved in OVC programmes • Circles of Support have been established in six regions of Namibia, working with school board members taking care of after-school needs such as cooking, washing, homework, etc. There is a need to expand to all 13 regions
Mozambique	• OVC Impact mitigation programme (pilot programme) with UNICEF and World Bank • The programme aims to capacitate teachers and school board members to identify and support OVC and retain them at school with the result that many children are returning to school • NGOs are also key role players in the programme

Source: Commonwealth Secretariat/ADEA workshop participants, 2006.

Figure 16 highlights the experience of schools as centres for support and care, which is being implemented in five Southern African countries.

Figure 16. Schools as centres of care and support

School as Centres of Care and Support (SCCS) model

The model is being implemented in five Southern African countries: Swaziland, Zambia, Malawi, Mozambique and South Africa

It aims to achieve HIV and AIDS care and support for children in schools, and "Inclusive Education"
Main objectives around OVC are to:-

- Establishes self-reliant school cluster and community structures around Education Centres, to deal with HIV and AIDS and health related issues
- Empower schools to develop and implement HIV and AIDS education and school policies
- Empower teachers to integrate HIV and AIDS into daily curricula;
- Empower school communities to care for OVC
- Ensure the initiative is managed and sustained by MOE and community-based structures.
- Activities include identification of OVC, home visits, food gardens and IGAs
-

Source: Media in Education Trust, 2006. Regional Framework document

9 Good Practices in Education Sector Responses to HIV and AIDS in Africa: Regional Workshop Summary

Introduction

The South African Human Sciences Research Council organised and hosted a regional workshop on behalf of the Commonwealth Secretariat and the Association for the Development of Education in Africa (ADEA), 12–14 September 2006. The focus of the workshop was on 'Good Practices in Education Sector Responses to HIV and AIDS in Africa'.

Forty delegates met over three days in South Africa and 13 Commonwealth countries were represented at the workshop. The main aim of the workshop was to provide a forum for the sharing, presentation and review of HIV and AIDS good practice education sector responses in Africa. Workshop discussions and themes included:

- HIV and AIDS and education sector responses;
- Good practices and successes from selected country case study presentations;
- Gaps and barriers to effective implementation or scaling up of successful programmes;
- Key/priority education sector strategies for implementation, based on evidence in practice and achieving maximum impact.

Speakers included technical experts and government officials, and presentations varied from overall education sector responses to specific country and programme experiences. Although learning experiences have also been incorporated throughout the document, this section presents a summary of the workshop proceedings.

Setting the scene: The education sector and HIV and AIDS

Six speakers set the scene for the workshop by presenting papers that varied from a welcoming address by a representative from the South African Ministry of Education, an overview of workshop objectives by the Commonwealth Secretariat to a summary of the results of the GRS.

Welcoming address: Mrs Cynthia Mgijima, Chief Director, Health and Wellness portfolio, South African Ministry of Education.

Mrs Mgijima from the South African Ministry of Education welcomed all workshop participants and indicated that the experience brought by each participant would assist in reshaping and refocusing education sector interventions and programmes. Mrs Mgijima's input focused on the need for policy changes, commitment, challenges and moving towards a better future.

The need for policy changes

Mrs Mgijima noted that the education sector is at a crossroads as circumstances

are forcing us to redefine what a school is. Some of our learners and educators are either affected or infected by HIV and AIDS. This has forced the education sector not only to concentrate on the pedagogy, as a conventional school was once known, but also to create environments that cater for the well-being of both the educator and learner. Because of this evolution, many frameworks have emerged, such as, 'Health Promoting Schools', 'Child-Friendly Schools' or 'Schools as Centres of Care and Support'. All these share a common principle and objective, that of promoting healthy lifestyles and behaviours among children and staff members in schools.

There is a global realisation that an effective and quality education system can be sustained through ensuring that children and their educators are healthy and able to teach and learn in a healthy environment. It is also acknowledged that various factors impede or create barriers to effective teaching and learning in our schools, such as poverty, poor physical environment, nutritional deficiencies, social and mental issues such as violence, trauma, bullying, suicide, injury, gender violence, life style behaviours such as drug and substance abuse, sedentary lifestyles, hearing, vision and speech impairment, and sexual behaviours such as unprotected sex, STIs and unplanned pregnancy.

Commitment

It is widely accepted that education remains one of the most effective approaches to preventing HIV transmission and that it militates against the many barriers which impact on effective learning. Quality education influences not only the acquisition of knowledge, but also the development of the constructive attitudes, skills, behaviours and value systems needed to respond to the epidemic.

Box 12. Initiatives and interventions by the South African Ministry of Education

- Phased curriculum interventions were introduced to address HIV and AIDS and health promotion from Grades R to 12.
- National Policy on HIV and AIDS for Learners and Educators was promulgated in 1999.
- The Department of Education held inter-sectoral conferences on 'Sexuality Education: Protecting the Right to Innocence' (19–21 August 2001) as well as 'HIV and AIDS and the Education Sector' (30 May–1 June 2002).
- The Youth Risk Behaviour Survey (2002) in partnership with the Department of Health was conducted among 15,000 Grades 8–1 learners.
- Anecdotal reports on the perceived high absenteeism, as well as HIV and AIDS prevalence in the system, were analysed by the Department of Education, which led to participation in the ELRC/HSRC study in 2005.
- A consultative workshop on 'Health and Wellness in Education' was held in 2006 to discuss the Department of Education's health related programme with various stakeholders

Source: C. Mgijima, Welcoming address, presented to the regional workshop on 'Good practices in education sector responses to HIV and AIDS', 12–14 September 2006.

In the absence of a medical cure for HIV and AIDS, our central focus in the (South African) education sector has been, and will continue to be, on prevention, targeting learners and educators. Our collaboration with, and the support of, the teacher unions in mitigating the epidemic among their members is also yielding some benefits. Learners, through the Youth Risk Behaviour Survey conducted among Grades 8–11, cited the education sector as the medium for learning about HIV and AIDS.

Challenges

Mrs Mgijima noted that despite the gains which had been highlighted, the sector is still experiencing increased teenage pregnancies; she noted that there is 'no statistical evidence' indicating a slowing down of infection rates among young people. She indicated that while peer education programmes have been introduced in some schools, others are lagging behind with implementation. Peer education has been demonstrated to complement awareness and give better results on behaviour change. Behaviour change remains one of the biggest challenges in the fight against HIV and AIDS.

Moving towards a better future

Mrs Mgijima concluded by wishing that all participants would use the opportunity of the workshop to engage with and exchange ideas on some of the challenges raised, and find creative ways to enhance and strengthen various responses and interventions to HIV and AIDS.

Objectives and expected outcomes of the workshop: Dr Jyotsna Jha of Commonwealth Secretariat

Dr Jyotsna Jha from the Commonwealth Secretariat presented a background to the workshop and the focus on HIV and AIDS and the education sector. The Commonwealth is an association of 53 member countries and is home to approximately 60 per cent of all persons living with HIV and AIDS. One of the Secretariat's main roles is around advocacy and assisting member countries' responses to the challenges posed by the pandemic through technical assistance (individuals placed in countries), gender-mainstreaming across sectors, policy reviews, facilitating information sharing, multi-agency initiatives and partnerships.

The engagement of the Secretariat's Education Division is recent and some of its activities include: a review of education sector responses; the Commonwealth-UNESCO chair in the University of West Indies (UWI) in the Caribbean; collaborating with other agencies for specific events and interventions; and policy and programme reviews in Asia. This is to be followed by policy dialogues and this particular workshop on good practices in Africa.

Dr Jha outlined the main objectives and outcomes of the workshop, summarised below.

- **Situation analysis** of the impact of HIV and AIDS on education systems, including the role and limits of the education sector in mitigating the adverse impact, specifically in the African context;
- **Sharing experiences** relating to education sector responses to HIV and AIDS in the Africa region which lead to identification of practices and approaches that are effective and have potential for replication and/or up-scaling.
- **Identifying initiatives** from different African countries and increasing understanding of the relative advantages, effectiveness and potential of the initiatives;

- **Consolidating reports** on existing situation as well as good practices in education sector responses to HIV and AIDS in Africa;
- **Opening new channels** for sharing and partnerships;
- **Establishing directions** for future intervention from the Commonwealth, ADEA and/or other agencies in providing assistance.

Box 13. What prompted the regional workshop?

- HIV and AIDS is an emerging criticality *for* the education sector and an emerging criticality *of* the education sector;
- Africa continues to be the most severely affected region in the world, followed by the Caribbean;
- Suggestion coming from education ministers from the region in the Sierra Leone mid-term review meeting;
- Dynamic nature of the interventions and experiences, and the need for sharing at periodic intervals;
- ADEA welcomed the idea of a workshop and agreed to collaborate.

Source: J. Jha, 'Background, objectives and expected outcomes', presented to the regional workshop 'Good practices in education sector responses to HIV and AIDS', 12–14 September 2006.

HIV and AIDS in Africa, the education system and the need for an accelerated response: Dr H. Boukary, ADEA

Dr Boukary's presentation provided an interesting perspective on the impact of the HIV and AIDS epidemic on the core business of the education sector, but from the bottom up, i.e. the classroom and learning environment. The presentation provided an overview of the challenges and threats posed by the pandemic and ADEA's stock-taking of 'Promising Responses to HIV/AIDS in Education'. It also set out ADEA's *Current Strategic Framework*. Dr Boukary also highlighted national and international state of readiness, responses to the pandemic and lessons learned.

Dr Boukary noted that the challenges and threats posed by HIV and AIDS have major implications for the teaching–learning process. He highlighted the impact of the epidemic on the classroom, school environment, teachers and community in general (see Box 2). This includes severe psychological and physical stress, absenteeism, high drop-out rates, discriminatory practices, disruption in management of teaching personnel and the overall organisation of schools, all which have negative implications for quality education. This is exacerbated by parents and community leaders being ill-informed about, and ill-prepared to cope with, HIV and AIDS, resulting in spill-over effects into the immediate community environment and a climate of suspicion which strains relationships between schools, teachers and communities (Boukary, 2006).

