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Education in the context of HIV/AIDS

HEROES AND VILLAINS: teachers in the education response to HIV



David J. Clarke



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Heroes and villains
Teachers in the education response to HIV

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AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
AusAID	Australian Agency for International Development
CBO	Community-based organization
DEMMIS	District-level education monitoring and management information system
DFID	Department for International Development (United Kingdom)
EDC	Education Development Centre
EFA	Education for All
EI	Education International
GBV	Gender-based violence
GIPA	Greater involvement of people living with HIV and AIDS
GTZ	Gesellschaft für technische Zusammenarbeit [German technical co-operation for development]
ELRC	Education Labour Relations Council
EMIS	Education management information system
ESP	Education sector plan
FRESH	Focusing resources for effective school health
FTI	Fast Track Initiative
GTU	Guyana Teachers' Union
HEARD	Health Economics and HIV/AIDS Research Division
HIV	Human Immunodeficiency Virus
IATT	Inter-Agency Task Team
IBE	International Bureau for Education
ICT	Information communication technology
IEC	Information, education and communication
IIEP	International Institute for Educational Planning
ILO	International Labour Organization
INSET	In-service teacher training
KENEPOTE	Kenya Network of Positive Teachers
KNUT	Kenya National Union of Teachers

LSE	Life skills education
LSHE	Life skills HIV education
MDG	Millennium Development Goal
MOE	Ministry of Education
MTT	Mobile Task Team
MOEYS	Ministry of Education, Youth and Sport
MUSTER	Multi-Site Teacher Education Research project
NAA	National AIDS authority
NACO	National AIDS Control Organisation
NGO	Non-governmental organization
OVC	Orphans and vulnerable children
PEPFAR	President's Emergency Programme For AIDS Relief
PLHIV	People living with HIV
PSABH	Primary School Action for Better Health
PTA	Parent Teacher Association
PTR	Pupil-teacher ratio
SADTU	South African Democratic Teachers' Union
Sida	Swedish International Development Cooperation Agency
SPRINT	School Programme of In-Service of the Term
SRA	Situation and response analysis
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TB	Tuberculosis
TTC	Teacher training college
UIS	UNESCO Institute for Statistics
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UPE	Universal primary education
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
VSO	Voluntary Service Overseas
WHO	World Health Organization

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Chapter 1

Heroes and villains: teaching in HIV epidemics

“Everyone in the education sector needs to be more honest, to stop pretending that the sector is doing its best or that teachers are the ones best disposed to teach safe sex and reproductive health” (Coombe, 2004: 22).

“... government ministries such as agriculture and education have not succeeded in the HIV roles imposed on them” (England, 2008: 1072).

1.1 Introduction

It is now over 25 years since the human immunodeficiency virus (HIV) was first identified in 1983, two years after the first identified cases of immune system failure in gay men, women and injecting drug users in the USA. In that same year, a heterosexual HIV epidemic was revealed in central Africa. By 1985, at least one case of HIV had been reported in each region of the world (UNAIDS, 2006a). The virus has since become a global phenomenon. In 2007, 33.2 million people worldwide were estimated to be living with HIV (UNAIDS, 2007a). Every day more than 6,800 people become infected and more than 5,700 die from AIDS (UNAIDS, 2008).

While HIV is a global phenomenon, sub-Saharan Africa is the most affected region, accounting for more than two thirds of all HIV-positive people, 61 per cent of whom are women. Southern Africa alone accounts for 35 per cent of all people living with HIV (UNAIDS, 2007a). National adult HIV prevalence exceeded 15 per cent in eight countries in 2005 (Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe). The extremely high levels of HIV prevalence call for an intensified response in these countries.

The education sector response to HIV has been a long time coming. Its emergence at the international level can be traced back to the International Conference on Education at its fortieth session, held in 1986, which unanimously adopted a special recommendation

entitled *Education in the Fight against AIDS*, based on a proposal by the delegation of Venezuela (UNESCO, 1987*a*). UNESCO's Draft Plan of Action in Education for the Prevention of AIDS (UNESCO, 1987*b*) was presented as an integral part of the World Health Organization (WHO) Global Strategy for the Prevention and Control of AIDS.

Since the late 1980s, many countries have attempted to harness the education sector to prevent the spread of HIV as part of the multi-sectoral national response. Ministries of education (MOEs) have done this with varying degrees of commitment, intensity, programme coverage and effectiveness. Evidence from research on HIV in the sector presents a mixed picture: While the response has grown in scale, progress has generally been slow (World Bank, 2004*b*). Moreover, it has recently been alleged, somewhat contentiously in the absence of empirical evidence, that MOEs have not succeeded in carrying out the roles imposed on them in the response to HIV (England, 2008). It is possible to take a more optimistic view, but it is abundantly clear that the education sector response to HIV represents work in progress and more long-term investment is required almost everywhere. More research is also needed to identify success factors. It is surely time to take stock of what the education sector response to HIV has achieved and what it now needs to accomplish to reach its objectives.

As the global HIV epidemic becomes better understood, it is becoming clear that a stronger emphasis on cost effectiveness is required, as well as greater investment in health systems. In particular, it is now recognized that other countries are unlikely to follow the disastrous path of countries in Southern Africa, which has resulted in high rates of HIV prevalence in the adult population. This requires a fresh look at risk and vulnerability. Instead of assuming that everyone is at risk, HIV interventions need to be tailored to address the specific risk behaviour dynamics of local HIV epidemics, and ensure that those at higher risk are prioritized in programming (Wijngaarden, 2007).

The role and effectiveness of the education sector response to HIV are likely to come under increasing scrutiny. For some HIV specialists, the formal education sector represents a low priority for resource allocation in a low prevalence epidemic. The most vulnerable and at risk are not in school. The cost-benefit calculation, however, seems to ignore the fact that education can reduce stigma and discrimination of people living with HIV, help create a broad understanding of HIV-related risks

in society, and build a constituency to address the social factors which foster vulnerability and unsafe behaviour. The education sector response to HIV is an investment in the long-term development of society and its competence to deal with the challenges of HIV. It is a necessary investment. It is not a quick fix, the kind of solution so often beloved of politicians and development agencies.

Enhanced scrutiny would be useful because hard evidence is lacking that formal education is providing a significant contribution to rolling back the HIV epidemic anywhere. In the case of successful national responses to HIV, such as in Brazil, Cambodia, Senegal, Thailand and Uganda, it is hard to discern the impact of education sector contributions. In contrast, the effectiveness of scaling up condom use to ensure that sex work is safer, and provision of needle exchange programmes for injecting drug users, stand out as proven HIV prevention interventions. Thus, a critical question to consider is how the education sector can best make a cost effective contribution to the national effort to address HIV.

After almost a quarter of a century of responding to HIV, the education response shows mixed results. This is probably inevitable given the diversity in and scale of education systems. There are conflicting discourses, of success and failure, of heroes and villains in schools. A case can be made that the education sector response to HIV has generally been very slow and disappointing (World Bank, 2004*b*). Many schools have struggled to deliver the knowledge and skills that young people need for living healthy lives, including protecting their sexual health. Much of the blame has been levelled at teachers for the various shortcomings in HIV education, however conceptualized. Yet there is also demonstrable evidence of success. Research across developing countries shows that curriculum-based sex and HIV education works in increasing knowledge and even changing some reported behaviours when the key factors or characteristics of effective programmes are present. Such programmes have not led to increases in unsafe sexual behaviours (Kirby, Obasi and Laris, 2006). The lack of a consistent internationally agreed monitoring framework for the education sector response means that the picture is often like a jigsaw puzzle, to which important pieces are missing.

The promise of education as a significant contributory factor to HIV prevention remains pertinent if elusive. With no vaccine on the horizon, the need for effective HIV education remains. In a world where it is widespread for parents to be unwilling or unable to provide education

about HIV-related risk and associated issues, this responsibility perhaps inevitably falls upon teachers as significant actors in the lives of children. This is often a new challenge for teachers; in general, one they have yet to meet adequately. A critical concern is the well-evidenced difficulties that many teachers, in a wide range of cultures, have in teaching about sex, which is the main mode of transmission of HIV and must be considered as a fundamental aspect of HIV education. This represents a critical hurdle to overcome. Without the political commitment and technical competence to address this issue, the important and wide-ranging education sector response to HIV risks being largely ineffective.

As with all forms of formal face-to-face education, effective teachers make a significant difference to learning outcomes. The challenge for education policy-makers and planners is to optimize the contribution teachers make to the HIV response, often in the context of an under-funded and under-performing education system. This poses new challenges in classroom teaching for those involved in delivering HIV-related education. Such challenges include new content matter which, since it deals with sexual behaviour, is usually culturally sensitive or even taboo; different and more participatory teaching skills; and new perspectives on students' learning needs. It is essentially a new education paradigm for many teachers who have been schooled in more didactic modes of education delivery. Thus, it is important to consider how MOEs can successfully introduce, scale up and sustain such a radical new approach in education service delivery.

At the same time that teachers are being called on to help prevent HIV infection among their students, in high prevalence settings, HIV is changing the way schools operate as the virus is impacting significantly on families and at the community level. This may require a shift in the roles that schools play in addressing the needs of young people to expand the provision of care and support services. In such contexts, HIV has radical implications for how teachers are trained and supported, particularly where epidemics are a credible threat to the achievement of national development objectives, including poverty reduction as is the case in some countries in sub-Saharan Africa, the Caribbean region and in Asia.

Research has revealed the response of teachers to HIV to be a continuum of performance. At the two opposite poles are to be found the 'heroes' and 'villains', with the overwhelming majority of teachers

positioned in neither category. However, it is the extremes that most clearly illuminate the issues that need to be tackled to strengthen the effectiveness of teachers and schools in addressing HIV, with the learning processes and outcomes of young people uppermost in mind.

1.2 Heroes and villains

Heroism requires courage in the face of adversity. The severe HIV epidemics in East and southern Africa, in particular, have amply demonstrated the destruction that AIDS can cause in families and communities. In addition, the stigmatization of people who are, or reputed to be, living with HIV is almost universal, with the consequence that their human rights are frequently violated. In this context, teachers who break the silence on HIV in many communities need to be brave and be supported by the education system.

The heroes are usually unsung. Perhaps the most conspicuous heroes in HIV education are those ministers of education who are prepared to speak out about HIV and to show leadership on HIV. They have been too few in number. The slow development of comprehensive education policies and sector strategies on HIV that have been implemented around the world is arguably a testament to a lack of heroism and commitment at senior level in governments to the well-being of all young people.

Teachers are local heroes. They generally have a prominent status in the communities in which they serve. They are often role models for the young and are likely to be perceived as moral actors. How teachers behave and the attitudes they hold are likely to contribute to shaping the worldview of the children they teach. This can be positive or negative in impact. Therefore, they can be potentially enormously influential in changing attitudes towards HIV in society and in preparing young people for life in a world with HIV and its related risk factors. Due to lack of research in this area, the influential and long-term contribution of teachers to enabling societies to be more competent in preventing HIV and dealing with its consequences is undocumented and largely unproven. However, it is known that capable teachers who have been trained and are supported are a characteristic of effective HIV and sex education programmes in developing countries (Gallant and Maticka-Tyndale, 2004; Kirby *et al.*, 2006). At the same time, there is sufficient research evidence to suggest that many teachers are not succeeding in delivering HIV education as intended. The overall picture is cloudy, contradictory and confused.

HIV has impacted severely on the teaching stock in high prevalence settings in East and southern Africa. Some teachers have responded to the new adversity with courage. Teachers are performing heroically in continuing to work while living with HIV, though hiding their status from fear of stigmatization and the risk of 'spoiled identity' that typically results from stigma (Goffman, 1963). There are reported instances of teachers valiantly continuing to teach in class even though seriously ill with an HIV-related infection. Some have made preventing HIV among their students their mission, and in effect have become local activists. Others have reached out to provide care and support to children who have been orphaned by AIDS where only ostracism was to be found in the community. Those working in faith-based schools may have made a more significant contribution in this regard.

Who are the villains? While it is clear that some teachers are responding energetically to the HIV challenge, a problem is that many are not contributing positively or effectively to the education sector HIV response. Whether or not they are to blame is an open question. There are many factors to be considered and they will be investigated in this book.

In high HIV prevalence settings, the role of the teacher is arguably the most problematic and challenging. It is here that the highest expectations are being placed on the teacher to help reduce infections among adolescents and young adults. Yet in these contexts, teachers have been cast as sexual predators, with some male teachers being identified as abusing and exploiting female children in their care. It was put to me in a workshop setting that some teachers in one such country regarded this as 'a side benefit' of the job. The sexual abuse of girl students by male teachers has been given a potentially fatal twist by the threat of HIV infection, and the issue has perhaps assumed higher prominence than it otherwise might have in education systems which traditionally have turned a blind eye to such practices.

In some parts of southern Africa, teachers have been accused of spreading HIV in the community because of their ability to purchase sex, their higher status and their mobility (Kelly, 2000). It has even been suggested that teachers might constitute a 'high-risk group' for HIV transmission, presumably in addition to 'high-risk behaviour groups' (or 'most at-risk populations') such as female sex workers, men who have sex with men and injecting drug users. Teachers also stand accused of stigmatizing and discriminating against children who are living with HIV or who are affected by HIV due to parental infection or death, and of

denying them access to education. They are also capable of stigmatizing their colleagues who are living with HIV. These are serious issues with profound implications for the equitable and sustainable development of education sectors in high HIV prevalence contexts. How should such ‘villains’ be dealt with and how can school environments be made safe, secure and conducive to learning for all?

A challenge for policy-makers is identifying which interventions will maximize the potential for teacher effectiveness in the field of HIV education and to relate these to wider issues of professionalism and development. This is often in an environment where there is competition for scarce resources, and where the voice of civil society for increased investment in HIV-related education is weak. How then can more teachers become local heroes in the HIV response? More contentiously, under what circumstances do they have the courage to teach openly about HIV?

1.3 Teachers as duty-bearers and rights-holders

A human rights perspective is essential when addressing HIV. In human rights parlance, teachers are ‘duty-bearers’ who have obligations to fulfil the rights of the children who are in their care, *loco parentis*. These include the right to education, information and the highest attainable standard of health. Children have the right to protection from sexual exploitation and abuse, as well as from all forms of physical or mental violence. The UN Convention on the Rights of the Child (United Nations, 1990) provides a comprehensive framework that is applicable to responding to HIV. On the basis of this, it can be argued that children have a right to appropriate education about HIV and related issues, especially as this has implications for the right to health and even to life. This responsibility in education service delivery in practical terms would ultimately fall to the teacher, although at school level the school principal has a critically important role. In spite of the obvious need, engaging teachers in HIV education has proved to be a difficult challenge, at times verging on a ‘mission impossible’. As a result, the rights and the best interests of children have often been denied. It is tempting to conclude that this has had real life consequences among the more vulnerable school population in high HIV prevalence settings.

The duty-bearer role of teachers concerning HIV is challenging. In a range of contexts, empirical evidence has shown that teachers struggle with both the content matter and pedagogy of HIV education. Many teachers lack confidence in teaching about socially sensitive issues, especially

those connected with sex, sexuality and sexual health, which creates embarrassment in class and compromises effective teaching and learning. The practice of selective teaching is widely reported in HIV education, which occurs when teachers omit the content that they are uncomfortable with and sometimes promote their own perspectives or beliefs. This is a teacher survival strategy, in line with what Scott (1985) has termed a 'weapon of the weak'. In selective teaching, only those content areas in which the teacher feels confident are treated. The consequence is that the logic of HIV prevention education is damaged, partial information is provided, and perhaps the most important preventive knowledge is denied to students. This has led to the widespread perception that teachers cannot deliver effective HIV education. They are not uncommonly perceived as poor deliverers of sex education.

Since probably the vast majority of school-based HIV education programmes are teacher-led, how teachers personally situate themselves with regard to sex education is likely to be critically important for their implementation. This requires that they be aware of their own gendered beliefs, values and practices in everyday life. Their ability to address harmful social attitudes towards people living with HIV, homophobia and gender inequality is critical to achieving long-term social change that will be important for reducing not only the spread of HIV, but also other social issues that adversely affect the poor and the marginalized.

While the need is for a transformative approach to education, the reality is that many teachers are conservative in their professional approach and are often responsible for replicating the social order rather than changing it. HIV education requires something different of teachers rather than business as usual. Aside from needing their social activism, it entails that teachers play a key role in forming the attitudes, values and behaviours of young people, to enable them to live responsible lives in a fast changing world. This is, of course, a traditional function of education, part of being a 'guru', but one that appears to have been somewhat marginalized in the development of education for economic opportunity. In a world where communication between parents and children is difficult or non-existent, especially over issues of adolescence, sexuality and youth culture in a rapidly globalizing world, the importance of teachers as guiding influences cannot be overestimated.

It is important to recognize that teachers are not only duty-bearers, they are also rights-holders. HIV threatens the human rights of those teachers living with HIV through the stigmatization and discrimination that people living with HIV typically face. This can involve exclusion

or restrictions in a wide range of areas, including health care, welfare, insurance and employment. Teachers living with HIV can face isolation and discrimination from colleagues, humiliation, and being regarded as immoral. In this instance, teachers are also victims and their rights need to be ensured within the workplace and the sector as a whole. They need both protection and empowerment.

Teachers are a heterogeneous group. They include heroes, villains and victims. Among the teachers who have been willing and able to meet the challenge of HIV education in various contexts, some are inspirational and most likely have a profound effect on many of their students. In the author's own experience, some such teachers have spoken of their strong personal commitment to preventing HIV and to eliminating the stigmatization of those affected by or living with the virus. Some, in effect, make tackling HIV their life's work. What shines through in such cases is their concern and care for the children in their charge, motivated by the simple reward of being appreciated by their students. Teachers at their best are outstanding people.

1.4 A failure to invest in teachers and to recognize the threat from HIV

This study has its origins in the perception that the education response to HIV was generally failing to equip teachers with the necessary skills and resources to be effective in the classroom. There has been an understandable concern with proving the effectiveness of school-based HIV education in delivering the knowledge and skills that would help young learners protect themselves from HIV infection. The focus has been almost exclusively on the learner, with the teacher at risk of becoming a residual category, a factor of education service delivery.

HIV education programmes have often been donor designed, financed and driven. The project drivers have all too often not been educationalists, but health specialists of one kind or another. Interventions have been well meaning, but typically lacking an understanding of the complexities of education systems and of managing change processes within them. Too often the education response to HIV has been an enclave project. The negative consequences of this include a failure to mainstream the HIV response within the overall education development framework, usually the Education Sector Plan (ESP); a lack of ownership on the part of the local ministry of education, and a lack of synergy with education sector processes and best practice. Unsurprisingly, this also risks compromising programme coverage, effectiveness and sustainability.

A positive consequence is that the robustness of health sector research has been applied to HIV education sector programmes. These have demonstrated that such programmes are indeed effective in increasing knowledge and changing reported behaviours, provided certain interventions take place (Gallant and Maticka-Tyndale, 2004, Kirby *et al.*, 2006). This is good news as some mainstream education delivery is manifestly failing to achieve its intended learning outcomes.

Teachers are being asked to deliver HIV education programmes for which they feel they are inadequately prepared, resourced and supported. They are being required to teach about topics concerning sexuality, which have traditionally been taboo in schools in most countries. The comfort levels of teachers in dealing with these issues varies somewhat across countries, but it would not be unsafe to state that perhaps the majority of teachers face some sort of embarrassment in teaching about HIV. Some are able to overcome their shyness; many are not and omit the topics and activities that are threatening to their confidence and self-esteem.

The dominant paradigm for HIV education is life skills education (LSE). Life skills-based HIV education is based on a health promotion framework that requires the teaching and practice of cognitive, emotional and social skills through a range of participatory activities rather than didactic teaching. There are two immediate problems with LSE. The first is that it represents a new conceptual paradigm for the majority of serving teachers. The second is that it requires participatory student-centred teaching and learning to be introduced in education systems that rely on didactic teaching. The prospects for success are slim without adequate long-term political, technical, financial and social support for this innovation. In some contexts, LSE may be an innovation beyond the current carrying capacity of the education system.

MOEs in high prevalence HIV countries have been slow to recognize the threat to their human capital. In East and southern Africa, the losses to AIDS have been substantial. Interventions aimed at minimizing the impact of HIV on the teaching stock have been slow in coming. That they have emerged at all is in part due to the courageous activism of a few inspired and far-sighted individuals who have undertaken much needed impact research and identified potential interventions. That the main problems to be faced were clearly identified in the early 1990s (Shaeffer, 1994), the reluctance to respond by governments and donors now appears reprehensible and negligent of the teaching stock.

Finally, there is what is sometimes referred to as the ‘wider crisis in education’. Expectations about what teachers can reasonably accomplish in HIV education programmes need to be tempered with a realistic assessment of the various constraints to be encountered as a result of long-term inadequate investment in the development of the sector, perhaps exacerbated by the impact of HIV on the supply and quality of education. The result is that teachers are all too often ill prepared for the complex and difficult task of teaching in a world with HIV. They deserve better than this. Some teachers perform heroically in the teeth of adversity, but they are a minority. With greater support and better conceptualized interventions, more teachers can become local heroes.

1.5 HIV and new challenges for the teaching profession: some personal perspectives

In a training workshop for teachers on HIV which I attended in Fiji in the late 1990s, a group of male and female teachers was asked by a confident and outgoing facilitator to map parts of the body associated with sexual practices. Where the practice had a name it should be mentioned. All work was done in plenary format with no opportunity for small group work. The reluctance of the teachers to reveal their sexual knowledge was an immediate barrier to discussion. The sense of embarrassment, not to mention fear, was palpable. It was a deeply uncomfortable experience for many of the participants. The NGO facilitator, who clearly revelled in openly discussing sexuality, had to work exceptionally hard to break the ice and obtain the opening responses. He achieved this with the female teachers who were more able to discuss sexual practices than their male counterparts, who remained very reluctant to give anything away and contributed little to the discussion.

A number of conclusions can be drawn from this experience. First, any training for teachers on HIV involving issues of sexuality would have to be carefully tailored to the context of the teaching profession. Teachers can be very conservative, as seen in the experience mentioned above. Second, gender norms and relationships are clearly of huge importance when developing training content and processes. Thirdly, it is important for teachers to be able to communicate sexual issues with confidence. A failure of nerve among learners, let alone by the teacher, is contagious and can vitiate the learning experience.

In another context, that of a village in rural Uttar Pradesh, India, I was recently engaged in a review of school-based HIV education involving a focus group with community leaders. I recall the head teacher arguing

vehemently that masturbation should not be mentioned in school. If boys knew about masturbation, how could they have a normal married life? The anatomical illustrations of the human body in the teachers' guide were considered to be 'pornography' and the flip chart depicting these was not to be used in class. Traditional cultural perspectives were clearly going to be difficult for any teacher in teaching about sex and sexuality. The buy-in and support of the school head teacher would likely be of critical importance to effective implementation.

It has become clear to me that many teachers, perhaps the majority, would encounter personal and social impediments in teaching about sexual behaviours and HIV in the classroom. A certain amount of necessary personal heroism would be required to teach about such culturally sensitive issues.

A few years ago, in Nigeria, I was involved in reviewing a LSE programme that had been introduced in secondary schools in one state. I was struck by the enthusiasm students had for the subject and by what teachers reported in terms of improved student behaviour in class towards the teacher and each other, including in terms of enhanced respect for gender. Although the school contexts were sub-optimal in terms of their available resources, something very positive was being delivered by the programme, with benefits that went beyond its original remit, and was even contributing to an improved learning environment in the classroom. Success appeared to be possible in quite unpromising circumstances.

1.6 What this book is about

This is an investigation from the standpoint of the classroom teacher into how school-based education is addressing the global HIV epidemic. It attempts to examine issues concerning teachers and HIV in a comprehensive framework, investigate the available evidence, take stock and make sense of the various conclusions for policy-makers and practitioners.

The critical importance teachers have in the delivery of education sector outcomes is reflected in the perception in many countries that they constitute the most important element where educational quality is concerned (World Bank, 2005). It is therefore likely that the contribution of the teacher will be of enormous significance in achieving the objectives and intended learning outcomes of HIV prevention education.

While there is a growing literature on HIV education, there are few studies which focus on the teacher. This study will seek to address that gap

and synthesize evidence from a diversity of HIV epidemics and education systems with the aim of drawing lessons learned and recommending steps to be taken by MOEs, teachers' unions and development partners to strengthen the role of teachers in tackling HIV and related issues. It will also identify gaps in our knowledge where further research is required.

The intended audience for this work consists of education policy-makers and planners, teacher trainers and teachers who are working in the field of HIV prevention education. The work will attempt to discuss the available evidence for effective programmes, provide accessible guidance and suggest resources that can be used up by those who are concerned with practical action.

This is not a straightforward task. The education sector response to HIV has been a neglected and contested policy area for more than two decades. The nature of contest varies from country to country, but in general the divide is between those who believe that schools have an important role in providing sexuality education and those who do not. The political sensitivities surrounding education about sex and morality have affected and continue to influence the design of the curriculum for HIV prevention and how it is actually implemented. The sensitivities can affect development organizations too. I can vividly recall some years back discussing HIV education with a senior education adviser for a bilateral agency with technical responsibility for education assistance to some of the most severely affected African countries who considered the issue too sensitive to raise with ministry officials. I can also recall being told by an eminent education researcher that HIV issues were 'not interesting theoretically'.

This study recognizes the heterogeneity of teachers. Teachers constitute a large work force with multiple perspectives influenced by age, gender, ethnicity, religious and secular beliefs and values. It recognizes the hazards of generalization and the importance of valuing teachers as individual human beings who are rights-holders rather than as dehumanized factors of education service delivery. Above all, it is guided by the belief in the fundamental importance of teachers in moulding the lives of young people. They can make a difference to young people's readiness to prevent HIV and to building societies competent to deal with HIV and AIDS.

1.7 Structure of the book

This book is structured so as to present evidence of the critical issues concerning HIV education, and teachers and then examine current national education sector responses. It is essentially a situation and response analysis (SRA) that investigates the teacher in an HIV context.

Chapter 2 introduces the critical issues and sets out an analytical framework for investigating the education response to HIV. This is derived in part from practical experience in undertaking SRAs of the education sector response to HIV in a number of countries.

Chapter 3 investigates in greater detail the contexts of teachers in responding to the multiple challenges of HIV. Education systems and teachers have been caught unprepared. How can the sector improve its readiness to respond? It identifies a number of key impediments to effective teacher performance, not only with regard to HIV education, but also more generally.

Chapter 4 analyzes the evidence of and issues concerning teacher performance in delivering HIV education and teacher effectiveness more generally. It also investigates teacher training about HIV.

Chapter 5 examines the negative aspects of teacher behaviours and practices with regard to HIV, including sexual harassment and abuse, discriminatory attitudes and behaviours, poor motivation etc. with a view to overcoming them.

Chapter 6 investigates how best to prevent or mitigate the impact of HIV on teachers. It examines available country-specific evidence on how teachers have been impacted by HIV, especially in sub-Saharan Africa, the most severely affected region. How can the vulnerability and risk environment for teachers be reduced?

Chapter 7 presents a summary of the findings together with recommended actions for MOEs.

Chapter 2

The global HIV epidemic and the education response

“HIV reaches very high levels only in areas where there are lots of simultaneous sexual relationships, lots of untreated STIs [sexually transmitted infections] and lots of uncircumcized men” (Pisani, 2008: 134).

“Gender roles are the engine of the AIDS epidemic” (Plummer, 2007: 6).

2.1 The global HIV epidemic: implications for the education sector response

In order to contextualize the education sector response to HIV, it is necessary to have a brief overview of the global HIV epidemic. Global HIV prevalence has remained stable since early 2000, but AIDS has remained among the leading causes of death and the primary cause of death in Africa (UNAIDS, 2008; 2007a). The global estimate of the number of persons living with HIV in 2007 was 33.2 million (UNAIDS and WHO, 2007). This represented an estimated 16 per cent reduction on the 2006 estimate of 39.5 million (UNAIDS and WHO, 2006). The decline in the number of estimated people living with HIV arises from advances in methodology and better quality data rather than trends in the epidemic. Some 70 per cent of the reduction arises from new data in six countries (Angola, India, Kenya Mozambique, Nigeria and Zimbabwe).

With no vaccine currently on the horizon, the first priority must be prevention of HIV transmission. Aside from infection from infected blood and through vertical transmission in mother-to-child infection, this entails addressing the specific behaviours that put individuals and groups at risk and the underlying social constructions of vulnerability to risk. Experience has shown that this is best achieved through a co-ordinated range of multi-sectoral interventions encompassing access to sexual health services and behaviour-oriented education. Advances in treating HIV-related disease or AIDS now mean that life in most cases can be significantly prolonged with the provision of antiretroviral therapy

(ART). HIV is now no longer an automatic death sentence. The challenge in providing treatment is for governments to finance access to ART for those that require it, and to ensure that provision is for life.

The examination of global and regional epidemiological trends by UNAIDS suggests that there are two broad patterns. First, epidemics are being sustained among the general population, chiefly in sub-Saharan Africa, especially in the southern part of the continent. This is the region that is most seriously affected by HIV, where it is the leading cause of death. Second, epidemics elsewhere in the world tend to be concentrated among most at-risk populations, such as sex workers and their clients or partners, men who have sex with men and injecting drug users. These patterns imply that different response strategies are required. A more concentrated epidemic requires greater targeting of interventions for those at most risk and less investment in HIV prevention among the general population. The education sector response must position itself appropriately, which means a less intensive school-based approach.

Preventing HIV requires an understanding of how it is transmitted, biologically and socially. HIV is transmitted from person to person primarily through blood and sexual fluids such as semen and any body fluid that may contain blood. According to Chin (2007), the main persons or groups at risk of infection are:

- heterosexuals, or men who have sex with men, who have unprotected sex with multiple partners, especially within large and overlapping sex networks;
- injecting drug users who share needles with each other, especially within large networks;
- persons who are regular sex partners of HIV-infected persons;
- infants born of HIV-infected mothers;
- persons who receive HIV-contaminated blood or blood products in health care settings, or who are accidentally injected with HIV-infected medical equipment.

A rapid mapping of these risk profiles against the school-age population is likely to produce a poor fit in the majority of social contexts. It is only where widespread early initiation into sexual activity is prevalent that significant numbers of children (up to the age of 18) will be drawn into adult sexual networks and the risk of HIV infection. This does seem to be the case in the context of the high prevalence epidemics of East and southern Africa, but rarer elsewhere. Generally, it is those

who are out of school who are more likely to be involved in drug use and engaged in sex work, and activities which are not readily compatible with school-going life. Street children may be especially vulnerable to HIV infection, for example. This has extremely important consequences for the designing of the education response to HIV.

It is important to recognize that across the world, the majority of persons are not at any measurable risk of HIV infection (Chin, 2007). This applies to school-going populations. The majority of children at school do not have multiple and concurrent sex partners, the major driver of explosive HIV epidemics.

The infectivity of HIV through vaginal intercourse is very low in the absence of facilitating factors such as sexually transmitted infections (STIs), while male circumcision has recently become recognized as a protective factor. The factors required for a sustained generalized epidemic with high HIV prevalence rates (greater than 1 per cent of the adult population infected) include:

- large, open or overlapping sex networks;
- high numbers of daily sex partner exchanges;
- a low percentage of male circumcision;
- low condom usage rates;
- high prevalence of facilitating factors, such as STIs.

The main parameters of sexual risk behaviour among young people are the following (Chin, 2007):

- median age of first sexual intercourse;
- percentage of young male and females who engage in premarital sex;
- percentage of sexually active males and females who had non-regular and commercial sex;
- percentage of males and females in regular sex partnerships (married or otherwise) who report having sex partners outside their regular sex partnership.

The risks are gendered. For girls, early marriage to or an unprotected sexual relationship (voluntary or coerced) with an already infected older man are clearly major risk factors. For boys, early and unprotected sexual initiation with an infected girl or woman (or man), possibly within the context of commercial sex work represents a clear risk. This implies that the education sector response to HIV in the field of primary prevention

needs to provide a comprehensive education about sexual health contextualized in the local risk environment. It should include strategies to promote the delay of sexual intercourse, fidelity to one sexual partner and the use of condoms if there is any risk of STIs and HIV transmission. Education programmes that promote abstinence only among adolescents do not make good public health sense and have been proven to fail in high-income countries (Pisani, 2008; Underhill *et al.*, 2007; Bruckner and Bearman, 2005).

Sex education should begin *before* sexual initiation in order to prevent or mitigate future unsafe behaviours, which will take place later in adult life. Programmes targeting younger, primary school children have had greater success in influencing sexual behaviours compared with those targeting older, secondary school children. Likewise, there appears to be varying success among youth who were virgins at programme initiation compared to those already sexually active (Gallant and Maticka-Tyndale, 2004).

Where school-going children are already involved in adult sexual networks, there will be a need for more intensive behaviour change programmes. It follows that school-based preventive education is concerned largely with developing a society that is competent to deal with HIV, rather than providing behaviour change programmes for high-risk-taking behaviour groups and individuals. It should be forward looking and preparatory, as well as dealing with any immediate sexual risks. Where children are involved in adult sex networks, it is critically important to increase the age of first sexual experience and minimize the extent of sexual relationships of those already sexually active.

Unfortunately, HIV preventive education programming has had the tendency to design courses as if all students were at immediate high risk of HIV infection. The methods of behaviour-change developed for high-risk groups such as sex workers and men who have sex with men, such as peer education, have been applied without much careful interrogation of the life worlds of children and the local reality of HIV risk. A 'one size fits all' approach well describes the current paradigm, which is out of kilter with epidemiological evidence of varying risk.

In order to respond effectively to the HIV threat, it is clearly necessary to 'know your epidemic' (UNAIDS, 2007*b*). This is a belated recognition that HIV epidemics are socially constructed and vary according to social context. The mantra implies a *think local and act*

local paradigm, but taking into account global experiences in responding to local epidemic drivers. An important component of this is qualitative and quantitative research to obtain local risk behaviour data. These have strong implications for measuring the behavioural objectives and outcomes of HIV education programmes. They need to be based on evidence of vulnerability to and risk of HIV infection in the local context, rather from a universal template of HIV-related knowledge and skills.

2.2 Looking at different epidemics

The region worst affected by HIV and AIDS is sub-Saharan Africa and particularly southern Africa. A recurrent question is whether such severe epidemics are a precursor of epidemics elsewhere in the world or the outcomes of specific local social conditions. The current assessment is that the hyper-epidemics of southern Africa will not be replicated elsewhere as the sexual risk environments are different.

It is illuminating to compare data from Africa and Asia. For example, knowledge, attitude, behaviour and practice surveys have found that a consistently higher proportion of young people in Africa, especially females, reported unsafe sexual behaviours than in Asia (Chin, 2007). Single women in Asian countries such as the Philippines, Singapore, Sri Lanka and Thailand reported far lower rates of sexual intercourse than their African counterparts. In many Asian countries, sexual relations before marriage are not condoned by society and are condemned by religious teachings and leaders. In these contexts, sexual risk-taking is strongly conditioned by gender norms and practices. As a result, it may be the practice for young males to seek out commercial sex or older women who are already sexually experienced. This is particularly marked in Cambodia, Thailand and Myanmar. Median ages of reported first sexual intercourse in Asia are significantly higher than in many sub-Saharan African contexts. These are notably late in Singapore (over 25) and Sri Lanka (27 for males).

The Commission for Africa (2005) comments that the sexual transmission of HIV involves “embedded traditions and power hierarchies” (p. 203), including men who have multiple partners, and truckers and combatants who sometimes pay for sex. In addition, women are unable to negotiate safe sex and experience high levels of violence and discrimination. It follows that HIV prevention must attempt to address the constructions of masculinity and the status of girls and women.

According to the Commission on AIDS in Asia (2008), HIV epidemics in Asia are centred around unprotected paid sex, the sharing of contaminated needles and syringes by injecting drug users and unprotected sex between men. Of these factors, sex work is the single most powerful driving force. Since relatively few women have sex with more than one partner, the epidemics are unlikely to be sustained independent of sex work, injecting drug use and men who have sex with men. HIV prevention efforts will need to focus on these three risk domains, with the recognition that a substantial proportion of the male population may be the clientele of sex workers at some time in their lives.

In the Caribbean region, heterosexual epidemics are driven by early sexual activity and frequent partner exchange by young people, with sexual mixing between older men and younger women being common (Kelly, 2005). An ethnographic study of young women and sexual relationships in Jamaica found that despite pre-dominant social norms to the contrary, multiple concurrent relationships are an accepted reality (Rolfe and Hemmings, 2007). Different partners fulfil various emotional and economic needs. Multiple partners are likely to be the norm and can be considered a rational response to socio-economic realities, rather than the result of individual behaviour preferences. Women risk transgressing expected boundaries of behaviour by developing a range of relationships with men to access various resources. Older men are generally preferred partners for a number of reasons, beyond the important financial imperative. Condom use is influenced by type of partner and stage in relationship. The data suggest inconsistent use with non-primary partners, and reluctance to use with primary partners after the initial stages of the relationship. Beliefs in ability to detect sexual risk, and stereotypes associated with HIV, represent a local risk assessment framework for judging HIV risk, which may cause people to underestimate their risk. The World Bank (2003a) states that sexual and physical abuse is high in the region, while the onset of sexual initiation outside of marriage is the earliest in the world.

A number of conclusions may be drawn from the discussion above. It is clearly of considerable importance to understand the dynamics of the local HIV epidemic when developing education interventions. For example, the dynamics of HIV epidemics in Asia appear to be substantially different from those in sub-Saharan Africa, especially in East and southern Africa. Proportionately fewer young people are at risk in Asia, but unsafe sexual behaviour among men needs to be specifically

addressed. The importance of understanding local gender norms and practices in addressing the behaviours that are conducive to STI and HIV transmission needs to be understood by policy-makers if they are genuinely committed to effective HIV prevention programmes.

We have already seen that UNAIDS guidelines on HIV prevention (UNAIDS, 2007*b*) emphasize the importance of knowing your epidemic and your current response, which enables countries to match and prioritize responses that are most appropriate and effective to the context. For example, Wijngaarden (2007) recommends that in Asia an increase of resources for age- and gender-specific HIV prevention be based on a hierarchy of risk and vulnerability. Thus the prevention response needs to be tailored to the specific HIV transmission dynamics. This paradigm has major implications for the education response to HIV.

Programmes will need to be tailored to the context in HIV prevention education, which will prove to be a considerable policy challenge in complex multi-cultural countries where the risk environments may vary considerably within the country. This implies some provision for a flexible decentralized response in HIV education to incorporate local perspectives issues and risks. In this approach, fostering local ownership and building local capacity are likely to be critical to effectiveness. Centralized uniform responses are in danger of being inappropriate, ineffective and wasteful of resources in all, but small and relatively homogenous states. This has significant implications for teacher preparation and support.

2.3 HIV and sex education

UNAIDS (2007*b*) recommends that schools provide sexuality education for HIV prevention. Youth in schools are easy to reach and are accessible in large numbers, while adopting safe behaviours is easier if started before patterns are formed. For low-level and concentrated epidemics, it is recommended that issues such as sexual and reproductive health, gender, substance abuse and health education should be included in school and teacher training curricula. The emphasis should be on formative behaviour in schools. For high HIV prevalence settings, it is recommended that comprehensive life skills programmes be provided for all young people in school focusing on the delay of sexual debut, condom use, HIV testing, reduction of concurrent and number partners, gender inequality and risks arising from drug use. This implies a stronger focus on behaviour change. This distinction in approach has not been

well articulated with much clarity to date, theoretically or practically, in any international guidance on HIV education. This is a concern since it implies different interventions in teacher preparation and support, for example, as well as in other components of the education sector response.

Education should be added to all HIV-related programmes to prevent or reduce HIV-related stigma and discrimination. Stigmatization can contribute significant obstacles to an effective HIV response and result in human rights violations among students and staff. This implies the inclusion of elements of human rights education.

A key issue for MOEs is the entry point for HIV education in the school curriculum. Sex education is a contentious topic in many countries. It is a much misunderstood field of education. As one headmaster said, “Young people do not need sex education, they just do what comes naturally” (personal communication). Sex and sexuality are intertwined with religion, morality, personal identity and even politics. It is a fundamental aspect of our lives, yet one that is often at the margins or beyond the boundaries of public policy discourse. Stalin famously banned sex education and prohibited any public discussion of sex in attempting to control and channel the lives of Soviet citizens into the construction of the socialist state (Druckerman, 2007). It was a commonly told joke that “there was no sex in the Soviet Union”. In contemporary India, attempts at providing sex education for adolescents have been met with a furious backlash from conservative religious individuals and groups accusing its proponents of attempting to corrupt Indian youth resulting in a suspension or even ban of the Adolescent Education Programme in a substantial number of states, including some of those with the highest HIV prevalence rates. Sex education is a particularly and peculiarly sensitive field of educational policy.

Few HIV education programmes dare to mention sex or sexuality education in their title. The course name may be variously termed adolescence education, family life education, population education, school health, or more rarely HIV or AIDS education. In some cases a vague brand name may be more publicly acceptable, such as ‘Good things for young people’ in Tanzania, ‘My future is my choice’ in Namibia, ‘Project light’ in Belize, ‘Teen path’ in Thailand, or ‘Teen star’ in Chile. What’s in a name? What is clearly important is that any HIV education programme must somehow address sex and sexuality in the lives of children and their prospective lives as adults.

It appears then that a core problem in HIV education is that it has to do with sexual behaviours. MOEs are much more comfortable addressing issues of sexual health through the biology of sexual reproduction and anatomy than through education about sexuality in a social context (Smith, Kippax and Aggleton, 2000). Curricula rarely seem to address sexual behaviour from the perspectives of young people (Allen, 2005). They are generally constructed by adults, with little or no involvement of young people. Sexual behaviour of young people is often viewed as a problem to be controlled through abstinence until marriage.

Few programmes address sexual risks arising from purchasing sex, men who have sex with men or rapidly changing sexual cultures among male and female youth. Heterosexuality is assumed and constitutes the normative paradigm. Education about HIV tends to be education about the HIV virus including sometimes attention to quite advanced virology rather than about social gendered sexual norms and practices. Introduction of HIV education is therefore more easily accomplished at secondary school level where reproductive biology is taught. Whether this is the most appropriate level for HIV prevention is entirely another issue, depending, as has been demonstrated, on how early sexual activity is commenced. In some contexts, primary education is the more appropriate entry point. HIV education is thus an emerging and contested paradigm, often pushing at the boundaries of what is permissible for young people to learn about sex and sexuality in school and society. Teachers are to be found positioning themselves in this rather hostile and exacting educational terrain and not always for the benefit of the children in their charge.

2.4 HIV and drugs education

Drug use is another key dimension of HIV-related risk among young people. Youth drinking and intoxication are related to aggression and risky sexual behaviour, though this is culturally variable (Bullock and Room, 2006). Research in high-income countries suggests that approximately 30 per cent of young people attracted to the same sex are problematic substance users (Howard and Arcuri, 2006). A study of men who have sex with men in Cambodia (KHANA and International HIV/AIDS Alliance, 2003) found about 25 per cent used alcohol or mood-altering substances prior to sexual activity. Young people involved in sex work, whether as sex workers or clients, may also be drug users or drinkers and may be more likely to have unprotected sex as a result

(Overs and Castle, 2006). Regular drug dependency may cause young people to sell unprotected sex or exchange it for drugs (UNESCAP, 2003). Race, culture and ethnicity are central to understanding young people's use of both licit and illicit drugs (Jenkins, 2006).

Injecting drug use is the most serious risk factor and the interventions that have proven effective are needle exchange programmes. These needle exchange programmes allow injecting drug users to exchange potentially contaminated syringes for sterile ones. Drug abuse treatment, including methadone treatment, has also resulted in consistent reductions in HIV-related risk behaviour (Strathdee, Newell, Bastos and Patterson, 2006). UNAIDS 'best practice' case studies on injecting drug users in transitional and developing countries (UNAIDS, 2006*b*) focus on HIV prevention through harm reduction and do not mention drugs education.

Efforts to address drug use among youth through primary prevention have overwhelmingly taken place in school-based education (Hunt, 2006). Evidence that is available on their effectiveness suggests that they are poor in achieving their intended behavioural outcomes (Hawkes, Scott, McBride, Jones and Stockwell, 2002).

2.5 Gearing up the education response to HIV

Since it became clear that the HIV virus was a global health threat with no vaccine or cure on the horizon, the education sector has been viewed as an important vehicle for HIV prevention among young people. Education would provide not only the knowledge to avoid infection, but would also help develop skills to assist individuals to remain healthy through adolescence and into adulthood. This would provide a 'window of hope' in Africa (World Bank, 2002), and even offer a 'social vaccine' against HIV.

Soon after its establishment, UNAIDS (1997*a* and 1997*b*) developed technical guidance on teaching and learning about HIV at school. It emphasized the ability of young people to adopt safer behaviours more easily than adults, but at the same time recognized their vulnerability to STIs and HIV infection. A number of difficulties were being encountered in providing HIV education, remarkably with no reference to teachers, which remain remarkably pertinent to this day, such as the following:

- The subject is considered too sensitive or controversial to be taught.

- It is difficult to find space for HIV education in an overcrowded curriculum.
- Participation in education may be limited due to high school drop-out rates.
- Coverage of HIV education programmes may be limited to a small number of schools.
- HIV education may be information-based and not include behavioural skills.
- The HIV curriculum is of poor quality.

An earlier review of HIV education and school health programmes in selected countries in Africa and Asia (Barnett, de Koning and Francis, 1995) identified the following key factors influencing impact:

- links with health services;
- teacher preparation;
- time devoted to health education;
- parent participation;
- the timing of health education input (in terms of pupils' age);
- peer support and the presence of operational school policies which support health-promoting behaviours.

In addition, it is now clear that not all school environments are safe for children (UNAIDS IATT on Young people, 2008*b*).

Despite these problems, the education sector has increasingly become a key partner in the national multi-sectoral response to HIV. In the right circumstances, research evidence has shown that education institutions are able to provide knowledge, attitudes and skills to contribute to enabling the learners to prevent themselves from becoming infected with HIV before they become sexually active (Kirby, Laris and Roleri, 2005; Kirby *et al.*, 2006) or begin to experiment with psychoactive substances such as alcohol or drugs (UNAIDS IATT on Young People, 2008*a* and 2008*b*).

Experience gathered over more than a decade in education sector responses to HIV from a range of sources permit the identification of at least five potential key benefits arising from effective programmes. These are:

1. vulnerability reduction;
2. risk reduction;
3. reduction in HIV-related stigma and discrimination;

4. mitigation of HIV impact on children and staff;
5. promoting access to and uptake of health services and treatment.

These will be described below.

Vulnerability reduction

Vulnerability is defined by UNAIDS as a range of factors which may include both personal and social factors which reduce the ability of individuals to avoid HIV infection (UNAIDS, 2007*b*). Examples of such factors include lack of knowledge and life skills for HIV prevention, lack of access to basic services, and forms of social marginalization (UNAIDS IATT on Young People, 2008*a*).

Vulnerability to HIV is highly context specific. MOE responses need to be prepared based on comprehensive assessments of child and adolescent vulnerability to social situations that may expose them to HIV infection. Children and adolescents (the latter defined by the United Nations as between 10 and 19 years) who are particularly vulnerable need to be identified. They may include children who have parents who inject drugs or sell sex, without parental care on the streets or in institutions (UNAIDS IATT on Young People, 2008*c*). Young people who have lost one or both parents, who are extremely poor, socially marginalized, disabled, displaced through conflict or who have migrated between rural and urban areas are among the vulnerable (UNAIDS, 2007). Those who are socially excluded may include members of national minorities (Homans, 2008). This implies that education responses to HIV must be built on the research evidence of vulnerability among children and young people. Such assessments, of course, are crucial for addressing Education for All.

Vulnerability reduction can be achieved through interventions which increase access to education for marginalized and poor children, especially for girls, and putting in place strategies to support attendance, completion and the achievement of learning outcomes as part of a multi-sectoral response to addressing the development needs of poor and marginalized children. Studies have shown that girls who have completed secondary education have a lower risk of HIV infection and are more likely to practice safer sex than girls who have finished primary education only (ActionAid International, 2006).

Schools and places of learning help to reduce vulnerability to sexual exploitation by increasing the social connectedness of students

(UNAIDS IATT on Education, 2003). Schools play an important and influential role in the community and teachers act as a trusted source of information for children (World Bank, 2002). Vulnerability can also be addressed through education, which aims to promote gender equality through changing discriminatory gender norms, and addressing harmful masculinity practices. Interventions such as child-friendly schools may also contribute to vulnerability reduction, as well as school health and nutrition programmes, which also have an important role to play in the healthy development of children (Jukes, Drake and Bundy, 2008).

The role of teachers is clearly important in ensuring that vulnerable children are not excluded from school, discriminated against or abused, and their sense of self-esteem is nurtured. In this regard, the education response to HIV fully converges with that of Education for All (EFA) and the Millennium Development Goals (MDGs) for education. Through fostering an equitable and inclusive environment in class, teachers can help support the reduction of child vulnerability or they can actually increase it by discriminatory behaviour, which increases school drop-out. The newly minted concept of ‘especially vulnerable adolescents’ may be useful in focusing attention on various forms of vulnerability, but it may also result in the labelling and stigmatization of such populations.

In higher HIV prevalence settings, teachers may also be vulnerable to HIV infection themselves at times during their professional career. Young teacher trainees, who are perhaps away from their families for the first time, may be exposed to risks of HIV infection, including access to sex workers. Serving teachers may also be made more vulnerable sexually through mobility arising from teacher deployment practices. Where teachers are vulnerable to HIV infection, this needs to be recognized and addressed in policy and programmes. They are a costly and valuable human resource with rights.

Risk reduction

Risk is defined by UNAIDS as the probability that a person may become infected by HIV (UNAIDS, 2007*b*). Certain behaviours are considered to create, enhance and perpetuate risk. These include unprotected sex with an infected partner, multiple and concurrent unprotected sexual partnerships, and injecting drug use with contaminated needles and syringes.

Risk reduction can be achieved through education programmes that specifically address those HIV-related risks which confront the target group. School-based programmes offer a very large target population and provide an opportunity for interventions to reach a very large number of young people before or around the time that they become sexually active and engage in high risk behaviours. Good quality risk reduction programmes encourage young people to delay the onset of sexual activity, to reduce the number of sexual partners, and to use condoms if they are already sexually active (UNAIDS, 2007*b*). They also address risk-taking behaviours related to alcohol consumption and injecting drug use.

Not all adolescents are at equal risk. Thus, age-appropriate programmes need to be based on assessments of risk and identify those adolescents ‘most at risk’ (sometimes unfortunately referred to as ‘MARA’). These represent a high priority for HIV-specific resources and are typically out of school (Wijngaarden, 2007). School-based programmes, however, are less useful for primary prevention in contexts where the majority of adolescents are out of school, unless the intervention reaches them *before* they drop out, which would be in upper primary education. It should also be noted that teachers may also be at risk of HIV infection through their sexual behaviours and social context, and also by the sexual behaviours of their spouses. Risk reduction should therefore be a component of teacher education, especially where there are clearly identified HIV risk factors for any members of the profession.

The characteristics of effective school-based risk-reducing education programmes are now becoming understood as a result of international research. These are discussed later in this section. Risk reduction education programmes are at the heart of the education response to HIV and necessarily require specialized teacher training and support at school level. Trained and motivated teachers are clearly critical to their effective delivery. At the same time, teachers may constitute an obstacle to effective programme implementation because they object to teaching sensitive or controversial sexual subject matter.

Addressing vulnerability and risk involve four core areas of action (UNAIDS IATT on Young People, 2008*a*):

- information to acquire knowledge about HIV prevention, modes of transmission, common misconceptions, sexual and reproductive health, safer sex and access to health services;
- opportunities to develop life skills;

- access to appropriate health services for young people;
- creation of a safe and supportive environment.

Stigma and discrimination reduction

Identification of arbitrary discrimination is important not only to protect human rights, but also as a public health measure to control HIV. HIV-related discrimination has three negative health consequences (UNAIDS, 2000). First, it creates a climate of fear and intolerance that interferes with the implementation of effective prevention interventions, since individuals are discouraged from taking HIV tests and seeking information. Secondly, it may foster a sense of complacency in individuals or groups who are not discriminated against. Thirdly, discrimination tends to exacerbate existing forms of social marginalization, including sexism, homophobia and racism.

The international response includes the development by UNAIDS (2000) of a protocol for the identification of discrimination against people living with HIV. This is a tool for the identification of discrimination in a range of areas in everyday life. It focuses on three possible sources of discrimination:

- the law;
- internal regulations of public and private bodies, organizations or groups;
- practice, for which there is no written basis.

Ten major areas of social life are identified in which discrimination resulting in exclusions of or restrictions against people living with HIV may occur. These are as follows:

- health care (e.g. refusal to treat, non-confidentiality, differential treatment);
- employment (e.g. recruitment, dismissal, restrictions and HIV status);
- justice/legal process (e.g. criminalization of men who have sex with men and commercial sex workers);
- administration (e.g. prison administration and special detention);
- social welfare (e.g. denial of access to benefits);
- housing (e.g. mandatory testing);
- education (e.g. denial of access or restrictions imposed);
- reproductive and family life (e.g. mandatory pre-marital testing);
- insurance and other financial services (e.g. denial of insurance);

- access to other public services (e.g. funeral services, transport and leisure facilities).

The restrictions concerning teachers living with HIV may cover a wide range of these issues. What is required from a public policy perspective is a generalized rights-based response that benefits all people living with HIV and does not discriminate against any group. At the same time it is important to single out the teaching profession as a category for policy support, recognizing the special needs of teachers as both duty-bearers and rights-holders. The teaching profession should lend its weight to support all people living with HIV and to ensure that within the education sector they are not subject to stigmatization, discrimination and abuse. This also requires that the teaching profession as a whole is fully supportive of the right of teachers living with HIV to continue working without any workplace discrimination or stigmatization.

There is emerging evidence that HIV-related stigma can be reduced through education programmes (Catalyst Management Services, 2003; Swasti, 2004; Thatun, 2004). These can contribute to dispelling myths and misconceptions about HIV as well as building compassion for those infected and affected. Workplace policies have a key role in addressing HIV-related stigma and discrimination among the teaching force in particular, though a critical issue concerns how these are developed, disseminated and implemented.

The role of trained teachers in addressing stigma and discrimination in the school appears to be important for preventing or reducing these harmful phenomena. At the same time teachers violate the rights of children if they stigmatize and discriminate against those who are affected by or living with HIV.

Education programmes that involve people living with HIV appear to be particularly effective in reducing stigma. The GIPA (greater involvement of people living with HIV and AIDS) principle encourages the active involvement of people living with HIV in policy-making, and in the development and implementation of programmes. GIPA needs to be embraced by MOEs and included as a guiding principle on HIV-related policies and strategies. The active involvement of people living with HIV in prevention and care programmes has the potential to reduce HIV-related stigma and discrimination. It can do this by promoting the empowerment of people living with HIV, and by strengthening the capacity of affected

communities to accept affected individuals. More specifically, involving people living with HIV in prevention and care activities can:

- encourage greater community acceptance of people living with HIV by promoting a better understanding of their situations;
- reduce self-stigma by increasing the confidence of those living with HIV;
- encourage further disclosures of a seropositive status by promoting openness and discussion around HIV.

Activities such as training and supporting people living with HIV as public speakers, educators and counsellors have helped to reduce stigmatization. Training people living with HIV, for example, to deliver personal testimonials in participatory educational sessions can encourage others to place themselves in the position of someone who has suffered discrimination and thereby appreciate the injustice of discriminatory actions. It may also have a positive impact on prevention efforts, by helping to personalize risk. The ensuing realization that HIV is a shared concern may lead to the reduced stigmatization of people living with HIV.

In addition to promoting a better understanding of the circumstances of affected people, increasing the visibility and integration of people living with HIV in education programmes can further reduce stigmatization by reinforcing the message that people living with HIV have the potential to lead productive lives and contribute constructively. This involvement can also help to reduce self-stigmatization, by building the confidence of people living with HIV, and by reducing their feelings of isolation and powerlessness. This is particularly the case where affected individuals are supported by associations of people living with HIV to participate in income-generating and skill-development activities. In this regard, it is interesting to note that associations of teachers living with HIV are being established in Africa in high HIV prevalence contexts.

Finally, it should be said that the education sector contribution to reducing HIV-related stigmatization and discrimination in society has not been adequately researched. Few studies have taken these issues fully into consideration. This is an important area for future international research.

HIV impact reduction

In generalized epidemics over time, HIV can impact on the supply of education staff reducing the number of qualified and experienced staff available to the sector. The increased attrition rate of teachers as a consequence of HIV epidemics threatens also to impact on the quality of education service delivery, which can also potentially reduce demand for education. The impact of HIV is an additional impediment to the achievement of EFA, especially in east and southern Africa.

The impact of HIV can reduce the demand for education among infected families, especially where orphaning has taken place. Again this is a particular problem for sub-Saharan Africa where the impact of HIV has been the most severe.

In such contexts, impact prevention and mitigation are critical to safeguard the essential functions of the sector and to ensure that national educational goals are achieved. Education policies and programmes have the potential to mitigate the impact of HIV on children, the so-called ‘orphaned and vulnerable children’ or ‘children affected by AIDS’ and ensure that despite their adversity, they are able to continue to participate in education. This is a form of vulnerability reduction, but more specific to generalized HIV epidemics. What needs to be done to achieve effective responses to HIV impact will be examined later in this book, as well as the role of teachers in their implementation. There are also strategies that can mitigate the impact of HIV on the teaching stock in high HIV prevalence settings, including ensuring access to treatment, care and support for teachers living with HIV.

Promoting access to and uptake of health services and treatment

Education for HIV prevention needs to make effective linkages between schools and youth-friendly health services. School health programmes would seem to be a particularly promising vehicle in this regard. Among the HIV-related services that need to be promoted are:

- STI diagnosis and treatment;
- HIV testing and counselling;
- condom provision.

Education can also promote greater awareness about HIV treatment including prevention of mother-to-child transmission and ART. This has been called ‘treatment education’ (UNAIDS IATT on Education, 2006) and represents a facet of HIV education that is probably under-

emphasized in many current curricula. Treatment education also represents an under-researched component of the education response to HIV. Teachers also need access to health services and treatment, and this is related to the HIV workplace policy.

2.6 An analytical framework for the education sector response to HIV

We have seen that education sector interventions should be tailored to match the nature and dynamics of the national and localized HIV epidemics. In all cases, the highest priority needs to be given to HIV prevention through education programmes which aim to reduce vulnerability to and risk of contracting HIV. These programmes need to be evidence-based; that is based on evidence of the factors of vulnerability and risk behaviours of the target group and evidence of what constitutes an effective response in delivering the intervention. All programmes should seek to address HIV-related stigma. In concentrated and especially in more severe epidemics, greater attention needs to be given to understanding and mitigating the current and projected impacts of HIV on education. This requires further investment in evidence-gathering about the situation of education service delivery and the effectiveness of current strategies, although disaggregating the specific effects of HIV may be problematic and even counter productive if it leads to social stigmatization of those affected or infected.

There is a strong tendency for education responses to HIV to be developed outside the education mainstream on the margins of curriculum and practice. This is due to the perception that HIV is essentially a health and not an educational issue. It may also be because funding tends to be external and accessed through HIV financing channels, such as national AIDS authorities (NAAs), rather than education sector budgets. A third factor is that educators also tend to stigmatize HIV education, including sometimes those who deliver the programme, i.e. the 'AIDS teachers'. A fourth factor is that mainstream educationalists frequently do not fully understand the specialized field of HIV education. What needs to be better understood is how HIV education responses can contribute to improving the quality of education, to improving educational access and to improving equity and *vice-versa*. The HIV response, therefore, needs to become part of the educational mainstream.

The need for an effective rather than a token education response to HIV, and its key components are now becoming better understood by practitioners. The following elements of such a response are based on a synthesis of different models recommended by UNESCO and the Education Development Centre (2005), the World Bank (Bakilana, Bundy, Brown and Fredriksen, 2005) and the EDUCAIDS Framework for Action (UNESCO, 2006a and 2008a).

- *Policy and strategy*: Education sector policy for HIV, including workplace policy, and strategic planning for its implementation.
- *Institutional capacity and management systems*. Technical and managerial capacity to implement policy and programmes at all levels, including monitoring and evaluation.
- *Curriculum content and process*: Skills-based curriculum and learning materials for HIV prevention and for preventing HIV-related stigma. Means of assessment of learning outcomes.
- *Co-curriculum support*: Complementary approaches to HIV and stigma prevention, including co-curricular interventions and the promotion of access to youth friendly health services.
- *Teacher training and support*: Teacher pre- and in-service training, supervision and support, supervision and continuous professional development.
- *Prevention of and mitigation of HIV impact*: Planning and management capacity to mitigate the impact of HIV. Ensuring educational access for children infected and affected by HIV. Support for teachers living with HIV.

2.7 Conclusions

HIV education is a new field of policy and practice. It has been driven largely by the national HIV response rather than the education sector, and largely financed by external agencies. It has generally been developed as a separate area of intervention rather than as a mainstream concern with the MOE.

There is a need for a holistic approach to HIV within the education sector, which should address the main components of a comprehensive approach. The sector response to HIV must be tailored to the context of the epidemic and the capacity of the education system. The undertaking of comprehensive and participatory SRAs can play a role in developing a more strategic and comprehensive response.

Teachers will play a critically important role in any education sector response to HIV. They are both duty-bearers and rights-holders with a wide range of roles and responsibilities. Thus, there needs to be a strong focus on the situation of the teacher in the epidemic. How are teachers being impacted and what positive roles can they play in HIV prevention education and impact mitigation? How can currently harmful teacher practices be prevented?

In its 2007 annual report, UNAIDS (2008) identifies the following challenges for delivering better HIV results:

- mobilizing leadership and advocacy;
- engaging civil society and developing partnerships;
- promoting human rights;
- intensifying HIV prevention;
- scaling up to universal access to HIV prevention, treatment, care and support;
- monitoring and evaluating the HIV epidemic and response.

These challenges also apply in full measure to the education sector response to HIV and the teaching profession. The next chapter examines the range of challenges that education systems and teachers have faced as a consequence of HIV, and the constraints that exist in responding effectively.

Key points

1. The education sector response to HIV needs to be sensitive to the dynamics of the local HIV epidemic. It needs to be based on research evidence of risk and vulnerability of young people to HIV infection. Programmes need to be tailored to the social dimensions of epidemics.
2. Issues of gender related to HIV transmission should be central to the HIV education programme.
3. HIV prevention education should include sexuality education. It should also address substance abuse/drugs education within a broader health education framework. Addressing stigma and discrimination should be central to all HIV education programmes.
4. Sexuality education represents an especially sensitive area of educational policy and practice for MOEs. Unless governments are committed to finding ways of introducing or strengthening existing

- education about sexuality and sexual health, school-based HIV education is unlikely to be cost effective.
5. HIV education programmes can support, and should include, strategies aimed at:
 - vulnerability reduction;
 - unsafe behaviour reduction;
 - stigma and discrimination reduction;
 - HIV impact mitigation;
 - increasing access to health services, including treatment.
 6. It is important to use an analytic framework for a comprehensive response to HIV in the education sector. Otherwise there is the risk of developing an *ad hoc*, fragmented and ineffective approach.

Chapter 3

Caught unprepared: the lack of readiness of the education sector to respond to HIV

“Many teachers graduate without having learned about active learning, integrated curricula and other suggested approaches to enhancing learning.”

“The context in which teachers have to perform is invariably one of scarcity of materials and resources” (UNESCO, 2007a: 18).

3.1 Introduction

The HIV epidemic caught many governments unprepared and in denial that they were confronted with a serious public health problem. Some of the earliest successful responses, such as in the USA or Australia, owed much to civil society activism for their achievements. Slowness to react on the part of many governments allowed HIV to spread, especially in sub-Saharan Africa, the region arguably the least equipped to deal with the epidemic. In many countries, the lack of political engagement with regard to the epidemic continues to be an impediment to effective national responses (De Waal, 2006). The weakness of civil society activism and its lack of engagement in the education sector response to HIV undoubtedly contribute to the slowness of progress in responding to the needs and rights of children in HIV contexts.

It has taken the best part of two decades for the emergence of a clearer understanding of how governments should respond to HIV. The education sector has been slower than the health sector, which has typically led and dominated national responses. Where the spread of HIV has been successfully reduced in developing countries such as Brazil, Thailand and Uganda, the education sector has not played a noticeably significant role in successful prevention efforts.

The current international HIV response paradigm emphasizes the ‘Three Ones’ principles to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management (UNAIDS, 2004). The Three Ones are:

- **one** agreed HIV and AIDS action framework that provides the basis for co-ordinating the work of all partners;
- **one** national AIDS co-ordinating authority, with a broad-based, multi-sectoral mandate;
- **one** agreed country-level monitoring and evaluation system.

In practice, this approach may actually privilege the health sector, which tends to dominate the HIV action framework and undermine multi-sectoral partnerships, but it makes life simpler for donor financing. How MOEs are included in the national HIV response framework is clearly a critically important issue regarding their engagement and ability to access external funding. It must be admitted that MOEs have generally been challenged in developing their contributions to the national action framework for HIV, establishing co-ordination mechanisms within the education sector and putting in place an appropriate monitoring and evaluation system to capture HIV-related data. The development of an international evidence base for effective HIV interventions in the education sector to help them in these tasks has been slow.

Despite the difficulties encountered, the MOE is widely recognized to be pivotal in the national multi-sectoral response to HIV. However, it is often among the most difficult tasks for the line ministry to mobilize (World Bank, 2004*b*). MOEs are the largest employers in most countries and they reach every community, but because of their size and the inherent difficulty in reaching consensus on changes in curricula, they have often been slow in responding to the challenge effectively.

If MOEs are reluctant to mobilize their resources to address HIV, it follows that it will be extremely difficult for teachers to provide appropriate and effective education at the front line in schools. How to galvanize the political leadership of ministries to regard HIV as a key sector issue is therefore an important consideration. Beyond that, it is clearly important that the senior political leadership of the government lend their weight to the national multi-sectoral effort.

HIV epidemics require changes in service delivery from MOEs. The magnitude of the changes needed will depend on the severity of the national epidemic. Yet the sheer scale of most education systems tends to preclude radical change. The time-scale for reforms to become institutionalized also tends to militate against innovation. Educational change requires a long-term perspective both for implementation and

for results; there are few quick fixes. Success is not guaranteed and few innovations are sustained (Marsh, 2004).

In considering educational development in the context of HIV, it is instructive to revisit Fullan's eight lessons regarding educational change in the table below (Fullan, 1993). Some of these are contentious, for example the lack of vision and strategic planning, but the lessons do provide a means of stimulating thinking about educational change processes.

Box 1. Eight lessons for educational change

Lesson 1: You cannot mandate what matters. The more complex the change, the less you can force it.

Lesson 2: Change is a journey, not a blueprint.

Lesson 3: Problems are our friends. They are inevitable and you cannot learn without them.

Lesson 4: Vision and strategic planning come later.

Lesson 5: Individualism and collectivism must have equal power.

Lesson 6: Neither centralization nor decentralization works. Both top-down and bottom-up strategies are necessary.

Lesson 7: Connection with the wider environment is necessary for success.

Lesson 8: Every person is a change agent.

Source: Fullan, 1993.

If we accept the validity of these lessons, it is clear that educational change requires the consent of those who will implement it and the engagement of teachers as change agents. Ownership of the innovation and the mobilization of the sector staff in its implementation are likely to be critical to success. A system-wide approach is required. Enclave-like projects or programmes are likely to be unsuccessful.

The educational changes required by the HIV response are complex. They are likely to involve the gamut of educational institutions and functions. Attitudinal, behavioural and practical changes are needed. There are substantial political risks involved in these changes, which may be resisted by sector stakeholders, especially where they involve education about sexuality. The threats might outweigh the perceived benefits to a government.

It would appear that the best strategy for an MOE to adopt in embarking on an HIV response is one that involves incremental change. This would build on existing structures and practices. The journey would begin with where the ministry and its administrative and teaching staff are now in terms of delivering health education. Such an approach would be pragmatic, and to be effective would necessitate appropriate investment in monitoring and evaluation and to learn from the interventions. Thus the change management process would be evidence-based. This is entirely consistent with an HIV mainstreaming process, which is about selectively integrating HIV into education sector activities on the basis of potential impact and comparative advantage.

3.2 Lack of mainstreaming of HIV

The process of HIV mainstreaming is widely accepted to be the most cost effective way to implement a multi-sectoral response. In this approach line ministries use their comparative advantages to bring their relevant strengths to the tasks of HIV prevention, stigma reduction, access to treatment and care and impact mitigation.

MOEs have been painfully slow in mainstreaming HIV in sector policies, strategies and activities. Instead of taking a systematic approach to the education response to HIV, many ministries have adopted a fragmented project-based modality. They have tended to be opportunistic in taking advantage of funding opportunities, rather than being proactive and identifying what actions should constitute a priority for medium- to long-term investment. This has possibly set back a comprehensive response in high prevalence countries by a decade or more. HIV mainstreaming has perhaps been prosecuted with even less vigour than gender mainstreaming in education. The two processes are rarely co-ordinated.

The term ‘mainstreaming’ has been employed with regard to gender in development, and there is a great deal that can be learned from practical experiences in this field that can be applied to HIV mainstreaming. The concept, unfortunately, is not well understood in the education sector. This is exemplified by the findings of a study of 12 education sector plans endorsed by the EFA Fast Track Initiative (FTI) where, among the countries that did make significant reference to gender in their education plans, there was variation in the degree to which the concept of gender

mainstreaming (integration of gender in the core business of the sector) was understood and employed (Seel and Clarke, 2005).

Similar concerns apply to HIV mainstreaming. A study by the UNAIDS, UNDP and World Bank found that documented evidence of the process of mainstreaming HIV in national development instruments is very limited (UNAIDS, UNDP and World Bank, 2005). While examples of documented best practices do exist, such as for Uganda, Ghana and Zambia, in-depth analysis about the process of mainstreaming HIV is rarely available. The review identified the following issues:

- *Lack of shared understanding:* A lack of consensus on what the term ‘mainstreaming HIV’ means. It is sometimes interpreted to mean integration in *all* activities, regardless of the strength of their relevance to HIV.
- *Low commitment to mainstreaming HIV:* Stakeholders at country level tend to locate the responsibility for addressing HIV in the health sector, as opposed to adopting a multi-sectoral and mainstreamed response.
- *Role of national AIDS authorities (NAAs):* Although NAAs may be aware of the importance of mainstreaming, their capacity and credibility to take on a lead role in supporting mainstreaming may be limited. Channelling finances through NAAs may have inadvertently undermined incentives for HIV mainstreaming.
- *Limited participation of key actors:* There has been insufficient attention given to developing appropriate institutional arrangements for involving key actors in the process of mainstreaming HIV in national development instruments.
- *Limited budgetary incentives:* Recent increases in HIV funding have often been extra budgetary and have largely remained confined to the health sector connected with universal access to care and treatment. This has not encouraged the mainstreaming of HIV responses in national development instruments and in non-health sectors.

A barrier to effective implementation is that while the term ‘mainstreaming’ is much used, it is also often misunderstood. Attention needs to be paid to clarifying the concept and how it is applied to the education sector. A useful conceptual framework for mainstreaming HIV together with implementing principles was developed by the German technical co-operation for development GTZ and UNAIDS (2002). This contrasts *integration* with *mainstreaming*, noting that the two terms are

often used interchangeably. *Integration* occurs when HIV issues are introduced as a component or content area, without much interference with the specific core business of the institution or main purpose of the policy instrument. *Mainstreaming*, however, moves beyond integration by:

- identifying specific areas of responsibility related to HIV, relevant to the institution;
- outlining context-specific actions, underpinned by adequate financial commitments addressing each of these areas in its relationship with the core mandate and activities of the institution.

HIV mainstreaming contrasts with integration, which is considered an ‘add-on’ approach in that it becomes aligned with and influences the core business of an institution. This approach is more likely to be effective than one which increases the already complex environment of the educational sector by adding new initiatives and activities.

The core business of an education system is arguably the effective delivery of the national curriculum. A key issue for HIV mainstreaming is where HIV education should be placed within that curriculum for maximum impact. Curricula that have natural entry points for HIV mainstreaming have, in all probability, facilitated the MOE’s preventive education response. Such entry points include school health, biology, civics and social studies. Of these, school health appears to be particularly promising since it potentially allows for issues related to HIV, such as reproductive and sexual health, to be included, as well as topics such as treatment and care. HIV also needs to be mainstreamed in teacher training for HIV-related curriculum implementation and for general HIV prevention among the teaching stock, especially where HIV prevalence is high.

It seems to be important for NAAs to provide guidelines to line ministries on what HIV mainstreaming is and how it is to be implemented, including specific guidance for MOEs. For example, India’s National AIDS Control Organisation (NACO) has developed clear guidance on mainstreaming for all its partners (NACO, 2006). This is an essential first step. The second step is ownership of the mainstreaming principle and process by the MOE, resulting in its inclusion in the policy and strategic planning framework for the sector. In other words, HIV mainstreaming becomes part of the education mainstream.

The importance of mainstreaming in the education sector response to HIV is reflected in the toolkit developed by the UNAIDS Inter-Agency Task Team (IATT) on Education on HIV and AIDS. It is intended for development co-operation agencies (UNAIDS IATT on Education, 2008*b*). As yet there is no evidence-based toolkit for MOEs on how to mainstream HIV effectively, which seems to be a critical gap in the international guidance that is available.

3.3 The neglect of school health programmes

MOEs have been slow to appreciate the importance of school health education in promoting healthiness among young people. School health and HIV have been linked since AIDS was recognized as a significant educational issue in the mid-1990s, with the education sector having a ‘heavy responsibility’ in curbing epidemics through preventive education (McKenna, 1994). An early conceptualization of HIV prevention education came to the following conclusions (Pridmore and Chase, 1994):

- Education about HIV cannot be separated from the wider issues of health in the community. Teaching about HIV must become an integral part of the whole school education to promote health.
- A broad integrated approach promoting positive health and well-being is needed.

School health in general represents a broad approach to address the poor health that compromises the ability of the most disadvantaged children to attend school and learn effectively. Within that, HIV prevention becomes an area for the development of relevant skills, practices and knowledge.

UNAIDS (1997*b*) published a position paper on integrating the prevention of HIV and sexually transmitted diseases (STDs) in schools, which stated that:

- health promotion activities in schools should be strengthened;
- HIV and STDs should be integrated into education about health issues;
- policies are essential for effective programmes, including on pre- and in-service teacher training;
- young people need to learn how to cope with increasingly complex demands when they are in a relationship;

- prevention and health promotion programmes should begin at the earliest possible age;
- a life skills approach is important in HIV and STD programming;
- the school system as a whole must respond to HIV and STDs.

These recommendations are eminently sound. They appear to have had little traction with MOEs and their development partners. A major barrier to developing HIV prevention education within a broad school health paradigm has been the general lack of importance given to health promotion in the school curriculum and to developing and implementing school health policies. A review of major global trends since Jomtien in 1990 in school health and nutrition as a thematic contribution to the EFA 2000 assessment (Vince-Whitman, Aldinger, Leniger and Birdthistle, 2001) identified various barriers hindering progress at national level, including the following:

- absence of political concern;
- lack of well-defined national strategy and policies for school health programmes;
- limited funding allocations;
- weak inter-sectoral links between education and health and with other relevant sectors;
- emphasis on pilot projects rather than national programmes;
- lack of relevant disaggregated data for programme planning.

These factors remain pertinent. Moreover, the quality of education delivery in many countries provides a serious set of constraints on developing effective school health programmes. These may include the following:

- overcrowding of pupils in schools and of content in the curriculum
- inadequate production and supply of teaching and learning materials and school supplies;
- lack of monitoring and evaluation arrangements;
- lack of trained people, including teachers, to implement school health programmes;
- unsupportive conditions in the school and its environment;
- international aid or developmental agencies have generally been slow to give funding priority to school health programmes.

It must be said that the ramifications of these factors go beyond delivery of health education and militate against any form of effective

education. They are symptomatic of a wider crisis in state education. Unless issues of large class sizes, overcrowded curricula, teacher preparation, school supplies and enabling environments for learning are systematically addressed, education systems will continue to under-perform and EFA targets will be missed. Delivering effective HIV education will be highly problematic in these contexts.

Unfortunately, the 2000 Dakar EFA Framework (UNESCO, 2000) provides a weak basis for school health action. The development of the Focusing Effective Resources on Effective School Health (FRESH) framework and network of agencies appears to offer some hope of a strengthening of school health policies and strategies. The four key components are:

- health-related school policies;
- access to safe water and provision of adequate sanitation;
- school-based health and nutrition services;
- skills-based health education.

HIV would be mainstreamed within these components. Unfortunately, there is lack of any evidence base on how effectively the FRESH framework is being implemented by MOEs within education policy and planning frameworks. A survey of international support to school-based health and nutrition programmes carried out by the Partnership for Child Development found that only a minority of organizations working in the field were making explicit use of the FRESH framework to guide their activities (Partnership for Child Development, 2006). This suggests that this inter-agency initiative is underperforming in advocacy. How FRESH is contributing to an effective education sector response to HIV is unknown, which implies a lack of an effective monitoring framework for the initiative. In this context, it is critically important to strengthen the evidence base around FRESH and HIV.

3.4 The wider crisis in education

Mainstreaming HIV in the education sector is clearly problematic in an underperforming or dysfunctional system. At the same time, the impact of HIV has the capability of exacerbating existing problems (Badcock-Walters, 2002). It follows that any response to HIV must take into account the current state of the sector through a participatory SRA process. Many low-income developing country education systems remain in a poor state following decades of under-investment and are

not well positioned or endowed to respond effectively to HIV. If the majority of adolescents are out of school, a school-based response to HIV prevention is going to miss the majority of its target audience and certainly those who are most at risk of infection. In this case it is critical to reach children with age-appropriate HIV education before they drop out of school and become more vulnerable to HIV exposure.

The wider crisis in education, which affects many developing countries, has meant that the sector has been ill prepared or equipped to tackle HIV. The situation is exemplified by the findings of the 2008 EFA Global Monitoring Report (UNESCO, 2007*b*). Based on current trends, 58 out of 86 countries that have not yet reached universal primary enrolment will not achieve it by 2015. Despite overall enrolment increases, sub-national disparities in school participation persist between regions, provinces or states and between urban and rural areas. Children from poor, rural, indigenous and disabled populations are also at a systematic disadvantage, as are those living in urban slums. These are the vulnerable populations that most need education for HIV prevention.

The importance of accelerating progress in achieving EFA is captured in the background documents to the 2000 EFA meeting in Dakar, following disappointing progress since Jomtien in 1990. Fourteen thematic studies were commissioned by UNESCO for the World Education Forum in Dakar with the aim of providing theoretical vision and practical guidance to educational planners and decision-makers at national and international levels. They attempted to describe best practices as well as successful and unsuccessful experiments in policy implementation. In retrospect, what is truly remarkable is that there was no thematic study that focused on teachers (neither was there one on HIV and its implications for EFA).

The education response to HIV needs to be mainstreamed within national efforts to achieve EFA and universal primary education (UPE). Attempts to address HIV should go hand in hand with efforts to improve the coverage and quality of basic education. This, however, still remains more of an aspiration than a reality in educational policy and planning. It will require better co-ordination and harmonized efforts by donors. Current responses are based on a short-term vision, agency specific agendas and a lack of co-ordination by partners (UNAIDS IATT on Education, 2008). A crucial issue is how the education sector response to HIV fits into the mainstream ESP. Assessments of the integration of the education sector response to HIV within the EFA FTI-endorsed ESPs by Clarke and Bundy (2004 and 2008) found that this was highly variable

and often lacking in essential details. There is still much to do in aligning HIV education responses with the long-term ESP.

3.5 Lack of focus on the teacher

There is an urgent need for MOEs, civil society and development partners to strengthen the education policy and strategic focus on the teacher and on improving the effectiveness of teaching. The current relative neglect of teachers is hard to understand, but perhaps explained by the fact that changes in teaching require long-term vision, strategy and investment. Many incentives for governments and development agencies seem to emphasize the short-term success story and the gathering of what I recall one minister of international development refer to as ‘the low hanging fruit.’ Another putative explanation is the strong emphasis on the learner and the quantitative expansion of education to meet the targets of the MDGs. Quality is in effect a secondary factor to enrolment.