Dr Boukary noted that the education ministers decided at the Arusha meeting that the approach has considerable potential and that the findings are instructive. The ministers noted that there is need to move towards a systemic intervention strategy (more action) and that *capacity strengthening in the sector is crucial*.

Box 14. ADEA's 'Identifying Promising Responses' exercise

Objectives of the exercise

- To take stock of HIV and AIDS interventions and policies initiated by African ministries of education and their partners to address the impact of the HIV and AIDS pandemic on the education sector.
- To examine country studies aimed at identifying relevant experiences, provide empirical evidence on effectiveness and provide a critical analysis.

Assumptions

- Actions/responses to the challenges of the HIV and AIDS epidemic can and should come from within the African context (praxis approach).
- There is a wealth of experience, information and analysis to guide innovative, cost-effective and rigorous approaches to the problem.
- Analysis is useful at country, international community and development agency levels.
- Country studies could identify partnerships that work, such as those between public sectors (ministries of health, social affairs, finance), the media, communities, non-governmental actors, the ADEA working groups and external funding agencies.

Participation

- Thirty-three positive responses were recorded, with 17 reports finalised, analysed, presented and discussed at the 2001 Arusha Biennale.

Results

- Prevention measures outweigh system protection measures (very little is known about teacher replacement policies and other coping strategies).
- Programmes have little variation and focus primarily on learners.
- Teachers and managers are largely left out.
- Among the most successful/promising strategies are: the anti-AIDS clubs, peer education (e.g. SHIP in Swaziland);
- The proliferation of multisectoral partnerships reflects new awareness and understanding of the complexity of the problem and of the need to adopt multi-disciplinary approaches.
- Using ministry employees to evaluate their own programmes is an approach that shows considerable potential in terms of learning and capacity building.
- Countries need to develop their capacity to sustain interventions, to assess them and then take the most promising ones to scale.

Source: H. Boukary, 'HIV and AIDS in Africa, the education system and the need for an accelerated response', presented to the regional workshop on 'Good practices in education sector responses to HIV and AIDS', 12–14 September 2006.

Dr Boukary also highlighted other ADEA ad hoc follow-up activities:

- Support countries in the development of sector policies and plans;
- Document promising experiences;
- Facilitate exchanges of lessons learned;
- Coordinate HIV and AIDS initiatives in sub-Saharan Africa;
- Facilitate countries' access to technical and financial resources;
- Work with other ADEA working groups on Higher Education, the Teaching Profession, Early Childhood Development, Books and Learning Materials.

Lastly, Dr Boukary posed some thought-provoking key questions, highlighted below. These could form the basis of further exploration, research and/or monitoring and evaluation.

Figure 17. Questions requiring further exploration

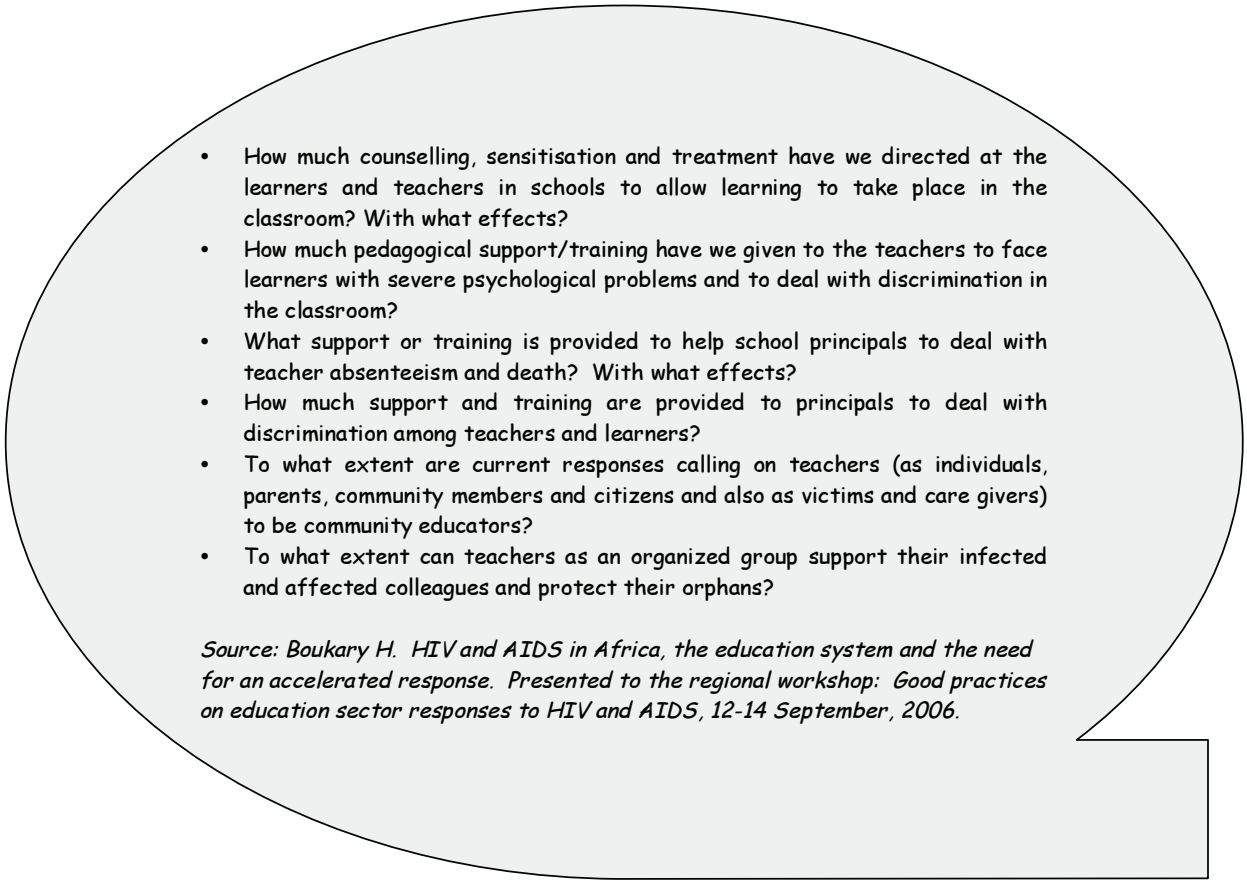
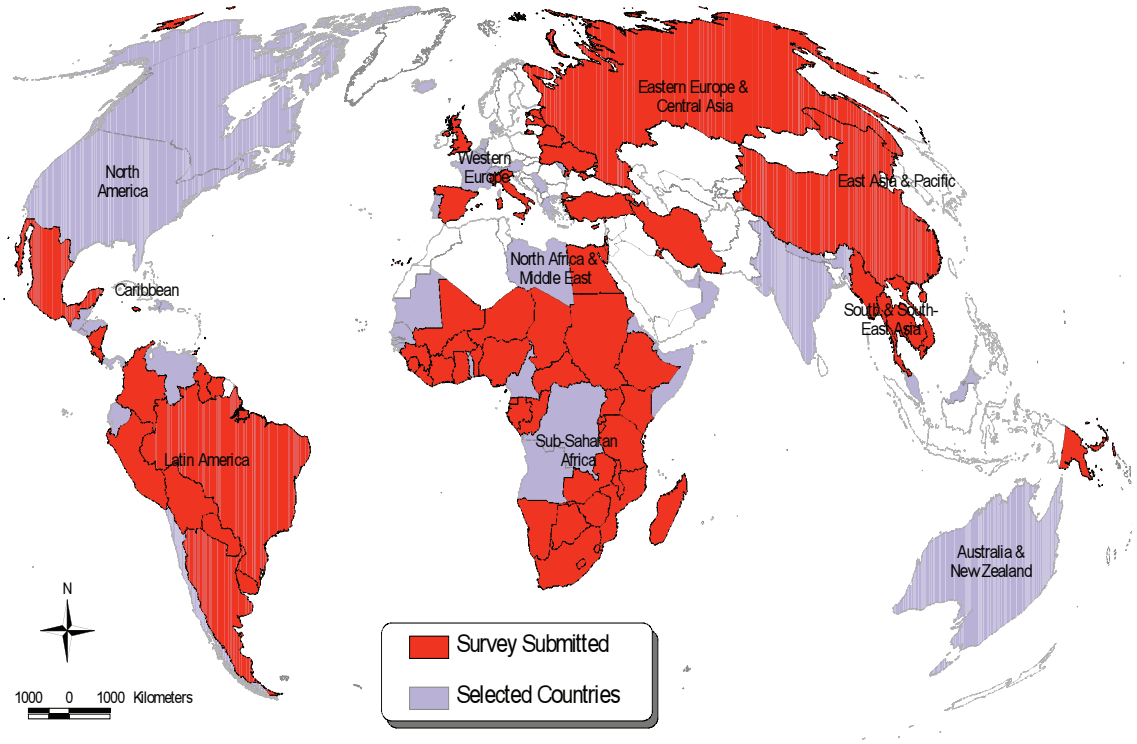


Figure 18. Countries participating in the GRS



Results of Education sector HIV and AIDS Global Readiness Survey for Africa – Progress, challenges and key recommendations: Mr P. Badcock-Walters, Director of Edusector AIDS response, University of KwaZulu Natal

Mr Badcock-Walters presented the findings of the *Education Sector HIV and AIDS Global Readiness Survey*. The main objectives of the survey were to capture up-to date qualitative and quantitative data on vulnerability, readiness and action/response capacity, benchmarking country readiness on the basis of low, medium and high HIV prevalence, and to analyse policy implications and develop recommendations to guide development, support and activities in the sector. Figure 18 shows the selected and participating countries in the GRS (Badcock-Walters, 2006).

The GRS indicates that most education ministries had structures in place or that these were in development, although only just above half (59%) had dedicated budgets focused on awareness, prevention and curriculum. Few education ministries had implemented strategic plans; there was limited decentralisation and few full-time staff dealing with HIV and AIDS.