Educational quality cannot be ignored by governments. Education for All needs to ask the question “Education for what?”, since the education on offer should prepare young people for life and work in a complex and challenging world by providing them with the necessary knowledge, attitudes, values and skills. This is sometimes referred to as the *quality* of education, and its pertinence seems to be forgotten at times. The quality of education critically depends on the quality of teachers, and this is particularly true in primary education (Carron and Chau, 1996). Despite this there is relatively little research available on the teaching profession in most countries.

The Oxfam Education Report prepared for Dakar acknowledged that teachers are at the heart of education systems and that the presence of well-motivated and skilled teachers is fundamental for the quality of education (Oxfam, 2000). A long list of deficiencies was identified concerning teachers, including:

- low teacher morale and teacher absenteeism;
- low and inadequate teacher salaries;
- poor training with insufficient subject mastery and lack of skills in active teaching and learning methods;
- insufficient teacher support;
- poor teacher deployment practices;
- inadequate teacher recruitment strategies;
- under-representation of female teachers.

This is a wide-ranging list of weaknesses, the presence and severity of which will vary from country to country. They clearly have the potential to impact adversely on the quality of educational service delivery and need to be addressed on a sector-wide basis. At the same time these shortcomings can severely undermine the quality of an HIV education programme, which points to the need to undertake a comprehensive national situation analysis of the teaching profession when planning an education sector response to HIV.

The critical issues of teacher motivation, absenteeism, large classes, teachers' qualifications, training and content knowledge are discussed below.

Teacher motivation

The issue of teacher motivation and incentives is particularly important. A review for the Department for International Development (DFID) covering sub-Saharan Africa and Asia found that very limited good quality data on this area had been published, and more research was urgently needed (Bennell, 2004). A wide range of issues was identified that appear to play a significant role in how strongly teachers are motivated or not to carry out what is expected of them.

Incentives for good performance are often weak. Low pay results in many teachers taking on secondary work in private tutoring and other activities. De-motivation may arise from poor human resource management, increasing workloads, large class sizes, poor living environments, lack of accountability, corruption, violence at school, lack of training and the impact of HIV.

Another study on teacher motivation in developing countries by Voluntary Services Overseas (VSO) found the following (VSO, 2002):

- Teacher motivation is fragile and declining.
- Teachers have low self-esteem in their professional role and feel they are not respected by others.
- Teacher performance is strongly influenced by their motivation.
- Teacher motivation is a factor that is ignored in education policy formulation at all levels; it is not appropriately prioritized in sector development by national policy-makers and their international development partners.
- Teachers wish to be able to perform well.

The motivation of teachers involves a complex set of issues. They are clearly of fundamental importance to classroom performance and the quality of education on offer. Low pay is not the only issue, but probably a significant one in general and related to the lack of adequate financial support for education in many countries.

As part of any situational analysis of an education sector in the preparation of a policy or strategic plan, there needs to be an assessment of the incentive framework in which teachers are recruited and work. More specifically, there also needs to be an assessment of the incentives necessary for teachers to respond effectively to HIV in their work.

While examining the general status on teacher motivation, it will be fruitful to explore the potential motivation for teachers to teach HIV education. What are the incentives and the disincentives for becoming involved in such programmes? If there is additional work, what compensations will be considered, financial or otherwise? This is likely to be a critical element of HIV education programme design.

Teacher absenteeism

Teacher absenteeism represents a waste of resources, a factor that reduces the quality of education and, according to the 2004 EFA Global Monitoring report, is persistent in many countries (UNESCO, 2004). High rates of absenteeism have been reported in sub-Saharan Africa, with many possible causes:

- lax professional standards;
- lack of supervision and support by education authorities;
- inadequate salaries resulting in teachers taking a second job;
- HIV-related illness.

A DFID-funded research project attempted to quantify systematically teacher and health care provider absence in six countries based on unannounced visits to schools and health facilities (Chaudhury, Hammer, Kremer, Muralidharan and Rogers, 2004). The absenteeism rates varied, but were generally high despite a conservative approach to measurement. The highest in the study was Uganda, with 27 per cent; second was India with 25 per cent; followed by Indonesia and Zambia with 19 per cent and 17 per cent respectively. The study did not attempt to assess the role of HIV in absenteeism. However, it is noticeable that the rates of absenteeism in India and Indonesia are high despite low HIV

prevalence rates, which suggests that HIV-related absenteeism will be difficult to disaggregate from other potential causes.

In a study which investigated teacher absences in nine schools in Kavango and Caprivi in Namibia the study results confirmed that stigma keeps people in denial over HIV in the two regions, and that the epidemic has a serious impact in some schools (Castro, Duthilleul and Caillods, 2007). HIV was never directly mentioned as a direct cause of teachers' absences; sickness was never mentioned as affecting either teachers or learners. Only in one school was the presence of a high number of orphans mentioned, and by only one informant.

The most important manifestations of the epidemic were attendance at funerals and burials, but it is possible that some teachers reported as being very frequently absent without a clear cause (sickness) or having behavioural problems (remaining silent in front of a class) were living with HIV. It was not possible to isolate the impact of HIV on teacher absences, but it was possible to conclude that the problem of teacher absences in an HIV context is serious.

HIV is but one factor that influences teacher absenteeism, and there may be considerable difficulties in obtaining robust data in this regard, given the widespread stigmatization of PLHIV. As with teacher education above, this suggests that HIV-related absenteeism should be considered within the mainstream of education system monitoring. An approach is required for the management of teachers that minimizes teacher absenteeism from all causes. The establishment of effective monitoring of teacher absence at school level may be an essential intervention in high HIV prevalence districts.

Large classes

A key issue raised in the 2005 Education for All Global Monitoring Report (UNESCO, 2004) is class size and the occurrence of very large classes in developing countries, and how these are not conducive to effective learning. High pupil-teacher ratios (PTRs) may be indicative of an overstretched teaching profession. PTRs tend to be high in precisely those countries which most need teachers to increase coverage of primary education to achieve UPE. PTRs may also vary considerably across a country.

Large class sizes are also likely to be detrimental to effective teaching and learning about HIV, especially as participatory methods are

considered to be preferable to whole class activities. Variation in class size across a country is likely to result in educational inequality, including inequality in the quality of HIV education provided. Again these issues are clearly important for the design and development of HIV education, which must be within the mainstream of educational policy and strategic development.

There may be some benefit to be gained from developing teacher guidance on how to deliver participatory activities in large classes. This could also be specifically linked to participatory activities for HIV education. Such practical guidance could be used in pre-service teacher education. The burden for the teacher in managing large classes is almost certainly reduced if learning materials are available for group and individual learning activities. At minimum, this should be a textbook, but could also include games, exercises and supplementary readers. In summary, if large classes are part of the education ecosystem, there needs to be a strategy to enhance teacher effectiveness in these environments in general, and for teaching about HIV.

Teacher shortages

The UNESCO Institute for Statistics (UIS) report on monitoring global needs for teachers and educational quality for 2015 highlights the issue of massive teacher shortages in relation to the achievement of UPE (UIS, 2006). The regions that are most affected are sub-Saharan Africa, the Arab States and South Asia. UIS calculates that sub-Saharan Africa will need to increase its teaching stock by 68 per cent from 2.4 million to 4 million in less than a decade. This is the region that has seen its human capital most severely impacted by HIV. Unfortunately, HIV analysis is limited in scope in the report and not mainstreamed. There is no discussion of the need for teacher training for HIV prevention among the teaching stock to help reduce HIV-related attrition. It is conceded that it is difficult to assess the degree to which HIV affects attrition rates and therefore projection models are relied upon to provide different scenarios (low and high attrition rates). This seems to indicate that the implications of HIV for the sustainability of the teaching stock in high prevalence settings is still not well enough understood by educators, and that more research is required to provide evidence-based guidance for policy-makers and planners.

The Global Coalition on Education report on teachers for all states that the world desperately needs more teachers (Global Coalition

on Education, 2006). It is estimated that between 14 and 22.5 million teachers are required for primary education alone as a result of increased enrolments, the impact of HIV, teacher migration and attrition, and fragile states and countries affected by conflict and natural disasters. The range in the number of teachers required suggests that this is a rough estimate. The report, however, usefully includes discussion of the need to provide teachers with HIV education to protect themselves as well as to teach effectively. It also considers HIV-related stigma and discrimination of students and teachers living with HIV.

The challenge is enormous. Given the scarcity of resources, a strategic and evidence-based approach is clearly required at country level to teacher preparation in a world living with HIV. Approaches and interventions will need to be underpinned by robust research at the country level. It is clear that any estimate of teacher requirements in high HIV prevalence settings will specifically need to include this factor within the overall analysis. Empirical research will be needed to complement projection-based modelling.

Inadequate teacher qualifications, training and content knowledge

Available data suggest that large proportions of primary school teachers in developing countries lack adequate qualifications, training and content knowledge. One conclusion that is frequently drawn is that pre-service training is often failing and much is ineffective. In some countries where there is pressure to expand the number of teachers rapidly, there has been a shortening of the length of college training and the contracting of untrained and unqualified teachers. This is surely the triumph of the short-term horizon over the long term. In the longer run, a failure of governments to invest in ensuring effective pre-service teacher education risks compromising the sustainable development of educational quality.

National qualification standards vary considerably for entry into primary school teaching. In sub-Saharan Africa they vary from lower secondary school to a tertiary degree level (UNESCO, 2005a). Countries also vary considerably in their ability to meet their own standards in this regard. At the low end of the performance continuum are Benin and Burkina Faso (less than 10 per cent meet standards) to countries where almost all teachers reach the standard (Botswana, Cote d'Ivoire, Kenya and Zambia).

Teacher education on HIV must be considered in the light of these findings. Appropriate approaches need to be found for particular educational circumstances. It follows that HIV education for teachers must be considered within the mainstream of teacher educational practice at country level. It should not be developed in a contextual vacuum. A holistic approach to teacher development is required, within which priority would be given to HIV education that is appropriate to the local epidemic and the education of the teaching stock.

Teacher education in many countries is a zone of conspicuous neglect and under-investment. Findings from the Multi-Site Teacher Education Research (MUSTER) project, undertaken in five countries (Ghana, Lesotho, Malawi, South Africa and Trinidad and Tobago) to explore the process and practice of teacher education in those countries, show that policies on teacher education at the primary level are fragmented, incomplete and usually non-existent (Lewin and Stuart, 2003). The authors conclude that, in spite of the obvious centrality of teacher education to the achievement of national education goals, the development of coherent and financially sustainable policy in this area has been widely neglected. This represents a first order priority for policy-makers and for the policy to be integrated into the medium term planning process.

The MUSTER findings pose the following questions for the development of policy on teachers, which would need to address issues of demand for and supply of teachers, quality, curriculum and deployment:

- *Goals:* What are the skills and competencies that newly trained teachers should possess?
- *Methods:* How are such skills to be acquired?
- *Costs:* What resources are needed?
- *Time-scale:* How long will it take to realize the desired policy outcomes?

Other areas relevant to policy development include:

- *Demography:* The number of pupils which determines the number of teachers required.
- *Enrolment rate targets:* E.g. universal primary completion.
- *Trainee selection:* What procedures are viable and cost effective?
- *Teacher attrition:* Loss of teachers through retirement, alternative employment, health issues including HIV.

- *Technology*: The application of information communication technology in teacher education.
- *Financing*: Financing of teacher education needs to be predictable, regular and accountable.
- *Performance monitoring*: Applying norms on staffing and achieving value for money.
- *Linkages with in-service training (INSET) and continuing professional development*.
- *Role of non-government resources*: Public-private partnerships, including the involvement of NGOs.

These parameters have clear relevance to HIV education. There is very little published research on teacher education or teacher training for school-based HIV education. As a result, very little is known about the strategies that MOEs are adopting, the capacity that is being built in TTCs, the types of courses that are being provided and, lastly, but most importantly, how effective these course are in training teachers for classroom delivery of the curriculum.

What is required is a MUSTER-type study that focuses on teacher education and HIV education. This would help provide evidence for normative guidance to be made accessible to MOEs in planning their teacher education in general, and specifically on HIV.

3.6 Is there a crisis in teacher education?

It appears that the importance of effective teacher education has been neglected in developing policies on EFA and MDGs. Teacher development has not been at the forefront of national and international responses. Primary teacher education policy has often been an afterthought, a seemingly residual concern. Secondary education teacher training may have been even more neglected. There has been an astonishing slowness to re-conceptualize teacher education to meet the needs of education reform and the needs of the teaching profession in the twenty-first century by governments and their development partners.

Expenditure on learning and training materials for teacher education is often minimal. Procedures to ensure the replenishment of materials and to protect spending on books and learning aids do not exist. Norms on staffing are seldom applied, and teacher training institutions are in some cases understaffed and in others overstaffed. The internal efficiency of training institutions is often low. The largest element of training

institution costs is that of boarding facilities. Pre-service training is too often not well linked to in-service training and continuing professional development.

Policy on teacher selection is in general poorly articulated and lacking an evidence base. In general, minimum academic standards – and it should be noted that levels of qualification are often low – are used as selection criteria, but there is no evidence that this is a good predictor for subsequent performance. Findings from the MUSTER research indicate that school-leaving scores are not a good predictor of college performance. This suggests that other selection methods, such as interviews and aptitude tests, have potential use. The adoption of such methods would likely assist in the selection of teachers who are more willing to teach about HIV.

Leu (2005) writes that many education systems are starting to advocate matching active learning approaches to teacher professional development. While significant changes are taking place, a robotic approach to teacher training persists, and this produces neither the teaching skills nor the understandings and attitudes required for improving classroom teaching and student learning. She suggests that if teachers are to become reflective practitioners who use active learning approaches in their classrooms, where students learn through problem-solving, critical dialogue, inquiry, and the use of higher-order thinking skills, teachers must themselves learn in professional development programmes to not only advocate but also use and promote these same methods. This has strong relevance to the attempt by many countries to introduce LSE and to harness this for HIV prevention education.

Investment in teacher training curriculum development is long overdue. Too often it is overly academic in content adapted from university or school curricula rather than being designed for the acquisition of knowledge, attitudes and skills relevant to the teaching profession. The place of relevant personal experience, local context and realities, interpersonal skills and the different learning styles of adults are seldom recognized.

Key issues include the following:

- *Lack of mechanisms for curriculum development, evaluation and renewal in teacher education;*

- *Lack of appropriate sequencing of reforms:* In principle, teacher education reform, arguably, should lag behind wider reform. Attempts to introduce simultaneous system-wide reforms in curriculum content, pedagogy and organization may overstretch institutional capacity for change;
- *Innovation:* Innovations need to be grounded in local realities, be owned and fully understood by those who will implement them. Demand creation, establishing a climate of opinion favourable to their adoption and building a constituency for change are important for successful innovation (Lewin and Stuart, 2003).

In conclusion, efforts to prepare the teaching stock to teach HIV education effectively are likely to be compromised in contexts where there is an ongoing crisis in teacher education. Teacher education in HIV can contribute to improving the quality of teacher professional preparation, but it is likely to be most effectively developed in a context of overall reform of TTCs.

Teacher training colleges (TTCs)

A significant conclusion of the MUSTER research was that teacher education institutions no longer play a key role in the development of national education systems. Little evidence was found to suggest that staff were directly engaged in the development of curricula, either at the national level or in the case of teacher education itself. Links with the school system were either non-existent or fragile; TTCs were operating in both physical and intellectual isolation. The key areas identified to address the development of teacher education institutions include the following:

College governance

TTC governance needs to be clearly defined in terms of being able to support a professional academic institution. This would contribute to raising the status of such institutions, which is characteristically low in many national contexts. Linkages of a formal nature, such as affiliation with universities, may be one way of achieving this. Competent TTC governance is needed to put in place appropriate workplace policies and programmes to tackle HIV.

Staffing

Good quality TTCs need appropriate and sustained staffing. Attention needs to be given to fostering an appropriate gender balance on

the staff in the college. This is also important in developing responses to HIV. It seems important to have in place a cadre of professional teacher educators who are suitably experienced, qualified and committed to educational development. To maintain this cadre and to ensure continuing improvement, it is important to have the right incentive framework which would include salary and career opportunities, including professional development such as research and higher degrees.

From an HIV perspective, it is clearly important to develop a cadre of professional teacher educators who are able to train teachers in both technical content and pedagogy. This implies developing sustainable expertise in life skills-based education. The development of post-graduate courses, accessible to serving teacher trainers, which specialize in school health, for example, could help professionalize such training.

Links with schools

Meaningful linkages with schools, and therefore the reality of everyday education, are clearly important to ensure that TTCs provide training that is relevant to what is required in the classroom. MUSTER found few examples of good practice in this area. Partnerships with schools can be built up in a number of ways, including having special arrangements with nearby schools for professional development, teaching practice and that allow trainers to spend time in school doing research, teaching or mentoring staff.

From an HIV perspective, school-TTC linkages should include consideration of HIV issues where this is appropriate, as in generalized epidemics. This is likely, if well designed to prove beneficial in strengthening the support of the community for HIV education, as well as in exposing the TTC to the various hard realities of HIV at the school level.

TTC strategic planning

Strategic planning for TTCs could play a key role in strengthening the quality of their service delivery. This would best be organized in terms of a whole college costed strategic approach to institutional development. This would clearly require that adequate resources, human and financial, be made available to the institution to carry out the process of change and to sustain it.

From an HIV perspective, HIV issues should be included in college strategic planning in most epidemiological contexts, but especially in

high HIV prevalence settings. At the same time, TTCs need to implement MOE workplace policies on HIV. This implies the availability of human and financial resources to undertake this effectively. Evidence of good practice in this regard is as yet hard to obtain.

3.7 In-service education (INSET)

There is a lack of research evidence on in-service training effectiveness in general and specifically on preparing teachers for HIV education. There is therefore a corresponding lack of evidence-based best practice guidance. UNESCO's guidance on INSET for Africa dates back more than 30 years with no sign of having been updated (UNESCO, 1970).

A review of INSET for teacher development for sub-Saharan Africa (Monk, 1999) identified the following issues:

- The material and social features of a teacher's environment exert selection pressures as to which varieties of action will continue to be sustainable in the classroom.
- There is variation in teachers' backgrounds, practices and in-service needs. Teachers are not homogenous in their pedagogic and content knowledge. Teachers bring differing biographies to the classroom and therefore have different in-service needs.
- In-service activities provide new knowledge and skills. There is evidence in the literature that supports the idea of teachers reflecting on their own practice. This is best done with the help of colleagues in school in a whole-school approach. Local support groups are a necessary complementary strategy. Inputs from advisory staff can be supportive.
- Changes to pedagogic content knowledge can be achieved with deliberate interventions as well as through the teachers' own variations in practice.
- Activities that will change a teacher's pedagogical content knowledge are best carried out with demonstration and coaching. In-service training aimed at changing teachers' actions, rather than their knowledge, values, or affect does require the teachers to practise those actions.
- Distance education has many advantages for developing teachers' knowledge. It also can be used to develop affect and values. What is more difficult is to support change in teachers' skills through distance learning.

These findings are highly relevant to INSET on HIV.

3.8 Summary of key points

1. HIV caught MOEs and their development partners unprepared. Many Ministries still have not developed appropriate sector responses, and few appear to be investing appropriately in teacher education on HIV.
2. Education systems are hard to change. They are large, complex and conservative. Change is a long-term and not a short-term process. HIV mainstreaming appears to offer the best chance of cost-effective sustainable success.
3. School health offers opportunities for HIV education, but appears to be neglected in policy and practice. There is growing international support for school health through the FRESH framework, but it is currently unclear how this is specifically benefiting the HIV response.
4. The effectiveness of HIV education is constrained by the wider crisis in education. There is a need to align the education response to HIV with the mainstream ESP. Teacher education has been severely neglected in many contexts.
5. More strategic investment in reforming the quality of teacher education is needed. In particular, increased investment is required to strengthen the capacity and performance of TTCs generally, and this should include integration of appropriate HIV interventions.
6. There is a need to increase the focus on strengthening the effectiveness of teacher pre-service education in addressing both the wider crisis and the education response to HIV.
7. Teacher motivation, absenteeism and shortages, as well as large classes and the quality of training, are critical issues in many developing countries. These issues need to be considered when planning the education response to HIV. A comprehensive SRA is required to inform education sector plan development.
8. There is a need for multi-country research into teacher education and HIV to provide evidence-based guidance for MOEs on how to make initial and in-service teacher education effective.
9. There is a need for research to provide data on how the FRESH initiative is strengthening the education response to HIV.
10. There is a need to develop evidence-based guidance on how MOEs can best mainstream HIV.

Chapter 4

Looking for a hero: HIV education and teacher effectiveness

“All competent teachers know their subjects. They know the appropriate teaching methods for their subjects and curriculum areas and the ways pupils learn” (McBer, 2000: 8).

“In order to teach effectively about HIV and AIDS as well as address HIV and AIDS in their own lives, educators must be provided with appropriate HIV-related knowledge, skills and resources, and be supported by institutions and communities in their work with colleagues and students” (UNESCO, 2008c: 33).

4.1 Introduction

In any field of face-to-face education, teachers play a central role in programme effectiveness. Since curriculum-based HIV education is generally a teacher-led intervention, there is no reason to suggest that HIV education will be any different. Questions of teacher effectiveness in HIV education are likely to be strongly related to more general considerations of educational quality, teacher and school effectiveness. At the same time there are likely to be specific characteristics which are exhibited by HIV education.

Thus HIV education provides a new lens for analyzing issues of teacher effectiveness. It is important to identify the factors and conditions that enable teachers to perform well in the classroom, as these are likely to be critical to the achievement of curriculum learning objectives. This chapter will investigate teacher effectiveness in general and apply the findings to HIV education. The chapter will also examine the factors that seem to result in effective teaching about HIV and also those that lead to disappointing outcomes. It will begin by examining the LSE approach.

4.2 Life skills-based HIV prevention education: the dominant paradigm

The dominant paradigm for HIV education is what is variously termed ‘life skills education’, ‘life skills-based education’, ‘life skills-based HIV

prevention education’ or ‘skills-based health education’. Its range of nomenclature hints at difficulties in conceptualizing what this approach entails. It is probably fair to say that many mainstream educators do not fully understand the concept of life skills or know about its origins. Given the problems of definition, it is likely that significant difficulties will be faced in implementation at the sector level.

So what are life skills? Life skills-based education is a relatively new education response to the socialization function of education. It is perhaps best conceptualized as an approach to equipping young people with the personal and interpersonal skills and competencies that they will need to meet and overcome the various challenges they will face in everyday life (UNICEF, 2008). As such it is a critically important area of educational development, especially so for those MOEs which go beyond academic and vocational training and seek to address socialization and social problems through education.

We have already seen that the term ‘life skills education’ is beset with definitional difficulties. There is sometimes a tendency to include all skills which are relevant to life within its framework. But the broader the definition, the fuzzier the concept and the more difficult it is to monitor results. It therefore may be advisable to provide a specific label for those skills and competencies which relate to personal development and interpersonal relationships. These are psychosocial skills rather than technical or academic skills.

The concept of developing personal and interpersonal skills in young learners is relatively straightforward. There are different ways in which these can be categorized, but all approaches share a considerable amount of common overlap in terms of social, emotional and cognitive skills that are important in life or to address specific objectives such as HIV prevention or reducing violence. The appropriate selection and organization of the specific skills to be taught and learned will clearly be an important issue in any LSE programme design.

The key educational issue is how to operationalize the approach effectively and ensure that it delivers the intended life skills. This requires viewing LSE as an innovation in curriculum development and drawing on the lessons learned from best practice in the field to develop effective implementation in the classroom. It should be borne in mind that curriculum innovation is an especially challenging area of

educational change and many interventions fail because the risks were underestimated.

Life skills-based education has been applied to a wide range of social issues, but probably the main response area internationally has been HIV preventive education. Life skills-based education programmes have been developed in sub-Saharan Africa, the Caribbean region, South and southeast Asia. As a result, a large corpus of data on the process and outcomes of such programmes is now available and continues to grow. These data reveal a wide range of implementation difficulties, many of which reflect the poor quality of education that is being delivered. The content matter of HIV prevention education programmes also presents its own particular challenges for the teacher. Despite the significant difficulties that are being encountered, there are grounds for optimism. Research findings demonstrate that life skills-based education for HIV prevention can be effective in increasing knowledge, changing attitudes and even modifying behaviours. Effectiveness in achieving learning objectives does not occur in all cases, and a great deal seems to depend on the development of programmes according to the characteristics of effective programmes which have been derived from analysis of research findings.

A critical factor for success seems to be teacher preparation, motivation and support. This is not surprising given this is generic to successful curriculum development and effective teaching and learning. In addition, the importance of putting in place robust monitoring and evaluation arrangements for LSE cannot be overestimated. Without this, it is problematic and may even be impossible to determine programme coverage or effectiveness. The assessment of learning outcomes and life skills acquisition is an area that MOEs seem to find especially difficult.

Origins of life skills education

LSE has a specific origin in health education and promotion. The approach was developed in the 1990s in response to a range of health-related issues that included the prevention of adolescent pregnancy (Mexico), child abuse (UK), substance abuse and violence (USA) and HIV prevention (Thailand and Zimbabwe). In South Africa, efforts have been made to create a curriculum for Education for life called *Life orientation education*. LSE thus may be introduced for the promotion of healthy children and adolescent development; primary prevention of some key causes of child and adolescent death; disease and disability; socialization

and preparing young people for changing social circumstances (WHO, 1999).

Life skills-based education draws on the concept of life skills. These are a group of social, emotional and cognitive competencies and interpersonal skills that help people make informed decisions, solve problems, think critically and creatively, communicate effectively, build healthy relationships, empathize with others, and cope with and manage their lives in a healthy and productive manner. Life skills may be directed toward personal actions or actions toward others, as well as toward actions to change the surrounding environment to make it conducive to health, which is defined as a state of complete physical, mental and social well-being (WHO, 1999). Life skills may underpin skills-based health education which is an approach to creating or maintaining healthy lifestyles and conditions through the development of knowledge, attitudes, and especially skills, using a variety of learning experiences, with an emphasis on participatory methods.

Life skills-based education aims at facilitating the development of the social, emotional and cognitive skills that are required to deal with the demands, challenges and opportunities of everyday life. It includes the application of life skills in the context of specific risk situations and in situations where children and adolescents need to be empowered to promote and protect their rights. The LSE approach is conceived as an interactive methodology that not only focuses on transmitting knowledge, but also aims at shaping attitudes and developing interpersonal skills. The main goal of the approach is generally to enhance young people's ability to take responsibility for making healthier choices in life, resisting negative pressures, and avoiding risky behaviours. The teaching methods that are used are youth-centred, gender-sensitive, interactive, and participatory. The most commonly used methods include working in groups, brainstorming, role-playing, story telling, debating, and participating in discussions and audiovisual activities.

The term 'life skills' can encompass many behaviours, skills and competencies. It is open to wide interpretation and misunderstanding. The term 'skill' is itself one with many meanings subsuming concepts of ability and capability (NCERT, undated). Three examples are given below to exemplify the different ways in which the basic concept of life skills/behaviours and competencies can be categorized:

The first example involves WHO. From a mental health perspective, WHO (1999) initially identified five basic areas of life skills that are relevant across cultures:

- decision-making and problem-solving;
- creative thinking and critical thinking;
- communication and interpersonal skills;
- self-awareness and empathy;
- coping with emotions and stress.

These were subsequently reduced by WHO (2001) to three broad categories:

- *Communication and interpersonal skills*: These include negotiation and refusal skills, empathy-building, co-operation and teamwork, and advocacy skills.
- *Decision-making and critical thinking skills*: These involve problem-solving and critical thinking skills.
- *Coping and self-management skills*: These involve skills for increasing personal confidence, taking responsibility, managing feelings and stress.

The second example involves the Collaborative for Academic, Social and Emotional Learning (CASEL) in the USA, which has identified five core groups of *social and emotional competencies*:

- *Self-awareness*: accurately assessing one's feelings, interests, values and strengths.
- *Self management*: regulating one's emotions to handle stress and control impulses.
- *Social awareness*: being able to take the perspective of and empathize with others.
- *Relationship skills*: establishing and maintaining healthy and rewarding relationships, resisting inappropriate social pressure, resolving conflict.
- *Responsible decision-making*: making decisions based on appropriate social norms, respect for others, and applying decision-making skills to academic and social situations.

The third example involves the National Guidelines Task Force in the USA, which was convened by the Sexuality Information and Education Council of the United States of America in response to an increasing number of states mandating that schools teach young people about HIV,

STDs and other sexual health topics. This developed the ‘Guidelines for comprehensive sexuality education: Kindergarten to twelfth grade’ in 2004. The organization of this was based on the identification of life behaviours, which could serve as a means of assessing successful outcomes in an adult. From these, the skills necessary to achieve these behaviours were determined, compiled and organized into six key concepts, each of which was considered to encompass an essential area of learning. They are as follows:

- *Human development*: The interrelationship between physical, emotional, social and intellectual growth. This includes reproductive and sexual anatomy and physiology, puberty, reproduction, body image, sexual orientation and gender identity.
- *Relationships*: These are central to our lives. This includes families, friendship, love, romance, marriage and commitments and raising children.
- *Personal skills*: These include decision-making, communication, assertiveness, negotiation and looking for help.
- *Sexual behaviour*: This is a central part of being human. This includes abstinence, masturbation, sexual fantasy, human sexual response and sexual dysfunction.
- *Sexual health*: Sexual health promotion requires specific information and attitudes to avoid unwanted consequences. This includes contraception, pregnancy and antenatal care, abortion, STDs, HIV and AIDS, sexual abuse, violence and harassment.
- *Society and culture*: These shape the way we learn about and express our sexuality. It covers gender roles, the law, religion, diversity, the media and the arts.

The three organizations cover a considerable amount of common ground, but organize the ‘life skills’ somewhat differently according to the objectives of their LSE. MOEs will need to select the appropriate set of life skills in accordance with the evidence of need among the target group and the capacity of teachers to deliver them.

The concept of LSE entered the educational mainstream within the Dakar Framework for Action on Education for All (UNESCO, 2000) as a component of the third goal: *ensuring that the learning needs of all young people and adults are met through equitable access to appropriate learning and life-skills programmes.*

Life skills are also included in the sixth goal: *improving all the aspects of the quality of education and ensuring excellence of all so that recognized and measurable learning outcomes are achieved by all, especially in literacy, numeracy and essential life skills.*

What constitutes essential life skills is always likely to be a definitional problem. Following Dakar, many countries are now seeking to promote life skills-based education. This is perhaps most commonly observed in programmes which are designed to prevent HIV. LSE is also being promoted in response to the need to reform traditional education systems, which often appear to be out of step with the realities of modern social and economic life. In some contexts, LSE is being developed to address social problems such as violence in schools and student drop-out which are hampering the ability of school systems to achieve their academic goals. Furthermore, in addition to its wide-ranging applications in HIV prevention and the advantages that it can bring for education systems, life skills-based education can lay the foundation for developing the learning skills that are increasingly in demand in job markets.

In practice, life skills are being taught in a range of modalities. These can be summarized as follows (UNICEF, 2005a and 2005b):

- stand-alone life skills curriculum;
- integration into an existing curriculum;
- co-curricular programme;
- a combination of the above three modalities.

How life skills are contained within the national framework for teaching and learning is obviously of considerable significance for the delivery of learning outcomes. Inclusion within the national curriculum is clearly important for the status of life skills-based education, especially if they are assessed, since education systems and teachers in particular strongly tend to prioritize the assessed curriculum. There is also an argument for inclusion of LSE in the co-curriculum, as this is an area of school practice where there is more flexibility and scope for innovation. A combination of integration in both the curriculum and co-curriculum might prove to be most effective, but this needs to be researched.

Critics of LSE from an HIV perspective have raised the following issues (Boler and Aggleton, 2004):

- Future programmes and interventions should be based on theories that take the realities of young people's lives, their vulnerabilities

and risk-taking behaviours with all their complexities, as the starting point.

- There is a need for greater political commitment at national level from a range of ministries and within the MOE itself.
- A clearly defined pedagogical framework for learning and teaching should be the starting point of any educational process. It is important to clarify which skills should be taught in life skills-based HIV education, why these skills are chosen, and how they should be taught.
- Life skills approaches need to be more educationally-driven, building upon evidence regarding which educational processes have transformative capacity and how to strengthen teacher and school effectiveness.
- More effort needs to be placed on introducing a participatory approach into non-participatory education systems. There is a need for research to look at the circumstances under which life skills-based education can be suitably integrated in the formal education system.
- Whole-school approaches are needed, which take into account the reality of the school and the factors which promote school effectiveness.
- Life skills-based curricula should be developed and reviewed as part of a wider education sector curriculum reform. Too often life skills-based education is at the margin of educational development.
- Life skills require highly skilled and motivated staff with an in-depth understanding of issues. A massive injection of resources is needed to train teachers to deliver life skills and to support them in their work. A greater focus on effective pre-service education is required.
- For life skills curricula to succeed, the wider crisis in formal education must also be addressed. This includes improving the capacity, motivation and professionalism of teachers, the quality of teaching, introducing a learner-centred pedagogy in place of examination-based assessment, and developing child-friendly schools (UNICEF, 2005*b*).

These perceived shortcomings indicate the need for a comprehensive review of the LSE approach to HIV prevention in a range of countries. They point to a crisis in LSE delivery. A key question for researchers is

under what conditions can life skills-based education be effective and institutionalized in low- and middle-income countries?

4.3 Characteristics of effective sex and HIV education programmes

The most comprehensive review of research on preventing HIV in young people and including curriculum-based HIV education programmes was undertaken by the UNAIDS IATT on Young People (Ross, Dick and Ferguson, 2006). The research on school-based HIV sex and HIV education reviewed their impact on both risk behaviours and the psychosocial factors that affect them (Kirby *et al.*, 2006). The most important conclusions are that all the studies included had a positive impact on knowledge. Curriculum-based interventions with the characteristics of effective programmes which had been identified also had consistent positive results in reported behavioural change in reducing risk behaviours. It is therefore suggested that there is a sufficiently strong evidence base to support widespread implementation of school-based interventions that incorporate the characteristics of effective programmes.

What are these characteristics of effective sex education and HIV education programmes, and what do they say about teachers? They are derived from a research corpus of evaluated programmes that used either an experimental or quasi-experimental design and which measured the impact of the intervention on sexual risk behaviours. The evaluation studies comprise a range of interventions, not all of which were curriculum-based, from Belize, Brazil, Chile, Jamaica, Kenya, Mexico, Namibia, Nigeria, South Africa, Tanzania, Thailand, Uganda, Zambia and Zimbabwe. Some of these appear to have been small-scale targeted interventions rather than a component of the national curriculum. Some of the sample sizes in the studies were small e.g. six schools (three intervention schools and three comparison schools in Thailand) and some caution may be warranted in applying the findings to a large-scale education system.

What is extremely interesting and noteworthy in the review of the various case study research findings is the lack of discussion and evidence on LSE. The term is missing, presumably reflecting its problematic nature. Also missing is the term 'gender', and any research findings which refer to gender analysis or gender issues in any the stages

of curriculum development. This is truly remarkable in the case of HIV education since gender norms and practices are recognized by most, if not all, to be a driver of HIV epidemics.

The characteristics that are derived from these studies are organized in four areas:

- developing the curriculum;
- content, curriculum goals and objectives;
- activities and teaching methods;
- implementation.

These are set and discussed below. Some comments made by Senderowitz and Kirby (2006) have been incorporated, in an attempt to establish standards for HIV education. To these, questions have been added in italics concerning teacher-related issues.

Developing the curriculum

Five characteristics are given in this first area. It is important to note that teacher involvement is recommended in the curriculum development process, though the mechanics of this have to be worked out elsewhere. The main focus is on the target group for the curriculum and matching content to their needs. There is some concession to teachers in the fourth characteristic, which includes consideration of staff time and skills in designing learning activities. Otherwise there is little overt consideration of teachers at this stage.

Characteristic	Guidance from Senderowitz and Kirby (2006)
Involve multiple people with different backgrounds in theory, research and HIV education.	<p>The curriculum development or adaptation process involves professionals with backgrounds in behavioural theory, education, instructional design, evaluation, reproductive health and HIV; stakeholders such as teachers, parents, and youth; and others who can lend expertise and relevance such as those familiar with the local culture and infrastructure.</p> <p><i>How are representative teachers selected?</i></p>
Assess relevant needs and assets of target group.	<p>The planning team reviews data on HIV, STIs, pregnancy rates, sexual and contraceptive behaviour, protective and risk factors, and other relevant matters, supplemented by focus groups and interviews with the target audience(s) and relevant adults, if possible.</p> <p><i>How is this assessment made available to teachers?</i></p>
Use a logic model to develop the curriculum that specifies the health goals, the risk and protective factors affecting those behaviours, and the activities addressing those risk and protective factors.	<p>The development/adaptation process uses a framework (or logic model) that specifies the health goals, behaviours affecting those goals, determinants of those behaviours, and activities addressing those determinants.</p> <p><i>How is the curriculum logic made accessible to the teacher?</i></p>
Design activities consistent with community values and available resources (such as staff time, staff skills, facility space and supplies).	<p>Community norms, values and traditions are identified and, as appropriate, incorporated into the issues, examples, and priorities of the content. The planning team identifies human, infrastructure and financial resources for use in the programme and factors these resources into the design so that the approach and activities are feasible.</p> <p><i>How are issues related to teachers assessed and incorporated?</i></p>
Pilot test the programme.	<p>The developed curriculum is tested with individuals who represent the target population, and revisions are incorporated as suggested by the testing.</p> <p><i>How does the evaluation of the pilot-testing assess teacher performance?</i></p>

The characteristics of effective HIV education programmes relating to curriculum development currently contain no explicit mention of teachers. However, each one has implications for teachers, as can be seen

in the column on the left. They imply some form of assessment of how teachers will be able to implement the curriculum and an evaluation of teacher effectiveness during the pilot-testing stage.

Content: curriculum goals and objectives

Characteristic	Guidance from Senderowitz and Kirby (2006)
Focus on clear health goals such as the prevention of STIs and HIV.	The curriculum clearly states specific health goals (HIV prevention, STI and/or pregnancy prevention), focusing on susceptibility to the risks and consequences of not reaching these goals. It also gives a clear message about achieving these goals. <i>How are teachers made aware of the curriculum?</i>
Focus narrowly on specific behaviours leading to those health goals (such as abstaining from sex or using condoms or other contraceptives); give clear messages about these behaviours; and address situations that might lead to them and how to avoid them.	The curriculum covers the behaviours that relate to HIV and STI infection and/or pregnancy (such as abstinence, frequency of sex, number of sexual partners, and use of protection) in clear and consistent ways with good examples of situations that could lead to, or avoid, negative consequences. The curriculum tailors messages to the target group(s) and advocates for responsible, desirable behaviour. <i>How are teachers trained to master the content related to these issues?</i>
Address multiple sexual-psychosocial risk and protective factors (such as knowledge, perceived risks, values, attitudes, perceived norms and self-efficacy).	The curriculum focuses on, and is designed to change, the specific risk and protective factors (e.g. knowledge, values, attitudes, perceptions of peer norms, intentions, skills and self-efficacy) that affect the specified behaviours. <i>How are teachers trained in behaviour change pedagogy?</i>

The three characteristics in the section on goals and objectives focus on curricular content. Once again, there is no explicit mention of the teacher who would deliver the curriculum. In the column on the left, some questions are raised from the perspective of the teacher. They anticipate implementation, including piloting.

Since the next set of characteristics involves activities and teaching methods, some mention of teachers can be expected.