There was also little evidence on education sector HIV and AIDS policies and workplace/human resource (HR) policies on HIV and AIDS, with few having data on teacher morbidity and mortality, absenteeism/attrition, demand and supply impact analysis and monitoring the effects of HIV and AIDS on HR. All of these weaknesses are limiting impact planning and responses within countries. Furthermore, anecdotal evidence suggests limited strategic planning, decentralisation or implementation, poor impact monitoring and lack of HIV and AIDS sensitive indicators. With regard to responses aimed at the infected and affected, a low percentage of ministries of education had programmes for orphans and

vulnerable children in their systems, with assumptions that other ministries will take care of OVC. Responses to out-of-school youth were often found to be driven by Education for All goals, with little evidence of activity. In terms of teachers, only 25 per cent of high prevalence countries trained them to care for infected pupils, with limited training and counselling service capacity.

Box 15. Take home message from the Global Readiness Survey

'The 2004 Education Sector Global HIV and AIDS Readiness Survey found that much more has been assumed to have been done than is evidenced on the ground. Efforts, while often well intentioned and undertaken with real commitment, have for the most part been single-dimensional and failed to mount a balanced, comprehensive and sustainable response'.

Source: Badcock-Walters, 'Results of Education Sector HIV and AIDS Global Readiness Survey (GRS) for Africa: Progress, challenges and key recommendations', presented to the regional workshop on 'Good practices in education sector responses to HIV and AIDS', 12–14 September 2006.

Badcock-Walters noted that what has been done must be recognised and applauded, but must be measured more effectively against the resources employed. Monitoring and evaluation and reporting is limited and fails to engage all levels of the sector. The GRS confirms that HIV and AIDS is a systemic problem and requires a systemic response. Such a management approach provides a tremendous opportunity to reform the system in pursuit of HIV and AIDS mitigation, to the benefit of all.

Some key recommendations from the GRS are summarised below.

HIV and AIDS Management Structures

- Develop functional models with identified roles, responsibilities and sustainable budgets.
- Take a comprehensive approach to prevention; treatment, care and support; workplace issues; and management of response.
- Dedicate staff for full-time response.
- Develop training programmes to professionalise skills and retain dedicated staff.
- Emphasise coordination, monitoring and reporting.

Enabling Environment

- Identify sector 'champions' and equip them to become effective advocates and guide responses.
- Develop flexible, comprehensive education sector HIV and AIDS policies through inclusive, consultative country processes.
- Harmonise all country sector and HIV and AIDS policies.
- Ensure inclusion of key guiding principles.

- Hold public officials accountable for delivery.
- Empower civil society to monitor implementation.

Mainstreaming

- Develop time-bound, realistic and comprehensive strategic plans to decentralise response.
- Integrate HIV and AIDS into Education Management Information System (EMIS) and decision support.
- Train managers at every level in the use of evidence-based HIV and AIDS-sensitive decision-support systems.
- Disseminate impact assessments to widen understanding of key issues among all stakeholders and mobilise internal and external resources.

HR and Workplace Issues

- Establish and regularly review HIV and AIDS workplace policy within wider education sector HIV and AIDS policy and protect employees from workplace discrimination.
- Harmonise country HR policies and international guidelines.
- Improve the quality and frequency of HIV and AIDS impact monitoring on HR and develop reliable analyses.
- Link payroll and operational systems data to integrate key HR information to provide 'early warning' of crisis, inform demand and supply projections, and plan for recruitment and training.

Responses Aimed at the Infected and Affected

- Develop decentralised multi-sector/partner response.
- Establish out-of-school youth life skills development programmes.
- Increase teacher training and counselling services for learners infected and affected.
- Reinforce/coordinate partnerships between ministries of education, NGOs, unions and civil society to increase capacity.
- Pilot community-based local responses and provide training materials and supervision.

Are we overly optimistic on what the education sector can achieve with regards to HIV and AIDS?: Professor M. Kelly, University of Zambia

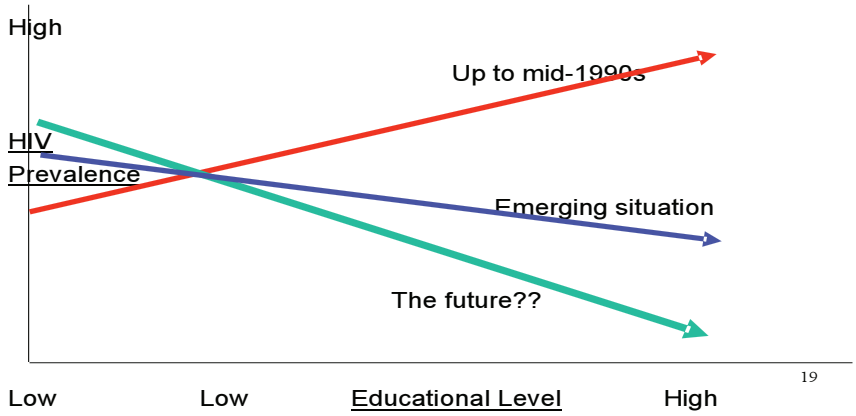
Professor Kelly's presentation focused on the role, achievements, impact and limitations of the education sector with respect to the epidemic and concluded with a model of the four pillars of learning in a world with HIV and AIDS (see Figure 2).

In line with the title of the paper, Professor Kelly noted the demands on the education sector for its contribution to preventing HIV transmission, extending care and support to learners and educators and promoting their treatment,

addressing issues of stigma and discrimination, human rights, gender and poverty, and ensuring the well-being of the education system itself. However, we should not forget that educators cannot accomplish everything, and that they need to collaborate with communities and other social actors. Importantly, the education sector is more than schools and the ministry of education: there are other levels of education and a new education orientation is needed to enable the sector to do justice to all the demands put upon it (Kelly, 2006).

Professor Kelly pointed to the positive contribution of education in mitigating the impact of the epidemic (see Box 4). Despite the challenges with which the education sector is faced, its achievements include improved HIV-related knowledge, practices and attitudes, which contribute to the reduction of HIV prevalence rates; constructive prevention practices; less stigmatising attitudes towards those who are HIV-positive; and providing support for orphans and affected children. Furthermore, the sector has continued to function: teachers teach, students participate and some learning occurs (Kelly, 2006). Figure 19 shows the changing relationship between HIV prevalence and the level of education.

Figure 19. Changing relationship between HIV prevalence and level of education



Source: Kelly, 2006

Professor Kelly argued with passion that we are not optimistic enough and that we are not taking the actions that we know are necessary to fight the epidemic. There is a strong evidence base to support the widespread implementation of school-based interventions that incorporate the characteristics of effective programmes and that are led by adults; these programmes reduce sexual risk behaviour and increase knowledge. He concluded by setting out the four pillars of learning and noted that in order for education to achieve its potential, key prerequisites must be met:

- Every young person must be given an opportunity for education;
- HIV, AIDS, sexuality and life skills should be given their rightful place in the curriculum;
- Teachers should be trained in dealing with these issues;
- Full professional support must be given to this curriculum area, including materials, back-up support and resources.

Leadership and Education Sector Responses to HIV and AIDS in Africa: Practical Lessons for Implementation: Ms Z. Akiwumi, independent consultant (previously with WHO)

Ms Akiwumi's presentation explored the meaning of leadership and the need for the education sector to respond to and address the challenges posed by HIV and AIDS. She highlighted practical experience of education sector responses in Africa with some positive results and the challenges and barriers to effective implementation and programme expansion. Ms Akiwumi noted that education sector leadership is necessary because of the impact of the epidemic on the sector in terms of supply and demand issues, absenteeism and the epidemic's threat to achieving EFA goals that are vital for economic and social development. Lastly, the school system is ideally suited for HIV education, because of the numbers and reach of children, teachers' role in communities and because schools are seen as a credible source of information.

Ms Akiwumi indicated that there are numerous programmes and projects implemented in different countries, albeit with varying results. She presented an example of the EI/EDC/WHO teacher training programme launched in 2001 (see Figure 13), aimed at preventing HIV infection and related discrimination through schools, with 15 African countries participating. The main objectives of this programme are to provide teachers with knowledge of how to protect themselves from HIV infection and train others how to prevent infection; to train teachers and students to advocate for effective HIV prevention efforts in schools; and to help young people acquire knowledge and skills to prevent HIV infection. The programme has already reached over 150,000 teachers in more than 37,000 schools and has significantly increased teachers' HIV-related knowledge and confidence to apply and teach HIV prevention skills, and provided competences and skills to protect themselves and teach others. It has also helped teachers to deal with the usual barriers associated with discussing sensitive issues and sexual behaviour, decreased discrimination and increased support for HIV-positive persons, and had a positive impact on teachers' own behaviour.

Ms Akiwumi noted that barriers to effective implementation and programme expansion include lack of motivation of teachers; low wages, low morale, unpaid salaries, lack of commitment and the problem of teacher retention; poor quality of teachers and teacher education; increased workload, as teachers are not always replaced, overcrowded classrooms and insufficient time for participatory exercises; drop-outs and out-of-school children; conflict areas; and adaptability of programmes to local realities.

Ms Akiwumi concluded by stating that 'the education sector cannot afford not to take the lead and respond to the impact of HIV and AIDS on its members, i.e. teachers, students and support staff'. She recommended a multisectoral approach which includes advocacy and lobbying, implementing and providing quality teacher training with better conditions of service (such as a possible 'HIV education' allowance) and a curriculum focus on skills building. Finally, she emphasised that there is a need to intensify and accelerate interventions that work, and to innovate in order to find effective ways to address the HIV problem within the education sector.