Activities and teaching methods

Characteristic	Guidance from Senderowitz and Kirby (2006)
Create a safe social environment in which youths can participate.	<p>The curriculum includes guidelines for participant involvement that foster an environment of respect, trust, confidentiality, openness and comfort in discussing sensitive issues.</p> <p><i>How are teachers trained to create a safe environment for HIV education?</i></p> <p><i>In many contexts, this requires a radical change in the school's teaching and learning environment.</i></p>
Include multiple activities in which youths can participate.	<p>Activities to change targeted risk and protective factors use approaches that facilitate such changes, involving effective ways to learn information, discuss and consider behaviours, and practice skills. This requires the provision of teaching and learning materials to support activity-based learning and teacher training for successful implementation.</p> <p><i>How are teachers trained and supported?</i></p>
Use instructionally sound teaching methods that actively involve participants, that help participants personalize the information, and that are designed to change each group of risk and protective factors.	<p>The curriculum identifies instructional approaches that actively involve the participants and help participants to personalize the information. This requires a shift away from didactic, teacher-centred classroom activity to child-centred learning.</p> <p><i>How are teachers trained and supported?</i></p>
Use activities, instructional methods and behavioural messages that are appropriate to the culture and sexual experience of the participants.	<p>The curriculum content emphasizes instructional methods, responsible behaviours, issues, needs, and examples relevant to the target audience(s) as researched and assessed.</p> <p>The curriculum includes issues of gender discrimination and power imbalances, looks at how males and females experience reproductive health/HIV issues differently, and uses gender-sensitive approaches to teaching sexual health.</p> <p><i>This requires prior research into relevant cultural factors and issues.</i></p> <p><i>How are teachers trained and supported?</i></p>
Cover topics in a logical sequence.	<p>The curriculum presents topics in an order conducive to learning, following stages of motivation, information, values and attitudes, and skills.</p> <p>The content presented is accurate, with myths and incorrect beliefs clearly identified as such.</p> <p><i>How are teachers trained and supported?</i></p>

Five characteristics are given regarding teaching methods and activities. It is striking that no explicit mention is made of teachers. In the column on the left, some issues are identified that are relevant to the teacher. The first relates to the ability of effective teachers to establish an appropriate classroom climate. The second, third and fourth relate to the repertoire of teaching skills that teachers possess and the availability of teaching and learning materials to support these. A critical new factor is the inclusion of attention to matching instructional methods to the sexual experience of the target group. The latter characteristic implies delivery of the curriculum as designed and intended. It also implies that HIV education is integrated within a single subject rather than diffused across the curriculum.

Implementation

Characteristic	Guidance from Senderowitz and Kirby (2006)
Secure at least minimal support from appropriate authorities, such as ministries of health, school districts or community organizations.	Building on the support obtained prior to implementation, continuing communication assures that local government, the health and education sectors, and local community leadership (such as youth group leaders, faith-based representatives and parents) are kept informed and remain supportive. <i>This requires a strategic approach to planning for the involvement of stakeholders at all levels in the education system.</i> <i>How is ownership garnered among teachers?</i>
Select educators with the desired characteristics, train them and provide them with monitoring, supervision and support.	The educators who will implement the curriculum are selected through a transparent process that identifies relevant and desirable characteristics, such as interest in teaching the curriculum, commitment to young people’s development, comfort with discussing sexuality, and ability to communicate with, and relate to, participants. Training of the selected educators uses appropriate trainers and training curricula, sets clear goals and objectives, covers participatory methods, provides practice opportunities, offers a good balance between learning content and practising skills, conducts a performance-based assessment, and requests participants’ feedback. Managers and supervisors (existing or recruited) are trained to manage and oversee implementation

	<p>activities and are available for assistance to educators after training. <i>Selection is a major challenge in implementing a programme on a large scale.</i> <i>In-service or pre-service training?</i></p>
<p>If needed, implement activities to recruit and retain youths and overcome barriers to their involvement (for example publicize the programme, obtain consent from youths and parents).</p>	<p>The programme plans effective ways to recruit participants, if needed (such as for non-school-based programmes), through such actions as providing information to youth in places where they congregate, partnering with local organizations, offering sessions at convenient times and locations, and removing barriers to participation, including transportation. Youth participants are monitored for programme participation and satisfaction, with feedback used to improve retention. <i>Requires a strategy to sensitize parents and communities on the programme</i> <i>How are teachers involved?</i></p>
<p>Implement virtually all activities as designed</p>	<p>Easy-to-use monitoring systems to track implementation, type and amount of participation are established from the beginning of the programme, including the training of those responsible for the monitoring. Findings that result from this monitoring are made available to programme managers in a timely way, in order to make the needed adjustments in the programme design. Evaluation of programme effectiveness is conducted, if possible. Implementation of the curriculum avoids significant omissions or alterations and follows the intended order. <i>This requires commitment at all levels to implement the programme as designed. This poses a particular challenge in large education systems. Monitoring is important to ensure implementation is taking place as intended.</i> <i>How is teacher classroom performance monitored?</i></p>

Four characteristics are given for programme implementation. The first involves institutional support but misses out school level support involving school principals. The second involves teachers ('educators') and concerns how these are selected in terms of desired characteristics. It is also mentioned that they should be trained, supervised and supported, but with few details on how, for how long etc.

The issue of teacher selection is problematic. If HIV education is a co-curricular programme, then teachers may be selected at school level by the school principal, and possibly with student input. If HIV education is mainstreamed within the school curriculum, it is practically impossible to select teachers specifically for HIV education. In this case the critically important policy decision lies in selecting the most appropriate carrier subject in the curriculum, and selection will include finding the right recruits; setting and maintaining standards for recruitment; broadening the range of recruitment methods, including aptitude and motivation tests and interviews. The issue of curriculum mainstreaming of HIV is discussed below.

4.4 HIV curriculum mainstreaming

UNICEF (2002) recommends that HIV prevention education be placed in the context of other related health and social issues, such as reproductive health and population issues relevant to children, young people and the community in which they live. For example, carrier subjects within the existing formal curriculum can be useful entry points by accommodating the necessary balance of knowledge, attitudes and skills *together*. Examples of carrier subjects include health education or civic education, or population education. Programmes that are integrated or infused thinly throughout a curriculum rather than within a discrete, intensive module have generally been disappointing (Gachuhi, 1999, Smith *et al.*, 2000). Programmes that are part of the national curriculum and officially timetabled have the advantage of having greater coverage as well as a greater likelihood of training, support and actual delivery. Where co-curricular approaches are utilized, they should be clearly linked to other school-based activities and issues, such as human rights, gender, early pregnancy and reproductive health, violence and bullying, and general health promotion. Whether curricular or co-curricular approaches are employed, isolated or one-off programmes should be avoided, as they tend to be unable to address the complexity of and the interrelationships between the full range of relevant issues. There are three options. The first two only are recommended.

Within a carrier subject

Integrating HIV LSE into an existing subject that is relevant to the issues, such as civics, social studies or biology, it is suggested as a good short-term option.

Strengths	Weaknesses
Teachers of the carrier subject are likely to see the relevance of the topic to other aspects of the subject.	Risk of an inappropriate carrier subject being selected.
Teachers of the carrier subject are likely to be more open to the teaching methods and issues being discussed due to their subject experience.	Integration in biology would focus on biomedical knowledge, while health education or civic education would permit a more holistic approach involving social and personal issues.
Cheaper and faster to integrate the components into materials of one subject than to infuse across all.	Integration may be a marginal addition.

As a separate subject concerning health or family life education

Teaching LSE within a specific subject to address HIV in the broader context of other important issues, such as health education or health and family life education, is considered a good longer-term option.

Strengths	Weaknesses
Likely to have teachers who are focused on the issues, and can be specifically trained;	The subject may be accorded very low status and not seen as important, especially if not examinable;
Most likely to have congruence between the content and teaching methods in the subject, rather than shortcutting which may occur through 'infusion' or 'carrier subject' approaches.	Requires additional time to be found in already overloaded curriculum if not already included. Other teachers may make no effort to promote HIV education within their teaching

Integration across the curriculum

The least effective way of including life skills-based HIV prevention education is when it is integrated into all, or many, existing subjects and delivered by regular classroom teachers.

Strengths	Weaknesses
<p>A whole school approach can be taken. It utilizes structures that are already in place and is often more acceptable than a separate course of family life education or sex education. Many teachers are involved, even those not normally involved in teaching HIV education. High potential for reinforcement.</p>	<p>The issues can be lost among the higher status elements of the subjects. Teachers may maintain a heavy information bias in content and methods applied, as is the case with most subjects. The logic of HIV prevention is lost. Very costly and time consuming to access all teachers and change teaching materials. Some teachers do not see the relevance of the issue to their subject. Difficulty in ensuring the consistency of message across subjects and the logic required for HIV prevention. Potential for reinforcement seldom realized due to other barriers.</p>

There is potential for MOEs to waste resources in making poor decisions about where HIV education should be placed in the curriculum. These resources might have been effectively used elsewhere in the education system or to support a more evidence-based approach to HIV education.

In summary, the IATT on Young People (Kirby *et al.*, 2006) characteristics of effective sex and HIV education programmes provide very little detailed practical guidance to planning a programme, especially from the perspective of teacher effectiveness. It is important, therefore, to examine other sources of information on teachers and HIV education. In contrast to the upbeat and positive characteristics mentioned above, these accounts focus on the difficulties that teachers have in implementing HIV education.

There is, however, a paucity of sources of information on effective programmes. Opportunities to obtain robust data relevant to teacher effectiveness on HIV education are not being taken. The World Bank sourcebook on education prevention programmes contains a substantial

number of NGO-supported HIV programmes in Africa, with many involving peer education rather than curriculum-based programmes (World Bank, 2003). There is very little information on teacher effectiveness in this sourcebook. The UNAIDS IATT on Education (2005) *Global HIV/AIDS Readiness Survey* – a self-reporting study carried out by 71 MOEs with no triangulation to corroborate data – asked only two questions related to teaching about HIV:

- Have orientation programmes been undertaken for teachers in school life skills and HIV and AIDS? (49 per cent of responding countries confirmed that they had).
- Are HIV and AIDS and life skills integral components in the curriculum for the professional preparation of all new teachers? (63 per cent of responding countries stated that they were).

These data provide insufficient detail to permit any conclusions for evidence-based planning. In a similar vein, a UNESCO cross-country study (UNESCO, 2006b) on higher education institutions included only one teacher education institution (Hanoi University of Education in Viet Nam) where HIV has been integrated into the teaching curriculum in the faculties of Psychology and Pedagogy, Geography, Political Science Education, and Biology and Agricultural Techniques. There is a University Committee for HIV/AIDS, Social Evils and Prostitution. However, most informants indicated that they expected to learn more about sensitive issues through extra-curricular activities.

Typical of school-based HIV interventions is the provision of information on sexual and reproductive health as part of a life skills, family life education, or HIV prevention curriculum. It is rare that the learning acquired from these courses is assessed, graded or examined, or that teachers are trained to teach the material or rewarded according to the quality of their work (Lloyd, 2007).

4.5 Investigating teacher effectiveness

In order to ground this discussion in terms of more general education discourse, the literature on teacher effectiveness will be examined and conclusions drawn regarding the implications for teaching about HIV. In doing so, the discussion will draw on issues emerging from the discussion of LSE and effective curriculum-based HIV education programmes.

A rapid survey of the literature suggests that much of the research into teacher effectiveness takes place in industrialized economies. There appears to be a paucity of research in the lowest-income countries and Africa in particular. This is indicative of a lack of resources to undertake such research. It is also tempting to conclude that this is not a high priority for many governments or their international development partners in an international development paradigm that prioritizes quantitative targets over expanding educational effectiveness.

Reynolds and Muijs (2000), in a review of the literature on comparative pupil outcomes resulting from different kinds of teaching styles and practices, identify the following teacher-related factors which lead to more effective learning:

- opportunity to learn an academic orientation;
- effective classroom management teacher expectations;
- active teaching;
- instructional variety;
- brisk pace;
- frequent and appropriate questioning;
- lesson clarity;
- teacher task orientation;
- engagement in the learning process;
- both time on task and use of higher order thinking skills.

This is a complex set of variables, but clearly in line with the demands of a life skills-based education approach. They speak of teacher commitment to achieving learning outcomes, of using scarce resources efficiently and of commitment to the students. They indicate that effective teachers have an expanded repertoire of teaching skills and techniques and the ability to use them flexibly. They imply that teachers need to have had a good academic education, sound practical professional training and operate within an incentive framework that encourages professional excellence.

These factors reappear in the summary provided by Craig, Kraft and du Plessis (1998) of elements that are to be found in effective teachers. They conclude that effective teachers at a mature stage of development tend to:

- know their subject matter;
- use pedagogy appropriate for the content;

- use an appropriate language of instruction, and have mastery of that language;
- create and sustain an effective learning environment;
- find out about and respond to the needs and interests of their students and communities;
- reflect on their teaching and children's responses, and make changes to the learning environment as necessary;
- have a strong sense of ethics;
- be committed to teaching;
- care about their students.

The importance of the teacher in establishing a learning environment that is conducive to effective learning comes out strongly in the list. These factors can be grouped so as to provide a framework for analysis and action. They are all applicable to teaching about HIV and a LSE approach. A critical issue is probably helping teachers to know their subject matter and to be able to deliver it in an interesting and confident manner.

Researching teacher effectiveness in the UK, McBer (2000) found three main factors within teachers' control that significantly influence pupils' progress:

- teaching skills;
- professional characteristics;
- classroom climate.

These three factors seem to capture the main elements from the research cited above. Effective teachers create learning environments in their classrooms that are conducive to pupils' progress by deploying their teaching skills as well as a wide range of professional characteristics. All competent teachers know their subjects. They know the appropriate teaching methods for their subjects and the ways pupils learn. The study found that more effective teachers make the most of their professional knowledge in two linked ways: in the extent to which they deploy appropriate teaching skills consistently and effectively in the course of all their lessons; and in the range and intensity of the professional characteristics they exhibit in ongoing patterns of behaviour which make them effective.

McBer's findings will be set out in the following sections to provide a framework for informing discussion of teacher effectiveness for HIV education.

Teaching skills

Teaching skills are defined as those micro-behaviours that the effective teacher constantly exhibits when teaching a class, such as:

- involving all pupils in the lesson;
- using differentiation appropriately to challenge all pupils in the class;
- using a variety of activities or learning methods;
- applying teaching methods appropriate to the national curriculum objectives;
- using a variety of questioning techniques to probe pupils' knowledge and understanding.

Lesson observations revealed that in classes run by effective teachers, pupils are clear about what they are doing and why they are doing it. They can see the links with earlier learning, they have ideas and they want to know more. They feel secure in an interesting and challenging learning environment. Effective teachers were very actively involved with their pupils at all times. Many of the activities were teacher-led, which maximized opportunities to learn. Time was used efficiently; the learning environment was characterized as purposeful and businesslike. This set of characteristics sounds close to the ideal LSE programme.

Teaching skill factors include the following:

1. **High teacher expectations:** Effective teachers set high expectations for the pupils, which they communicate directly to the pupils. They challenge and inspire pupils, expecting the most from them, so as to deepen their knowledge and understanding. The most effective teachers were found to determine the appropriateness of objectives for pupils by some form of differentiation, which means expecting different outcomes from pupils of varying ability. Effective teachers are relentless and consistent in their pursuit of a standard of excellence to be achieved by all pupils.
2. **Lesson planning:** Effective teachers are good at planning. This involves setting a clear framework and objectives for every lesson. The effective teacher is systematic in the preparation for, and execution of, each lesson. The lesson planning is done in the context of the broader curriculum and longer-term plans. The approach used is structured, beginning with a review of previous lessons and an overview of the objectives of the lesson.

3. **A variety of teaching strategies:** Effective teachers employ a variety of teaching strategies and techniques to engage pupils and to keep them on task. Individual work and small group activities were regularly used as ways of reinforcing pupil learning through practice and reflection. When effective teachers were not actively leading, they were always on the move in the classroom, monitoring students' work and their understanding of materials. Lesson contents and presentations were varied to suit the needs of the class and the nature of learning objectives.
4. **Student management:** Effective teachers have a clear strategy for student management. As a result, there is a sense of order in the classroom. Pupils feel safe and secure. This maximizes pupils' time on task and thus learning opportunities. Effective teachers establish and communicate clear boundaries for acceptable pupil behaviour. They exercise authority clearly and fairly from the outset. In their styles of presentation and engagement they are able to hold the attention of the students. Inappropriate behaviour is stopped with immediate direct action from the teacher. Effective teachers recognize and reinforce good behaviour and reinforce it with praise.
5. **Management of time and resources:** Effective teachers manage time and resources wisely. Effective management of pupils, time, resources and support promotes good behaviour and effective learning. Effective teachers effectively manage a class by having a clear structure for each lesson, making full use of planned time, using a brisk pace and dividing his/her time fairly amongst pupils. Effective teachers start their lessons on time and finish with a succinct review of the learning that has taken place.
6. **Assessment:** Effective teachers employ a range of assessment methods and techniques to monitor students' understanding of lessons and their work. These included tests, competitions, questioning or regular marking of written work. Effective teachers look for gains in learning, gaps in knowledge and areas of misunderstanding through their day-to-day work with pupils. Effective teachers encourage pupils to judge the success of their own work and to set themselves targets for improvement. They also offer critical and supportive feedback to pupils.

These factors illuminate some of the contemporary difficulties in delivering HIV education programmes. Some questions are raised below:

- How can teachers of HIV education be trained to set high expectations for their students? Do teachers know what to expect from the students in terms of learning outcomes on HIV? How do they set their expectations for lessons?
- Do teachers have enough training and support in lesson planning for HIV education? How can lesson planning be facilitated?
- Are teachers equipped with a broad enough repertoire of teaching skills to implement a LSE approach? How can teacher education provide the necessary repertoire of teaching skills?
- Do teachers have sufficient practice and the requisite competencies in managing student interaction in learning activities? How can teachers be trained in student management techniques?
- Do teachers have enough training and support in managing lesson time and teaching resources well? How can teachers be trained to use time and resources effectively?
- Do teachers know how to assess the understanding of their students on HIV-related learning? How can teachers be trained and supported in relevant assessment techniques?

These factors bring us back to the importance of effective pre-service training and the careful preparation of teaching and learning resources that optimize support for the teacher in delivering the course. They also imply a need for continuous support at school level from school management, and regular in-service training to strengthen the development of teaching skills.

Professional characteristics

Professional characteristics include professionalism, thinking, planning and setting expectations, and leading and relating to others. Effective teachers need to have some strengths in each of them.

(a) **Professionalism:** This characteristic includes four attributes:

1. **Respect for others:** Everything the effective teacher does is expressed in a constant concern that everyone should treat pupils and all members of the school community with respect. Effective teachers explicitly value others, value the diversity in the school

community, and retain their respect of others even when under extreme pressure.

This characteristic is directly relevant to addressing issues of HIV-related stigmatization and discrimination at school. This needs to be recognized by teachers, TTCs and by teachers' unions.

2. **Challenge and support:** Effective teachers not only cater for pupils' needs for physical and psychological safety, but also repeatedly express positive expectations and build students' self-esteem and belief that they can succeed, as learners and in life.

This is particularly relevant to the situation of children infected with and affected by HIV.

3. **Confidence:** Effective teachers show confidence in most situations, expressing optimism about their own abilities and making an active contribution in meetings.

This is directly relevant to the ability of teachers to deliver sex education.

4. **Trust:** Effective teachers are consistent and fair. They create trust with their pupils because they honour their commitments. They are genuine, and generate the atmosphere where pupils can be themselves, express themselves and not be afraid of making mistakes – an important starting point for learning. They are a dependable point of reference in what, for many pupils, is a turbulent world. As they progress in the profession, increasingly they live up to their professional beliefs.

This is directly relevant to addressing HIV in school. Professional integrity is likely to be a characteristic of great importance in this regard.

- (b) **Thinking:** Effective teachers are thinking teachers. The thinking that effective teachers bring to the job is characterized by both analytical and conceptual thinking. Effective teachers plan individual lessons, units and programmes of work, based on evidence-led assessment of pupils and evaluation of results. They have a logical, systematic approach in order to achieve success for all pupils.

A challenge for MOEs is to help teachers think analytically, conceptually and creatively about HIV education. This aspect of HIV education is poorly researched and documented.

- (c) **Planning and setting expectations:** This involves targeting the key elements which will make the most difference to their pupils, and

the results they are able to achieve. Effective teachers are committed to meeting the needs of all pupils and to including everyone in the class in learning activities. This means carefully prioritizing and targeting effort so that all pupils get their fair share of attention and everyone achieves good results. Three attributes constitute this characteristic:

1. **Drive for improvement:** All effective teachers want not only to do a good job, but also to set and measure achievement against an internal standard of excellence.
2. **Information seeking** works with the drive for improvement of results. All effective teachers ask questions to get a first-hand understanding of what is going on.
3. **Initiative:** All effective teachers use their initiative to seize immediate opportunities, sort out problems before they escalate, and are able to act decisively in a crisis situation.

An impediment to achieving professional effectiveness in HIV education is arguably the difficulty in setting appropriate learning standards for students.

(d) **Leading:** There are four attributes to this characteristic:

1. **Managing students:** All effective teachers are adept at managing students. They get pupils on task, clearly stating learning objectives at the beginning of a lesson and recapping at the end, and giving clear instructions about tasks. They keep pupils informed about how the lesson fits into the overall programme of work, and provide feedback to pupils about their progress.
2. **Passion for learning:** All effective teachers demonstrate a passion for **learning** by providing a stimulating classroom environment, giving demonstrations, checking understanding and providing whole class, group and individual practice in using and applying skills and knowledge.
3. **Flexibility:** Effective teachers show a high degree of flexibility. They are open to new approaches and able to adapt procedures to meet the demands of a **situation**. They are also flexible in the classroom and outside.
4. **Holding people accountable:** Because effective teachers are determined that pupils will achieve good results, they are committed to holding people **accountable**; both students and others with whom

they work in the school. They set clear expectations of behaviour and for performance.

How can teachers be supported or empowered to become leaders in HIV education in their schools and communities?

- (e) **Relating to others:** This characteristic encompasses three attributes:
1. **Understanding others:** Effective teachers have strengths in understanding others and working out the significance of the behaviour of pupils and others, even when this is not overtly expressed.
 2. **Impact and influence:** Effective teachers can use their ability to impact on and influence pupils to perform.
 3. **Team working:** Effective teachers are good team players. Not only do they provide help and support to colleagues, they also seek and value their ideas and input.

This set of factors illuminates the need for teachers to be equipped with relevant psychosocial skills for teaching. LSE for teachers should perhaps be considered as a component of initial teacher training.

Classroom climate

Classroom climate is defined by McBer (2000) as the collective perceptions by pupils of what it feels like to be a pupil in any particular teacher's classroom, where those perceptions influence every student's motivation to learn and perform to the best of his or her ability. Effective teachers use their knowledge, skills and behaviours to create effective learning environments in their classrooms. They create environments which maximize opportunities to learn, in which pupils are well managed and motivated to learn. From the pupils' perspectives, they are mostly looking to the teacher to create a sense of security and order in the classroom, an opportunity to participate actively in the class, and to make it an interesting and exciting place.

Each climate dimension represents an aspect of how the pupils feel in that classroom. They are defined as follows:

1. **Clarity:** A clear purpose of each lesson. How each lesson relates to the broader subject, as well as clarity regarding the aims and objectives of the school.

2. **Order:** Within the classroom, where discipline, order and civilized behaviour are maintained.
3. **Standards:** A clear set of standards as to how pupils should behave and what each pupil should do and try to achieve, with a clear focus on higher rather than minimum standards.
4. **Fairness:** The degree to which there is no favouritism, and a consistent link between rewards in the classroom and actual performance.
5. **Participation:** The opportunity for pupils to participate actively in the class by discussion, questioning, giving out materials, and other similar activities.
6. **Support:** Feeling emotionally supported in the classroom, so that pupils are willing to try new things and learn from mistakes.
7. **Safety:** The degree to which the classroom is a safe place, where pupils are not at risk from emotional or physical bullying, or other fear-arousing factors.
8. **Interest:** The feeling that the classroom is an interesting and exciting place to be, where pupils stimulated to learn.
9. **Environment:** The feeling that the classroom is a comfortable, well-organized, clean and attractive physical environment.

The importance of an appropriate learning environment cannot be overstated. While there is some useful recognition of this in the UNICEF 'Child Friendly Schools' approach, it is probably not unfair to suggest that this has been a neglected aspect of HIV education to date. The review of sex education and HIV education programmes in this chapter (Kirby *et al.*, 2006) identifies a safe social environment for participation as being a key characteristic of effective programmes. A more nuanced approach informed more by wider research evidence on teacher effectiveness seems to be required.

4.6 Investigating school effectiveness

Delimiting the boundaries between teacher effectiveness and school effectiveness is a difficult undertaking. There are clear synergies between effective teachers and effective schools. It is therefore necessary to go beyond teacher effectiveness and examine the literature on school effectiveness and again draw conclusions for effective teachers of HIV education. Teacher effectiveness research looks at the characteristics of the individual teacher or teachers as a group, while school effectiveness research looks at the school as a system. The two are complementary.

As with teacher effectiveness research, it appears that this is undertaken mostly in industrialized countries. A review of school effectiveness in rural Africa (Saunders, 2000) identified eight domains of school effectiveness, defined in terms of effective teaching and learning. These are:

1. the physical environment of the school (location, health and safety, equipment etc.);
2. the curriculum and its assessment, instructional aids;
3. teacher supply, training and professional development/support;
4. school leadership, internal organization and culture;
5. the well-being, attendance and motivation of students;
6. links and partnerships with parents and communities;
7. accountability mechanisms and processes, including school governance;
8. quality assurance and support systems, especially at local level.

An earlier study concluded that consistent positive effects were derived from the availability of textbooks and supplementary reading material, teacher qualities, instructional time and the work demands placed on students (Fuller and Clarke, 2000).

A comparison between school effectiveness characteristics in the United States of America and Nigeria (Adewuyi, 2002) found that school effectiveness factors could be grouped into internal and external factors. Internal factors in effective schools include:

- strong, supportive and action-oriented principals;
- a positive relationship with the community in which they are located;
- a positive school climate and culture conducive to meaningful teaching and learning activities;
- clear and goal-oriented programmes;
- teachers use instructional strategies to enhance their students' learning.

External factors include:

- the quantity and the quality of the teaching staff;
- school effectiveness is strongly associated with the socio-economic status of students;

- class size affects effectiveness: the larger the class size, the less effective the school. However, according to Scheerens (2000) the international evidence is inconsistent.

School leadership

School leadership is an important factor in school effectiveness. Leithwood, Day, Sammons, Harris and Hopkins (2006) provide an overview of findings from international research evidence. They find that school leadership is second only to classroom teaching as an influence on pupil learning. Almost all successful leaders draw on the same basic repertoire of leadership practices. The main elements are: building vision, developing people, re-designing the organization and managing teaching and learning. The ways in which leaders apply these basic leadership practices, not the practices themselves, demonstrate responsiveness to the contexts in which they work. School leaders improve teaching and learning indirectly through their influence on staff motivation, commitment and working conditions. School leadership has a greater influence on schools and students when it is widely distributed, and a small handful of personal traits explain a high proportion of the variation in leadership effectiveness.

A study in the UK (Price Waterhouse Coopers, 2007) found that effective school leaders:

- adopt an open, consultative and non-hierarchical approach;
- distribute leadership responsibilities effectively;
- are approachable and visible throughout the school;
- communicate effectively with all staff;
- take performance management of staff seriously, and provide clear development pathways for staff;
- understand classroom practice as well as the role of the school in the wider community.

School leadership is likely to have enormous significance for the effectiveness of its response to HIV in the classroom, the school environment and in the local community. It is likely to have strong implications for the effectiveness of teachers in that response.

4.7 International guidance on how to teach about HIV

International guidance on teacher preparation and HIV is often pitched at a general level. The UNAIDS IATT on Education, for example,

specifies that priority should be given to ensuring that teachers are well prepared and supported in their teaching on HIV through pre-service and in-service education and training (UNAIDS IATT on Education, 2003). UNESCO states that appropriate training and support are needed for educators, since in many settings they lack the competence and commitment to teach about HIV, with most receiving little to no training on the subject (UNESCO, 2006e). UNESCO advocates that teachers need to examine their own vulnerability to infection, their knowledge of HIV and how it is transmitted, and their attitudes towards helping others avoid infection (UNESCO, 2006d and 2006e). UNESCO identifies the following specific strategies for teacher ('educator') training and support (UNESCO, 2006d):

- Promote teacher (educator) awareness of the needs of learners and their environments. Ensure that educators are aware and informed of HIV risk behaviour among school learners, and are able to identify learners who are especially vulnerable. Promote educator awareness of the impact of HIV on learners, and provide guidance on care and support for infected and affected learners.
- Improve training of educators.
- Select HIV and AIDS educators on the basis of personal qualities.
- Integrate HIV and AIDS into formal pre-service and in-service training.
- Provide educators with ongoing support and information.

This list requires further unravelling. What is required is normative data and evidence-based guidance on *how* to improve the training of teachers on HIV. Which interventions produce demonstrable improvements in training effectiveness? How is HIV education most effectively integrated into pre- and in-service teacher training? What kinds of support from teachers improve their classroom effectiveness? The issue of selecting teachers on the basis of personal qualities is problematic, especially if HIV has been integrated into the national curriculum.

In discussing the education response to HIV in the Caribbean region, Kelly and Bain (2003) are more specific on teacher training. With regard to initial professional training of teachers, every newly qualified teacher needs to be made AIDS competent, in two respects:

1. Every newly qualified teacher should have the knowledge and understanding needed by a teacher who is to teach at a given level.

2. Each newly qualified teacher is to be psychologically comfortable with teaching HIV and sexuality issues to children and adolescents, both boys and girls.

The initial training programme must first impart the knowledge, understanding and skills to be acquired for 'successful' or effective teaching about HIV, sexual health and life skills. This is in line with research findings on effective teachers. It is about ensuring that teachers know their subject. Secondly, teaching methodologies and instructional skills for delivering HIV education need to be acquired in training. Again, this is consistent with the findings on effective teachers and the importance of teaching skills, though the specific skills are not described in any detail. Finally, the training needs to address the taboos, stigma, anxieties and psychological blockages that stand in the way of effective teaching. These issues are part of knowing the subject matter, but they are also linked to developing professionalism.

Teachers require ongoing support in introducing the enquiry-based, rights-oriented types of education that are known to work best. Many of these approaches encourage active participation and skills development (UNAIDS IATT on Education, 2003). This is where in-service teacher training (INSET) has a clear role to play. Kelly and Bain (2003) prescribe a wide range of INSET programmes for serving teachers to bring all teachers up to a minimum standard of quality on HIV education.

Existing literature has little focus on the education response to HIV to the professional development of teachers. This is conceptualized by Villegas-Reimers (2003) as a long-term process that includes regular opportunities and experiences planned systematically to promote growth and development. This may involve a wide range of models which include university-school partnerships, school networks, teacher networks and distance education. Teachers' unions play a role in promoting the professional development of teachers, though this is an area still in its infancy in many low-income countries. Most continuous professional development has typically taken the form of short-term training designed and delivered by trainers who have not based it on specific knowledge about what is taking place in the trainees' classroom and there is little, if any, follow-up (Schwille and Dembele, 2007). Research has found this type of fragmented short-term training to be ineffective.

A number of training resources have been developed for teacher training (Education International, WHO and Education Development

Centre, 2004; UNESCO, 2005; UNICEF, 2005c; International HIV/AIDS Alliance, 2008). These can usefully inform the development of teacher education programmes and should be made widely available to MOEs and TTCs.

4.8 Teacher training and HIV

The evidence base

For appropriate and effective HIV education to be delivered, teachers need appropriate pre-service and in-service training and professional development. This is an area of considerable importance to programme effectiveness, and yet there is apparent widespread neglect.

We have already seen that in some countries there is a lack of teacher training in general, not just in relation to sexual and reproductive health. Teachers' wages are so low that they need to supplement their incomes with second jobs, such as private tutoring, especially in secondary school education. Many teachers, especially in remote areas and poorer countries, lack formal training. These existing conditions do not provide a strong foundation for specialist training in sexual and reproductive health or HIV education. A holistic approach to teacher education reform is required.

An attempt to document teacher training on HIV in 10 African countries for the UNESCO-supported Teacher Training Initiative in Sub-Saharan Africa was unable to present a clear and coherent picture of the steps MOEs are taking (UNESCO, 2006c). It was in fact heavily reliant on the self-reported data provided by the *Global HIV/AIDS Readiness Survey* and detailed data on TTC HIV-related interventions are generally not available. The study observed that there is inadequate information about how subject matter is taught, the role and support of the college administration, the quality of programmes and funding arrangements. A clear shortage of teaching and learning materials for pre-service training and INSET was also observed.

A multi-country study conducted in Asia on HIV and sexual health education found that data could be elicited from only a few respondents involved in teacher education and training (Smith *et al.*, 2000). Myanmar and Mongolia were exceptions where respondents were involved in multiple levels of project development and implementation. Teacher training was, however, identified in the great majority of countries as a fundamental barrier to the delivery of good quality HIV and sexual

and reproductive health education in schools. It was reported that reproductive and sexual health pre-service training was provided in only three countries: Thailand, Papua New Guinea and Viet Nam. By contrast, all countries except Brunei provided some form of short-term in-service teacher training. The model of training is skills-based and often at least partly funded by development partners.

The study found that the general model of in-service training follows the cascade model and involves training a core group of master trainers, who in turn train other trainers, who in turn train teachers. The method is a means of maximizing the number of trainers with limited human and financial resources. The approach was found to be effective in scaling up the co-curricular HIV education through the Adolescent Education Programme in India, but was not institutionalized, was dependent on donor funding and lost some of its efficacy in some of the district-level training (Clarke, 2007).

Data on teacher education for HIV are not readily accessible. A survey conducted by Education International (2007) in 10 selected countries through affiliated trade unions provides an illuminating status report. The findings are presented below:

Country	Pre-service teacher education	In-service teacher education
Burkina Faso	All primary education pre-service trainees underwent HIV training over a period of six months. The focus of the programme was knowledge, and no learning materials were made available for the classroom.	No teachers had received INSET on HIV, only school directors.
Guinea	All teacher trainees in TTCs had received 12 hours of training on HIV-related knowledge and skills.	12-hour programmes of INSET on HIV were being introduced to both primary and secondary school teachers. Only a very small proportion of teachers were being reached and a correspondingly low impact was being made.

Guyana	No pre-service training on HIV	Almost half of all primary school teachers had received in-service training of some description on HIV. The focus was on knowledge and life skills. Trainees received teaching material in the form of a booklet called 'Teaching about HIV and AIDS in the Caribbean'. The duration of the training was six hours. Some two thirds of secondary school teachers had received training on knowledge and life skills towards HIV prevention. The duration of the training was short. The MOE training tends to involve training teachers on how to lecture students and to give them tests. Training to facilitate participatory learning is still missing.
Côte d'Ivoire	At the pre-service stage, to date no students had been exposed to training on HIV.	Out of a total of some 32,000 primary school teachers, 1,500 were trained between October 2005 and March 2006 by staff of the national MOE. At secondary level, of about 12,000 teachers, 500 had been trained by the MOE during the same time period. The teachers were chosen based on the subjects that they teach, and generally life sciences teachers had been chosen.
Kenya	At the pre-service level, all 24,000 student teachers had been trained this year. Teaching methods in training colleges are usually lecture-based. The MOE has just produced a syllabus and support materials for teaching on HIV in the colleges.	In the schools themselves, some 38,706 of the total 222,250, or about 17% of all teachers received training on HIV. The main focus of the training was building the teachers' capacity to implement the HIV curriculum. HIV is not taught as a stand-alone subject but is integrated into a range of different subjects.
Malawi	No training of teachers on HIV took place at teacher training colleges in 2007.	At the in-service level, no teachers received training on HIV from the MOE.

Namibia	762 out of 895 teacher trainees had received 2-3 hours a week training on HIV knowledge and life skills.	Increasing numbers of teachers at primary (4,823) and secondary (3,781) levels received 9 and 18 hours of training respectively on HIV.
Sierra Leone	Data are not available. Little training of teachers on HIV took place at teacher training colleges in 2007.	Data are not available.
Tanzania	No training of teachers on HIV had been provided by the government in 2007.	No training of teachers on HIV had been provided by the government in 2007.
Uganda	All trainee teachers (13,119 in primary teachers colleges and 2,827 in national teachers colleges) received training on HIV. The actual content of the training tends to be limited to knowledge rather than focusing on life skills.	At the in-service stage, no training on HIV was conducted for primary school teachers. Training is normally organized by civil society organizations such as the Uganda Program for Human and Holistic Development (UPHOLD). Coverage was limited and thousands of teachers, especially in the secondary sub-sector, have not been reached. Furthermore, these programmes do not address the needs of the teachers themselves, they target learners only. In the previous year, UPHOLD, together with the Ministry of Education & Sports, had trained 8,337 primary teachers under the Presidential Initiative on AIDS Strategy for Communication to the Youth programme. Under this programme, teachers are required to give messages to children through school assemblies. They have designed so-called school 'talking compounds' or spaces where messages on HIV are written. No HIV training was conducted in 2007 at secondary level.

The data provide a mixed picture, including some disappointing results for high HIV prevalence countries which appear not to be investing in teacher education on HIV. A number of key points emerge:

- Training may be focused on content and not on teaching skills development or fostering professional attitudes and values.
- Training may be delivered without the use of teaching and learning materials.
- Effective INSET may be more difficult in remote areas.
- Pre-service training appears to be cost effective in achieving 100 per cent coverage.
- Achieving high rates of coverage in INSET is challenging and likely to be costly.
- Some MOEs are not giving teacher education on HIV adequate priority.
- Some training appears to be *ad hoc* and project-related. It does not seem to have been institutionalized.
- Teachers' unions can play an important role in advocating better training of teachers on HIV.

Research is required in more countries to further illuminate issues of teacher training policy, programme content, duration, coverage and effectiveness.

4.9 Case study: HIV and teacher training in Zambia

An illuminating study of teacher education on HIV in Zambia investigated both pre- and in-service education provision (Ramos, 2007). The institutional architecture for teacher training is complex. Pre-service teacher training for lower and middle basic education is provided by 10 government and grant-aided institutions/colleges of education. Two government colleges are the main providers of such teacher training for upper basic (grades 8 and 9). The University of Zambia has been providing initial teacher training for high school/senior secondary (grades 10-12). There are 10 private teacher training colleges, out of which only one offers training at Diploma level for grades 8 and 9. In total, Zambia has 24 colleges of education. All subjects, as they appear in the primary school curriculum, are regrouped into six study areas. HIV and life skills are considered as cross-cutting issues, and thus to be dealt with in all six study areas.

A manual on interactive methodologies for HIV prevention in Zambian schools was developed in 2003, but ensuring that all the teachers are trained in interactive methodologies and life skills for psychosocial competencies has remained a challenge. A lack of high-level commitment, curriculum congestion and inadequate training of trainers were the three

main reasons identified for this problem. Generally, it was found that there were very few HIV-related activities in colleges of education and HIV materials were not available to all students in tertiary education.

Several strategies have been put in place to reach teachers with in-service training for HIV. Teachers' group meetings in the School Programme of In-Service of the Term (SPRINT) share HIV information and methodology. SPRINT is a school-based system that delivers in-service through a cascade model, involving heads of schools, zonal resource centres and district resources centres. The primary diploma, which is provided through distance learning, has a specific module on life skills, while the primary reading programme introduced HIV-related texts. Several books have been produced, printed and were being distributed to help teachers to integrate HIV into their lessons.

Ramos (2007) investigated a TTC in Zambia in what was essentially an HIV situation and response analysis. She concluded that teachers were not being adequately prepared to teach the subject, nor were they being properly equipped with the skills, attitudes and competence to challenge ways of thinking about the epidemic and prepare the future generation to deal with living in a world with HIV. She identified an urgent need to mainstream issues of HIV, sexuality and life skills into the teacher training programmes.

The findings of her study indicate that HIV is considered to be a very serious threat and impacts on the daily operations of the college. There was no education management information system (EMIS) to monitor deaths, and no records were kept of HIV-related deaths or number of people living with HIV. The findings also show that students are considered to be at great risk during their teaching practice and that the most vulnerable groups are female students and first year students. Factors identified as heightening the risk of infection include peer pressure, a culture of sexual exploitation of female students (transactional sex) and multiple sexual partnerships among the students in a context of 'sudden found freedom' for first year students.

Misconceptions about HIV as well as student-lecturer sexual relationships were found to be widespread at the college, and the latter appeared to be affecting the quality of the learning. Emotional and psychological stress on lecturers, non-teaching staff and students was observed. Absenteeism was also seen as a barrier to effective teaching and negatively affected the quality of education being delivered at the college.