Developing a Shared Perspective on Best Practice and Approaches in Africa

This intensive workshop session commenced on Tuesday afternoon and consisted of the Screening of a World Back DVD entitled *A Window of Hope*, two focus

papers on educators and three country case studies on Uganda (East Africa), Lesotho (Southern Africa) and Ghana (West Africa). The theme was continued on Wednesday morning with the screening of a DVD of a South African teachers union-led intervention programme for teachers; plenary inputs on school-based programmes, including life skills programmes, gender and the girl-child; programmes for out-of-school youth; and community responses and partnerships.

The South African Educators Survey and Implications for Planning and Implementation: Dr O. Shisana, CEO and President, HSRC

Dr Shisana presented the findings of the research study on the impact of HIV and AIDS on the South Africa public education sector commissioned by the Ministry of Education and the Education Labour Relations Council (ELRC). The research was prompted by worrying anecdotal reports of large numbers of educators leaving the system because of deaths due to AIDS, emigration, low job satisfaction and low morale. Key findings of the survey are highlighted in the box below.

Box 16. Key findings of the South African Educators Survey

- HIV prevalence of 12.7% among educators, 3.9% among further education and training (FET) lecturers and 8.2% among third and fourth year teaching students.
- Highest prevalence among educators who are 25–34 years of age, those with lower education levels and in high prevalence provinces.
- High blood pressure (15.6%) and arthritis (6.62%) were the most commonly reported illnesses among educators.
- Children are often left without teachers or teachers are overloaded with work due to high morbidity.
- 54% of educators intended to quit because of high job stress and low job satisfaction.
- Mortality rates are high, largely due to HIV, and there is likely to be a shortage of educators by 2008.

Source: O. Shisana, 'The South African Educators survey and implications for planning and implementation', presented to the regional workshop on 'Good practices in education sector responses to HIV and AIDS', 12–14 September 2006.

Dr Shisana noted the implications for planning services in South Africa, summarised below:

- Foster a healthy life style among educators;
- Increase capacity in the sector;
- Introduce HIV prevention programmes targeted at educators (i.e. couple VCT, sex with partners whose HIV status one knows, consistent condom use for HIV-positives with regular partners and increased access to female condoms);
- Establish a comprehensive workplace health programme that would help educators deal with stress; provide regular screening for cholesterol, glucose and high blood pressure; and provide treatment for chronic diseases, opportunistic infections and ARV treatment.

All the recommendations were accepted by the ELRC and Department of Education, although implementation has proved challenging in some cases. Attention has been given to improving the working conditions of educators and addressing the career paths of educators, and unions have also taken on the challenge of implementing a comprehensive AIDS intervention programme (see Figure 15). However, the challenge of providing ARV for all the estimated 10,000 educators requiring treatment remains.

Dr Shisana concluded by pointing to the importance of the study in highlighting the intervention needed to make the education system sustainable in the face of AIDS and the need for partnership between the Department of Education, other government departments (e.g. Health and Social Services) and trade unions.

Leading and Living Positively: Ms M.G. Boroswa, Kenya Network of Positive Teachers, Kenya

'*Why should teachers die of a treatable, preventable, and manageable disease if they can be made part of the solution not the problem'?* (Boroswa, 2006). This was the concluding comment of Mary Boroswa of the Kenya Network of Positive Teachers (KENEPOTE) at the regional workshop.

Ms Boroswa's presentation focused on the establishment and activities of KENEPOTE and the lessons learned from the programme implementation. The network was formed to empower positive teachers with psychosocial and economic support, thereby ensuring that their dignity as disseminators of knowledge is not compromised (see also Figure 14).

KENEPOTE's objectives are to influence the policy environment to put in place better working conditions for HIV-positive teachers, to reduce stigma and discrimination, to intensify advocacy and lobbying for protection of the rights of HIV-positive teachers and to increase their access to treatment, care and support. The network also aims to provide care and support for the children of their members, strengthen their capacity to ensure effective and efficient implementation and management of its programmes and restore the dignity and professionalism of HIV-positive teachers.

As of January 2006, the network had 3000 members. Some of its achievements include positive living among its members; drug adherence; nutrition; status disclosure; attention to the social needs of positive teachers and how to reduce self-stigma, shame and denial; formation of support groups; and personal commitment by individual members. Boroswa indicated that KENEPOTE has been recognised as a model of good practice for other African countries.

Ms Boroswa spoke passionately about the challenge of discrimination and stigma. Despite the positive impact the network is having on HIV-positive teachers, there have been some setbacks. The network does not have an office or secretariat and members serve as volunteers operating in their schools. The high numbers of orphans left behind by KENEPOTE's members are in need of economic support which the network cannot provide. The members' hopes and desires are not always adequately met because of lack of economic empowerment. The network is also dominated by women, mainly because male teachers have refused to acknowledge their status and reluctantly join the network when it is too late.

Ms Boroswa recommended to other countries the creation of a forum for teaching professionals living with HIV to enable them to:

- Exchange experiences;

- Provide support and advocacy for needed policy changes in policy and programming at all levels, developing and advocating for mechanisms to conduct research on, and monitor the impact of, greater involvement of teachers living with AIDS (GITA) principles at all levels;
- Incorporate GITA principles and concepts into workplace policies, with teachers living with HIV and AIDS becoming involved in developing, implementing and reviewing these policies;
- Sensitise health professionals about the active role that can be played by HIV-positive individuals in health care, and the importance of using non-stigmatising language.

Other recommendations included the implementation of a comprehensive effort to build and support human resources, including HIV-positive professionals who can be deployed as personnel at the AIDS Control Units (ACU) at district and municipal levels and in ministries of education.

Ms Boroswa concluded by calling for the promotion and protection of the rights of HIV-positive teachers, orphans and vulnerable children and their empowerment; the training of teachers to enable them to teach about HIV and AIDS; and for both in-service and pre-service teacher training to include compulsory examinable HIV and AIDS components.

Country Case Studies: Towards Accelerated Delivery – Learning from Experience:

Lesotho (Southern Africa): Dr M Maruping

Dr Maruping's presentation indicated that the government of Lesotho has scaled up its response to HIV and AIDS by establishing a National AIDS Commission to regulate funds and monitor and evaluate HIV and AIDS interventions. It has also adopted a multisectoral approach and included other ministries and relevant stakeholders in the commission. The government is in the process of developing a national policy which hinges on poverty alleviation, development and human rights (Maruping, 2006).

The Lesotho Ministry of Education has established a unit whose mandate is to map, coordinate and evaluate the quality and scale of HIV and AIDS programmes in the education sector. Teachers, instructors, administrators and district management officers were trained in basic information about HIV and AIDS. Further training was provided in life skills and basic skills to cope with orphans and vulnerable children and give lay counselling. About 276 teachers and educators are trained in play group therapy. Both primary and secondary school teachers were encouraged to test and receive treatment paid by the Ministry, if they disclosed their status. Training services were also provided for Lesotho students, youth and tertiary institutions. The Ministry, together with other organisations, also offers scholarships, material and psychosocial support to school pupils and out-of-school children.

Uganda (East Africa): Mr A. Kibenge

Mr Kibenge presented a broad view of the impact of HIV and AIDS and the strategies of the Ugandan government to deal with HIV and AIDS in the education sector. Box 17 highlights the key elements of the strategy.

Box 17. Key elements of the Ugandan education sector response

- Prevention
  - Prevention education through schools and institutions
- Mitigation and Care
  - Facilitating access to care, support and mitigation
  - Workplace interventions
- Capacity Building
  - Provision of evidence-based facts on the impact of HIV and AIDS on the sector (research).
  - Managing the response through strong coordination mechanisms within the sector both at national and district levels.
- *The Presidential Initiative on AIDS strategy for Communication to Youth (PIASCY)* is viewed within the whole school approach.
- The primary focus is the development of key assembly messages and provision of basic facts on HIV and AIDS.
- The delivery mechanisms for PIASCY are rooted in the teacher effectiveness concept, in which HIV and AIDS competence has been adopted as a major skill needed by teachers.
- PIASCY has supplementary curriculum and other activities, including music, dance and drama, and provision of supplementary HIV/AIDS readers to schools

Source: A. D. Kibenge, *Towards accelerated delivery: Learning from Uganda*, 2006.

The Ministry maintains and strengthens partnerships by collaborating and working with stakeholders in the area of HIV and AIDS such as:

- People Living with HIV and AIDS (PHA), supporting teachers living with HIV and AIDS and working on anti-stigma/treatment advocacy;
- Uganda Young Positives, supporting students to open up, advocacy for voluntary counselling, anti-stigma measures, peer education and support;
- The AIDS Support Organization (TASO) – all interventions include training of teacher counsellors and school interventions for behaviour change;
- AIDS Information Centre (AIC), providing youth-friendly HIV and AIDS activities and school support programmes for information and services;
- Uganda Counsellors Association (UCA) – quality assurance on materials for training teacher counsellors, including support for training.

Mr Kibenge also highlighted some of the critical challenges. These include the wide scope of the education sector; limited funding for HIV and AIDS due to a budget ceiling on sector funding; sustainability of donor funded programmes; attainment of a fully mainstreamed response; coordination of local and external partners; fatigue and sticking to conventional approaches; low motivation on the part of teachers, coupled with absentee supervisors (head teachers); resistance among parents, the community and faith-based organisations to dealing with sexuality matters, including the 'condom debate'.

Mr Kibenge concluded by indicating that Uganda's government is finalising

and widely disseminating the education sector's HIV and AIDS policy and strategic plan, as well as finalising the district-based HIV and AIDS implementation guidelines and plans, training more HIV and AIDS counsellors in the education sector and incorporating HIV and AIDS indicators into the EMIS. He noted the importance of flexibility that permits innovation and recognises the vital roles of the different stakeholders, including the young people themselves, teachers, parents and FBOs.

Ghana (West Africa): Ms B. Biney

Ms Biney shared the case study from Ghana and noted that in 2002 a full-time HIV and AIDS Secretariat was established within the Ministry of Education to coordinate HIV/AIDS interventions within the sector. The main responsibility of the secretariat includes sensitisation and solicitation of support across the Ministry and training programme for teachers at the pre-tertiary level (basic and senior secondary school levels). This activity is being implemented in collaboration with World Education, an NGO. HIV and AIDS issues have also been integrated in the school curriculum so that there will be no need for further training when the teachers are out of training college.