Some of the main causes of the weaknesses in the response of teacher training institutions are the lack of structures, services and policies. The college does have response structures such as the anti-AIDS committee, student clubs, and the partnership with an NGO for the training of peer educators. These units have organized various activities in the college such as guest speeches, drama and plays, but these activities and programmes appear to be faced with many challenges including time and resource constraints. Lastly, the study found that there were teaching programmes in the college as a response to HIV, and that students do receive some form of training on the epidemic before they become teachers. HIV is not a stand-alone subject, but instead integrated into other subjects. The curriculum was being updated for the TTCs, which offered an opportunity to re-conceptualize and integrate HIV education more boldly. Some barriers for the effective teaching of HIV that were identified include:

- lack of materials;
- lecturers shying away from teaching the subject in front of family members;
- lack of adequate training for lecturers;
- lack of time.

Among the recommendations made were the following, which are reproduced below because of their generic applicability:

1. Colleges should be given technical and financial support to customize and implement the education sector HIV policy.
2. The MOE should assist colleges in developing nationwide objective indicators for monitoring and evaluating their HIV programmes.
3. The MOE needs to allocate more resources to support HIV initiatives in TTCs while also encouraging TTCs to mobilize resources from other sources through proposal development and fundraising activities. Training should be provided for this purpose.
4. The managerial skills of HIV programme co-ordinators in the college should be enhanced and strengthened, and at the same time, all college teaching staff should be given skills on how to integrate HIV into the college curricula.
5. The college principal, who is usually the HIV focal point in each college, should be released of such duties and HIV focal points should be re-selected. This new role should also be included in their job description or terms of reference.

6. The job description of lecturers should be assessed, and for those lecturers that are most motivated and who are currently teaching HIV in their subject, this should be specified in their job description.
7. The MOE should consider making HIV an integral part of the core college curriculum and also an examinable subject, so that both staff and trainees can take the teaching and learning of HIV more seriously.
8. TTCs need to be supplied with adequate information, education and communication (IEC) materials on HIV, and also be encouraged to be innovative and develop their own. Colleges could also be encouraged to develop relevant creative art activities on HIV such as skits, plays, games, art and songs to reinforce the existing IEC materials. TTCs could also establish research programmes on HIV.
9. Since most TTC students are adults, the MOE should give explicit policy direction on condom distribution in TTCs. This will ensure that students have easy access to quality condoms if and when they wish to use them.
10. While it is understood that TTC students are adults, there is still a need for vigilance in enforcing the professional code of ethics so as to minimize the occurrence of lecturer-student sexual relationships. Appropriate disciplinary measures need to be applied to both staff and students engaging in such relationships. The entire college community needs to be fully aware of the code of conduct.
11. MOE needs to provide the colleges with a clear policy on absenteeism. College staff need to know how many leave days they are entitled to when they are caring for sick loved ones.
12. Since there seems to be no system of replacing lecturers when they are absent, it might be beneficial for colleges to have a core of substitute lecturers that can be called on to give the lecture so that students do not suffer the consequences of continued absenteeism by lecturers.
13. Guidance and counselling should be strengthened and professionalized at the TTCs so as to adequately address an array of problems such as coping with stress or substance abuse and HIV.
14. Before students undergo their teaching practice, they should participate in in-depth training on HIV prevention education that includes condom demonstrations.
15. Either the curricula should address positive peer group norms, or workshops should be conducted with the students on peer group

norms and coping with peer pressure, as it is prevalent across the college.

4.10 Case study: HIV and teacher education in Cambodia

A rare window on building capacity for HIV in TTCs is provided by World Education in Cambodia (World Education, 2006). World Education was involved in scaling up pre-service teacher training for HIV prevention education among primary teachers. Five-day training sessions were given to a total of 159 TTC trainers in 10 Primary TTCs. Monitoring and evaluation focused on pre- and post-test results. The tests focused on HIV-related attitudes and knowledge. Lesson observation was used to assess training outcomes. Post test results showed improvements in knowledge. An observation checklist was developed for TTC trainers for their students' practice teaching. An HIV and AIDS teacher trainer manual was drafted for use in TTCs.

The monitoring and evaluation results showed that the trainee trainers enjoyed the participatory training. They felt they needed further reinforcement and support. The trainees requested better IEC materials in the form of handouts or resource guides that they could follow during teacher training sessions. More time was required for the practice teaching of the educational content of the training.

In conclusion, it appears that pre-service teacher training represents an area for more research and more investment in the education sector response to HIV.

4.11 HIV and teacher training colleges

Very little is known about how TTCs are responding to the challenge of HIV. There are pockets of information, but there is no systematic overview available and no framework for analysis. We have already seen how vague prescriptions about teacher training are in relation to HIV. There is little published research on how teacher-training institutions, including teacher trainers, are being developed to address pre-service HIV education. It appears that much of the current teacher training occurs through project-related in-service training, much of which has not been institutionalized. Very often this is delivered or assisted by NGOs, both international and local.

An attempt to investigate how TTCs are responding to HIV was undertaken in four countries in Africa: Ethiopia, Kenya, Uganda and

Zambia (Nzokia and Ramos, 2008). The study found that only one college in the survey, which was in Kenya, had a specific HIV policy for the institution. All the sampled TTCs were implementing HIV-related activities, but in an *ad hoc* manner. Much of the support for this came from NGOs. No HIV training budgets were available in any of the countries. Most TTCs had HIV focal points, but they carried out this role in addition to their other institutional responsibilities. Most TTC management argued that HIV only constituted a minor problem that did not warrant full-time staff, or indicated they did not have the financial means to employ a full-time member of staff to deal with HIV in the institution.

Much of the training provided in the TTCs focused on life skills, peer counselling and HIV prevention education. In the case of Zambia, HIV prevention education was mainstreamed into subject courses such as biology and geography, and no separate training was provided on HIV. Trainees were also exposed to HIV prevention education in one-day interactive methodology classes offered before undertaking teaching practice. All TTCs studied had tried to integrate HIV into most of the subjects, but with varying degrees of success. Kenya, Uganda and Zambia reported progress. With financial support from the MOE, all TTCs in Kenya had provided training for tutors and student trainees in HIV. In Zambia, Ethiopia and Uganda however, most TTCs had no trained tutors in HIV.

The TTCs had not conducted any surveys or assessments on the impact of the epidemic on their operations and functioning. Staff illness and deaths were reported to lead to increased workload for other staff, and to diversion of resources from academic programmes to meet burial and funeral expenses and to support ill and bereaved family members of the teacher-training college community. HIV-related deaths were said to lead to a reduction in the morale of staff and students since they empathized with PLHIV. It was reported that the deaths of tutors disrupted teaching, especially if there was a shortage of trained staff in a particular subject or if the deceased was highly experienced and specialized.

The major challenges found to inhibit an effective HIV response of TTCs were:

- limitations in financial resources to support HIV-related activities;
- lack of training and skills among TTC staff;
- lack of HIV teaching and learning materials;

- excessive teaching workload;
- institutional silence on HIV;
- lack of strict sanctions for teacher-student sexual relationships;
- lack of a workplace policy on HIV.

Greater attention needs to be paid to supporting TTCs in developing appropriate institutional HIV policies and strategies within the college development plan. This includes implementing an HIV workplace policy. Attention also needs to be paid to funding knowledge generation and the role of educational research on teachers and HIV education.

Civil society consultations connected with the *Global HIV/AIDS Readiness Survey* report (UNAIDS IATT on Education, 2005) highlight the importance of teachers in the success of school-based HIV education, and complain about the lack of investment in teacher training and support. MOEs had made systematic attempts to train teachers on HIV in only three of the countries surveyed, while teacher training had been largely piecemeal in the other countries concerned.

4.12 Implications for HIV education

Anderson (2004), in his review of teacher effectiveness, makes the following recommendations for improving effectiveness:

- Teachers must have a sound understanding of the standards that define intended or expected student learning.
- Teachers must use their understanding of standards to design appropriate and effective learning units.
- Teachers must be aware of the need for curriculum alignment; i.e. the critical connections between the standards, the assessments and the instructional activities and materials.
- Teachers' guides should be organized around learning units with careful attention to the alignment among standards, instructional activities and materials and assessments.
- Workshops must be planned and offered to help teachers learn how to teach well within a standards-based curriculum.

While notions of teacher effectiveness may vary across differing cultural contexts, it seems clear that teaching skills and competencies, professionalism and the ability to establish a classroom climate conducive to learning are likely to be important in any school setting.

On the basis of the factors discussed in the sections above on teacher effectiveness, it seems reasonable to suggest that in HIV education, attention needs to be given to the following in teacher preparation:

- mastery of subject matter on HIV;
- pedagogy for HIV education including a range of teaching strategies;
- how to undertake lesson planning;
- student and time management;
- how to set learning objectives and assess learning outcomes;
- professional conduct in relation to HIV;
- establishing an appropriate classroom climate for HIV education.

These factors taken together constitute a substantial training agenda and imply a considerable investment in time and resources if teachers are to be adequately prepared to be able to teach effectively about HIV.

The most obvious implication is that training for teaching about HIV must be commenced in pre-service training, where more time and resources should be available for teacher trainees to acquire the knowledge and skills to become effective teachers. During initial training, teaching behaviours can be fostered that may be more difficult to promote after embarking upon classroom teaching and developing certain habits that will later need to be changed. For pre-service training to be effective, it will likely require attention to the very same factors that make teachers effective. This implies investing in trainer training too, and the creation of teacher training resources for HIV education.

Pre-service training is likely to be of critical importance in preparing teachers to become effective HIV education teachers. Yet it is unlikely to be sufficient to ensure that teachers are effective and for that effectiveness to be sustained. Regular in-service teacher education is likely to be required in most, if not all, contexts where HIV education is on offer in the curriculum.

As with the research on teacher effectiveness, that on school effectiveness provides a number of important insights that are pertinent to teaching about HIV. The teacher is part of a school system that in turn is part of a larger education system. Individual teachers need a supportive environment to be effective. Of particular importance to HIV education would appear to be:

- the well-being of the school (health and safety);

- the curriculum and associated instructional aids.
- school leadership;
- links with parents and communities;
- quality assurance and support systems.

From this perspective, HIV needs to be appropriately integrated into school policies on health and safety. This is consistent with the international guidance provided by the multi-agency Focusing Resources for Effective School Health (FRESH) framework, which includes four core components: school health policies; school health services; skills-based health education; and water and sanitation. Integration within the school curriculum (e.g. health education) is another obvious area.

School leadership is an issue that has been picked up by UNESCO in Asia in terms of the untapped potential to strengthen school-based responses to HIV (Wijngaarden, Mallik and Shaeffer, 2004). Six reasons are given for focusing on school directors: their influence in the community; their role in defining the curriculum; their ability to advocate for sex education with the community; their role in preventing HIV-related stigma and discrimination; their role in implementing education policy at school level; and their role as fund raisers. Interestingly these are largely exceptional factors specific to the education response to HIV. What is missing is the importance of school directors in ensuring that schools and teachers are effective in achieving their learning objectives.

4.13 Key points

1. HIV education needs to be linked more closely with more general considerations of teacher and school effectiveness. HIV education needs to be brought within the education mainstream.
2. Teacher preparation for HIV education needs to include appropriate consideration of developing the necessary teaching skills, professional characteristics and classroom climate for effective teaching and learning.
3. Teacher effectiveness in delivering HIV education cannot be detached from more general factors of school effectiveness. Teachers need support from school leadership, parents, communities and education quality assurance systems. They need an enabling curriculum and associated instructional aids.
4. The placement of HIV education in the curriculum has profound implications for the teachers who will be called on to deliver it.

Inappropriate placement is likely to do long-term harm to the education response to HIV, resulting in ineffectiveness and waste of scarce resources. A mainstreaming approach implies including HIV in the curriculum where it will have the most impact, not possible everywhere in the curriculum.

5. International guidance on teachers and effective HIV education is remarkably vague. It is not enough to prescribe that teachers be trained. Greater detail is required on the factors which result in effective teacher education about HIV.
6. Current characteristics of effective HIV education programmes imply, but do not explicitly state, that teachers need to be involved in developing the curriculum. More research is needed in this area on the benefits of teacher participation in curriculum design and piloting.
7. The effective HIV education characteristics specified by the IATT on Young People imply that teacher preparation for HIV education needs to include skills for creating a classroom climate for effective learning; teaching skills in multiple participatory activities; and professional skills in confidently managing students and resources. This implies a holistic training experience.
8. The issue of teacher selection is difficult. If HIV education is a co-curricular programme, then teachers may be selected at school level by the school principal, possibly with student input. If HIV education is mainstreamed within the school curriculum, it is practically impossible to select teachers specifically for HIV education. In this case the critically important policy decision lies in selecting the most appropriate carrier subject in the curriculum. Infusion of HIV education across the entire curriculum is not recommended.
9. More research needs to be done and published on HIV education programmes, with a greater emphasis on the education/teacher factors in the programme. A significant amount of research in this field is being conducted by researchers who are not primarily education specialists. As a result, education issues risk being under-researched.
10. Finally, gender issues are under-represented in the international research evidence on effective HIV education. This is a serious shortcoming that needs to be urgently addressed.

Chapter 5

The teacher as villain

“Many countries across the world are unearthing distressing evidence of school children being abused by teachers in return for the payment of school fees, the promise of good examination grades, appointment to positions of responsibility or leadership, or for the sheer gratification of teacher power” (Kelly and Bain, 2003: 142).

“I’m not comfortable with sensitive topics because children can use information like condoms and Copper T to explore sex ... also I feel uncomfortable to teach girls because it can discredit my image. I don’t know much information to tell them ...” (Adolescence Education Programme Teacher, Tamil Nadu State, India, in Clarke, 2007).

5.1 Introduction

This chapter will examine the main ways in which teachers as duty-bearers are failing to fulfil the rights of children in the context of HIV epidemics. There are several dimensions to the problems that will be presented. The critical issues are connected with gender inequality, sexual abuse and violence, the stigmatization of people living with HIV and the failure to deliver the HIV education programme as intended.

To what extent are teachers to blame? It is hard not to fault those teachers who sexually exploit their students. On the other hand, social norms and practices are partly responsible for creating a climate in which teachers are able to perform ineffectively, act in discriminatory ways and abuse the children in their charge. That these problems should occur at all in school settings is ultimately the responsibility of the MOE and individual school management, especially the school principal. They are symptomatic of a wider crisis in educational quality, exacerbated by HIV.

The problems identified in this chapter can all be solved through the adoption of appropriate policies and the political will to implement them. It will require that MOEs monitor more carefully what is taking place in schools, in the classroom and in the school environment more broadly. It will require that teachers and their unions put a higher priority on

developing and ensuring standards of professionalism in relation to the service delivery aspects of their role and their duty to care for the children in their protection, *loco parentis*. It should be unacceptable that children learn how to practice corruption at school first hand from their teachers, for example, in trading sex for grades or other educational rewards. It also entails that teachers be better prepared through pre-service training to undertake their roles in school with the requisite teaching skills, professionalism and attention to provide an appropriate environment in their classrooms.

5.2 Children's rights and HIV: the teacher as duty-bearer in child protection

Another dimension of the teacher's role of duty-bearer is to protect children from harm. Article 19 of the Convention on the Rights of the Child (or CRC) declares that States Parties shall take all appropriate legislative, administrative, social and educational measures to protect children from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parents, guardians or any other person who has the care of the child (United Nations, 1990). This latter clearly includes teachers. Article 36 provides for the protection of children against all forms of exploitation prejudicial to any aspect of the child's welfare. While the CRC predates the worst impacts of HIV, there is recognition in Article 24 of the right of the child to the highest attainable standard of health.

Looking at these issues through an HIV lens, it could be argued that the rights of children have been violated by teachers where they have:

- sexually abused and exploited children;
- failed to deal with gender-based violence (GBV) in the school setting;
- stigmatized children infected with or affected by HIV;
- stigmatized other members of staff who are infected with or affected by HIV;
- denied children who are infected or affected by HIV the right to an education;
- denied children access to the knowledge and skills on HIV prevention that would enable them to enjoy the highest standard of health,

either by selective teaching or by not delivering the prescribed HIV programme as intended.

There is clearly a range of seriousness in terms of rights' violation. Arguably the most severe of those listed above is the sexual abuse of the children in their care by school teachers. In many states this is a criminal act. The failure of teachers to tackle sexual harassment and other forms of gender-based violence in the school setting by pupils is also clearly a dereliction of duty if the teacher is aware of the problem.

HIV-related stigma is widely pervasive in almost all contexts. It is a prejudiced reaction to disease which is based on fear, ignorance and moral judgement. It can lead to the social ostracism of those stigmatized and selective discriminatory treatment involving a denial of basic rights such education, health care and employment. HIV is not the first nor the only medical issue that is stigmatized. Leprosy, for example, has historically been highly stigmatized, in part because of fears of contagion. Children, or for that matter teachers, infected with or affected by HIV may also be one of several groups which are stigmatized in the school setting. Social prejudice varies considerably across cultures, but among those facing some form of stigmatization may be ethnic minorities, children with disabilities, nomadic children, children of migrant workers and children of low caste or low economic status families. It is tempting to see stigmatization as part of the human condition as it is so commonplace. The challenge for education is to help create equitable and inclusive societies where prejudice against the socially marginalized or different is eliminated. The education response to HIV-related stigma and discrimination needs to be specific in addressing these issues, but at the same time should be subsumed within a broader framework of policies, strategies and programmes aimed at fostering equitable and inclusive education.

The third category concerning teacher effectiveness in helping to deliver learning outcomes is more contentious. The MOE as a duty-bearer has a clear responsibility to provide teachers with the wherewithal to deliver the intended knowledge and skills in schools. This entails that teachers receive adequate and appropriate training to perform the various tasks required of them in the classroom, the materials required for teaching and learning, and support from the school administration. If the state is not meeting its responsibilities for enabling and empowering the teacher to perform effectively, it is manifestly unfair to criticize the

teacher for such shortcomings. However, if the teacher has been trained and provided with teaching materials to implement an HIV education programme, it is arguably within the remit of the duty-bearer role to implement the programme as intended, rather than as the teacher perceives is appropriate. If there are issues of conscience or belief that interfere with the ability of the teacher to deliver the course, these should be addressed separately with the school administration.

The abovementioned issues are discussed in greater detail below, and some of the available evidence is examined.

5.3 Gender-based violence and abuse at school

In *Chapter 4* it was seen that one of the characteristics of effective teachers is their capacity to create and sustain safe classroom environments conducive to learning. It can be argued that this is a responsibility of the teacher as a duty-bearer, and at the same time it is the responsibility of the school administration to ensure that schools are safe and effective places of learning. It is a sad reflection on those education systems where this is not the case, where some male teachers are sexually predatory on the girls and female teachers in the school. This is an extreme consequence of gender inequality.

Reliable information on sexual harassment and GBV, including violence against girls, in schools is generally not available. It is under-reported and largely unaddressed (OSISA and ActionAid International, 2006). This is not surprising given the illegal or illicit nature of such behaviour. There is a need to break the silence on school-based sexual abuse, in general *and* in the schools where it occurs (Leach, 2002). The data that have been collected on GBV generally do not differentiate between experiences within and outside of school settings (Lloyd, 2007). A more nuanced picture of the problem is desirable. However, the problem is real and prevalent in some contexts. Moreover, there is evidence that GBV has short- and long-term consequences, including physical, psychological damage, as well as social repercussions including school drop-out (USAID, 2007).

Addressing GBV is essential in preventing the spread of HIV. GBV, or the fear of it, may interfere with the ability to negotiate safer sex or refuse unwanted sex, while evidence also exists that living with HIV can constitute a risk factor for GBV, with many people reporting experiences of violence following disclosure of HIV status, or even following

admission that HIV testing has been sought (Harvard School of Public Health, 2006).

Research shows that violence against girls intersects and increases with other forms of vulnerability such as disability, HIV orphaning, migration and being out of school. It increases in adolescence (OSISA and ActionAid International, 2006). There is growing evidence that childhood sexual abuse, coerced sexual initiation and current partner violence are linked to increased unsafe sexual behaviours, including having multiple partners and engaging in transactional sex (Harvard School of Public Health, 2006).

It is commonly alleged that sexual interactions between teachers and learners occur because of the willingness of (female) learners to trade sexual favours with (male) teachers in return for educational rewards such good grades, access to the contents of examination papers, or entrance to a higher educational level. That this practice is prevalent is reflected in the joking reference to ‘sexually transmitted grades’, or ‘STGs’ (Kelly, 2008).

An investigation into the abuse of girls at junior secondary school level in Zimbabwe found that girls were subjected, on a routine basis, to aggressive sexual advances from older male students, and also from male teachers, at school (Leach and Machakanja, with Mandoga, 2000). In the vicinity of the school, girls were preyed on by ‘sugar daddies’ – older men who sought sex in exchange for gifts or money. This is in the context of high levels of HIV prevalence. Ascertaining the scale of such activity is problematic. Self-reported data obtained in a study undertaken in Kenya (Dupas, 2006) suggest that about 10 per cent of sexually active grade 8 girls are sexually involved with an adult partner. However, it is conceded that teenage girls may underreport their involvement with older men.

A follow-up to the Leach *et al.* study (2000) was undertaken through a multi-country study of the abuse of girls in Ghana, Malawi and Zimbabwe (Leach, Fiscian, Kadzamira, Lemani and Machakanja, 2003). The findings in Malawi and Ghana were remarkably similar to the findings reported above in Zimbabwe, including some fresh insights into the impact of abuse from teachers on the quality of learning. Schools were found to be breeding grounds for harmful gendered practices which will likely stay with pupils into adult life. Sexual aggression went largely

unpunished in the schools. It seemed to be a common occurrence for girls to engage in transactional sex to pay school fees and living expenses.

In both Ghana and Malawi, the studies revealed cases of teachers having sexual relationships with girl pupils in their school. Little, if any, action was being taken by the educational authorities in response. It is abundantly clear that efforts to teach effectively about HIV will be thoroughly compromised if the school management tacitly condones the sexual abuse of girls by teachers and male pupils, and if the school itself is a site for high-risk sexual practices.

A study undertaken in Uganda (Kiragu *et al.*, 2007) focusing on teachers' perspectives found that they have concerns about the school environment: nearly half felt that alcohol consumption is a problem in the schools in their areas; more than a quarter felt that sexual harassment between learners is a big problem; and nearly 40 per cent felt that teacher-learner sexual relationships are a concern in their schools.

A baseline survey was conducted on violence, abuse and mistreatment among school children and teachers in the Machinga District in the southern region of Malawi in April 2006 (DevTech Systems, 2007). The study was conducted in 40 schools (upper primary and lower secondary schools) participating in the Safe Schools Programme. The main findings are summarized below:

- Incidents of sexual, physical and psychological violence and abuse were found at every school.
- Violence and abuse occurs at schools (classroom and compound), on the way to and from school and in school dormitories.
- Violence is experienced by both girls and boys, although in most categories girls experience a higher rate of violence and abuse.
- The perpetrators are schoolgirls, schoolboys, and male and female teachers, although men and boys are most often identified as perpetrators in most categories of violence and abuse.
- These acts of violence and abuse are not often perceived as a violation of children's rights by schoolgirls and boys, male and female teachers, parents and community members.
- Students' awareness of and/or access to youth-friendly services within the school or community is limited when they experience violence or abuse.

Pupils who participated in the study reported that they had experienced or witnessed several types of sexual abuse and harassment, including sexual comments, pupils trying to peep at other pupils' genitals, teachers propositioning girls and trying to pressure them into sexual relationships, rape, attempted rape, girls being pressured into sex, forced removal of clothing, exposure of genitals, coerced viewing of sexual acts or pornography, insertion of objects into the genitals, and, most frequently, sexualized touching and grabbing. This amounts to a long list of sexual abuse practices in the school and community. It is important to note that very few pupils surveyed identified teachers as the perpetrators of their most recent school-related sexual abuse incident. In fact, only nine of these incidents involved teachers (reported by six boys and three girls). These incidents included touching, peeping, sexual comments, forced removal of clothes and unwanted sex; of these, in only one incident was the perpetrator reported to be a female teacher.

The attitudes of teachers to sexual abuse and violence within the school are revealing. Twenty-one per cent of teachers surveyed agreed that it is a girl's fault if she is sexually harassed. Ninety-nine per cent of male and female teachers in the survey disagreed that male and female teachers have the right to demand sex from school children; they also disagreed that it is acceptable for teachers to have sexual relationships with their pupils. However, a minority of both male and female teachers (13 per cent, including 5 per cent of head teachers) believed that teachers should not be punished for having a sexual relationship with a pupil, and only slightly more than half (55 per cent, including 56 per cent of female head teachers) considered that a teacher who has a sexual relationship with a pupil should be dismissed and not allowed to teach again. Male head teachers were somewhat less tolerant of such behaviour, with 67 per cent agreeing that such teachers should be dismissed. This is a considerable way off zero tolerance of sexual abuse.

It seems that it is necessary for education researchers to investigate the gendered roots of such behaviours, and in particular the role of masculinities in encouraging and legitimizing violence to obtain sexual access or dominance. These may be reinforced in school through peer interactions and conversations (Kenyway and Fitzclarence, 1997). This is a widespread phenomenon found in studies on GBV in Asia, Latin America and the Caribbean. In the Caribbean region, contemporary dominant masculinities are considered problematic when they are

associated with GBV, misogyny, homophobia and a rejection of academic pursuits in favour of 'hard physical masculinity' (Plummer, 2007).

In the context of concerns about the safety of children in school and in the local environment with regard to sexual abuse, it is important to undertake broad-based research into the risk environment to provide evidence upon which to plan interventions. This can throw up surprising results. For example, in 2004, the University of Pretoria was contracted by UNICEF and the Limpopo Department of Education to conduct research in Limpopo, South Africa, to examine issues related to safety and threats for learners at the foundational (grades R-3), intermediate (grades 4-7) and senior (grades 8-12) levels of school (University of Pretoria, 2006). The overall findings from the surveys indicated that the respondents felt safe at home (87 per cent), at school (86 per cent) and in the classroom (85 per cent). Fewer learners felt safe on the playground (66 per cent) and on their way to school (61 per cent). Overall, the most common fear identified by the respondents was exposure to and threat of experiencing crime. HIV and sexual behaviour were hardly mentioned by the learners, both boys and girls. The fact that HIV was not directly mentioned was a matter of concern. The findings suggest that HIV is still too stigmatized to discuss openly. This implies that the HIV education programme is failing to achieve its objectives, and teachers are implicated in this.

In recognition of the findings, the following practical arrangements were suggested, which include making better use of teachers in assuring overall security, and training them in related life skills and HIV education approaches:

- There is a need for trained guidance counsellors and teachers to provide psycho-social support and referrals for children who are at risk.
- Schools should ensure that there is adequate teaching staff at school at all times, for example, one or two teachers to supervise children during breaks and while they are on the playgrounds.
- Infrastructure development for schools needs to be fast-tracked, especially for those areas that impact on security, such as school fencing and repairing broken windows.
- Children rely heavily on positive interpersonal skills and traits as coping and safety themes. These are to be taught through the Life Orientation part of the new curriculum. There is a need to fast-track

the training of teachers on Life Orientation, or in the interim, allow for NGOs to provide such teaching.

- While the purpose of life skills is, amongst others, to raise awareness about HIV and promote responsible sexuality among young people (Life Orientation is now a mandatory and key learning area), it needs to be re-examined to ensure that it is meeting its objectives.
- There is a need for integrated HIV awareness campaigns, including dealing with stigma and discrimination, providing for appropriate messaging, and teachers who are comfortable discussing issues related to HIV, without moral or other judgments. Teachers also need to confront their stigma, and this can only be through ongoing HIV training and related interventions, including the creation of a conducive environment for them to seek assistance if/when they need it themselves.

Addressing GBV

In order to address a range of GBV problems, researchers recommend that the tackling of sexual abuse and GBV at school be undertaken through a holistic approach involving a range of stakeholders. Although some are responsible for GBV, teachers are viewed as key to bringing about change at school and eliminating abusive behaviour.

Leach and Humphreys (2007) identify a common set of methodological principles in interventions which have been designed to address GBV in schools:

1. A commitment to behaviour change and a belief that this can only be accomplished through participatory methodologies and experiential learning.
2. A commitment to seek out and value children's knowledge, opinions and perspectives, and to engage adults in a democratic and open partnership.
3. Creating a non-threatening and safe environment in which young people can openly discuss sensitive topics, question traditional views, express fears and seek advice.

The main interventions include the following:

At the school: Each school should have a clear policy statement. This statement must not only spell out that sexual violence and harassment are unacceptable and will not be tolerated within an institution, but should also include an explanation of what constitutes unacceptable behaviour,

procedures for dealing with it, including sanctions. It should also assure confidentiality and protection of the rights of all parties (Panos, 2003).

Sexual abuse at school can be addressed through the strengthening of guidance and counselling, and effective implementation of life skills and HIV education. A whole-school approach should be adopted to improve the school's response to abusive behaviour. School principals and management need to play an active role in preventing sexual abuse and violence in the school environment in contexts where such behaviour is prevalent. A system for data collection on GBV needs to be put in place. This includes the recording and reporting of incidents of sexual harassment, abuse and GBV. School norms on the protection of children need to be changed and maintained through working with school governing bodies, Parent Teacher Associations (PTAs), communities and teachers' unions (UNESCO, 2006e).

Specific mechanisms and initiatives are needed to protect girls. Ensuring that schools have separate toilet facilities for girls is one obvious response. Teachers have an important role in creating a climate in class and in school that is protective.

Teacher training: Most initiatives on violence and sexual violence in recent years recognize the need to support teachers and educators first, before hoping that they can implement effective interventions in their schools and classrooms (Panos, 2003). Teacher trainees should be provided with comprehensive gender training that includes attention to GBV issues. Teacher training colleges need to provide more training on ethical conduct as a teacher, and a better understanding of the responsibilities at school. Teachers need to serve as positive role models for both boys and girls.

Ministry of education policy: The willingness of political parties to tackle the issue at national level will have considerable influence over how seriously individual institutions take the issue. Where new policies and legislation are developed, they need to be publicized, promoted and enforced. Crucial to the effectiveness of policies is back-up – an accessible network of people available to provide support to victims of sexual violence and to whom it can be reported in confidence (Panos, 2003).

MOEs need to have in place laws and policies that prohibit the misconduct of teachers and provide for enforceable sanctions against

those that engage in such activities. Disciplinary procedures need to be put in place and implemented.

Codes of conduct for staff are critical for child protection. The development and implementation of these is an important area in which teachers' unions should be engaged. Ministry policies on sexual harassment and abuse need to be properly disseminated and, where necessary, strengthened. Clear guidelines and training need to be provided to schools, school committees and PTAs on dealing with abuse at the school site. A special unit could be set up to deal with reported cases of abuse.

In Uganda, Kiragu *et al.*, (2007) report that in the schools they surveyed:

- over 76 per cent of all schools had a procedure in place for dealing with 'defilement' (sexual harassment or sex between teachers and learners);
- 85 per cent of all schools had a policy in place to deal with teachers who make schoolgirls pregnant;
- 60 per cent of all schools had a procedure in place that allows learners to anonymously submit questions or report problems;
- 75 per cent of all schools reported that they had a protocol in place to address the confidentiality of the guidance and counselling sessions;
- 60 per cent of all schools (80 per cent of intervention schools and 33 per cent of comparison schools) had a record-keeping system in place for counselling sessions;
- 67 per cent of all schools had a referral system in place with local health facilities.

These data illustrate that how to achieve 100 per cent coverage of a policy intervention is clearly an issue within an education system.

Curriculum: GBV needs to be addressed through the curriculum and co-curriculum. In order to combat sexual violence and harassment effectively, the subject must be introduced and discussed with students through the curriculum, and be supported by other measures (Panos, 2003).

Life skills, sexuality and relationships education can provide an excellent forum for introducing issues relating to sexual violence. Approaches can be used that develop a supportive environment in which

to discuss relationships and gender roles, and build communication skills (Panos, 2003). HIV education should be used to develop a more positive conceptualization of sexuality and what it means to be male or female (Leach, 2002). The curriculum should also address homophobia and the stigmatization of sexual minorities, but not many countries will do so because of legislation against homosexuality. The United Kingdom is one of a very few countries which has provided teachers with clear policy and guidance on the prevention of homophobic bullying in schools (Department for Children and Schools, 2007).

Human Rights Watch (HRW) recommends the following: the setting-up of procedures for identifying and tracking abusive teachers; better reporting mechanisms to allow children to report abuse to school authorities without facing hostility and humiliation; creating a system to redress the harm that schoolgirls subjected to sexual violence suffer; and better co-ordination and communication of policies at all levels (HRW, 2001).

Teachers' unions have an important role to play in promoting professional standards with regard to the behaviour of teachers towards vulnerable children in the school setting. Some have already acted. The South African Democratic Teachers' Union (SADTU), for example, has called for zero tolerance and has a code of conduct for its members. It has an advocacy and training programme called Know your Boundaries. The Teachers' Union of Malawi has implemented a project (Malawi CARER) in six districts which aims to raise awareness and curb violence against girls (OSISA and ActionAid International, 2006).

Both pre-service and in-service teacher training should include training on GBV where this is identified as an issue. Examples of such teacher training approaches include the Gender-based Violence Project in Cape Town, South Africa, which involves primary school teacher pre-service training (Wellesley Centres for Research on Women and Development and Training Service, 2004). The thematic content of the training includes sexual harassment and rape, child sexual abuse, teachers as healers, and gender violence-free schools. Skills-building is integral to the training. A whole-school approach was adopted. An impact evaluation found that the programme changed the attitudes of the teachers towards tackling GBV and their perceptions of the role of the school in this agenda.

There is a very weak evidence base on how effectively TTCs are responding to gender issues including GBV, in initial teacher training in general, and in particular in connection with HIV education. This is an area where more research is required in order to identify what might constitute the characteristics of effective interventions. Leach and Humphrey (2007) comment that most work has focused on identifying and understanding the issues around gender violence rather than on developing interventions.

Finally, the WHO (2003) has identified a range of technical approaches for integrating gender into HIV programmes, which form a continuum that includes ‘harmful’ responses that negate any potential programme improvements through incorporating discriminatory gender distinctions. In addition, the following approaches are identified:

- *Do no harm*: This approach involves the elimination of damaging assumptions and stereotypes concerning men and women. It constitutes a first step along the continuum.
- *Gender-sensitive programmes*: Gender-sensitive responses involve the recognition that the various HIV-related needs of men and women are often different, not only because of physiology, but more importantly on account of gender norms and relations.
- *Transformative interventions*: These are interventions that seek to transform gender roles and create more gender equitable norms and relationships. They seek to change the underlying conditions that cause gender inequalities.
- *Interventions that empower*: Empowering interventions are those which seek to equalize the balance of power between men and women.

This continuum of response is highly applicable to the education sector in relation not only to HIV education, but also to education service delivery in general. It is important that MOEs understand the different approaches and are able to place themselves on the response continuum. Whether their current position is appropriate to the context of the epidemic is an important question, and this involves the ministry understanding the gendered factors of vulnerability and risk among the student population and what education can do to address them. It would be instructive to attempt some form of mapping of current MOE gender-based responses to HIV using this framework. It is predicted that few programmes would be categorized as transformative or empowering, with many struggling

to be gender-sensitive, though it is the latter categories that have been identified as critical to the HIV response in African schools (Pattman and Chege, 2003).

It remains to be said that there needs to be commitment at all levels in the education system to protect girls from sexual abuse at school and in the adjacent environment. This needs to be included within the sector's approach to reducing gender inequality.

Partnerships: Partnerships between schools and NGOs can be advantageous. NGOs have developed many innovative strategies for working with students – to provide support, inform students of their rights, and offer educational initiatives that cannot be provided by schools (Panos, 2003).

5.4 The impact of HIV on children: the rights of orphans and vulnerable children

Teachers are duty-bearers with a responsibility to care for all the children in their care, including the most socially marginalized. Children who have been orphaned or whose parents are living with HIV constitute a new category of vulnerable children. The impact of HIV on their families and communities in effect makes them more vulnerable to HIV. Children living with HIV form another highly vulnerable population. Both children infected with and affected by HIV have been widely reported to have faced severe stigmatization and discrimination by teachers and school management in numerous contexts.

The various impacts of HIV on children have been comprehensively described, including the ability of children orphaned or made vulnerable by HIV to continue to access and benefit from education. Research has identified a number of ways in which HIV impacts on educational opportunities (Grainger, Webb and Elliott, 2001). In school, children who are either infected with or affected by HIV face possible discrimination by fellow pupils and by teachers. There is also the reduced ability of affected families to cover school fees and pay for uniforms, books and shoes, as well as the increased demand for children to work, either at home or in paid employment, or to provide care for sick members of the household. In HIV-affected households, there may be a lower expected return on the investment in children's schooling. The learning capacity of children affected by HIV is negatively affected, including by poor nutrition, hunger, trauma and emotional distress. Teachers often report

that orphaned children are listless, withdrawn and do not play or laugh as much as other children (Kelly, 2005).

It is essential to make schools more responsive to the needs of orphans and vulnerable children (sometimes referred to as OVC) and enable them to continue their education despite the challenges they face at home or in the community (USAID, 2003). Human Rights Watch (2005*b*) recommends the development of best practices for schools. They report in a study of children affected by HIV in Kenya, South Africa and Uganda that schools are often ill-equipped to deal with the increasing burden of children affected by HIV and in need of feasible strategies within the constraints of limited resources. Possible strategies identified include the following:

- training teachers or guidance counsellors to address bereavement issues;
- supporting school-based peer support groups;
- liaising with community-based organizations to identify the most vulnerable children;
- sensitizing teachers to the needs of HIV-affected children.

Much is likely to depend on the effectiveness of teacher preparation for service in a community affected by HIV through initial training and INSET. Little is known about such interventions and how effective they are. In reporting on initiatives which were being implemented to increase primary education for orphans and vulnerable children in east and southern Africa, nine lessons were learned, none of which focused specifically on the contribution of teachers (Hepburn, 2001). However, a number have strong implications for teachers, including: addressing safety concerns for girls; ensuring that educational quality and access concerns are not separated; and investing more in research into the costs and benefits initiatives, including those involving supplemental teachers and psycho-social training for teachers.

In Malawi and Zambia, an initiative was developed to increase the relevance of the school curriculum to orphans and other vulnerable children through providing apprenticeships to students to acquire vocational skills. Implementation was reported to have varied levels of success. The programme did not include life skills training. Training was also given by NGOs to teachers in the two countries to sensitize teachers to the psycho-social needs of orphans and other vulnerable children. While psycho-social support is critical for supporting children affected

by HIV, it is questioned whether such services are best provided by classroom teachers who have their own counselling needs, and this also adds to their workload, which risks diverting them from other educational priorities. It is suggested that other community workers may be better placed to provide such support. The World Bank (2004) *OVC Toolkit for Sub-Saharan Africa* advocates developing school-based psycho-social counselling services.

In Zambia, an initiative was piloted to supplement teachers with trained volunteers from the community as paraprofessional teachers to assist in delivering certain key parts of the curriculum such as basic literacy, numeracy and life skills. This draws on local resources and has the potential to relieve the teacher of significant pressure. However, if teachers are overstretched with their current responsibilities, they will likely not have the time to supervise or mentor the paraprofessionals.

In north-western Tanzania, a pilot project (The HUMULIZA Pilot Project) has provided counselling sessions and seminars to inform primary school teachers on the importance of communicating with children (Subbarao and Coury, 2004). The sessions have aimed to sensitize teachers on:

- how to identify a child's problems and needs;
- the importance of attachment;
- how to improve a child's self-esteem.

The project reports positive results in a short time frame. Teachers have become better at identifying children's problems, while the school environment has become more conducive to allowing children to express their feelings. As a result, attendance at school is reported to have improved. Teachers have also visited orphans in their homes after school and followed up on their progress, including discussing the rights of the children with their caregivers. Teachers have created an orphan fund from their own salaries, mainly to cover the school supplies of orphans.

Efforts to develop a prototype for a child-friendly schools approach for promoting health, psycho-social development and resilience in children and youth affected by HIV have taken place in Thailand (Devine, 2001). A component of this approach included enhancing the capability of teachers, community child development caregivers, parents and guardians to interact with children, including those affected by HIV, in ways that are supportive and nurturing. The Life Skills Foundation,

which was involved in the implementation of the abovementioned project, had identified a number of strategies to develop the capacity of teachers (Life Skills Foundation, 2003):

- a participatory child rights sensitization process;
- involvement in the local generation of child-friendly criteria and indicators for schools;
- the creation of a network of core trainers, model teachers and supervisors to promote and model supportive behaviour;
- involvement in a school self-assessment exercise, which is a school-based participatory learning situation analysis to identify local social environmental risk factors, protective factors, psycho-social needs and the problems of children in distress;
- development of local priorities for specific LSE for schoolchildren affected by HIV;
- training on active learning and learning styles;
- training for educational supervisors and all teachers on how to raise the self-esteem of pupils and how to deal with the death of their parents or relatives.