Box 18. Ghana revises its Code of Professional Conduct to deter sexual misconduct of staff

The Ghana Education Service (GES) has revised its code of professional conduct for its teaching and non-teaching personnel on sexual misconduct in order to deter teachers from sexual misconduct in view of its consequences, including HIV and AIDS transmission.

Sexual offences are classified as major misconduct which attracts stiffer sanctions.

These include:

- Deferment of salary increments
- Reduction in rank or of salary
- Suspension not exceeding two years
- Dismissal from the service depending on the severity of misconduct

Source: B. Biney, *Towards accelerated delivery: Learning from Ghana*, 2006.

Ms Biney noted that a situational analysis of the education sector response to HIV and AIDS in Ghana is being conducted. The focus of this publication is to provide a snapshot of HIV and AIDS programmes and interventions. This is expected to facilitate a more targeted response by the sector and to help in the review of the sector's response.

Steps taken in Ghana to ensure sustainability of programmes include the following:

- District directors of education are required to include HIV and AIDS in their district strategic plans and budgeting.
- District directors are members of the Social Services Committee of District Assemblies which are the decentralised political and administrative authorities through which the Ghana AIDS Commission channels funding for HIV and AIDS activities.

- A Capitation Grant has been introduced, which together with the abolition of school levies and the introduction of a school feeding programme, has already seen school enrolments increasing. It is expected that these measures will ensure that orphans and vulnerable children continue their schooling.

Challenges include building a credible data base on HIV and AIDS in schools; removing the stigma, so that students and teachers can discuss HIV and AIDS; the willingness of students and teachers to disclose incidents of sexual abuse; establishing care and support systems within the sector to support education staff living with HIV and AIDS; and mobilisation of funds for different activities.

Screening of DVD: Teachers Caring for Teachers: South African Democratic teachers Union

The second day commenced with the screening of the DVD *Teachers Caring for Teachers*. The DVD highlighted the leadership role played by South African teaching unions in implementing the recommendations of the 2004/5 survey on the impact of the epidemic and shared some personal stories of empowerment from HIV-positive teachers (see also Figure 15).

HIV Prevention: Is Life Skills Education Making a Difference?: Ms A.M. Hoffman, UNICEF

Ms Hoffman's presentation provided a broad overview of why life skills education is important and reviewed the role of global developments in its implementation. Globally, EFA goals 3 and 6 are driving life skills education implementation. EFA calls for life skills learning for young people (10–24 years old), including how to deal with HIV and AIDS. At the same time, life skills are a desirable and measurable learning outcome of quality education. The UNGASS indicator is that by 2010 at least 95% of young boys and girls should have access to the information and education necessary to reduce vulnerability to HIV infection.

Box 19. Understanding life skills education and HIV prevention

- LSE is a methodology that is:
  - Child centred
  - Builds on children's needs and rights
  - Participatory – involves children in teaching and learning,
  - Skills-building, allowing time for building and practising skills and abilities.
- LSE is a methodology for enhancing risk aversion, i.e. addressing root causes of vulnerability, or person's ability or lack of ability to act on the decisions they make.
- HIV prevention= a risk reduction outcome, i.e. the level at which an individual or population engages in activities which place them at risk – for which the acquisition of skills is only one part.
- Cycle of social support at the school level, includes:
  - Life skills education
  - School policies
  - Learning friendly environments
  - Links to youth-friendly health and social services, school-community partnerships etc.

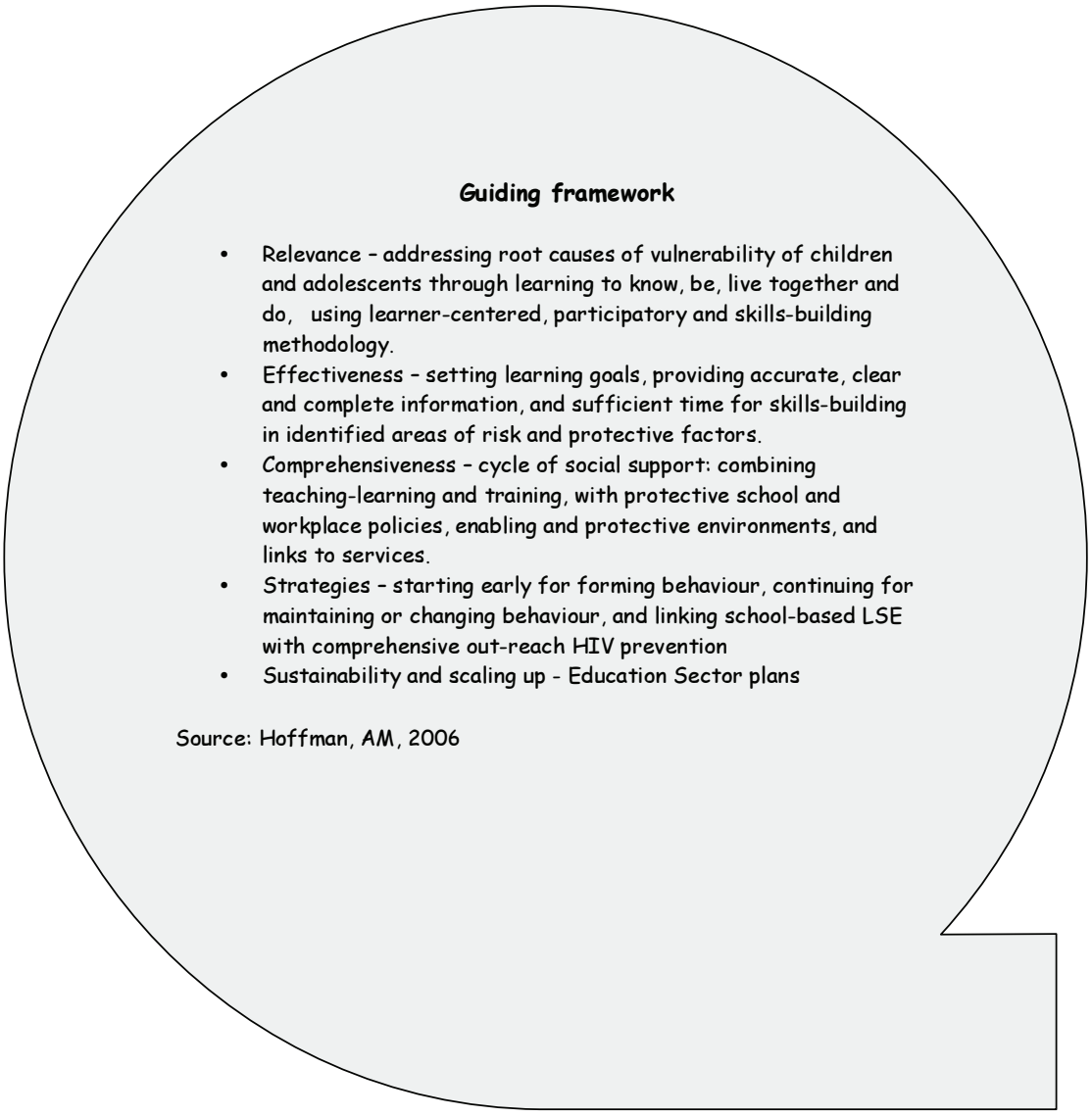
Source: A.M. Hoffman, *HIV prevention: Is life-skill education making a difference*, 2006.

Ms Hoffman noted that there is confusion about what life skills are, what they can achieve and what constitutes effective life skills education, and about understanding life skills education and HIV prevention. She argued that the main challenges are caused by poor design and evaluation of the effectiveness of life skills education, unclear strategies, sustainability and scaling up.

Ms Hoffman also argued that in most instances cognitive abilities are linked to resilience, and have a reflective, personal and social dimension (critical thinking for perception of risk, agency as an internal protective factor and social competence as an external protective factor). She defined life skill education as a methodology that develops the ability of children and young people to reason, and helps them to develop agency and social competence in order to act. It can be applied to a number of challenges facing children and young people, such as HIV and AIDS, but also to issues of gender, violence and human rights.

She also emphasised that for life skill education to be effective, it is important to acknowledge and address issues relating to sexuality, gender and power structures which restrict young people's choices. It is also important to question societal structures or norms which exclude, stigmatise and/or marginalise, and which inhibit access to necessary services.

Figure 20 summarises the guiding framework for making a difference.



Effective School-based Approach to Implementing HIV and AIDS Education: Experience from the Gambia: Ms Mbaye

Ms Mbaye gave a brief background on the prevalence of HIV and AIDS in the Gambia. Out a total population of 1.3 million, around 12,000 people are estimated to be living with HIV. Although there are no data on HIV among teachers, 3000 cases of full-blown AIDS were recorded between 1986 and the end of 2005. She indicated that awareness of HIV and AIDS is quite high among all age groups in the country, but risky sexual behaviour among youth is still a concern.

Ms Mbaye noted that the Gambian Government established different interventions and policies to deal with HIV and AIDS in 1987. There is no specific education sector policy, but a pronouncement which states that:

> *As HIV and AIDS is becoming more of a development problem rather than an exclusive health issue, vulnerable groups will be targeted to slow down the spread and progression of the pandemic. HIV and AIDS issues are to be taught in all learning institutions to ensure that these institutions are used as effective vehicles to intensify the HIV and AIDS sensitisation in communities.*

The Ministry of Education undertook, together with partners, programme formulation and implementation in order to:

- Prevent and control the spread of HIV and AIDS among teachers, other education sector personnel and young people in and out of school;
- Reduce the traumatic impact of HIV and AIDS on learners, educators and the education system itself;
- Improve management capacity and procedures to ensure that effective actions are taken to respond to this crisis.