The Life Skills Foundation reported that teachers improved their skills and schools provided a safe learning environment and activities to assist in improving the behaviour of students. Teachers were able to play a key role in reducing HIV-related stigma, provide a counselling service, and make home visits to students with psycho-social problems.

A review of social protection mechanisms for orphans and vulnerable children in the education sector in eastern and southern Africa undertaken by the University of Natal Mobile Task Team (MTT, 2005) developed an inventory of such mechanisms with education outcomes. Two distinct types of programme were identified: those with an education benefit as the intended primary outcome, and those in which they were a secondary outcome. Monitoring and evaluation systems were lacking in many of the programmes reviewed. The reviewers concluded that a strategic combination of programmes and an integrated basket of social protection support are required to broaden access to education, improve retention, ensure the quality of education and provide an enabling environment for education. Unfortunately, there was no discussion of the contribution teachers might make to any of these initiatives. It is, however, mentioned in the case study on the vulnerable children at schools database, KwaZulu-Natal, that teachers collected detailed profiles of all

their learners, including details on their home situation, and these can be used to identify vulnerable children.

The UNAIDS IATT on Education (2004) recommends the following interventions with regard to teachers in the protection, care and support of orphans and vulnerable children:

- train and support teachers and village committees to identify vulnerable children and support them to go to school;
- empower parent-teacher community associations to support schools to serve the needs of vulnerable children;
- establish school-community campaigns to reduce discrimination related to HIV;
- protect against sexual abuse and exploitation by focusing on safety and security in child-friendly schools through establishing and supporting clear codes of conduct and training for school staff;
- develop comprehensive HIV workplace policies compliant with the ILO Code of Practice on HIV/AIDS in the Workplace.

It is not known which of these recommendations have been taken up, and if so with what effect. The ways in which teachers can mitigate the impact of HIV on children constitutes an area where more research is needed.

UNESCO (2006*d*) has identified the following key strategies to respond to children affected by HIV:

1. Expand the role of the school in providing care and support. Schools need to establish a supportive and caring environment for children living with and affected by HIV. Links need to be established between schools and service providers, government and non-government, which provide social welfare, health, nutrition and psycho-social services.
2. Provide support for children in distress. Teachers need to be sensitized to recognize children who need help, and trained in recognizing the symptoms of neglect and abuse. They can play an important role in identifying children suffering from neglect or abuse. Teachers need to be trained in counselling, or schools should employ specially trained counsellors. Teachers need to know how to provide psycho-social support to students who are trying to cope with bereavement or sickness in the family.

UNESCO (2008*d*) has subsequently identified the following five principles for success in expanding school-centred HIV care and support based on the experiences of schools in southern Africa:

- providing a caring school environment;
- child-centred programming;
- using schools as a centre for providing integrated services;
- building on existing services;
- involving communities.

The implications for teachers in such high HIV prevalence settings include training in workplace policy, child protection and child rights. Training is also needed in treatment literacy. Among the challenges to scaling up implementation are stigma and discrimination, lack of monitoring and evaluation systems, and ever increasing demands on an increasingly fragile education system. There is a risk of overloading teachers and undermining their capacity to deliver a quality education.

In conclusion, there is a need for a balanced response to the needs of children infected with and affected by HIV. This needs to be proportionate to the severity of the impact on children in the school population and should build on the existing strengths of the teachers in caring for vulnerable children. In severe HIV epidemics, the expectations of teachers are likely to be higher, but the limitations of the profession need to be recognized and other agencies brought in to contribute in a co-ordinated response.

5.5 The harm of HIV-related stigma and discrimination

In the section above, the stigma and discrimination faced by orphans and vulnerable children was discussed. Teachers living with HIV can also face stigma and discrimination in the workplace. It is reported that many teachers living with HIV are reluctant to disclose their status for fear of unfair treatment or of losing their employment (UNESCO and EI-EFAIDS, 2007). They may isolate themselves from their colleagues in order to conceal that they are living with HIV. They may face stigmatization from the community, with parents finding it unacceptable that an HIV-positive teacher be in contact with their children.

The number of teachers living with HIV will depend on the severity of the national epidemic. Thus the largest numbers of teachers infected within a national teaching stock are most likely to be encountered in

east and southern Africa. However, even individual violations of human rights are to be deplored and should be prevented. Thus all MOEs need to have in place appropriate workplace policies, strategies and resources to support teachers living with HIV. Having a workplace policy in place is insufficient if it is not actually implemented (UNESCO and EI-EFAIDS, 2007). Steps need to be taken by MOEs and teachers' unions to disseminate HIV workplace policy among all stakeholders, to make it accessible to all, and to ensure that responsibilities for implementation are clearly established and appropriately resourced.

The impact of stigma and discrimination towards people living with HIV and AIDS in the family and in the community can be profound and wide-ranging. It appears to be related to gender, class and social status, with the poor generally most adversely affected. Associations of people living with HIV report reluctance to reveal their HIV status for fear of:

- being isolated and discriminated by colleagues;
- being humiliated by others;
- losing their jobs;
- being regarded as immoral.

Facing the above possible consequences of revealing their sero-status, teachers clearly risk jeopardizing their professional status. The UNAIDS IATT on Education (2004) recommends as a specific action: addressing stigma and discrimination in school policies and practice. There is, however, little in the way of practical guidance and best practice guidance, specifically for education sector policy-makers and planners to develop effective responses. There is very little to put into the hands of practising teachers that is specifically related to stigma prevention in the classroom or in the school environment more generally.

Local communities have been exploring ways of reducing levels of stigma (Aggleton and Parker, 2002) through:

- the dissemination of information;
- coping-skills acquisition;
- counselling approaches;
- programmes promoting GIPA;
- monitoring violations of human rights and creating a supportive legal environment to enable people to challenge discrimination.

What is required is accurate information on how HIV is and is not transmitted, together with secondary information on the impact of stigma

on people living with or affected by HIV (PAHO, 2003). It has been found that knowledge of the basic facts reduces the fear of casual contagion, but there is little evidence of the significant impact of secondary information on attitudes, possibly because fewer projects contain such information or because the information was poorly conveyed (Brown, Mackintyre and Trujillo, 2003).

Skills-building is clearly important. Interventions which provide information only are less effective than those which provide skills training (PAHO, 2003). Skills training can include ways to help staff to interact with people who are infected or affected in a respectful and non-discriminatory manner. Contact with PLHIV, ideally supplemented with training, has been shown to result in the modification of behaviour and changes in attitudes. However, changing social norms rather than individual attitude change seems to be more important in developing a social environment characterized by tolerance and respect for rights (Wood and Aggleton, 2002). Promoting rights through education is likely to be critical in achieving this.

Sensitive and participatory research is required to understand the contexts of stigma and discrimination, to identify the various needs of young people and to promote tolerance. Community-based approaches to understand the dynamics of HIV-related stigma and discrimination, such as documented by Hadjipateras (2004) in Uganda and Burundi, could be undertaken with a focus on the school context.

The education response to HIV-related discrimination prevention and mitigation is currently under-researched and reported. There is a lack of:

- project data on stigma and discrimination interventions in the education sector;
- detailed attention to addressing stigma and discrimination in education sector toolkits (e.g. UNESCO, 2003) and in some teacher training manuals;
- specific sector guidance and case studies of best practice at school and sector levels on stigma prevention and reduction;
- information on specific teaching and learning approaches and materials on stigma and discrimination;
- classroom research on teaching and learning in stigma prevention.

5.6. HIV curriculum implementation challenges for the teacher

Flustered and floundering in the classroom

The new paradigm of a life skills approach to HIV education described in *Chapter 4* is one that is likely to challenge teachers at a number of levels, including their teaching skills repertoire, their mastery of subject matter, their professional confidence and their ability to provide a classroom climate conducive to effective teaching and learning. It represents a ‘perfect storm’ of factors. Cultural taboos that prevent discussing sex seem to be the highest hurdle to leap. What is truly amazing is that teachers have been able to implement such programmes effectively at all. This is testimony to the ability of committed teachers to deliver learning objectives in difficult circumstances.

The evidence presented on effective HIV education programmes, perhaps understandably, makes scant reference to failings in the approach. The difficulties encountered by teachers in implementing effective HIV education are real and apparently widespread. They were identified some time ago and summarized by Kelly (2000) as follows:

- inadequacy of teacher knowledge and confidence;
- teachers’ embarrassment in teaching sexuality issues with the young, especially with students of the opposite sex;
- teachers’ concern about lack of preparation to teach in the areas of HIV, reproductive health and life skills;
- the reluctance of teachers who are aware that they or members of their family are living with HIV to teach about something that is ‘so painfully close to home’;
- teachers’ feelings that this is not what education is about;
- teachers’ anxiety that in dealing with sexuality and sexual behaviour they would break traditional taboos and offend parents;
- the low credibility teachers may have because of their own high level of infection.

Research on teacher effectiveness indicates the importance of teachers’ commitment to, engagement with and confidence in teaching about their subject. The problems identified by Kelly send out a strong warning that some current programmes may be a long way from fostering teacher effectiveness in HIV education. In particular, the reported difficulties teachers have in teaching about sex and sexuality is clearly a critical issue.

The initial difficulties in implementing a life skills-based curriculum are highlighted by Gachuhi (1999) in a study on HIV and education systems in east and southern Africa. She found that the implementation of life skills-based HIV education programmes had been sporadic, with low coverage, and some countries had yet to start. She reports that there was no consensus across the region on the definition, scope and methods of including life skills in the curriculum. Her individual country programme assessments show the importance of developing an effective research and monitoring component that generate data on the basis of which mid-course adjustments can be made to programmes. With regard to teachers, the following findings are worth noting and repeating:

- Teachers needed training not only in HIV, but also in participatory teaching and experiential learning methods.
- Teachers felt embarrassed handling sensitive topics related to sex and HIV, and some did not wish to teach the subject.
- When teachers were not confident to carry out experiential learning methods, they reverted to more conventional teaching methods.
- Teachers were selective in teaching the subject matter, avoiding topics that they considered to be particularly sensitive, such as condoms.
- Teachers did not teach all of the life skills lessons included in the timetable.
- Life skills was not perceived to be an important subject where it was not compulsory or examinable.
- Stand-alone life skills programmes had a better chance of succeeding than those which are infused in the curriculum.
- Too few of the programmes met the criteria for minimally effective education programmes.

A subsequent multi-country review of life skills and HIV education in Africa reported that HIV education is now part of the secondary school curriculum in most countries in sub-Saharan Africa; governments are showing signs of taking on a life skills approach and a range of programmes are being implemented (Tiendrebeogo, Meijer and Engleberg, 2003). The study, however, confirmed the difficulty of implementing such programmes. HIV prevention programmes had largely focused on knowledge transfer rather than skills-building. This suggests difficulties for teachers in shifting from a didactic to a participatory mode of teaching.

An investigation into HIV education in schools in Kenya and India identified obstacles to effective teaching and learning about HIV that are symptomatic of a wider crisis in education, such as large classes, an overstretched curriculum and a shortage of learning materials and training opportunities for teachers (Boler, 2003a). The key findings of the study were the following:

- It appeared that selective teaching was taking place in both Kenya and India, especially in rural schools. Teachers appeared to be selecting which messages to give, and some did not even teach HIV at all.
- Selective teaching in Kenya appeared to be linked to teachers having negative views on condoms and safe sex.
- A scientific approach to HIV leads to discussions without any direct discussion of human or sexual relationships.
- Where sex is discussed, it is only within a framework of abstinence.

It was recommended that there be an immediate and significant increase in the provision of training for teachers on HIV, which should reach all teachers through initial and in-service teacher training.

Selective teaching is also reported in a pioneering study on teachers' willingness to communicate about HIV in Mozambique (Visser-Valfrey, 2004). Teachers explained their reasoning being that: "kids will become promiscuous", "kids will become scared", "parents will not approve", "religious leaders are against it", "we will get disciplinary problems in our schools", "we will be accused of provoking disgrace". In fact, these were just a few of the reasons cited by teachers for why they find it difficult to communicate about HIV. In some cases, teachers confessed that they preferred not to talk about HIV. In other cases, teachers explained that they adapted their teaching content and strategies to their attitudes and beliefs by selecting topics, avoiding details, and giving preference to a lecture mode of delivery.

Visser-Valfrey's study (2004) aimed at identifying factors that impact on teachers' willingness to communicate about HIV, and was determined by analyzing three distinct behaviours: future intention to talk about HIV, past behaviour of talking about HIV in schools, and past behaviour of talking about HIV in the community. A total of 606 current or future primary and secondary school teachers for grades 1-12, in the province of Gaza in southern Mozambique, participated in the study.

Among the findings reported in this study were the following:

- Younger teachers talked more frankly and openly about HIV, including about the sexual issues associated with the disease.
- Personal experience emerged as a strong consistent predictor of teachers' future intentions and past school and community behaviour with regard to communicating about HIV. Teachers who had not been confronted with the impact of the disease expressed less conviction and confidence in their role as communicators of information about HIV.
- HIV knowledge emerged as a predictor of past school behaviour. From teachers' personal accounts, it appears that knowledge of the disease influences not so much whether they talk about HIV, but what they say about it, and how accurate the information they provide is.
- Teachers report that they are not able to find answers that satisfy their doubts and questions to the point that they can feel confident about what they are saying.
- Training, materials, incentives and support from colleagues and school directors emerged as key issues for teachers in all the interviews and, by their own account, affect their ability and willingness to talk about HIV.
- Support by colleagues and management of schools was a key issue. Many teachers said that their personal efforts in talking about HIV were hampered by lack of support from other teachers.
- For teachers in lower primary level (grades 1-5), one of the key constraints to talking about HIV is the difficulty in talking about sensitive sexual issues to young people. They do not know how to talk to young children about these issues. For teachers in the higher grades, particularly at secondary level, the difficulty is related to the fact that the children are older, more experienced and often already sexually active. Especially in the urban areas, teachers noted that children and young adults know so much about sex and sexuality that they ask complex and provoking questions which embarrass the teacher or which he/she has difficulty in answering.

Reports from HIV education in Africa

Evaluations of school-based HIV education programmes include the following findings from East and southern Africa (Tiendrebeogo *et al.*, 2003).

Many teachers were uncomfortable with the HIV materials from the *My Future is My Choice* programme in Namibia and did not wish to teach HIV prevention. Many teachers continued to lecture instead of using participatory teaching methods.

In South Africa, teacher preparation and curriculum were reviewed and it was recommended that teachers should have more in-service training to deal with life skills, and that master trainers and teachers lost to the programme needed to be replaced, while those retained needed to be retrained regularly. A subsequent review found that it was unclear how many teachers had actually received specific training on the life skills curriculum and teaching methods.

In Lesotho, many teachers reported that they lacked confidence to handle sensitive topics. In Malawi, there was an urgent need to train teachers and to develop participatory practices in schools. In Botswana, teachers lacked the skills to use participatory methods to ensure effective learning. In the case of Swaziland, there was no clear policy regarding HIV, and as a result the intervention was sporadic, and coverage was low and generally ineffective because of the methodology used.

It was concluded that in most countries in sub-Saharan Africa, teachers do not receive adequate training in appropriate techniques, and they are reluctant to teach sex education. Teachers tend to focus on knowledge rather than skills. The predominant teaching style is didactic using textbooks.

In the case of the Population and Family Life Education project in Uganda, it was reported that the teachers were found to lack knowledge and skills related to adolescent health, life skills and gender concepts (Carr-Hill, Katabaro, Katahoire and Oulai, 2002). Consequently they found it difficult to discuss adolescent problems, especially those related to sexual behaviour. Also in Uganda, in an IEC project involving the National Curriculum Development Centre, the Ministry of Education and the Population Secretariat with UNFPA support, many students blamed teachers and parents for lack of information and ignorance of reproductive health issues. They acknowledged these as the main sources of reproductive health information, but they did not provide sufficiently detailed information, leaving them to fend for themselves. Reasons for this included that teachers focused on what was covered in the syllabus so as to prepare students for examinations and for religious and cultural reasons. Some teachers were engaged in sexual relationships

with students. Yet parents wanted teachers to take a lead in reproductive health education.

Preparatory research undertaken for the Primary School Action for Better Health (PSABH) project in Kenya (Maticka-Tyndale, Gallant, Brouillard-Coyle and Sverdrup-Phillips, 2002) uncovered the following:

- Teachers were concerned about their students and wanted to take steps to ensure their protection from HIV.
- Teachers were certain, however, that they could not successfully carry out HIV prevention alone and supported a collaborative effort involving teachers, community members, parents and religious groups.
- Although teachers held positive attitudes towards HIV education, they were quick to point out a number of barriers:
 - lack of resources and/or training;
 - concern that students were too young to understand lessons on sex or HIV;
 - shy students;
 - warnings against teaching young people about condoms.
- Ultimately, teachers were most comfortable delivering didactic lessons on abstinence.
- Where teachers felt discomfort (i.e. condom use) they tended to convey mixed messages to young people. Young people were aware of these mixed messages and recognized that it stemmed from teacher discomfort (i.e. it was felt that teachers do not want to teach about condoms because they think it will make the students ‘play sex’).

The PSABH project confirms the importance of teacher training, provided in this case through a two-cycle week-long residential in-service training programme. Additional training was given to trainers at teacher training colleges. The responses of pupils indicated a direct relationship between the training of teachers and the messages delivered in the classroom. The programme had the capacity to respond to pupils’ needs and teachers’ concerns. However, at all stages of monitoring, evaluation and data collection, teachers presented abstinence as the only effective method of preventing HIV transmission. Gradually over time, teachers incorporated specific teaching strategies to help students remain abstinent as well to support their sense of self-control and efficacy in

sexual decision-making. Interviews with teachers revealed that while some teachers still felt uncomfortable talking about sex, the training provided had made them much more open to doing so (Maticka-Tyndale, Brouillard-Coyle, Gallant, Holland and Metcalfe, 2004).

Teachers struggled with the issue of condoms. They did not know how to talk about them to students, or indeed if they should be talking about them at all. By the final evaluation, teachers appeared to be more open in talking about them with students, although they still did not publicly support teaching pupils about them. Discussions tended to focus on dissuading against condom use, but there were indications of attempts by teachers to acknowledge their preventive qualities. School visits by trained health workers assisted in dealing with sensitive topics such as HIV prevention.

The programme was affected by the high rate of teacher movement in the project's 2,000 schools with 22 per cent of schools losing trained teachers due to transfer or death over the eighteen-month pilot period. The barriers to programme implementation reported in control schools were most often related to lack of training, while in target schools reported barriers were teaching difficulties, e.g. insufficient time and scheduling difficulties (Maticka-Tyndale, Wildish and Gichuru, 2004).

A Sida-funded study of HIV education in Iringa municipality in Tanzania found teachers struggling to cope, despite the fact that the problems concerning HIV were nothing new to many of the teachers and students (Setthammar, 2006). The problems were multifaceted and linked to the general lack of funding for quality education. HIV had been integrated into the curriculum in subject syllabuses such as biology, civics, geography and general studies. However, HIV issues were mostly taught during biology and civics. Teachers were observed to be lecturing about HIV in a theoretical manner and not connecting it with practice or local reality. The topics they addressed did not concern life skills or knowledge the students needed for HIV prevention. The pedagogical approach could be described as 'chalk and talk' on a poor quality blackboard, with some teacher-led questioning and a total lack of discussion. When interviewed, the teachers considered that the students did not need any information on sexuality, relationships or condoms to assist them with abstinence. They believed, on the contrary, that talking about sexuality and condoms would promote sexual intercourse.

It was reported that there was a great lack of teaching and learning materials for all subjects in all schools. The teachers were the only ones to have a textbook, and sometimes it was only a copied version. In the textbooks there was very little or no information about HIV. There were directives from the Ministry of Education and Culture, and also from TACAIDS (the NAA), but they were not implemented in schools. Teachers lacked the professional preparation to provide them with the knowledge and skills to teach about HIV in a social context, where talking about sexuality was taboo.

A study investigating whether a sample of high school teachers in South Africa were implementing HIV education found a range of variables that included teachers' generic dispositions, their training experience, the characteristics of their interactive context and the school climate (Mathews, Boon, Fisher and Schaalma, 2006). Female teachers were more likely than males to have implemented HIV education (74 per cent versus 58 per cent). The teacher characteristics associated with teaching HIV were previous training, self-efficacy, student-centeredness, beliefs about controllability and the outcome of HIV education, and their responsibility. The existence of a school HIV policy, a climate of equity and fairness, and good school-community relations were the school characteristics associated with teaching HIV. The findings demonstrate the value of teacher training and school policy formulation, as well as the value and importance of interventions that go beyond a sexual health agenda, focusing on broader school development to improve school functioning and the school climate.

A study of primary school teachers in South Africa found that some teachers had an incomplete understanding of the transmission and prevention of HIV in Africa (Ayo-Yusuf, Naidoo and Chikte, 2001). Furthermore only 9 per cent mentioned education as a way to prevent HIV infection. Of the respondents, 58 per cent indicated that they taught HIV prevention to their pupils. Of those who did not teach HIV prevention, 41.2 per cent believed that the pupils were too young, and 20.6 per cent put it down to non-availability of guidelines and resources. In conclusion, many primary school teachers were found to be wanting in HIV knowledge. This suggests that the teachers would need to be adequately trained prior to their involvement in delivering HIV education to pupils. Grade 3 and 4 teachers may be considered suitable to provide HIV education to their pupils, but there is a need for structured educational programmes that they can follow. This study also suggests

that teachers were not aware of the Department of Education's HIV policy of providing age-appropriate education to all pupils.

In Malawi, a study which conducted focus group discussions about HIV with male and female primary school teachers studying for certification, and informal discussions with faculty at two teacher training schools, found that teachers were very aware of the negative impact of HIV, especially in the villages which they described as becoming graveyards (Kachingwe *et al.*, 2005). Nearly all enthusiastically identified teachers as important role models and HIV educators. They recognized that HIV prevention must begin in primary school due to early sexual activity, high drop-out after primary school, and inadequacy of traditional and parental sex education related to HIV. However, they identified many barriers to the fulfillment of their role, which include discomfort in discussing sex with young people, stigma associated with HIV, and external barriers including lack of training and materials in rural areas, perceived constraints on explicit education such as condom demonstration, uncertainty about community, parental and church support, and lack of emphasis on HIV in the tested curriculum. It was concluded that the MOE should develop the support structures that are needed to enable teachers to fulfill their potential as HIV educators and role models. Many of the attitudinal barriers that affect teachers probably also affect MOE staff, so support is needed throughout the system, not just for teachers.

A number of barriers inhibit teachers as HIV educators in Malawi, such as the following:

- An HIV prevention curriculum has been introduced into all the schools, and teachers are mandated to cover this material. However, teachers reported that this material was covered in only a very superficial way, or even omitted.
- Personal barriers included risky personal behaviours, discomfort in discussing HIV, and lack of knowledge. As already discussed, the participants noted that personal risky behaviours were an issue for teachers, both putting them at risk personally and undermining their value as role models. Most teachers agreed that they felt uncomfortable in discussing HIV prevention materials. One important source of personal discomfort is the traditional cultural values that prohibit discussion about sexuality, especially by parents or elders like teachers. These attitudes persist despite

recognition that they are vitally important in the presence of an HIV epidemic. They also recognized that some teachers have personal characteristics such as shyness that make it harder to discuss the HIV curriculum.

- Teachers lacked an adequate knowledge base. Although the teachers had reasonably accurate knowledge about HIV, they also had many questions and incorrect beliefs.
- System barriers included: widespread stigmatization and denial surrounding HIV; lack of emphasis on the HIV prevention curriculum; lack of training and materials in rural areas; perceived constraints on explicit HIV education in the school curriculum are not a central focus of the health programme.
- Teacher preparation at the teacher training college put relatively little emphasis on preparing teachers to teach the HIV prevention curriculum.

Teachers may be willing and motivated to teach about HIV, but the system fails to provide them with the wherewithal to do the job. A study in Nigeria among secondary school teachers in Osun State found that the lack of guidelines and classroom resources were the main reason for not teaching about HIV (Hammed, Adedigba and Ogunbodede, 2007). An overwhelming proportion of the teachers sampled (93 per cent) wanted training to update their knowledge, 86 per cent wanted HIV to be made a compulsory component of the secondary curriculum, and 84 per cent stated that they would like to be part of an HIV prevention group for their community.

Mixed results in Asia

There have been a few evaluations of HIV education programmes in lower HIV prevalence settings in Asia, which are discussed below. Interestingly, they are all co-curricular programmes. The evidence base for the integration of HIV education in the national curriculum subjects is weak.

Andhra Pradesh State (India). An evaluation of the co-curricular AIDS Prevention Education Programme (APEP) in Andhra Pradesh was undertaken in 2003 using both quantitative and qualitative research methods (Catalyst Management Services, 2003). The study assessed the effects of APEP on students and other stakeholders, the effectiveness of the training of trainers approach, and the management of the programme. The main findings of the study include the following:

- If implemented according to the guidelines, the programme could reach a large number of students in a short period of time. Going to scale had effects on the community and district administration, strengthening their commitment in district HIV committees.
- The programme provided young people with space to discuss sensitive issues including sex and sexuality.
- The programme contributed to improving the knowledge levels of students on HIV transmission and protection methods, as well as dispelling common misconceptions.
- Positive changes were observed in students with regard to discussions on sensitive subjects such as the reproductive system.
- There were increased positive attitudes towards people living with HIV.
- The programme guidelines were not followed in all schools.
- Areas of non-compliance in following programme guidelines included not using the question box, having grades 9 and 10 in the same classroom, not spending adequate time on the subject, lecture-type sessions and large class sizes.

The training of trainers process had trained some 22,928 teachers (nodal teachers) through a cascade approach involving more than 700 trainers (22 core resource persons and 696 state resource persons), and the programme had been delivered to an estimated 2.5 million students. The approach was considered to be largely successful, but training content was observed to have been diluted at lower levels of the training cascade. A higher priority was given to content than to pedagogical skills-building. Many nodal teachers (APEP teachers, of which there were two in each school: one female and one male) were found to be hesitant to talk about sexual organs and issues related to growing up. Some 20 per cent of nodal teachers requested additional support materials on the latest data on the epidemic, references and methods to handle life skills sessions.

The choice of trainer (resource person) was considered critical to success. It was considered better to select these on the basis of their interest and track record in previous initiatives, and their communication skills and comfort levels in dealing with the sensitive content of the programme such as reproductive health. Training batch sizes of less than 50 nodal teachers were recommended to facilitate learning. Participation by people living with HIV was effective in training sessions at state level,

but did not take place at district level. The network of people living with HIV could not be involved at this level.

At school level, the programme was delivered by the nodal teachers in grades 9 and 10. In 29 of the 30 schools sampled, the programme was conducted within the planned time frame in one to three spells. Some topics, however, were considered not to have been given sufficient time. These included STIs, HIV testing and life skills. The duration of sessions varied widely, depending on the time allocated to the programme by nodal teachers and school authorities. The schools where students performed better in post-tests used interactive teaching methods such as role-playing, story-telling and discussion.

Attention needed to be paid to the quality, duration and content of headmaster sensitization in the district level training. They were considered to be key to programme implementation and needed to be convinced of the importance and utility of the programme. The number of nodal teachers needed to be proportionate to the size of the school.

Karnataka State (India). A similar evaluation was conducted in India in Karnataka State in 2003 (Swasti, 2004). The Karnataka State AIDS Prevention Society (KSAPS) had piloted the co-curricular School AIDS Education Programme (SAEP) in 2002. Based on the learning from the pilot phase, KSAPS had scaled up the SAEP to 4,013 schools in 2003. The main objective of this initiative was to ensure that all school-going children were provided access to reliable information on growing up and on HIV and AIDS in order to dispel common misconceptions and acquire life skills related to self-determination.

The programme was considered to have clearly contributed to increasing the knowledge levels of students with respect to changes relating to growing-up, STIs and HIV. Positive changes were observed in students with regard to education and discussions on sensitive subjects such as the reproductive system, which provides an enabling environment for the programme. Students showed clear evidence of positive change in attitudes towards people living with HIV. It was considered too early to make any conclusions on the skills imparted to students to handle peer pressure in their own lives.

The main lessons are listed below:

- If there was any impediment in the delivery of the information, it was the hesitation or discomfort of the teachers rather than shyness of students or resistance from the community or parents.
- Advocacy was required more for the school administration and management to take up the programme, rather than with parents or community. In most cases the resistance at school management level stemmed from logistic and administrative issues rather than from any ideological differences with the content being covered.
- Teachers did not require a high degree of technical knowledge to deliver the appropriate messages. Most nodal teachers found the session on HIV easiest to handle.
- A learning attitude, interest and enthusiasm of teachers to conduct the programme, strong communication skills and a good rapport with students were found to be determining aspects of the quality of delivery of the programme.
- Both girls and boys were more comfortable being taught by a teacher of the same sex. In a few cases where girls and boys were combined for the third session on life skills, there was uneasiness among the students.
- The training approach works, provided close monitoring is undertaken, support systems are in place for the trained resource persons, and appropriate follow-up is provided.
- Commitment of senior management of various institutions/ departments involved in the programme at all levels (state, district and school) significantly enhanced the effectiveness of the programme.

The lessons from the two case studies in India are largely positive, with some evidence of effectiveness in terms of learning if the programme was implemented as intended. The role of teachers in effective delivery is clearly critical, the main impediment being hesitation or discomfort on the part of the teachers rather than shyness of students or resistance from the community or parents. This signals the importance of paying due attention to teacher selection before providing appropriate training and professional support.

Sri Lanka. The issue of teacher shyness was also identified in Sri Lanka, where teachers were found to be reluctant to deal with issues relating to sex, sexual health and gender in the classroom (WHO, 2007).

The challenge of overcoming gaps in teachers' knowledge and increasing their confidence through pre- and in-service education was considered to be critical to the success of HIV education programmes.

Cambodia. There was limited monitoring of the effectiveness of the co-curricular Life Skills HIV Education (LSHE) programme. It was reported that the grade 5 and 6 classroom-based LSHE programme had mixed success where the district training team members, in pairs, taught example lessons to the classes, with the expectation that the regular classroom teachers would sit in on the lessons and then be able to teach these lessons themselves in subsequent years (Ministry of Education, Youth and Sport, 2006b). The model was not working as planned in many areas, as classes were still being scheduled outside of regular school time (on Sundays and public holidays) in most schools. As a consequence, the regular teachers were not attending the sessions and the drop-out rate of students attending from one session to the next was as high as 50 per cent. The failure of the MOE to provide an adequate number of textbooks and sufficient IEC materials had been a problem and had compromised the programme.

Incentives to teach LSHE are an important issue. It was reported that it can be difficult to persuade primary school teachers to participate in LSHE activities around LSE because they were not compensated for their participation. Teachers were being provided with US\$2 per day for lesson-plan development, but the LSHE design required district team members to work with primary school teachers to develop an additional lesson plan, for which they were not provided an incentive. Some primary teachers complained that it was difficult for them to continue teaching life skills classes to their students because they received no per diem or other incentive to do so.

It was reported that schools where the school directors more actively supported and participated in the programme *achieved more impact in terms of implementation and good results from monitoring and evaluation exercises*. When the school directors discuss the HIV education programme during the assembly or in meetings at their school, teachers view LSHE as a part of their regular responsibilities and not 'something extra'. This suggests the importance of a policy-based programme for schools to ensure that school directors give it their full commitment.

It was recommended that the Ministry of Education, Youth and Sport (MOEYS) design and provide certificates to the education personnel at

the provincial, district and school levels to recognize their completion of training courses related to LSHE. It is reported that trainees continually request this, which is another way to provide an incentive to participate in the programme.

The LSHE performance assessment (MOEYS, 2006c) identified the following critical components for successful programme implementation on the basis of qualitative participatory research:

- active support of the school director;
- active support of local authorities;
- adequate supply of materials;
- commitment and efficiency of NGO support;
- time when classes are held.

Interestingly, there were no references to teachers being unable to teach sensitive issues in the LSHE programme. The main issues identified by teachers were lack of materials for classroom teaching, insufficient time allocated for in-service training, lack of recognition for their work and the need for support from the school director (KAIROS, 2007).

5.7 Summary of findings

Many countries experience the same programming challenges in implementing HIV education, including a reluctance to acknowledge adolescent sexuality and the social roots of vulnerability, limited sectoral delivery capacity, difficulties in addressing behaviours, and a lack of child-friendly service delivery.

Most education systems introduce life skills programmes at secondary level, whereas they are more needed at primary level to reach the more vulnerable populations. The content of life skills programmes has not always been sufficiently relevant or appropriate. The training of teachers has often been inadequate with insufficient attention paid to building confidence in handling sensitive content matter and new teaching methods. The use of cascade teacher training approaches and peer education has proved to be problematic in delivering something as complex as life skills-based education pedagogy. Participation of teachers in programme development is limited. Monitoring of classroom delivery is lacking. Life skills-based education is often at the margin of the education mainstream and excluded from wider sector reform.

Programmes too often fail to take into account adequately the following issues related to teachers and HIV education (Kelly, 2000):

- *Inadequacy of teacher knowledge and confidence:* The subject matter around HIV is new to most teachers and they will not have been taught about HIV at school themselves.
- *Teacher embarrassment in teaching about sexuality issues with the young and the opposite sex:* This may result in the selective teaching of HIV, which results in critically important issues being left out by the teacher (Boler, 2003).
- *Teachers' concern about their lack of preparation to teach in the area of HIV, reproductive health and psycho-social life skills:* Most serving teachers will not have had any pre-service teacher training in life skills-based education for HIV prevention.
- *Teachers' perceptions that this is not what education is about:* Teachers may not see the need for HIV education, or may consider it instead to be the responsibility of others such as parents. This can result in low commitment to life skills-based education.
- *Teachers' anxiety about offending parents:* Teachers are often concerned that by teaching about HIV and sexuality they will come into disrepute with other members of staff, parents and the community.

Current HIV education programmes pay inadequate attention to defining and measuring performance. This includes the identification of measurable learning outcomes, including knowledge, skills, competencies and behaviour. Attention also needs to be given to identifying appropriate process indicators and monitoring progress more effectively. Monitoring and evaluation need to be accorded a much higher priority (Clarke, 2004).

In preparing teachers to communicate about HIV and related sensitive issues, Visser-Valfrey (2004) recommends the following:

- *More and better teacher training and support:* The predominant approach in Mozambique and other countries has been to train as many teachers as possible. Her study suggests that certain teachers may be better predisposed to the task of talking about HIV than others, and that an effective strategy would need to include investing time and resources upfront in identifying such teachers.
- *Promoting the greater involvement of teachers in the HIV response:* Teachers have much to contribute to the HIV debate. Ways need to

be found to break the culture of silence that surrounds the disease. Suggested ways of doing so include organizing support groups, broadcasting teachers' stories on community and national radio information and programmes, and generating local newsletters in which teachers can (anonymously) talk of their experience.

- *Providing information and resources:* Teachers indicated that they have a great need for more information, and for more complex information. Cost-effective local resources need to be identified and put in place that will make it possible, on the one hand, for teachers' experience to become part of the HIV campaign and, on the other hand, to allow teachers to have access to resources and information that they need.
- *Making optimal use of teachers' personal experience of HIV:* Teachers' personal experience and the way in which some teachers analyze these experiences and integrate them into their teaching suggests that there is potential for teachers to be involved in HIV action research.

Training can make a significant difference. Kiragu *et al.* (2007) report that teachers who had undergone Straight Talk Foundation School Environment Program training said they felt more comfortable than their counterparts in talking to adolescents about matters relating to sex.

5.8 Key points

The focus of most studies on school-based HIV education is on learning outcomes. This is appropriate, but there appears to be insufficient attention being paid to considerations of education effectiveness, including how best to prepare and support teachers in the classroom.

These studies amply demonstrate the value of research and review processes which investigate the effectiveness of school-based HIV education programmes. In undertaking these it is of utmost importance to ensure there is a strong and clear focus on the teacher, and ideally that teachers are consulted through key informant interviews or through focus group discussions to obtain a clear view of their perspectives.

The following conclusions are highlighted:

Sexual abuse and GBV at school

1. A holistic response is required to eliminate harmful teacher behaviours at school where these are prevalent. This includes policy, strategy, capacity building, curriculum development, teacher education and community participation. MOEs, teachers' commissions and teachers' unions have important roles to play.
2. There is a clear role for TTCs to address gender issues in initial teacher education. These issues also need to be included in INSET.
3. Teachers have a professional responsibility to create safe classroom learning environments, free from gender harassment, abuse and violence.
4. Sexual abuse and GBV issues need to be included in school workplace policies, as well as codes of professional conduct for teachers and education sector staff.

Children infected with and affected by HIV

1. Issues connected with education and orphans and vulnerable children need to be included in teacher education, particularly where HIV is prevalent in the local communities (initial training and INSET).
2. In high HIV prevalence settings, a holistic response is required at school involving school leadership, as well as monitoring systems to identify vulnerable children.
3. Issues related to orphans and vulnerable children need to be included in school workplace policies, as well as codes of professional conduct for teachers and education sector staff.

HIV-related stigma and discrimination

1. Teachers living with HIV are a stigmatized group and face discrimination in the workplace.
2. Teachers may discriminate against children affected by and infected with HIV.
3. Special measures are required to protect teachers from HIV infection and to protect the rights of teachers who are HIV-positive.
4. Issues connected with HIV-related stigma and discrimination need to be included in teacher education, particularly where HIV is prevalent in the local communities (initial training and INSET).

5. Stigma and discrimination issues need to be included in school workplace policies, as well as codes of professional conduct for teachers and education sector staff.

Ineffective teaching

1. Many HIV education programmes appear not to be fully effective. There is widespread evidence that the factors that make teachers effective are not being adequately considered in curriculum design, implementation or evaluation.
2. Many teachers struggle with the content matter of HIV education. They are being asked to do what they are uncomfortable doing. This appears to be an imposed burden on teachers and one that some will not respond to favourably.
3. MOEs working with teachers' unions need to develop a strategy tailored to local culture and context to help teachers deal with issues that are socially sensitive, whether this be sexuality, sexual health, GBV, homosexuality and homophobia or human anatomy. Societies have different cultural taboos and these need to be taken into consideration in developing countries. In Kenya, for example teachers may not be able to talk about condoms, whereas in Cambodia teachers include condom demonstrations in their HIV education lessons.
4. The design of HIV education programmes has to start with identifying where teachers stand in relation to their knowledge, attitudes and practices *vis-à-vis* sex and sexuality. This should be evidence-based and participatory.
5. There are unrealistic expectations about the ability of teachers to implement participatory multi-activity LSE. Serving teachers often lack the repertoire of teaching skills and professional characteristics that are required to make this approach effective in the classroom. The school may also lack the essential characteristics for this approach to be effective. These deficiencies cannot be remedied by short-duration cascade-delivered INSET alone. A comprehensive plan for education reform is required.
6. Teachers are generally not being provided with the training, support and resources required for effective HIV education. There needs to be a substantial investment in pre-service teacher education for HIV education and corresponding investments in teacher support and continuous professional development.

7. The placement of HIV education in the co-curriculum may provide more flexibility in programme delivery and enable more appropriate and willing teachers to be selected at school level to teach it.
8. It is clear that teachers are more likely to teach effectively if the enabling conditions are met. This is line with Kirby *et al.*'s (2006) findings. In particular, it seems important that teachers receive appropriate professional training, teaching and learning materials and support from head teachers, colleagues and the community.

Chapter 6

The impact of HIV on teachers: protecting and supporting the teacher

“In key respects, teachers are regarded in the same way as other economic migrants in Africa since they are often separated from their spouses and families due to lack of suitable housing. This coupled with the reluctance of their spouses and children to live in rural locations could lead to teachers having more sexual partners than less mobile occupational groups” (Bennell, 2003: 18).

6.1 The need for teacher protection from HIV

The need for teacher protection against HIV is clearly in proportion to the threat from the national epidemic. It is in countries where the epidemic has crossed into the general population that the problem is most critical. In these contexts, a major challenge is to prevent an impact on the teaching stock and to mitigate any unavoidable impacts. In many countries in East and southern Africa, the national HIV prevention response was too slow to prevent very significant impacts on the teaching stock.