Box 20. School-based programmes in the Gambia

The aims of school-based programmes are to:

- Enhance awareness of HIV and AIDS in the education sector;
- Increase knowledge and understanding about HIV and AIDS issues in schools;
- Inculcate HIV and AIDS education into the Gambia Teacher Training Programme as a compulsory subject.

There is also provision of continuous skills enhancement/training to teachers to enable them to handle HIV and AIDS issues in schools, particularly in the area of teaching methodology, preparation of curriculum materials on HIV and AIDS and integration of HIV and AIDS education in the school curriculum.

Challenges

- Denial of the existence of HIV and AIDS in some quarters
- Need to encourage more voluntary testing and counselling
- Religious controversy over the use of condoms versus abstinence
- Traditional practices

Source: A. Mbaye, *Effective schools-based approach to implementing HIV and AIDS education in the Gambia*, 2006.

Gender, the Girl-child, HIV and AIDS and Strategies for Action: Ms Rakgadi Mohlahlane, Centre for the Study of AIDS, University of Pretoria

Ms Mohlahlane introduced the subject by arguing that HIV and AIDS present society with two taboos: death and sex. In addition, the epidemic is layered upon existing forms of social oppression and inequalities based on gender, age, race and ethnicity, class, sexual orientation and ability/disability. She noted that there has been a major shift in new understanding of gender relations with an emergence of the discourse linking HIV and AIDS, gender, masculinity, femininity and sexuality. She argued that each man's gender role is developed over time in relation to various psychological and social forces and is shaped by these forces, with an outcome of a hegemonic masculinity in each society. The way in which society defines masculinity creates conditions for men to retain power. Hence HIV and AIDS can be classified among the social health problems in which information, education and power are closely related and interlinked.

Ms Mohlahlane argued that at the core of information and education is a continuum of gender and sexuality which permeates all levels of society. Society's socialisation into sexuality teaches girls and females that they have to be passive/dependent, while the opposite is true for males. For example, society expects men and boys to be more (innately) knowledgeable and experienced about sex, but with regard to HIV and AIDS they do not seek information about sex and protection, and they experiment with sex in unsafe ways at a young age. On the other hand, woman and girls are socialised into submissiveness and to comply with norms of fidelity. They have no control over how, when and where sex takes place (with a likelihood of unwanted pregnancy, STD and HIV), and they also face possible infection if their husbands have unprotected sex outside marriage.

An ideal response for school and education is to offer opportunities to integrate gender equality and teaching about sexuality and sexual health at the same time and possibly at the same level; to redefine and reconstruct gender roles and identities; and to instil in both females and males social norms that are mutually respectful. Mohlahlane noted that schools can serve as means of creating positive social 'coercion', community participation and development.

Box 21. Interventions to turn around gender bias

Possible interventions include:

- Focusing Resources on Effective School Health (FRESH), getting and keeping girls in school and improving the well-being of communities in resource-poor settings (health-related policies);
- Increasing enrolment of children who are most marginalised, i.e. girls and children orphaned by HIV and AIDS, through targeted programmes and creating localised school calendars that meet community needs, as in the case of the Bangladesh Rural Advancement Committee (BRAC);
- Girls Education Movement (GEM) that empowers girls through equal access to education, providing gender-sensitive curricula and life skills education, including education about HIV and AIDS and the abolition of harmful cultural practices.

Source: R. Mohlahlahne, *Gender, the girl child and strategies for action*, 2006.

Ms Mohlahlane noted that there is a need to provide quality life skill-based education which starts early and is age appropriate, sequential, interactive and relevant to students and their communities (formal schools, non-formal classes, peer education and community-based programmes). Important interventions should also seek to challenge and address gender roles and create more gender-equitable relations where young people's attitudes and behaviour in relation to sex is mutually respectful (e.g. Planned Parenthood Association of South Africa's Men as Partners (MAP) Project).

She acknowledged the challenges posed by the implementation of the suggested intervention/programmes. She noted that teachers are part of the patriarchal society and tend to reinforce damaging gender and sexual stereotypes.There are also poor parent–child relationships, resulting in the burden being shifted to schools. Ms Mohlahlane emphasised the importance of parents and families in forming part of the processes of influence which impacted on gender relations and the HIV and AIDS epidemic. Other challenges include the role of communities as agents of change (they can both obstruct or further change), cultural dictates, stigma and equity, and interventions that target women and girls and expect them to do everything, while ignoring the important role of males.

Ms Mohlalane concluded by noting that the struggle against HIV/AIDS is linked to finding solutions to major global social problems, from poverty, corporate greed, environmental disasters and discrimination (based on gender, age, race, class or sexual orientation) to dealing with personal relations. AIDS has to a large extent highlighted the power, control and status of Western countries in relation to poorer countries. Economic policies as laid down by the International Monetary Fund (IMF) and World Bank which prescribe funding limits in the areas of social services and education are counter-productive, as these areas are crucial in dealing with HIV and AIDS, as are national policy formulation that stress control and coercion rather than rights and inclusiveness (Mohlahlane, 2006).

Education, youth out of school and best practice programme: Ms Fortunate Thwala, Swaziland

Ms Thwala's presentation focused on young people out of school and the implementation of a successful edutainment programme in Swaziland. She noted that Swaziland has the highest prevalence of HIV and AIDS in the world (42.6%), but for the period 2002–2004, some stagnation of prevalence was noticed in the 15–19-year-old age group. Young people both in and out of school have been classified as the section of the population that are most at risk. Leaders in Swaziland acknowledged that the response to the epidemic required a multisectoral approach and a five-year multisectoral national strategic plan has been developed.

Ms Thwala presented the Lusweti Programme, a regional multi-media health and development communication programme implemented by SHAPE in partnership with the Soul City Institute since 2002. The programme was developed specifically for youth in and out of school between 16–24 years of age, to empower them with information on HIV and AIDS, sexual reproductive health and life skills, and to provide them with appropriate information and tools to enable them to make informed, responsible choices regarding HIV and AIDS, their sexuality, and other health and social issues.

The programme has also provided an opportunity for open and ongoing discussion on HIV and AIDS, and health and social issues among the people of Swaziland; created an enabling environment towards positive behaviour change on health and social development issues with particular reference to HIV and

AIDS; made it possible to monitor and evaluate the use and effectiveness of multi-media material; and built capacity within the country and provided systematic training in the development of multi-media health initiatives.

The uniqueness of the programme is that it acknowledges that behaviour change is a process that occurs over time. Knowledge alone cannot change behaviour, and other factors come into play, e.g. the socio-cultural environment. The benefits of the programme included exposing local people to training and experience, and creating employment and business opportunities for local people, especially in the media. For example, the programme led to the creation of Gilead Investments, a dynamic TV production company, which has assembled a pool of talent that would have otherwise have gone unnoticed.

Ms Thwala noted that the Lusweti Programme plans to advocate for policy implementation and social change; to set up a monitoring and evaluation strategy for the multi-media material developed; and to build capacity among young people. This includes training and developing other organisations on qualitative research, monitoring and evaluation, and utilising multi-media products in discussions and when conducting peer education sessions, as well as training service providers, media and internal staff on the management and development of quality edutainment multi-media products.

Community Responses, Orphans and Vulnerable Children and the Education Sector: Lessons from Southern Africa, Professor L. Simbayi, HSRC

Professor Simbayi's presentation focused on the research findings and practical experience of WK Kellogg's Foundation's OVC care intervention project. The HSRC managed the overall programme and conducted the research to develop evidence-based 'models of successful practice' that would help strengthen the capacities of households and communities to respond to the challenge of the growing number of OVC in three countries in the SADC region, Botswana, South Africa and Zimbabwe. The research found that between 4.8 and 19.1% of OVC from the three countries in the intervention villages were not attending school.

Professor Simbayi pointed out that although most SADC countries have developed OVC policies and programmes to mitigate the impact of HIV/AIDS, or are in the process of doing so, OVC services provided by governments are often inadequate with community-based organisations or faith-based organisations taking the lead. Sometimes these CBOs and FBOs have little or no financial resources and rely on the spirit of community and altruism among individuals or groups of people, responding to the challenge posed by OVC by initiating small projects. These organisations survive because of partnerships with government departments or funding from local and international donors. Services provided in the three countries vary, with some only providing day care, and some providing food parcels, school uniforms and fees, and so on.

Professor Simbayi noted that the communities studied responded altruistically in a truly African way to the challenge posed by OVC and successfully implemented OVC interventions or addressed gaps in OVC care. Although the interventions are meant to provide early childhood education to children below school-going age in all three countries, especially in Botswana, demand has been increasing in facilitating access to and success in education of older school-going age children (i.e. provision of school fees, shoes and uniforms, as well as homework support). There has also been a need to provide life skills training, including HIV and AIDS education for both in- and out-of school orphaned and vulnerable young people to help them reduce their vulnerability, especially in South Africa and Zimbabwe.

Professor Simbayi pointed out that there is still a need to determine the effectiveness of the various OVC interventions being implemented throughout Africa before calling them 'best practices' and scaling them up. Again, while impact evaluation is preferable, an alternative approach is to implement some action research (e.g., formative and/or process evaluations) to determine the usefulness of the interventions. He noted that there is also a need to cost the interventions to ensure that they are affordable, especially in the resource-constrained settings that are common in most sub-Saharan African countries.

Listening and Learning from Young People Affected by HIV and AIDS, Dumisane Kunene and Ms Buyiswa Mabaleka, Gauteng, South Africa

A very brief input was given by a young peer educator and programme manager and a formative DVD was screened. These illustrated the importance of involving young people in school-based and out-of-school programme implementation. Although the emphasis of life skills education has been on HIV and AIDS, in selected schools it was found to be effective in dealing with problems of violence and lack of discipline. Implementation has been relatively recent, but there are promising results.

Partnership and Sharing Best Practice Toolkits: Mr W. van der Schaaf, Education International

Mr van der Schaaf presented a profile of Education International, a global teacher trade union federation, and its HIV and AIDS interventions. EI is an organisation that represents more than 29 million teachers and education workers with 348 member organisations operating in 166 countries, from pre-school to university.