Teachers comprise a large workforce in any country – in many, the largest. They represent a diverse grouping, some of whom will be more vulnerable and at risk to HIV infection than others because of their sexual habits and the social contexts in which they live. The threat to the teaching stock as a whole in a country is likely to reflect strongly the extent to which the virus is present in the general population. With the highest levels of HIV prevalence, sub-Saharan Africa therefore faces the most serious challenges in protecting its supply of teachers, particularly in East and southern Africa, though some countries in Asia and the Caribbean region also face potentially significant impacts over time.

In preparing teachers to meet the challenges that HIV poses to the teaching profession, it is clearly important to start programmes as early as possible, preferably during pre-service training. Regular professional development on HIV-related issues can be provided through INSET and other forms of continuous professional development. Programmes need

to be tailored to context, and evidence-based understandings of the impact of HIV on the teaching stock, current and predicted, need to inform the development of appropriate interventions.

6.2 The impact of HIV on teachers

In general, the vulnerability of teachers to HIV infection in country contexts is not well researched or evidenced. The US National Academy of Public Administration reports that there are no definitive studies explaining why teachers are vulnerable to HIV infection (National Academy of Public Administration, 2006). There is anecdotal evidence that suggests that in Africa, in common with the general population in rural areas, they lack information about HIV prevention and safe sex. There is clearly scope for country-level research to contribute to a better understanding of the vulnerability of teachers to HIV, which can be used to inform evidence-based prevention programmes. At the same time, such research can inform the development of teacher preparation programmes for teaching HIV education. It constitutes a kind of situation analysis of teachers from the perspective of HIV, and should involve from the design stage the active collaboration of teachers' associations and unions.

Ultimately, the key long-term issue from the perspective of an education policy-maker or planner must be how to put in place measures that will, as far as possible, prevent HIV infection in the teaching stock. The impacts on education delivery arising from HIV infection in the teacher supply have been sufficiently well described for MOEs not to be complacent, particularly in countries with generalized HIV epidemics, where not addressing this issue is neglecting the best interests of the children and the staff who are employed to educate them. At the same time it is important that measures put in place also apply to and benefit those engaged in education service delivery in the private sector. The policy framework on HIV therefore needs to be inclusive and cover the entire sector.

A recently published study used the Ed-Sida model to make projections of the impact of HIV on education supply in 53 countries in three areas hardest hit by the epidemic: sub-Saharan Africa, the Caribbean and the Greater Mekong sub-region of South-East Asia. The study estimated the incremental economic cost attributable to HIV of providing sufficient teachers to achieve UPE by 2015 (Risley and Bundy, 2007). It projected the costs under two scenarios reflecting different levels

of availability to teachers of care and support, including ART. The results suggested that, in sub-Saharan Africa, the 2006 costs to education were less than half those estimated in 2002, reflecting reductions in estimated HIV prevalence and a better understanding of HIV epidemiology. However, the impact on teacher supply was estimated to be sufficient to derail efforts to achieve EFA in sub-Saharan Africa unless teachers have universal access to treatment, care and support. The results suggest that universal access to testing and treatment is always beneficial to education supply.

6.3 Are teachers a high-risk group?

Because of reported high losses of teachers to HIV in sub-Saharan Africa, the assertion has been made that teachers can be considered as a *high-risk group* for HIV transmission. For example, Kelly (2000), writing about teacher infection and mortality, found that while there is a scarcity of good data, there is some evidence to show that teachers constitute a high-risk group in several countries, including Zambia and South Africa. He attributes this to their status and conditions of service. In relation to the general population, they are better educated, have a higher income level, and their mobility is greater. Kelly is one of several authors who have usefully drawn attention to the vulnerability of teachers to HIV infection. There has been little discussion of high-risk sexual behaviour among the teaching profession, and the risks through unsafe sex and multiple sexual partners have been implied rather than researched and evidenced.

In considering the validity of the proposition that teachers as a group are at high risk, it is important to understand that teachers in any country tend to be a large and very heterogeneous group. Whether teachers can be categorized as a group in terms of their sexual behaviours is highly questionable. In any case, the concept of a high-risk group, although commonly employed in the international discourse of HIV during the 1990s in particular, is now contested. Fordham (2005), for example, in reassessing the Thailand response to HIV, shows how the 'high risk group concept' applied to sex workers is a simplistic construct at variance with the reality of sexual behaviours. Given the influence the Thailand national response to HIV has had on the international approach to HIV prevention, this is somewhat disconcerting. The labelling of teachers as a high-risk group is in any case potentially prejudicial to the public standing of the profession and risks becoming counter-productive in terms of

understanding their vulnerability. Social and epidemiological contexts are key variables. Even if teachers as a population were at significantly elevated risk from HIV infection in Zambia and South Africa, this does not necessarily mean that they might be at risk in other country contexts, and generalizing from country specific data is likely to be hazardous.

The challenge of assessing teacher vulnerability to HIV was usefully taken up by Bennell (2003), who investigated whether teachers could be considered a high-risk group based on findings of impact assessments of HIV on primary and secondary education in three sub-Saharan African countries – Botswana, Malawi and Uganda. He reviewed the available evidence, which he found to be very limited, and concluded that there was little to support the proposition that teachers are a high-risk group. This assumes that the concept had any descriptive validity in the first place.

The research questions posed were the following:

1. Do teachers have the specific characteristics that are likely to predispose them to unsafe sexual behaviour?
2. Do teachers engage in higher levels of unsafe behaviour?
3. Are HIV prevalence rates relatively high among teaching staff compared to the general population?
4. Are HIV-related mortality rates higher among teachers than the rest of the adult population?

To obtain evidence for the first two questions would require that ethnographic and survey-based research be undertaken on the sexual lives of teachers, especially in the context of high HIV prevalence settings. This does not appear to have been a priority for operational research to date. It would clearly be a socially and politically sensitive area of investigation given the reported incidences of sexual abuse of girls by teachers. There may be significant value in undertaking such research in collaboration with teachers' organizations to raise awareness of the prevention challenges among the teaching stock, especially in contexts of high HIV prevalence.

The third question is complex. Empirical investigations of HIV prevalence rates among teachers are only possible if a specific study is designed and carried out to measure precisely that. Otherwise, the national HIV surveillance system, which usually relies on antenatal clinic data and household surveys for estimates of prevalence in the general population,

are likely to be the only data available. Comparisons between teachers and other occupational groups in society, whether they are lawyers, doctors, truck drivers, or the population in general, are unlikely to be reliable or helpful in framing an appropriate response.

The fourth question is also tricky. Data about mortality rates and causes of mortality are likely to be problematic in many developing countries. The stigmatization occasioned by HIV has been a factor in the under-reporting of death by HIV-related disease, and therefore reliably disaggregating the cause of death is a difficult if not impossible task in many contexts. The loss of serving teachers through death from all causes can be ascertained in many contexts, though it should be borne in mind that it is one factor in teacher attrition rates, including those which are HIV-related.

It was concluded that the balance of the evidence suggests that teachers are at relatively low risk as an occupational group in most countries in sub-Saharan Africa. It was found that:

- the impact of HIV on teachers varied significantly by gender and by school level that they teach (primary or secondary education);
- it is hazardous to make blanket generalizations about the teaching profession. In some countries the majority of teachers at primary level are female (as in southern Africa); in others they are male (as in some French-speaking countries). The marital status of teachers varies across countries too;
- mortality rates for teachers are generally much lower than for the adult population as a whole.

Some country-specific sources of evidence on the impact of HIV on education are discussed below.

6.4 Assessing the impact of HIV on teachers

Botswana, Malawi and Uganda

Relatively little systematic empirical research has been done on the impact of HIV on education, including in high HIV prevalence settings. In order to begin to address this deficit, an investigation into the impact of HIV on the primary and secondary education sectors was conducted in Botswana, Malawi and Uganda (Bennell, Hyde and Swainson, 2002). The study obtained data generated from school surveys and key informant interviews administered in selected primary and secondary schools in two

sample districts, one rural and one urban. A common methodology was used to allow cross-country comparisons. A total of 41 schools across the three countries were surveyed.

From the research findings, it was apparent that teacher mortality rates correlated positively with the overall levels of HIV prevalence in the area in which they work. Rates varied significantly from district to district, tending to mirror local HIV prevalence rates. The overall mortality rate for teachers in Botswana declined to 0.8 per cent during 1999/2000 at a time when there was a threefold rise in staff taking ART, a significant finding pointing to the importance of providing access to treatment for teachers. In Malawi, mortality rates among primary teachers had risen rapidly from the mid-1990s to over 2 per cent in 2000, but rates were lower (less than 1 per cent) among secondary teachers. In Uganda, mortality rates had peaked in 1995-1997 at less than 1 per cent. In general, primary school level teacher mortality was higher than at secondary school level.

Teacher absenteeism was not considered to be a 'serious problem' by either teachers or students. Absences were occurring however, and it is tempting to conclude that teacher absence is not an unusual phenomenon. In general, there is a need for more rigorous empirical studies of teacher absence.

Five main reasons for absence were given: personal sickness, attendance at funerals, school-related events such as workshops, looking after sick relatives and 'other', which included maternity leave and collecting pay. These varied across the countries, with personal sickness being more significant in Botswana and Malawi (accounting for 35-45 per cent of absences of more than one day); in Malawi attendance at funerals amounted to around 35-40 per cent of absences, but 10-20 per cent in the other two countries. In Uganda, school-related reasons were the most significant. This probably reflects the greater severity in HIV impact in the former two countries, which are experiencing 'hyper-epidemics'.

Low motivation and morale were found to be very serious problems in many schools, especially in Botswana and Malawi, but these appeared to be more related to general conditions of service including low pay, poor conditions and incompetent school management than to reasons relating to HIV. The ongoing crisis in education surfaces again.

Stigmatization and discrimination against teachers living with HIV by school managers, teaching colleagues and students appeared to be significant in school settings. This resulted in high levels of secrecy and denial among teaching staff. However, little overt discrimination was reported in the study.

These findings suggest that:

- qualitative research such as this can be useful in illuminating issues for policy-makers and strategic planners;
- HIV impacts can be elusive. They are hard to disentangle from the other systemic problems faced by teachers at work. HIV-related stigma appears to play a significant role in hiding HIV impacts;
- ART can play a major role in mitigating the impact of HIV on the teaching stock;
- concerted action needs to be taken by MOEs to address issues relating to poor teacher motivation and conditions of service, HIV-related stigma and teacher absences from all causes to provide access to treatment and care for teachers living with HIV, and to give additional attention to teachers serving in districts where there is high HIV prevalence.

The findings argue that a comprehensive national assessment on the status of teachers should be carried out periodically as a significant contribution to the development and review of national plans on education.

Mozambique

An HIV impact study was carried out for the MOE in 2001 (Verde Azul Consult, 2001). The main aim of the study was to provide MOE and the Government of Mozambique with information for strategic planning and advocacy purposes.

The specific objectives of the study were to:

- determine the impact of the epidemic on the education sector at the national level;
- determine the medium- and longer-term effects on the education system's ability to meet its stated strategic objectives over the next 10 years;
- strengthen the capacity of the ministry's directorates to implement and manage similar assessments;

- increase awareness within the ministry about the nature and extent of HIV in Mozambique and its impact on education.

Over the period 2000-2010, the HIV epidemic was projected to result in the education sector losing some 17 per cent of its personnel. Across all levels, it was predicted that some 9,200 teachers would die, and an estimated 123 senior managers, planners and administrators would be lost. For each of these educators, it was estimated that some 18 months of productive work time would also be lost before they died.

Because the central region had the highest levels of HIV prevalence, they were projected to lose the greatest percentage of teachers (23.3 per cent), and because the region had the highest number of educators in the system, half of all teachers who were predicted to die would come from there. In order to maintain the system, trained teachers and senior personnel who would be lost to HIV would need to be replaced.

In order to accommodate the loss of trained teachers alone, it was estimated that there would be a need to expand the number of trainees in the system by 25 per cent, solely due to HIV. In order to replace teachers with university degrees who die of HIV, training at this level would need to be expanded by 28 per cent.

The HIV epidemic would therefore increase demands on teacher training institutions to increase the supply of trained teachers. However, it was judged unlikely that these institutions would be able to meet this increased demand and therefore more likely that trained teachers would be replaced with untrained ones, lowering the quality of education delivery. At the same time, the education sector would be competing with other sectors, including the private sector, in attracting those who have obtained at least some education. It was predicted that the epidemic would increase competition for trained personnel and may make it more difficult to attract people to the teaching profession.

The total estimated loss to the education system arising from HIV amounted to US\$110 million. This represents additional costs to the system of 6.9 per cent due to HIV. This was considered an underestimate of the actual costs, because some costs could not be quantified based on the available data. It was also an underestimate because it assumed that the ministry would bear no costs associated with expanded HIV prevention activities by, or within, the sector.

The bulk of these costs would be to cover HIV-related sickness and death benefits, and, to a lesser extent, expanded teacher-training. There are also costs associated with increased inefficiencies in the system, most notably increased drop-out and repetition rates. With education currently receiving some 14 per cent of the national budget, it has been predicted that these losses will have a significant impact on the ability of the state and the ministry to cover these additional expenses.

It was recommended that the ministry consider targeted educational and preventive measures for its educators with the assistance of key non-governmental organizations, including the teachers' unions. Despite the numerous constraints, it was also recommended that teacher-training opportunities be expanded to accommodate the impacts of the epidemic.

The findings provide:

- evidence of the usefulness of projection modelling to provide a clear warning of the likely impacts of HIV on the teaching stock in a high HIV prevalence setting, and the budgetary implications of this;
- a signal to take preventive action involving teachers' unions with teacher trainees and serving teachers;
- a signal to expand the supply of teacher trainees.

The implications of providing ART to teachers living with HIV do not seem to have been addressed, as this study predates the main drive to provide access to treatment, but this would have a significant mitigating effect on teacher loss. It would be illuminating to conduct an assessment of the actual impact of HIV on the teaching stock to see to what extent the projections have been realized in reality, and whether any impact mitigation measures taken have been effective.

In 2008, the Education and Culture Minister reported that more than 1,300, or about one sixth, of Mozambique's 9,000 teachers were dying annually of AIDS-related causes, lowering the quality of education in the country. He said that Mozambique was losing 17 per cent of the 9,000 teachers each year because of AIDS-related causes. This exactly matches the projected rate of teacher loss in the study.

Rwanda

A study on the impact of HIV on education in Rwanda funded by DFID reported that good data on HIV infection risk among teachers

are not available, but teachers are vulnerable to HIV due to inadequate knowledge about HIV and poor access to condoms (Kinghorn *et al.*, 2003). It was concluded that HIV was likely to cause a slight increase in rates of attrition, which were considered unlikely to exceed 0.9 per cent, even in the worst-case scenario. Other causes of teacher loss were judged to be more significant. ART could reduce deaths by around 50 per cent over the coming decade.

It was found that HIV was likely to exacerbate existing weaknesses in educational service delivery, such as absenteeism (already a substantial problem), staff vacancies (15 per cent of schools had vacancies) and reduced productivity due to low morale arising from conditions of service, stress and illness. The study estimated that HIV would add less than 5 per cent to teacher training requirements over the coming decade, which was considered manageable, but an added challenge to UPE achievement.

These findings highlight:

- the difficulty of disentangling HIV impacts from other factors which challenge teachers;
- that action required needs to be comprehensive in addressing causes of teacher absenteeism and attrition from all causes; the supply of teacher trainees may need to be expanded;
- the need to provide serving teachers with appropriate HIV education and access to services;
- that access to HIV prevention and treatment services will be key in reducing the impact of HIV on the teaching stock.

Nepal

An assessment of the impact of HIV on the education sector based on a survey of 12 schools in three locations in Nepal found no school that had been directly affected (Bennell *et al.*, 2003). No information existed about HIV prevalence among teachers; such data were, however, available for truck drivers and female sex workers. Mortality rates were higher for primary than for secondary teachers. These did not correspond with HIV prevalence rates by district. Overall, 0.2 per cent of the total number of teachers died in service in 2000, constituting 11 per cent of overall attrition.

The findings indicate that:

- HIV impacts are highly elusive in low-level epidemics;
- it is important to address teacher attrition from all causes.

The small sample of schools in this study may have been a contributory factor in the lack of evidence on impact. In low prevalence settings, impact will be much harder to locate and a larger sample size is necessary to find any impact. In such contexts it is likely to be more cost effective to undertake a modelling of the projected impact on education demand and teacher supply.

Nigeria

An assessment was made of educators' views on the impact of HIV on primary education in Nigeria by RTI International and funded by USAID (Ssengonzi, Schlegel, Chukwuemeka and Olson, 2004). It was undertaken in three states: Kano, Lagos and Nasarawa. The sophisticated study methodology included a research and documentation review. Some 50 relevant documents concerning HIV and primary education were reviewed. Primary data collection methods included structured interviews with head teachers and teachers on a one-on-one basis, focus group discussions with parent-teacher association (PTA) members, and in-depth interviews with key informants. A multi-stage sampling approach was applied to head teachers and teachers, while a purposive sampling approach was used to select other informants. Gender was used as a sampling criterion (at least one female teacher) for primary schools. Rural and urban schools were included in the study. Overall a total of 135 school administrators and 1,072 teachers were interviewed, representing a 96 per cent response rate. A total of 114 group discussions, with an average of nine members in each group, and 37 key informant interviews were held – a minimum of 10 for each state.

The research questions centred on three main themes:

- the impact of HIV on the demand for education;
- the impact of HIV on the supply of education;
- HIV-related stigma and discrimination in primary education.

About 1 in 10 school administrators perceived that the situation of HIV in their area was 'bad' and that there was some impact in their schools. With regard to the supply of education, self-reported school administrator absences show that illnesses (self, relatives and friends) combined with funerals accounted for the majority of absences. These

can be partly attributed to HIV. These two were also the primary causes of teacher absenteeism across all three states. Administrators reported that they managed teacher absence by using other teachers at the school, thus increasing their workload; merging classes; or, in a few cases, sending children home. The major reason for staff attrition was transfer, with a small proportion lost to illness and death. Ninety-two per cent of school administrators reported that there was no HIV education in primary schools.

About a third of teachers in Kano (34 per cent) and Lagos (31 per cent), and almost a fifth in Nasarawa reported a lack of willingness to talk about HIV at their workplace. The latter stated having the highest HIV prevalence rate of the three. The findings indicate the need to develop and implement workplace HIV programmes. Very few teachers (33 in total) reported having worked with someone living with HIV. Teachers were divided in their opinion of whether HIV-positive teachers should be allowed to teach or to receive benefits. Teacher willingness to be tested for HIV varied across the states, from 37.6 per cent in Kano to 79.3 per cent in Nasarawa.

In summary, teachers indicated that factors such as a lack of school materials, poor teacher incentives and poverty have a more negative impact on primary education than HIV. Teachers in Nasarawa (more than 40 per cent) were more likely to report the impact of HIV than in the other states (about 5 per cent in Kano and 3 per cent in Lagos). Impacts reported included feeling sad about the possibility of being infected and an increased workload through other teachers' absences.

It was recommended that a dialogue with teacher training institutions be initiated to explore ways through which training on HIV could be incorporated into pre-service teacher training curricula.

The findings show:

- It is useful to investigate the perceptions of school administrators and teachers regarding the impact of HIV on their work.
- HIV is having an impact on the education system, which is likely to grow unless there is an effective response, but it is less of a concern to teachers than other systemic problems.
- The research approach with appropriate contextual modifications would be worth replicating in other sub-Saharan African countries.

Tanzania

A study on the impact of HIV and AIDS on the education sector in Tanzania reported a rising trend in teacher deaths in the period 1999-2002 (Kauzeni and Kihinga, 2003). The majority were in the 41-50 year age range in each of the 20 regions in mainland Tanzania, and that this was likely to have created a number of orphans. Data from the Tanzania Teachers Commission indicated that most deaths were caused by HIV or related illnesses such as Tuberculosis (TB). The overall teacher attrition rate had increased from 0.5 per cent to 1.3 per cent.

The findings indicate:

- a loss of experienced teachers to HIV;
- that teachers have families who may also face impacts;
- that it is important for each country in Africa to conduct its own analysis of the impact of HIV on education supply.

Zambia

An analysis of the financial implications of HIV for the MOE and development partners used a mathematical model (Ed-SIDA) to project the number of primary school teachers and their HIV status within the planning framework for teacher recruitment and training (Grassley *et al.*, 2003).

Cost data were compiled from the MOE, the Teacher Education Department, teacher training colleges and the donor consortium for the Basic Education Sub-Sector Investment Programme. The modelling results indicated that costs to primary education arising from the impact of HIV to teacher supply would be an estimated US\$1.3-\$3.1 million in 1999 and projected to rise to US\$10.6-\$41.3 million between 1999 and 2010. The costs included salaries that would be paid to teachers who would be absent due to HIV-related illness (71 per cent of costs), additional costs of training teachers to cope with HIV-related attrition (22 per cent), and funeral costs met by the MOE (7 per cent). Teacher absenteeism was projected to result in close to 20 million teacher hours over the decade. The costs did not include the additional costs of prevention or care. The annual cost to MOE would amount to an estimated 2.5 per cent of its budget in 1999, but expenditure on teacher training would need to increase by 26 per cent if EFA targets were to be met. The resource implications of HIV for the MOE are therefore significant.

Zimbabwe

A study on the impact of HIV on education in Zimbabwe reported that education employees were at substantial risk of HIV infection, as with any other occupational group in the country, but their relative susceptibility was uncertain (IAEN, 2002). Available evidence suggests that the levels of HIV infection among teachers might be very similar to the general adult prevalence rate. In the absence of HIV sero-prevalence data for teachers, only crude projections were possible, and these could only serve as very rough guides for educational planners.

A major concern of both male and female teachers that was reported was being posted away from their spouses and other stable partners, with the temptation to become involved in extra-marital relationships that might lead to HIV infection.

There were limited data available to the study on mortality among teachers. The data for 1999-2001 suggested the following:

- Death rates among teachers were higher than would be expected in the absence of HIV.
- Over 2 per cent of teachers in 2001 had either died or retired due to ill health.
- There may be a rising trend in death and terminal illness rates.
- The cumulative impacts and social costs are likely to be substantial.

There was considerable variation among districts in terms of health impacts on schools, and there was no shared perception of the magnitude of the problem. Impacts that were reported included the following:

(a) Personal and family impacts:

- significant anxiety and stress of infected and affected staff;
- grief and loss causing depression among infected and affected staff;
- stress of covering for sick colleagues and teaching large classes with pressure to get good results;
- fear of personal infection or illness;
- care of sick family members, orphans and other surviving family members;
- stigma: The most common response reported was avoidance, with verbal or other abuse of infected and affected teachers also

mentioned. Self-stigmatization was also reported as infected staff became withdrawn and depressed;

- a disproportionate burden of care carried by women teachers due to traditional gender roles and responsibilities.

(b) School-level impacts:

- a general air of depression and anxiety at school and in the community;
- higher levels of teacher absenteeism;
- poorer quality of teaching and loss of time on task by teachers who were more severely ill or affected; severely ill teachers were reported by many children, colleagues and managers as struggling to teach with the physical and psychological effects of illness;
- loss of skilled staff, and the quality of staff being hard to replace temporarily or in the longer run in remote areas;
- exacerbation of existing high staff turnover;
- emotional stress on children who were being taught by a severely sick teacher. Feelings among students included anger at poorer teaching, guilt and compassion for the teacher;
- complications in staff allocation and distribution. HIV was reported to lead to increased mobility of teachers, as many sick teachers move from rural areas to urban areas with medical services, while terminally ill teachers may transfer to their rural homes. Transfer had become a major problem on account of the perceived decline in quality of health services in many parts of the country.

These findings present a picture of a severe HIV impact on education, which is what would be expected in the context of an epidemic with very high HIV prevalence. Once again, they point to the need to provide comprehensive prevention, treatment and support services to teachers. HIV-related stigma needs to be addressed comprehensively.

South Africa

South Africa is particularly rich in terms of attempts to measure the impact of HIV on its education. This, in part, reflects the severity of the epidemic and also the strength of the research capacity in the country.

An early attempt to explore the supply of and demand for teachers in the context of HIV was undertaken within the framework of the MUSTER project (Crouch, 2000). The study profiled patterns of income against teachers and made comparisons with the labour force as a whole.

It analyzed the characteristics of teacher turnover and attempted to forecast teacher demand under a variety of assumptions. It examined the implications of HIV on both teacher supply and demand.

It found that relative to the labour force as whole, teachers are more likely to be female, work fewer hours, have higher incomes, be more educated, be more unionized and be of increasing age. Entry and exit rates to the profession were relatively low by the late 1990s. Teacher supply levels were low by historical standards. This is not because incentives were poor, but because demand was restricted bureaucratically or by budget. Individuals were reacting to the probability of finding a job after teacher training. However, it was felt that the reasoning behind young people's decisions to enter the teaching profession or to follow a different career path were not sufficiently well understood, and research was needed in this area in order to reduce the risk of policy and planning mistakes.

Forecasts for teacher demand and supply suggested a large imbalance between the two, with the impact of HIV creating a situation where future demand for teachers was likely to be much greater than the supply. It was suggested that some 30,000 new teachers would have to be trained each year at a very substantial cost.

The impact of HIV on education was highly variable across the country. It would require a flexible response by the system of human resource allocation to respond to shortages in teacher supply at the local level. The implications of HIV were considered to be poorly understood, but very extensive. New systems of training and deployment would likely be needed to meet the challenge.

A study to quantify the effects of illness and death on education at school level and to analyze the implications for HIV responses was funded jointly by USAID and AusAID and undertaken by Health and Development Africa (Schierhout, Kinghorn, Govender, Mungani and Morely, 2002). The researchers addressed three questions concerning HIV impacts at school level on teachers and staff:

1. What are the currently experienced levels of staff absenteeism and attrition in sampled schools?
2. What is the likely current contribution of HIV to absenteeism and attrition, relative to other contributors?

3. What are the current capacity constraints and likely effect of any increase in current levels of absenteeism and attrition?

Measurement of staff attrition and absenteeism was found to vary according to the source of the estimate. Estimates of attrition obtained through official school records were considerably lower than those calculated through structured interviews with head teachers.

Teacher mortality was difficult to determine. Indications showed that the death of educators was an issue that affected a substantial proportion of schools. Enhancing the capacity of systems and managers to deal with illness and death was considered an important issue. However, illness and death appear to have had a relatively small impact on teacher numbers and attrition rates in the two states sampled. It is therefore important to understand why teachers are leaving the service and to provide incentives to offset the loss due to HIV or other causes. There was a need for reliable serial data to understand trends, for example, whether deaths and illness are becoming more prevalent. Collecting information on teacher absenteeism was found to be subject to many reporting biases, with possible perverse incentives to under-report. It was considered critical to develop tools and indicators to measure teacher absenteeism, and learners may be able to supply this information.

The Education Labour Relations Council (ELRC) of South Africa sponsored a study of gross teacher attrition rates and trends, which includes the analysis of the causes behind these by age and gender in public schools during the period between 1997/1998 and 2003/2004 (Mobile Task Team, 2005). The study claimed to be the first overview of teacher attrition and mortality trends that does not rely on estimates, models or projections, but is based on empirical data contained in government databases and registers.

The data were obtained from three sources: the Government of South Africa's Personnel and Salary Administration System (PERSAL), the Department of Home Affairs National Death Register, and the EMIS.

The study covered approximately 92 per cent of the total teaching force in South Africa; there are no data on the remaining college school teachers employed by school governing bodies who comprise the remaining 8 per cent. Data were analyzed by financial year.

The findings showed that gross attrition in the educator workforce fluctuated in the period under review, with rates varying significantly by

province. This workforce included school and office-based educators, i.e. teachers, heads of department, principals, subject advisors, district managers, but excluded administrative staff, personnel officers and senior management. Organizational change through amalgamation and rationalization played a significant role in these fluctuations.

The early years of the study were characterized by high numbers of severance packages and dismissals, but more recent years show rising proportions of mortality, medical retirement and resignation. Mortality was the third largest cause of attrition.

The proportion of gross attrition due to mortality increased from 7 per cent in 1997/1998 to 17.7 per cent in 2003/2004. A total of 12,990 educators died in-service during the period, and a further 430 were discovered using data from the national death register, where 'contract termination' rather than death was recorded. Some 3,853 deaths after service were identified from the same data source; a third of these (1,202) within one year of leaving the service. Provincial mortality varied significantly with KwaZulu-Natal having the highest number of deaths.

Disaggregation of data revealed that mortality rates by race are highest for male black Africans (in the 20-49 age range), and the highest proportional increase in mortality was among females in this age range. The highest provincial mortality rate was in KwaZulu-Natal among the 25-29 age range.

The main conclusions drawn by the Mobile Task Team include the following:

- There is a need for decentralized information systems to enable rapid decision-making and monitoring at the district level, capable of generating monthly or quarterly information. National analysis masks the extent of variation in attrition and mortality; some provincial systems are more vulnerable than others.
- While the study did not attempt at any stage to ascribe any mortality to HIV, the patterns of teacher attrition and mortality are consistent with the high levels of HIV prevalence in South Africa.
- Increasing mortality rates in the private and other sectors are increasing the number of resignations from the profession (53 per cent of all terminations in 2003/2004) as the market for the skilled workers intensifies.

- Educators in South Africa appear to be at less risk of contracting HIV than the general population in the same age band, but there is a growing loss of highly trained men and women, particularly in the worst affected provinces.

The Human Sciences Research Council (HSRC) and ELRC in South Africa set out to determine the prevalence and determinants of HIV and TB amongst South African educators by age, sex, race, qualifications, locality, learning area and phase of active teaching (Shisana, Peltzer, Zungu-Dirwayi and Louw, 2005). In addition, it aimed to estimate the attrition rate of educators and identify the reasons for this. The study comprised three components: (a) an epidemiological profile of educators, including HIV, TB and health status; (b) workplace policies; and (c) human resources.

The instruments used included individual questionnaires translated into local languages and HIV testing (blood or oral specimen) linked to the questionnaire by bar code, but no result could be traced back to any individual, thereby ensuring anonymity and confidentiality in a rigorously designed study.

There was a high response rate: 97 per cent for questionnaires and 80 per cent for specimens. The results were considered to be useful in developing a better understanding of the impact of HIV on educators and their vulnerabilities to HIV infection.

The main findings are given below:

Profile of educators: Public sector educators in South Africa are predominantly women, older than 34 years of age, mostly with 10 years or more experience, the majority with diplomas or degrees. Most were union members, though the rate of membership was lower in young educators and those with a low income. The educators in general rated themselves as not well-off financially. Many educators were teaching in subject areas for which they were not trained, which suggests that training is not well aligned to teaching needs.

HIV prevalence: The findings suggest that HIV is a serious issue for the teaching force with a prevalence rate of 12.7 per cent and between 42,809 and 47,804 infected. Infection rates among educators were found to be similar to that of the general population and not significantly different from that of health professionals, and it was suggested that the rates might reflect those of the communities in which they live. Concern

was expressed that only 59 per cent of educators had ever taken an HIV test, yet in other contexts this might be considered a relatively high proportion.

Gender: Overall, HIV prevalence did not vary by sex, although higher HIV rates for females were found in the 25-29 age range (21.5 per cent female; 12.3 per cent male) and in the 30-34 age range (24.2 per cent female; 19.4 per cent male). HIV was 2.7 times more prevalent among single than among married people (affecting 22.9 per cent and 8.2 per cent respectively). It was concluded that there is a need for a better understanding of gender dynamics of educators' lives. Gender disparities in the teaching force were observed. Women were more likely than men to obtain a posting in an area close to their families or in the city, less likely to be redeployed, and more likely to move with their family. However, they were less educated than their male counterparts, much less likely to be employed as principals or deputy principals, more likely to be employed in the lower ranks of the profession. They were lower paid and less likely to have a housing subsidy or medical aid.

Rural-urban differences: It was found that HIV prevalence was higher in rural areas than urban, the reverse of what is found in the general population. It is suggested that teachers in rural areas fall in the high-income group by local standards, and this may result in their being considered as a desirable group for sexual relationships. This appears to confirm the views of Kelly cited earlier regarding the enhanced vulnerability and risk of teachers in South Africa.

Differences by learning area and length of teaching experience: It was found that educators in the areas of additional languages, economics and management science, mathematics and science were more likely to be living with HIV. Prevalence was highest among educators with the least teaching experience (0-4 and 5-9 years) and lowest among those with more than 15 years.

Province and district levels: Differences were observed among these, with KwaZulu-Natal and Mpumalanga being worst affected.

Health-related productivity and attrition: The most significant factors leading to absenteeism were probably high blood pressure, use of tobacco, HIV, stomach ulcers, diabetes, arthritis, rheumatism and high alcohol consumption. In addition, low morale, low job satisfaction and high work-related stress were significantly associated with self-rated

absenteeism. Fifty-five per cent of educators intend to leave the profession. Violence at school was found to be a significant factor in reducing the morale of teachers. HIV negative educators were more likely to want to leave the profession than those who were living with HIV.

Determinants of HIV: The epidemic appeared to be driven by multiple sexual partnerships, particularly among men; low condom use; younger sexual partners among men; migration; and mobility. Gaps in knowledge about HIV transmission were reported.

Some conclusions

The different studies illustrate the importance and the utility of undertaking HIV impact assessments relating to teachers, especially in a high HIV prevalence setting. The main findings highlight the following:

- the importance for MOEs to know the situation and demographic composition of their teaching stock;
- the need for decentralized information systems to monitor teacher attrition, with HIV being one of several factors accounting for attrition;
- the importance of gender analysis in understanding teachers' lives.
- the existence of rural-urban differences in HIV prevalence;
- HIV prevalence varies among teachers depending on age, gender and teaching experience.

Uganda

A study on the impact of HIV on higher education institutions in Uganda (Katahoire and Kirumira, 2008) found that within the teacher training college this was experienced in various ways. The identified losses included:

- interrupted teaching as a result of staff members with AIDS;
- increased staff workload;
- poor performance by students in particular courses due to loss of staff;
- financial loss to the college through funeral contributions;
- increased stress on those infected and affected by HIV.

The impacts were largely invisible to senior staff and college administrators. Impacts were felt most in a few departments where some staff were HIV-positive and unwell.

6.5 Implications for the education sector response to HIV

It follows that MOEs in countries in the midst of a generalized HIV epidemic need to consider how best to undertake research to assess the risks HIV poses to the long-term development of the sector, including to the supply of teachers. A range of methods is now available, including the use of modelling tools such as the Ed-Sida model (Partnership for Child Development and World Bank, 2006) for HIV forecasting, as well as empirical qualitative and quantitative research and, in the case of South Africa, the use of anonymous HIV testing. It is up to MOEs, in collaboration with teachers' organizations, to tailor the research approach to their particular needs and capacities. There is clearly scope for cross-country sharing of experience and learning in this field, especially in sub-Saharan Africa.

The case studies reported above show the difficulty of disaggregating HIV from the array of interconnecting problems facing education systems and teachers which were described earlier in this book. They indicate the need to take a mainstreaming approach. Investigating education through an HIV lens can illuminate some of the wider problems affecting teachers in the system, such as absenteeism, low morale, poor motivation and high levels of attrition.

It is likely that the process of research is as important as the product. The South Africa research shows the importance of involving teachers' unions. The involvement of key stakeholders is conducive to building consensus on the nature of the problem and is likely to enhance the probability that the research findings will obtain traction at the political level and that the findings will be acted upon.

Monitoring the impact of HIV on teachers

In order to respond effectively to a predicted impact, it is important to have available good quality data on the nature of the threat. Accurate data disaggregated by gender are needed on teacher absenteeism, shortages and transfers from all causes (UNESCO, 2006e). Developing monitoring and evaluation systems for the impact of HIV is thus a key area for MOEs to invest in, especially in generalized HIV epidemics. However, the *Global HIV/AIDS Readiness Survey* found that very little formal monitoring of human resource impacts is taking place (UNAIDS IATT on Education, 2005). Only four countries reported that they have monitoring systems in place – Cote d'Ivoire, Kenya, South Africa and Zimbabwe.

A lack of accurate, relevant and timely information is a major obstacle to educational planning in many education systems (UNESCO, 2003b). Many EMISs currently collect data from schools on an annual or biannual basis. Data from schools are processed at a central level. Analysis may take many months, with the result that feedback is slow in being provided back to the local level, and in many instances none is received. In countries where the impact of HIV is most severe, there is a need to develop new data gathering systems at the local level to capture and monitor key management indicators. Data processing and analysis also need to take pace at the local level to provide feedback for a timely management response at school and district levels.

In this context, the District-Level Education Management and Monitoring Information System (DEMMIS) was developed by HEARD and EduAction to capture a limited number of key management and HIV and AIDS indicators in schools on a monthly basis. The availability of such data at local level would assist a timely management response at the district and school levels.

DEMMIS is an information system that is intended to capture sex and age disaggregated data on educators, learners, support staff and school governing bodies. Data would be sought on enrolment, absenteeism, attrition, loss of contact time, school drop-out, pregnancy and orphaning. The instruments for data capture are simple forms with a one page summary to facilitate analysis at the district level.

The system was piloted in KwaZulu-Natal, the worst affected province in South Africa. Return rates in the sample were considered to be excellent. Data from 32 schools were analyzed over a ten-month period with the following findings (Badcock Walters, Heard and Wilson, 2002).

- *Declining enrolment across grade 1:* the reasons for which are unclear, but HIV-related factors such as reduced fertility, household economic stress, infant and child mortality are likely contributory factors.
- *Educator absenteeism and leave:* amounted to 7 per cent of available classroom contact over the period. Peaks in absence were observed at times of the year coinciding with exam preparation.
- *Learner attrition:* Some 517 learners left school during the period, an annual attrition rate of 4.7 per cent. Five per cent of the total loss was due to orphaning and 3 per cent due to death.

- *Educator attrition:* Sixteen teachers were lost to the system out of a total of 371, a rate of about 5.1 per cent when annualized. Deaths were not recorded.

The pilot of DEMMIS confirmed that the system was able to deliver a time-series of monthly returns which revealed trends and fluctuations in the performance of schools, which could in turn guide intervention. Conditions for success, however, included an enabling environment backed by political will and co-operative schools and teachers. EMIS officials need to understand the benefits of DEMMIS. School record-keeping needs to be effective and functioning (Mobile Task Team, 2005).

The DEMMIS model has been adapted for Zimbabwe and piloted in seven districts (UNESCO, 2003*b*). Gender disaggregated data are collected on a monthly basis on a one-page summary sheet which is submitted to the district office. Information on teachers that are required include: application for leave, number of staff members at school (trained and untrained), the number of staff who left and the reason for their departure, the number of school hours lost through staff absenteeism, and the number of school days lost through teachers being on leave.

DEMMIS is being piloted in a number of countries in sub-Saharan Africa, including Zambia, Kenya and Uganda, as well as the Eastern Cape Province in South Africa. This is a promising innovation and evaluations of these pilots will likely provide fresh insights into how to manage the impacts of HIV and AIDS on the supply of education.

HIV impact-related research

Research is needed in high HIV prevalence settings in quantifying the impact of HIV on teachers (Boler, 2003*b*). Impact management must take into account the wider educational context and the multiple factors that need to be considered in understanding the impact on teachers. In order to do this, quantitative research must go hand in hand with more in-depth qualitative research.

There is a need to develop and utilize research expertise in HIV impact assessment in the education sector in universities and research institutes in sub-Saharan Africa, the Caribbean and in Asia. This implies that MOEs develop partnerships with researchers and universities. Institutions responsible for teacher education should also be involved.

HIV impact-related policy for the education sector

Workplace policies should include attention to gender, the rights of children infected and affected by HIV, and stigma and discrimination. The policy framework needs to define, prohibit and incur penalties for acts of GBV in the education system. MOEs also need to develop workplace policies on teacher misconduct involving sexual relations with students.

Workplace policies need to include provision for HIV prevention programmes for serving teachers. These should include behaviour change education activities, STI management, universal precautions, HIV testing and counselling, and prevention of mother-to-child transmission (UNESCO, 2006*d* and 2006*e*). In high prevalence settings they may include peer education sessions and activities. Treatment education seems to be an obvious topic for inclusion.