Mr van der Schaaf indicated that EI has gone beyond defending basic trade union rights, i.e. individual and collective interests, salaries and conditions of service. EI also promotes quality of education initiatives, curricula/teacher training on issues of HIV and AIDS, and programmes dealing with teacher motivation, pupil drop-out, financing and legislation in the education sectors. Since 2001, EI and its partners have been implementing the global programme on HIV and AIDS training. The aim of the programme is to prevent the spread of HIV through provision of knowledge and skills and promoting a change in attitudes. It also to enables teachers to avoid HIV infection and fight AIDS-related stigma and discrimination (see Figure 13).

Mr van der Schaaf argued that teachers' unions are an important resource. They function beyond the scope of any single project, operate countrywide and have established infrastructures. The EI programme is teacher-driven and school-based, and has proved that it can be scaled up. Mr van der Schaaf noted that there is no systematic, continuous and adequate training at pre-service level, and even less a systematic approach to in-service training. There is also a lack of public service leadership in training teachers on knowledge and life skills, and no insight into plans and implementation.

He pointed to the need to prioritise and making choices, rather than try to do everything at once, and indicated that EI has a 'New Stage 2006–2010 Comprehensive Approach', which focuses on policy development and adoption, training, advocacy, publicity and research.

Small Group Discussions

Following the plenary outputs, delegates were divided into four small groups:

- School-based programmes and learners/pupils
- Youth out of school

- Teachers and education sector staff
- Community responses, including OVC and involvement of parents

The small group discussions focused on the following:

- Highlighting country experiences with regard to the topic under discussion
- Listing good practices for which there is evidence, on condition that the be based on inputs made and country experiences or proven evidence
- Prioritise key actions for implementation (not more than 3), and discuss the barriers to up-scaling these best practices at country level and in Africa
- Make a limited number of recommendations for action and suggest how the Commonwealth secretariat and ADEA should support or take forward these recommendations.

Good practice examples provided by delegates are incorporated into the various sections of the report, and the recommendations developed by consensus are listed in the executive summary and in the concluding section. The box below highlights the key issues emerging from the small groups.

Box 22. Highlights of the four small group discussions

School-based programmes	Youth out of school	Teachers and other staff	Community responses, including OVC
• Strengthen and extend current programmes • Teaching and learning materials exist across region, but inadequate sharing • Need for broader framework to curricular approach • Extensive discussion on training of teachers • Need for more evidence-based M and E • Sustainability to be addressed • Recommendations address teaching and learning material, curriculum and training of teachers	• Small scale innovative programmes exist which vary from working with sex workers, to peer education and social clubs • Income-generating activities important • Barriers include resources, inadequate buy-in and often one person driven, lack of sustainability as programmes are donor driven • Recommendations made on role of education sector and out-of-school youth and coordination across sectors	• Good practices from countries highlighted • Key actions to be prioritised include providing support to all teachers including teachers living with AIDS and their involvement in decision making processes and research on demand and supply • Numerous barriers identified, which vary from bureaucracy, lack of coordination and institutional dialogue to donor policies • Recommendations include capacity building, including information and support for teachers	• Good practices in countries highlighted, almost all at initiative of NGOs/CBOs or FBOs • Good practices include linkages between schools and communities to enhance retention of children in schools, collaborations with community leaders, keeping OVC in families, feeding schemes or programmes and government support • Challenges identified include co-ordination; incentives for community volunteers • Develop mechanisms for identification of OVCs and provide adequate support for community initiatives • Recommendations made regarding advocacy, improved coordination and involvement of parents and communities

Source: Small group discussions and presentations, regional workshop, 2006.

Conclusion

The review and workshop has highlighted the key issues regarding HIV and AIDS in the education sector, summarised in the box below.

Box 23. Key issues emerging

- There is increased recognition of the importance of HIV and AIDS in the education sector.
- Education sector policies and strategic plans have been compiled in most countries.
- NGOs have tended to take a lead in intersectoral programme implementation.
- Unions have played an active role in implementation of programmes for teachers.
- There are many pockets of excellence in all countries, but not wide-scale implementation.
- Implementation generally weak with:
  - Small scale programmes rather than national programmes
  - Geographical disparity within countries (urban versus rural)
  - Mostly focused on school children
  - Programmes beginning to focus on teachers but less focus on other education sector staff
  - Parents have been left out of the loop.
- Mass media programmes: targeting and effectiveness remain doubtful.
- Girl-child progress difficult to determine.
- Life skills programme implementation not uniform.
- Condoms still remain controversial despite evidence for risk reduction.
- Out-of-school youth require attention in general.
- Attention on OVC has tended to focus on school-feeding programmes and other disparities listed above are also evident.
- There is inadequate focus on higher education and the pre-school sector.
- Socio-cultural issues: knowledge is limited and evidence lacking.
- Apparent, numerous overlapping initiatives from international organisations.
- Monitoring and evaluation is inadequate.

There is no scope for complacency and programme implementation must be geared for achievement of maximum impact. Much work still needs to be done, particularly in scaling up effective programmes, in caring for infected and affected teachers and in recognising the duality between the education sector and communities affected by the epidemic.

International initiatives have been taking place in the past few years to fight the spread of HIV/AIDS. The UNAIDS global initiative on HIV/AIDS and

education was initiated with the aim of enhancing national responses against the epidemic by helping governments to implement comprehensive, nationwide education programmes for young people (UNESCO, 2005). The initiative is also aimed at supporting countries as they develop comprehensive education sector-based responses to HIV/AIDS.

The Commonwealth Secretariat and ADEA should take advantage of the existing inter-agency initiatives around HIV and AIDS in the education sector. A multisectoral approach to HIV and AIDS is encouraged in responding and dealing with the disease, especially at national, provincial and community levels. However, full participation of all stakeholders need to be ensured from the conceptualisation of the activity, through to implementation, monitoring and evaluation.

Information sharing and communication is the key to the success of the activity, as is involvement of all the stakeholders in decision-making.

Recommendations

The recommendations listed below emanate from the workshop and represent a consensus view of delegates. The procedure followed was presentation and discussion in plenary sessions, with all delegates agreeing to key recommendations.

Teaching and learning materials

ADEA and the Commonwealth Secretariat should facilitate and encourage the sharing of teaching and learning materials that already exist in different regions in Africa. This can be done by:

- Adapting existing and/or developing teaching and learning materials on HIV and AIDS and sexual reproductive issues;
- Facilitating exchange programmes;
- Working in collaboration with existing structures, e.g. regional economic communities;
- Countries are also encouraged to learn from one another and be proactive in seeking or providing existing materials as well as learning about good practices in Africa and elsewhere.

Approach to curriculum development

- The curriculum should be based on a broader country approach/framework which includes, inter alia:
  - Emphasis on human rights, empowerment and sustainable development;
  - Social support, focusing on the most vulnerable groups;
  - Creating a protective and safe environment;
  - Teaching/learning environment for HIV and AIDS impact mitigation.
- There is a need to recognise and draw on existing frameworks and/or initiatives, e.g. Decade of Education for Sustainable Development documents and other materials.

Training of teachers

- Where relevant, countries should review immediately their teacher development programmes so as to incorporate life skills and HIV and AIDS and commence training without delay.
- Every teacher should be competent in life skills and HIV and AIDS education by 2015.
- Teaching of life skills and about HIV and AIDS should be integrated into the pre-service teacher development programme.
- Comprehensive programmes of in-service training and support should be implemented by 2010.
- There should be a review and/or evaluation of approaches to training teachers:
  - Draw on existing good practices/materials (within countries and other other agencies, e.g. International Institute for Educational Planning and Mobile Task Team modules on HIV and AIDS and education)
  - Management of in-services training.
- Ensure dissemination of information on good practices to all countries.

- Capacity building of education sector staff.
- Countries are encouraged to draw on existing good practices such as 'teachers caring for teachers', and the work done by support groups such as the South African trade unions and KENEPOTE.
- Advocacy and lobbying – trade unions and organisations representing teachers' interests (e.g. those living with HIV) need to be part of all strategic planning, meetings and implementation, such as the 16 CCEM in Cape Town.
- ADEA is encouraged to share its research expertise and to make it accessible to all levels of the education sector.
- Support for teachers with regard to demand and supply to reach EFA 2015

Role of education sector with regard to young people out of schools

- It is important for the education sector to identify vulnerable young people before they 'drop out' and to take remedial steps.
- Improved collaboration and/or coordination of ministries of education with relevant ministries and other relevant organisations or partners that deal with youth programmes, e.g. ministries responsible for youth and health.
- It is important to work with partners and stakeholders in the identification and re-integration of out-of-school youth).
- Provide approaches which include content and methodology for out-of school young people, in particular to give them access to information, skills and services.

Community responses and OVC

- Advocacy for increased public sector funding for OVC.
- Sensitisation and involvement of parents, communities and teachers.
- Use existing mechanisms to lobby and intensify advocacy for in-country public (ministries) and civil society (including private sector) co-operation and co-ordination, so that there is improved protection for OVC and they are enabled to access and remain in the education system.

General recommendations

- Monitoring and evaluation
  - Need for more evidence-based evaluation
  - Consistency of the conceptual framework
  - Coverage and impact
  - Cost effectiveness
  - Potential for replication and up-scaling
- Sustainability
- Governments and international agencies should invest more in building the capacities of local experts and institutions.

Governments should:

- Integrate issues discussed at workshop and programmes/activities of proven effectiveness into ministry of education activities.
- Increase and make available national resources to do the same.

Other education sector issues to be taken forward

- Conditions of employment and appropriate incentives both for training and working in rural areas;
- Pre-school and higher education: HIV and AIDS initiatives;
- The pre-service training of teachers to meet the shortfalls that are experienced and will be experienced;
- Stigma and discrimination must be actively addressed;
- Definition of out-of-school youth and challenges identified (e.g. young married woman of 15 years of age, re-integration, creation of youth ministries);
- Coordination and collaboration across ministries, with NGOs, CBOs, FBOs and international organisations;
- How to prevent shifting of burden of OVC from government to communities;
- Girls education and gender equality;
- HIV and AIDS programmes for other education sector staff, e.g. administrators.

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Appendix 1

Programme of the Workshop on HIV and AIDS and the Education Sector held in Johannesburg, South Africa, 12–14 September 2006

Tuesday 12 September 2006

9.00–13.00 **First Session: Setting the Scene: The Education Sector and HIV and AIDS**
Chair: **Dr Laetitia Rispel**
Rapporteur: **Ms Lebogang Letlape**

9.00–09.05 Opening and welcome

9.05–09.15 Welcoming address: **Mrs C. Mgijima**, *Chief Director, Health and Wellness portfolio, South African Ministry of Education*

9.15–09.45 Introduction, objectives and expected outcomes of workshop: **Dr Jyotsna Jha**, *Commonwealth Secretariat*

9.45–10.15 HIV and AIDS in Africa, the education system and the need for an accelerated response: **Dr H. Boukary**, *UNESCO and ADEA*

10.15–10.30 Questions/comments

10.30–11.00 Break

11.00–11.30 Results of Education Sector HIV and AIDS Global Readiness Survey (GRS) for Africa: Progress, challenges and key recommendations: **Dr P. Babcock-Walters**, *Director of EduSector AIDS Response, University of Kwa-Zulu Natal*

11.30–12.00 Are we overly optimistic on what the education sector can achieve with regards to HIV and AIDS?: **Professor M. Kelly,** *University of Zambia*

12.00–12.30 Leadership and Education Sector responses to HIV and AIDS in Africa: Practical lessons for implementation: **Ms Z. Akiwumi**, *independent consultant (previously World Health Organisation)*

12.30–13.10 Discussion

13.10–14.00 Lunch

14.00–18.30 **Second Session: Developing a Shared Perspective on Best Practices and Approaches in Africa**
Chair: Dr Jyotsna Jha
Rapporteur: Dr Laetitia Rispel

14.00–14.30 Screening of DVD, *A Window of Hope*, World Bank

14.30–15.00 The South African Educators Survey and implications for planning and implementation: **Dr O. Shisana**, *CEO and President, HSRC*

15.00–15.30 Leading and living positively: **Ms M.G. Boroswa**, *Kenepote, Kenya*

15.30–16.00 Break

16.30–18.00 Towards accelerated delivery: Learning from experiences: Lesotho (Southern Africa): **Dr M. Maruping**
Uganda (East Africa): **Mr A. Kibenge**
Ghana (West Africa): **Ms B. Biney**

18.00–18.30 Discussion

Wednesday 13 September 2006

8:30–13:00 **Third Session: Developing a Shared Perspective on Best Practices and Approaches in Africa** (continued)
Chair/facilitator: **Dr H. Boukary**
Rapporteur: **HSRC staff**

08.30–08.45 Screening of DVD *Teachers Caring for Teachers*, **South African Democratic Teachers Union**

08.45–09.05 Summary of key issues emerging from Day 1: **Ms Laetitia Rispel/ Ms Lebogang Letlape**

9.05–10.00 Comments/Discussion

10.00–10.30 HIV prevention: Is life skills education making a difference? **Ms A.-M. Hoffman**, *UNICEF*

10.30–11.00 Break

11.00–11.25 Effective schools-based approach to implementing HIV and AIDS Education: Experiences from the Gambia: **Ms A. Mbaye**

11.25–11.50 Gender, the girl-child, HIV and AIDS and strategies for action: **Ms Rakgadi Mohlahlane**, *Centre for the Study of AIDS, University of Pretoria*

11.50–12.15 Education, youth out of school and best practice programmes: **Ms Fortunate Thwala**, *Swaziland*

12.15–12.55 Discussion

13.00–13.50 Lunch

Chair/facilitator: **Mr V. Juvane**, *ADEA and Commonwealth Secretariat*
Rapporteur: HSRC staff

13.50–14.20 Community responses, OVC and the education sector: Lessons from Southern Africa: **Professor L. Simbayi**, *HSRC*

14.20–14.40 Listening and learning from young people affected by HIV and AIDS: **Dumisane Kunene** and **Ms Vuyiswa Mabaleka**, Gauteng, South Africa

14.40–15.10 Partnerships and sharing best practice toolkits: **Mr W. van der Schaaf**, *Education International*

15.10–15.45 Discussion

15.45–18.30 **Small Group Discussions**

There will be four small group discussions on the following topics:
- School-based programmes and learners/pupils
- Youth out of school
- Teachers and education sector staff
- Community responses, including OVC and involvement of parents

Tea included

The small group discussions will have a resource person experienced in the theme or topic under discussion and will focus on following:
- What are the best practices for which there is evidence, and based on country experiences (related to the topic under review)?

- What are the key actions that should be prioritised?
- What are the barriers to upscaling these best practices at country level and in Africa?
- What are the recommendations for action?
- How should the Commonwealth and ADEA support or take forward these recommendations?

19.00 for 19.30 *Gala Dinner and networking*
Programme director: **Mr V. Juvane**, *ADEA and Commonwealth Secretariat*
Keynote address: Time to act and deliver: The education sector and the response to HIV and AIDS
Dr K. Letlape, *President of the World Medical Association and of the South African Medical Association*

Thursday 14 September 2006

8:30–15:00 **Fourth Session: Consolidation and Way Forward**
Chair/facilitator: Dr Laetitia Rispel
Rapporteur: Ms Lebogang Letlape

8.30–10.30 Feedback from small group discussions

10.30–11.00 *Break*

11.00–12.00 Discussion on various inputs, including consensus (if possible and relevant)

12.00–13.00 Summary of Days 1 and 2 and proposed way forward: **Dr Laetitia Rispel**/**Ms Lebogang Letlape**

13.15–14.15 Discussion and ratification of recommendations/proposals: All

14.15–15.00 Closing comments by Commonwealth Secretariat, **Dr J. Jha**, and ADEA, **Mr V. Juvane** and **South African Department of Education**

Appendix 2

Guidelines for Small Group Discussions at the Workshop on HIV and AIDS and the Education Sector held in Johannesburg, South Africa, 12–14 September 2006

General

There will be four small group discussions on the following topics:

- School-based programmes and learners/pupils
- Youth out of school
- Teachers and education sector staff
- Community responses, including OVC and involvement of parents

A total of two hours will be spent in each small group. Each group will be allocated a chair and rapporteur, with one or two resource people. However, we consider all participants as resourceful.

The role of the chair

The chair must ensure that:

- All members have an equal opportunity to participate in the discussions;
- That the group discussions remain focused on the topic;
- That the allocated time is kept;
- That the discussions are recorded and summarised adequately and handed to the workshop convener.

The role of the resource people

- While all participants are resourceful, the resource people have added passion and have done extensive work in the area of discussion.
- They should assist with providing evidence-based programme information and assist the discussion and development of recommendations in an unbiased manner.

School-based programmes and learners/ pupils

Chair: Dr Jyotsna Jha
Resource People: Professor M. Kelly, Mr A. Kibenga, Ms B. Biney
Other resources: Background paper and presentations
Rapporteur: Ms Lebogang Letlape

Outline:

1. Each country representative should highlight country experiences with school-based programmes (8 minutes per country rep).
2. The group members must make a list of best practices for which there is evidence. This list must be based on inputs made and country experiences or proven evidence.
3. The group must prioritise key actions for implementation (not more than three) and discuss the barriers to upscaling these best practices at
   (i) country level
   (ii) in Africa?

4. Please make limited recommendations for action and suggest how the Commonwealth Secretariat and ADEA should support or take forward these recommendations.

Youth out of school

Chair: Ms Zainab Akiwumi
Resource People: Ms Anna-Maria Hoffman, Ms Fortunate Thwala, Ms Rakgadi Mohlalane
Other resources: Background paper and presentations
Rapporteur: Ms Fortunate Thwala

Outline:

1. Each country representative should highlight country experiences with out-of-school youth (8 minutes per country rep).
2. The group members must make a list of best practices for which there is evidence. This list must be and based on inputs made and country experiences or proven evidence.
3. The group must prioritise key actions for implementation (not more than three), and discuss the barriers to upscaling these best practices at
   (i) country level
   (ii) in Africa?
4. Please make limited recommendations for action and suggest how the Commonwealth Secretariat and ADEA should support or take forward these recommendations.

Teachers and education sector staff

Chair: Mr David Mbetse
Resource People: Mr Wouter van der Schaaf, Ms Mary Boroswa, Mr David Mbetse
Other resources: Background paper and presentations
Rapporteur: Mr Wouter van der Schaaf

Outline:

1. Each country representative should highlight country experiences wrt teachers and education sector staff programmes (8 minutes per country rep).
2. The group members must make a list of best practices for which there is evidence. This list must be and based on inputs made and country experiences or proven evidence.
3. The group must prioritise key actions for implementation (not more than 3), and discuss the barriers to upscaling these best practices at
   (i) country level
   (ii) in Africa?
4. Please make limited recommendations for action and suggest how the Commonwealth Secretariat and ADEA should support or take forward these recommendations.

Community responses, including OVC and involvement of parents

Chair: Ms Jill Tomlinson
Resource People: Prof Leickness Simbayi, Ms Felicity Haingura
Other resources: Background paper and presentations
Rapporteur: Prof Leickness Simbayi, Ms Boitumelo Molemo

Outline:

1. Each country representative should highlight country experiences wrt community responses and OVC programmes (8 minutes per country rep).
2. The group members must make a list of best practices for which there is evidence. This list must be and based on inputs made and country experiences or proven evidence.
3. The group must prioritise key actions for implementation (not more than 3), and discuss the barriers to upscaling these best practices at

(i) country level
(ii) in Africa?

4. Please make limited recommendations for action and suggest how the Commonwealth Secretariat and ADEA should support or take forward these recommendations.

Appendix 3

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