HIV workplace policies should also include access to treatment, care and support. Programmes should include nutritional advice and support, lifestyle education, psycho-social support, family support, prevention and treatment of opportunistic infections, and provision of ART (UNESCO, 2006*d*).

The workplace policy should address conditions of service which are relevant to HIV infection among the teaching stock. These should be reviewed to protect the rights of employees and to minimize the impact of the epidemic in the workplace. According to UNESCO (2006*d* and 2006*e*), issues that need to be considered and covered are:

- HIV-related stigma and discrimination;
- HIV testing, confidentiality and disclosure;
- safe working environments;
- equitable employee benefits;
- grounds for dismissal;
- grievance procedures.

For teachers living with HIV, measures need to be put in place to ensure that they are able to continue working effectively. The kinds of measures that can be considered are job modifications, flexible scheduling, job sharing, leave of absence and transfers.

It should be considered good practice to develop workplace training manuals specific to the education sector which can be used in school-level workshops. Ideally this should relate to the implementation of the workplace policy for the sector. Examples of such materials are

hard to find. The HIV/AIDS Secretariat of the Ministry of Education in Ghana (2002), with the support of the Ghana AIDS Commission, has developed a three-module workplace manual concerning:

- the implementation of workplace programmes;
- basic facts on HIV and AIDS;
- reporting.

It would be interesting to compare this manual together with an evaluation of its use/impact with other nationally developed materials designed for this purpose. The ILO (2001) has developed training materials for the implementation of the Code of Practice on HIV/AIDS in the Workplace, but there is nothing specific that has been developed internationally for the education sector at present. The only comprehensive international guidance on HIV workplace policy is that developed by the ILO and UNESCO for the Caribbean region (ILO and UNESCO, 2006a) and that developed for southern Africa (ILO and UNESCO, 2006b).

Teachers' unions have a key role to play in tackling stigma and discrimination among their own members. SADTU has developed a training manual for trainers to equip union leaders, staff and members with appropriate knowledge and skills on HIV and AIDS which is strongly rooted in a workplace policy approach (SADTU, 2004). This manual includes specific sections on stigmatization, discrimination and human rights.

Networks of teachers living with HIV

Networks of teachers living with HIV are a recent development. One such network has been formed in Kenya, called the Kenya Network of Positive Teachers (KENEPOTE). KENEPOTE's objectives are to unite HIV-positive teachers against stigma and discrimination; advocate for prevention, care and treatment; protect their rights; and promote their living positively with the virus in order to prolong their active lives (KENEPOTE, 2005). Similar networks have been set up in Namibia, Tanzania, Uganda and Zambia. Their prime function appears to be to serve as a pressure group for neglected and vulnerable populations.

The Education Development Centre (EDC), Education International and WHO (EDC, EI and WHO, 2007) have prepared a toolkit for teachers' unions to involve and support teachers living with HIV. This recommends inclusion of HIV-positive teachers. The fact that they have set up their own networks is perhaps testimony to their exclusion.

6.6 Conclusions

HIV has had significant impacts on teachers in high prevalence settings, especially in those countries of East and southern Africa where HIV prevalence rates are so high. Governments were slow to recognize the threat to their human resources. MOEs were especially slow. A great deal of our current understanding of the impact of HIV on teachers is due to the activism and research of a few highly committed individuals. The following conclusions are highlighted:

1. Much remains to be done by MOEs and their partners to respond effectively to HIV in the education sector, in high HIV prevalence countries in particular.
2. HIV impacts can be elusive. It is difficult to disentangle the impact of HIV from other factors undermining the quality of education in high prevalence countries. Evidence of HIV impact on teachers is elusive in low HIV prevalence countries. HIV impacts are highly elusive in low-level epidemics.
3. Impact studies are useful mechanisms for MOEs to gather data for policy and strategic interventions. The process of investigation is useful for mobilizing stakeholders and raising general awareness of the issues.
4. Access to ART is critically important for teachers living with HIV. ART can play a major role in mitigating the impact of HIV on the teaching stock.
5. HIV impact analyses need to be fully informed by gender analysis.
6. Qualitative research can be useful in illuminating issues for policy-makers and strategic planners.
7. HIV-related stigma appears to play a significant role in hiding HIV impacts.
8. The findings argue for a comprehensive national assessment on the status of teachers to be carried out periodically as a significant contribution to the development and review of national plans on education.
9. There is evidence of the usefulness of projection modelling to provide a clear warning of the likely impacts of HIV on the teaching stock in a high HIV prevalence setting and the budgetary implications of this. It is a signal to take preventive action involving teachers' unions with teacher trainees and serving teachers, as well as to expand the supply of teacher trainees.

10. A comprehensive package of interventions needs to be put in place by MOEs to prevent impacts of HIV on the teaching stock and mitigating those which are already impacting on education demand, supply and quality. Concerted action needs to be taken by MOEs to address issues relating to poor teacher motivation and conditions of service, HIV-related stigma, teacher absences from all causes, and to provide access to treatment and care for teachers living with HIV and to give additional attention to teachers serving in districts where there is high HIV prevalence. There is a need for decentralized information systems to monitor teacher attrition, with HIV being one of several factors accounting for attrition.

Chapter 7

Becoming a hero: maximizing teacher effectiveness for HIV education

“Teachers and classroom process are now front and centre, and they are generally agreed to be key to education quality” (Leu, 2005).

“Not only is the AIDS agenda marginal to almost everything else that schools do, but in fact the challenge is to be found nowhere inside the core business of a South African school” (Jansen, 2006).

“The teachers are not to blame” (Dani village elder, Tanah Papua, in Clarke, 2008: forthcoming).

7.1 The problem revisited

This book has shown that the education response to HIV is still work in progress. Despite more than two decades of interventions in the sector, it is clear that there are major problems to be faced in gearing up education sectors to roll back the epidemic among young people. The challenge is global, but it is more acutely faced in those countries where HIV has taken root in society. The epicentre of the HIV epidemic is now southern Africa, although serious epidemics are to be found in East Africa and, to a lesser extent, elsewhere in the Caribbean and in South-East Asia. It is in these regions that education is being called upon to play a more concerted role in HIV-related services, the main emphasis being on prevention. Elsewhere, education still has a role to play in keeping HIV at low levels of prevalence and in addressing related stigma and discrimination.

Teachers are caught up in the education sector response to HIV as active agents and as passive observers. They are simultaneously duty-bearers and rights-holders. They have been castigated as villains and identified as victims. There is only occasionally favourable press about positive teacher action on HIV. Few heroes have been documented in the sector who have successfully made a difference in HIV programmes. The discourse about teachers has seen a substantial amount of accusation, distress and failure. There are many who say that teachers cannot deliver

the learning outcomes, as they cannot deal with sex in the classroom. This is well evidenced. What is to be done?

7.2 Main lessons learned in the education sector response to HIV

General

The education response to HIV is evolving as better understandings of the dynamics of HIV epidemics emerge. Education responses to HIV need to be based on research evidence and tailored to the context of the local epidemic and the capability of the education system. This means a more intensive approach in countries with generalized epidemics, and particularly those with high levels of HIV prevalence. In high HIV prevalence settings, a comprehensive approach to HIV impact assessment, prevention and mitigation needs to be developed.

MOEs need to develop a comprehensive, coherent and co-ordinated approach to HIV, involving consideration of how HIV prevention should best be integrated into policy, the ESP, the curriculum and co-curriculum, teacher education and education management at all levels. How the HIV response is planned, costed and integrated into the education sector plan is critically important. A comprehensive and strategic approach to enabling, empowering and protecting the teacher is essential for programme effectiveness.

Mainstreaming of HIV education is much misunderstood. It should not be taken to mean inclusion in all activities. Rather, it should entail careful and selective integration into those activities that will likely have the most positive impact in the sector's core business.

A clear focus should be monitoring the processes and outcomes of the interactions between learner and teacher – who constitute the partnership in classroom teaching and learning, by policy-makers, curriculum specialists, managers and researchers.

Changing the education mindset on HIV

Political leadership needs to be strong and informed in supporting HIV education in schools. The importance of ministers of education giving their voice and support to HIV education cannot be overestimated. It must be recognized that leadership in the education sector in African

countries has been slow to mobilize around HIV and AIDS issues (Allemano, 2003).

Education leadership needs to be engaged and mobilized at all levels. While active leadership is essential at central government level, it is also critically important at decentralized levels in an education system. This is especially true in federal states, where decision-making is often devolved to provincial or state level political bodies. School leadership is a key element in effective education and head teachers need to show leadership on HIV education.

Strategies to strengthen the education sector response to HIV should combine top-down and bottom-up processes.

Teachers need to be recognized and valued as change agents. It seems that a new vision of teachers is required in many countries, not just for the education sector response but also for EFA and national development. Teachers are not simply vehicles for the delivery of knowledge.

Addressing HIV issues in education needs to be recognized as an intervention to improve the quality of education. Including HIV education in the curriculum can improve the relevance of its local content, as well as providing the opportunity for more participatory teaching and learning activities in the classroom.

Factors which undermine the quality of education and teacher motivation, such as large classes, poor working conditions, lack of supervision and support, inadequate salaries, etc. need to be addressed. A high priority needs to be given to improving the quality of teacher education in general and providing opportunities for professional development in national education development strategies. HIV needs to be mainstreamed into pre- and in-service teacher education.

A stronger civil society voice is required for HIV education. Community acceptance and participation in HIV education needs to be regarded as pivotal in its introduction in schools and to ensuring that teachers are comfortable in working in this subject area.

7.3 What is to be done?

Preparing the teacher to teach effectively in a world with HIV requires investment in a number of different areas. This involves a set of actions focusing on professional development and support involving policy development, strategic planning and capacity building, at all

relevant levels of the education system to the particular HIV response. Ideally, this should be a strategic approach that is holistic in its aims and coverage. At the same time there is room for a piecemeal approach to education reform around teachers which complements the most systemic approach.

The main instruments for education reform are the education policy framework and the national ESP. Of these, it is the ESP that in most cases has been the vehicle for international donor assistance, as in the case of the EFA FTI. If HIV mainstreaming means selecting those parts or activities of the education system that are the most influential or that constitute the core business, then a very strong case can be made for addressing HIV through the ESP processes.

The main entry points are:

1. plan preparation;
2. plan appraisal and endorsement processes;
3. plan review processes.

Improving teacher effectiveness in HIV education needs a package of multiple interventions. These involve:

- policy;
- education sector plans;
- institutional capacity and management systems;
- curriculum development;
- complementary approaches to HIV education;
- teacher training and support;
- impact prevention and mitigation.

These are discussed in more detail below. They comprise elements of a framework for undertaking SRAs. The SRA is useful for policy formulation, and for planning and reviewing progress. It is an information gathering and analysis process which looks at existing strengths and capacities, challenges and current interventions with a view to identifying means of strengthening the sector response.

7.4 Education policy on HIV

The importance of policy

Public policy consists of the issues that are identified for attention by government and the courses of action that are taken to address them

such as legislation, regulation and resource allocation. Policy-making is the process by which governments translate their political vision into programmes and actions to deliver outcomes that will achieve the desired change. Public policy on HIV may be enshrined in law, as in the case of the Philippines AIDS Prevention and Control Act of 1998 or the Cambodia Law on the Prevention and Control of HIV/AIDS. Policies may be framed at the national multi-sectoral level, as in the case of the National HIV/AIDS Policy of Zimbabwe (World Bank, 2007), or at the sectoral level such as the 1998 Botswana Policy on HIV/AIDS Education and the Jamaica 2001 National Policy for HIV/AIDS Management of in Schools. A range of policy instruments is likely in a multi-sectoral response. Considerable variation in the choice of policy instruments for the education sector response to HIV is observable across countries in sub-Saharan Africa (Wirak, 2003) and in Asia. However, it seems a reasonable hypothesis that a specific education sector policy framework for HIV will be most beneficial in addressing the particular issues to be encountered in and by the sector.

A coherent, comprehensive and scaled-up response to HIV is considerably more problematic to achieve without a specific policy in place. Policy is required to define priorities, rights, entitlements and responsibilities with regard to the HIV response in the education sector. It should include a comprehensive workplace policy consistent with ILO and UNESCO guidance (ILO, 2001 and 2002; ILO/UNESCO, 2006a, 2006b) and policies on curriculum-based HIV prevention, school health, teacher education and HIV impact mitigation in terms of the demand for and supply of education. In other words, policy needs to provide clarity about how HIV will be mainstreamed in the education sector. It should also specify clear responsibilities for implementation and monitoring/review.

An important aspect of having a policy in place is that it demonstrates ownership by the MOE of the issue and the response. It permits greater accountability by civil society, assuming, of course, that it is readily accessible to all through a national dissemination process. The lack of clear policy on HIV by governments implies the following:

- lack of political commitment to address HIV among young people;
- lack of concern for the rights of those involved in education;
- lack of clear government position on key HIV issues for young people;
- lack of accountability for government action on HIV in education.

Policy-making may mean having to address hard choices and difficult decisions. HIV education in schools and how to address the needs of orphans have proved to be among the issues most difficult to resolve in policy-making processes in Africa (Stover and Johnston, 1999). Countries appear to be learning from regional experience and putting in place more comprehensive educational policies on HIV.

Choice of process in policy-making is of critical importance to its eventual outcome. Evidence from Africa (Stover and Johnston, 1999) suggests that participatory approaches build momentum for implementation and often shorten the time required for approval. In effect, highly participatory processes may be more rapid than an expert-drafted approach, as well as being more comprehensive. ILO guidance on HIV workplace policies (ILO, 2001) stresses the importance of participation and social dialogue involving employee unions and organizations.

Policy on HIV for the education sector needs to be fully aligned with existing sector policies as well as other national policies on HIV. An initial exercise, therefore, is to review existing policy to establish how it currently supports and conditions the education response to HIV. This is likely to result in the identification of changes that will need to be made to the current policy framework. Among the issues that will require a policy response are: HIV-related stigma and discrimination, teacher training on HIV, workplace issues such as ill health and absenteeism, access to care and support services, and HIV prevention education curriculum and co-curriculum.

Since teachers constitute a critical component in the education sector response, it is vitally important that the HIV policy specifically includes a section concerning them. Participation by teachers and their unions would appear to be fundamentally necessary to effective policy-making. Policy should provide an enabling framework for effective teacher performance in the classroom and the school more generally, as well as providing workplace policy provision for their rights and entitlements. It follows that a policy on HIV for the education sector should provide clarity on issues such as teacher training, professional conduct, development, supervision and support in the school. Attention should be paid to ensuring that the policy framework is adequate to motivate and retain teachers in HIV education and also to attract good quality new staff.

Policy, once approved, needs to be disseminated across the entire sector or it will remain an archived artefact of little relevance to real world educational practices. Implementation may need enabling legislation to be passed. Guidance and resources need to be made available to decentralized levels of the education system and schools for implementation. Teachers need to be informed and aware of policy which is relevant to their work. Resource constraints, both human and financial, constitute a common barrier to implementation and need to be identified and addressed. A strategic approach to policy implementation is required, contained within the ESP, and systems need to be in place to monitor and review periodically its actual and intended outcomes in the sector. Policies need to be living documents, revised in the light of changing realities and better evidence of what is working in the sector.

A national policy on HIV is likely to be constrained in the attention to policy detail that it can provide for the education sector. It can provide general principles for sectors to adopt, and also draw attention to the education sector as a priority sector in the national response. A comprehensive response to HIV seems to require that MOEs develop their own policy framework in line with national education goals, capacity and the national HIV epidemic.

A number of MOEs have developed their own specific HIV policy. The majority of these appear to be in sub-Saharan Africa where the epidemics are most severe. The process of developing a sector specific policy can provide an opportunity to develop consensus on, and partnership and ownership of, the policies with key stakeholders. With regard to teachers, it seems particularly important that professional bodies representing teachers, such as their unions, be strongly involved. The institutions that are responsible for teacher professional training and development, such as teacher training colleges, should also be included in the formulation process.

The evidence base on education policy and HIV

There is very little research that has been published on national education policies in general, and probably even less on HIV policies. The *Global HIV/AIDS Readiness Survey* is the first attempt to quantify the countries which have developed specific education sector policies for HIV (UNAIDS IATT on Education, 2005). Out of a total of the 71 MOEs which submitted responses to the survey, 32 per cent claimed to have a specific policy for education. There was a qualitative investigation. The

low number of countries claiming to have an education policy on HIV was justifiably highlighted by the authors as a concern. Given that HIV has been a policy issue for more than a quarter of a century, this is quite remarkable. Civil society representatives attributed this lack of policy development to two factors:

- HIV is perceived to be the responsibility of the Ministry of Health;
- HIV is not perceived to be a problem in countries in Asia and Latin America.

The authors of the *Global HIV/AIDS Readiness Survey* recommend that every country should have a contextualizing HIV policy, an education sector policy and an education sector HIV policy. This seems to be the best way forward. However, there remains the key issue of content. What should an education sector policy include in terms of specific policies? Currently there is no normative guidance available, except in the important area of workplace policy. There are relatively few opportunities for cross-country exchange on policy development and implementation. Support for policy formulation is seldom a priority for development partners.

Countries appear to be learning from regional experience and putting in place more comprehensive educational policies on HIV. Examples include: Botswana (1998), South Africa (1999), Jamaica (2001), Namibia (2003), Zambia (2004), Kenya (2004), Sierra Leone (2005), Papua New Guinea (2005) and Uganda (2006). It is clear that many countries have yet to put in place comprehensive education policies for HIV and AIDS.

A matrix has been developed to investigate the coverage of issues relating to teachers within those available sector policies. This content mapping makes no attempt to assess the quality of the policy specifications. The results are shown in the table below.

Table 7.1 Policy issue mapping

Policy issue	Country								
	Botswana	Jamaica	Kenya	Namibia	Papua New Guinea	South Africa	Sierra Leone	Uganda	Zambia
Safe schools									
Sexual abuse			+		+	+		+	+
Harassment			+		+			+	+
Stigma and discrimination			+		+	+	+	+	
Violence			+			+		+	
Alcohol and drugs						+			
Responsibilities									
Head teachers			+	+					+
Teachers			+	+		+			+
Guidance and counselling teachers									
TTCs									
Teachers' unions							+		+
HIV prevention									
Peer education			+						+
Pre-service training			+		+			+	+
In-service training		+	+		+		+	+	+
Curriculum		+	+	+	+	+	+	+	+
Co-curriculum			+						+

Policy issue	Country								
	Botswana	Jamaica	Kenya	Namibia	Papua New Guinea	South Africa	Sierra Leone	Uganda	Zambia
Workplace									
Non discrimination	+	+	+	+	+	+	+	+	+
Gender equality									
Healthy work environment		+	+	+	+	+		+	+
Testing and confidentiality		+	+	+	+	+	+	+	+
Workplace HIV prevention programmes		+	+	+	+		+	+	+
Refusal to teach children living with HIV		+	+	+					+
Refusal to work with colleagues living with HIV		+	+						+
Ill health and absenteeism		+	+	+			+	+	+
Recruitment and deployment of staff			+						+
Access to health services			+		+			+	+

It is noticeable that there is considerable variability in content between country education sector policies. This is partly a result of time; some policies were developed earlier than others and have not incorporated issues which have recently become more salient, such as access to ART. This illustrates the need for policy to be a living document and subject to regular review and revision in the light of changed circumstances.

None of the sampled policies is fully comprehensive. Generally, they include issues concerning safety, sexual abuse and stigma and discrimination at school. Workplace issues receive significant attention, with the influence of ILO guidance (ILO, 2001) clearly discernable. Whether these policy measures are effective is another issue beyond the scope of this study.

It is striking that while some policies mention gender or gender responsiveness, there is a flight from the gender equality which is advocated in ILO guidance. This is really striking and hard to explain in an international response that seeks to eliminate gender disparities in education. Anyone looking for evidence of the conservative nature of education systems need look no further.

It is also noticeable that the policies do not provide clear positions on the various responsibilities of head teachers and teachers for the education response to HIV. Both are duty-bearers and there should be clarity in what is expected from them in delivering policy outcomes. There is little mention of teachers' unions, which are critically important partners in policy formulation and implementation.

There is inadequate attention across the country policies to teacher training and pre-service training in particular. All policies express a position on HIV in the curriculum, though very few explicitly consider the co-curriculum.

There is relatively little overt emphasis given to the impact of HIV on the supply of education in these policy documents, and little attention is given to the education system as a whole. There is no policy on assessing the impact of HIV, with the exception of Zambia, which includes interventions aimed at routine monitoring at all levels of the system.

There is no explicit attention given to teacher training colleges, which is a remarkable omission. Zimbabwe is probably unique in having developed a specific policy for teachers' colleges in response to the

impact on teacher supply, which should ensure a focus on providing all trainee teachers with HIV-related knowledge and skills. Some of the issues connected with the impact of HIV on teachers are included within the workplace policies. These should set out clear guidelines as to how HIV will be managed in the work environment, including the specific environment of the school. These include the following key policies:

- non-discrimination on the basis of HIV status;
- confidentiality and right to work of teachers living with HIV;
- prohibition of mandatory HIV testing for employees;
- access to treatment, support and care;
- HIV prevention education (initial and in-service teacher training) and access to services (VCT, condoms, etc.);
- sick leave and incapacity; employee entitlements and benefits;
- healthy work environment.

The ILO, in collaboration with UNESCO, has developed a workplace policy framework for education sector institutions in the Caribbean region (ILO/UNESCO, 2006a) and also in southern Africa (ILO/UNESCO, 2006b). These cover the following key areas of action:

- prevention of HIV infection;
- elimination of stigma and discrimination on the basis of real or perceived HIV status;
- care, treatment and support of staff and students who are infected and/or affected by HIV;
- management and mitigation of the impact of HIV in education institutions (a safe, healthy and non-violent work and study environment).

Policy on impact management and mitigation in the ILO and UNESCO documentation is hard to identify apart from those which are concerned with safeguarding the rights of employees who are infected with or affected by HIV. Policies on non-violence and universal precautions are provided to help develop a safe work and learning environment.

In the light of this discussion, it might be advisable for MOEs in high HIV prevalence settings to consider including a specific section within their policy document focussing on how specifically they will assess and manage the impact of HIV on the supply of education. What is required includes the following, which takes into account the findings

of a review of attempts aimed at mitigating the impact of HIV on service providers (Grant, Kinghorn and Gorgens, 2004):

- attention to attrition, skills loss and training requirements;
- absenteeism, including how to cope with absenteeism and avoid significant declines in access and quality; human resource systems to protect the system from disruption at work due to the illness or deaths of colleagues;
- attention to performance and morale: Attention to teachers' HIV needs and other professional needs including remuneration, conditions of service and professional requirements (e.g. teaching materials);
- cost implications: Adequate budgeting for HIV impacts;
- vulnerable workplaces: This may include remote schools where staff replacement or cover will be difficult, or where management is already weak and morale is low. Disruption may be disproportionately high where staff in key positions are lost.

Towards better policies on HIV for teachers

Where there are examples of good practice, education policy-making on HIV is still largely in its infancy. This is almost certainly in part because of the stigma and discrimination that surround HIV. Governments may feel that there is little political mileage in raising the profile of its HIV response, unless of course the issue already has political traction. In many cases, even in sub-Saharan Africa, this is not the case and HIV is seen as a political issue (De Waal, 2006).

Responsible governance, however, requires that states make every reasonable effort to prevent HIV transmission and to deal with its social consequences. Having a sound policy framework is an important component in the national and the education sector response. A set of questions is offered below (*Box 2*) based on the evidence of issues that beset the response to be used to develop a policy that is more supportive of teachers and aims to assist them in effective teaching and supporting professional conduct in dealing with HIV.

Box 2. Some questions for educational policy-makers and strategic planners

I. HIV curriculum

- At which age should HIV education be introduced in the curriculum and co-curriculum? What are the implications for teacher education?
- How should HIV education be integrated into the curriculum and the co-curriculum?
- What are the main factors of vulnerability and risk to be addressed?
- How will HIV-related stigma and discrimination be addressed?
- How will HIV relate to the school health policy and curriculum?
- Will treatment education be included?
- Which existing co-curricular activities will address HIV? Which new activities will be introduced?
- What should be the content, pedagogy and time allocation? What are the implications for teacher education?
- Will teachers need to be trained in how to work with especially vulnerable children including orphans and other vulnerable children?
- How will teachers and teacher trainers be involved in HIV curriculum development?
- What teaching and learning resources will be required by the teacher and by the learner? Are any different resources required for boys and girls?
- How do specialist teachers need to be prepared and supported to teach effectively about HIV?

II. Teacher education

- How will HIV be mainstreamed in pre-service training? What should be the content, process and duration of training? How will trainers be trained?
- How will teachers be trained to be confident and competent teachers of sexual health/sexuality etc?
- How will teachers be trained to become competent in using participatory techniques?
- How will HIV be mainstreamed in in-service training? What should be the content, process and duration of training?
- What continuous professional development support will be available for teachers on HIV?

III. Orphans and vulnerable children

- What are the issues concerning the education of HIV-positive children? What preparation and support do teachers need and what will be provided?

- What are the issues concerning the education of children whose parents are living with HIV or who have lost a parent/parents? How will teachers support the education of children affected by HIV?
- How will schools provide linkages with social services (for children infected and affected by HIV)? How are these gendered? What role will teachers play?

IV. Teachers living with HIV

- What are the issues concerning teachers continuing to work while living with HIV? How are these gendered?
- What support should be given to teachers living with HIV?
- How will schools provide linkages with health services (for testing and counselling, ART etc.)? How will these be provided for teachers?
- What relevant laws and policies are already in place or exist in draft form?

V. HIV in the workplace

- How will codes of professional ethics or conduct protect staff and students from sexual harassment, abuse and GBV? How will these be implemented? How will teachers be made aware of their responsibilities to uphold codes of conduct or practice?
- How are teachers vulnerable to HIV infection? How will teachers be trained and supported to enable them to remain uninfected by HIV? How is this gendered?
- How will schools ensure that there is no HIV-related discrimination in schools/education?
- What roles will teachers play in preventing HIV-related stigmatization and discrimination?
- What is the ministry's position on HIV testing and confidentiality?
- How will the ministry deal with absences and ill health?
- How will access to health services be achieved?
- How can teachers' unions support teachers with regard to their work and HIV?
- How will schools be made safer places (from abuse, violence, exploitation, HIV transmission through accidents, HIV-related stigma and homophobia etc)? How will teachers ensure that schools are safe places of learning?
- How will schools be made healthier places of learning? What gender-related interventions are needed (such as separate toilets for boys and girls)?

VI. Impact management

- Will HIV and AIDS impact on the teaching stock? Has there been any assessment of the current and future impact?
- How will teacher attrition from all causes be monitored?
- How will teacher losses be addressed at system and school levels?

VII. Management of the HIV response

- Who in the MOE at central and decentralized levels is responsible for implementation of its response to HIV?
- Who is responsible at school level for the HIV response?
- How will the HIV response be co-ordinated at central and decentralized levels?
- What additional managerial capacity needs to be built, or what existing capacity needs to be strengthened, to respond to HIV effectively?
- What institutional capacity is required to mainstream gender and HIV?
- How will the MOE manage the impact of HIV on its workforce, including the teaching stock?
- Has the EMIS been reviewed to include HIV-sensitive indicators?
- How will policy be disseminated?
- How will policy be monitored and reviewed?

The importance of policy dissemination

Policy dissemination is critically important. A study on Kenya's education policy for HIV revealed inadequate attention to dissemination (Ndambuki, McCretton, Rider, Gichuru and Wildish, 2006). The findings indicated that teachers, head teachers and other key stakeholders at the grassroots level:

- were generally not familiar with the policy;
- did not have access to copies of the policy document;
- were not sensitized or trained on the interpretation and implementation of the policy;
- did not know their mandate, duties and responsibilities in the interpretation and implementation of the policy.

It follows that there need to be clear guidelines on the access and utilization of resources for the distribution, dissemination, interpretation and implementation of the HIV education policy. There should be well co-ordinated approaches for the interpretation and implementation of the

policy, and a monitoring and evaluation system for the implementation of the policy.

The importance of having a communication and dissemination strategy for HIV policy is identified as an issue in Zambia requiring high priority in the response of the MOE (Visser-Valfrey, 2008).

There appears to be no evidence base on effective approaches for education policy dissemination in general, or specifically on HIV. An example of a country which has paid attention to policy dissemination is Jamaica, where the Ministry of Education and Youth, with support from the Japan International Cooperation Agency, has established a HIV and AIDS Response Team, which includes among its responsibilities policy dissemination and budgets for workshops at decentralized levels (Visser-Valfrey, 2008; Clarke, 2005).

7.5 Education sector plans

National AIDS plans and education sector plans

It is generally accepted that the education sector response should be a key component of the multi-sectoral national AIDS strategic plan in keeping with the ‘Three Ones’ principle, which prescribes *one* HIV and AIDS action framework (UNAIDS, 2004). There is no similar prescription for HIV policy.

It is abundantly clear that the education sector needs to develop its own specific costed strategic planning to respond to HIV, covering a multi-year period. It would be absurd for the education sector response to HIV to be included in the national AIDS plan, but not in ESPs. A mainstreaming approach would include the HIV plan components within the ESP itself and not maintain it as a discrete document. However, as an interim measure it may be necessary to develop a discrete HIV and AIDS response plan, which can subsequently be integrated with the ESP. The priority components of the education sector response, once defined and costed, then need to be included in the national AIDS plan. A problem with these parallel plan processes is that their time frames may not coincide and the overarching AIDS plan may need to be somewhat elastic to cater for this.

The international AIDS response prioritizes the multi-sectoral national HIV strategic plan, which either explicitly or implicitly is the vehicle for the operationalization of national policy on HIV. It is highly

probable that the Three Ones approach has undermined the multi-sectoral response and the multi-jurisdictional response in federal states. As a result, few governments appear to have invested in education sector strategic planning for HIV. Jamaica, Cambodia, Kenya, Kazakhstan, Mozambique, Senegal, Zambia and Zimbabwe are examples of countries which have developed specific strategies.

UNAIDS (1998) has developed a methodology for developing the national strategic plan on HIV, which can be applied to education sector planning for HIV. It attempts to be situation-specific, problem-solving, priority-setting, and seeks to be informed by learning from experience. This approach can be usefully applied with appropriate modifications to the education sector response to HIV, and possibly even to education sector planning more generally. The process involves the following steps:

- situation analysis;
- response analysis;
- strategic plan formulation;
- resource mobilization.

The situation analysis should attempt to answer three questions (Save the Children, 2000):

1. Who is vulnerable to HIV and why?
2. What are the most serious obstacles to expanding the national response?
3. What are the most promising opportunities to expand the response?

The response analysis concentrates on HIV responses in priority areas, determining the spread of HIV and its impact on the country. It should examine whether a response is appropriate to the situation and identify any gaps in the response and why they exist. It should also identify why some responses are working well and why some are not.

The fundamental questions to be asked are:

- What is working and needs to be continued?
- What is working and can be expanded?
- What is not working and needs a new strategic approach?
- What is not relevant to current needs and should be dropped?
- What has not been addressed at all?

The strategic plan should re-examine national guiding principles, set objectives in priority areas, develop strategies to reach objectives in priority areas, and plan flexible management and funding.

An evidence-based education sector response to HIV therefore needs to be based on data obtained through a comprehensive situation and response analysis with gender mainstreamed throughout. In more severely affected countries, such as in East and southern Africa, the evidence obtained needs to be informed by a gender disaggregated HIV impact assessment, covering both actual impacts and those that can be predicted on the basis of epidemiology. The information obtained through these assessments should provide the baseline data for monitoring the coverage and effectiveness of the education sector response.

The evidence base

There is a very weak evidence base on education sector planning in general. Little research has been done on education sector planning and HIV responses. The strategic plan should be the vehicle by which education policy on HIV is translated into action. In practice there seems to be a disconnection between the two instruments.

Integrating costed HIV activities into the ESP remains one of the greatest challenges. MOEs have generally been slow to develop an evidence-based comprehensive and costed strategy for HIV (Bakilana *et al.*, 2005). A study of the initial 12 EFA FTI-endorsed plans found that they did not adequately address HIV (Clarke and Bundy, 2004). A follow-up review of the next eight plans endorsed by the FTI found that five of these had included an HIV and AIDS response, but only three countries provided details of the costings of their HIV-related activities (Clarke and Bundy, 2008). Among the first 12 EFA FTI-endorsed plans, only Niger and Mozambique mentioned pre- and in-service teacher training on HIV.

Mozambique was the only country to refer to sector policy on HIV. Among the second batch of eight endorsed plans, four had included pre- and in-service teacher education (Ethiopia, Kenya, Lesotho and Madagascar, and the former three also included reference to HIV workplace policies).

A rapid analysis of the education plans for HIV from Cambodia, Jamaica, Kenya, Kazakhstan, Mozambique, Senegal, Zambia and Zimbabwe reveals significant diversity in goal and priority setting

beyond the differences in epidemiology being addressed. Goal setting differs depending on the perspective taken. Some countries focus on response themes such as prevention, impact mitigation and care and support, while others focus on stakeholder groups such as educators, schools and partners. Some include cross-cutting strategy areas. This is suggestive that there is lack of systematic guidance in this field and limited opportunity for countries to share experiences, including the finalized strategic plans. While there is a toolkit for development co-operation agencies to mainstream HIV in the education sector (UNAIDS IATT on Education, 2008), there is no toolkit available for MOEs to mainstream HIV in their sector plans and budgets.

There is surprisingly little mention of teachers in the plans, though they are sometimes referred to as 'educators'. Educator can embrace a range of instructor, including teacher trainer, teacher and peer educator. With the exception of Kazakhstan, the sampled MOEs avoid providing detailed strategies for developing effective teacher education for HIV, which includes both content mastery and pedagogical skills development. It is often not specified precisely how teachers will be equipped to do the job.

While the importance of addressing HIV impact is generally recognized and included in the strategic plans as a priority area for action, there is little specificity on how the impact of HIV on teachers will be addressed, or how teachers will be trained to deal with the consequences of HIV among orphans and vulnerable children. No mention is made of implementing policy, addressing gender inequality or GBV.

Moving towards more teacher-sensitive strategic planning requires greater specificity and costings in the following areas for school-based HIV education (according to HIV epidemic type):

- policy dissemination;
- pre-service training and professional capacity building in teacher training colleges;
- in-service training delivery;
- curriculum development for HIV education;
- co-curricular activities;
- teaching and learning materials for the teacher use in participatory teaching;
- school level professional support;

- school safety and observance of codes of conduct on sexual abuse and harassment;
- gender mainstreaming;
- implementing workplace policies;
- preparing teachers to cope with children living with HIV, orphaned or vulnerable through parental illness (high HIV prevalence);
- support for teachers living with HIV (high HIV prevalence);
- research on teachers and HIV.

7.6 Institutional capacity and management systems

The evidence base

Research has shown that the organizational response is a key link between the development of HIV policies and the implementation of HIV strategies and programmes (Grant *et al.*, 2004). The following key aspects have been identified for strengthening:

- effective, well-informed planning processes;
- mobilization of leadership commitment at all levels, including other sectors and organizations such as the health sector, national AIDS commissions, etc.;
- clear and appropriate roles, responsibilities and structures, including designated staff and institutional structures for HIV;
- capacity building to support the development, implementation, and monitoring and evaluation of interventions;
- budgets for HIV.

The evidence base on effective institutional development for the education sector response to HIV is weak and fragmented. There is no evidence-based guidance available to MOEs to assist them in using scarce human and financial resources to the best effect.

Capacity needs to be built to institutionalize the education sector response to HIV (Carr-Hill *et al.*, 2002). This comprises both technical and managerial capacity building in the key sectoral institutions at all levels of the system down to the school. This should be based on a functional analysis of tasks, as well as an investigation of capacity building needs.

A mainstreaming approach to HIV capacity building will seek to build on existing institutional strengths and capacities, rather than creating additional bureaucracy and increasing the costs of sustaining

such an intervention. It will select those departments and mechanisms which are likely to produce the greatest impact on the sector. Linkages with mechanisms for the mainstreaming of gender in the education sector are likely to be important for developing synergies between gender and HIV at all levels.

Capacity building to institutionalize the HIV response involves the following levels of action:

Central MOE HIV capacity

The MOE needs to manage the following functions in the education sector response to HIV:

- policy formulation;
- policy dissemination;
- education sector planning;
- monitoring and evaluating implementation of policy and plan;
- internal co-ordination (inter-departmental);
- external co-ordination (development partners, national AIDS authority etc.).

The institutional arrangements required will depend, to a large extent, on the severity of the national epidemic and the intensity of the education sector response. In all cases, however, it is clear that the range of tasks listed above is beyond the capacity of any single person, no matter how talented or committed. A team approach is clearly warranted.

The UNAIDS IATT on Education (2008) implicitly recommends the following:

- a senior strategic HIV and AIDS Team;
- an operational unit for HIV and AIDS management;
- focal people in key MOE departments.

A mainstreaming approach would strengthen existing capacity for the HIV response. It would engage those departments responsible for key functions such as primary and secondary education, strategic planning and finance, teacher education and curriculum development in policy formulation, and strategic plan development.

There is very little documented information on the capacity building strategies that are being adopted by MOEs to respond to HIV and the effectiveness of these in meeting the requirements of the system. It is

therefore unclear how these structures and interventions are responding to the professional needs of teachers.

Twenty-six MOEs were surveyed in sub-Saharan Africa, and 25 had HIV focal points (UNAIDS IATT on Education, 2004). While a focal point is likely to be essential for co-ordinating efforts, a single person, no matter how senior, skilled or motivated, is not likely to be sufficient to ensure that the range of issues that HIV brings to bear on an MOE is adequately addressed. Other structures are required.

The *Global HIV/AIDS Readiness Survey* (UNAIDS IATT on Education, 2005) found that 90 per cent of reporting MOEs claimed to have working groups or committees that address internal and external HIV issues. Further research is required to ascertain how these committees add value to the education response to HIV and how they specifically address the impact on the supply of, the demand for, and the quality of education.

The establishment of an HIV unit within the MOE is likely to be required in countries where there is a generalized HIV epidemic to deal with. A number of countries in sub-Saharan Africa such as Rwanda have set up such units. The HIV and AIDS unit in the Ministry of Education (MINEDUC) in Rwanda was set up in 2000 and is responsible for policy formulation and its implementation in the sector. However, the unit suffered from a lack of adequate resources. It lacked skilled personnel and effective support from the leadership in the ministry. The unit identified a number of factors that affected managerial capacity in the sector. There was an extreme shortage of experienced and qualified professionals. Decision-making and funding procedures had not been fully operationalized (Kabanyana-Zigara, Rutayisire, Muvunyi and Sebaruma, 2005).

Uganda has established a unit for HIV within the MOE with assistance from the Government of Ireland. It had three full-time staff, including a technical adviser who provides support for policy, strategic planning, resource mobilization and designing effective interventions for the education sector. Focal point officers have been appointed to the eight departments in the ministry to assist the HIV/AIDS Sector Co-ordinator, who co-ordinates sectoral initiatives and mobilizes the ministry.

In Tanzania, the Ministry of Education and Culture established the AIDS Management Committee. It was composed of the heads of

departments and institutions, and the chairperson was the Permanent Secretary. The Technical AIDS Committee was composed of HIV focal points nominated by heads of departments and institutions. The AIDS Management Committee and Technical AIDS Committee are served by a single secretariat, the AIDS Co-ordinating Unit. In addition to its secretariat role, the AIDS Co-ordinating Unit has the following functions:

- initiating and co-ordinating planning for HIV activities;
- co-ordinating implementation activities;
- conducting regular supervision and follow-up of HIV education;
- preparing quarterly, mid-year and annual progress reports;
- mobilizing resources.

In Zambia, the HIV/AIDS Management Unit within the Human Resources Directorate has been established and will be sustained to lead the MOE response. Dedicated management structures will be put in place at the national, provincial, district and institutional levels of the education system, which will be responsible for HIV policy implementation, direction, monitoring, evaluation and reporting. Accountable focal point persons will be appointed at every level and institution to report monthly, quarterly and annually to their supervisors. Further research is required on how these HIV units operate effectively and what lessons can be learned from their operations, so as to enable countries to build better institutional capacity to address HIV.

Focal points for HIV have been established in MOEs throughout countries of the Economic Community of West African States and in all CARICOM countries (the Caribbean Community) and networks established to support the sharing of experience.

In Cambodia, the Ministry of Education, Youth and Sport (MOEYS) has set up the Interdepartmental Committee for HIV and AIDS (ICHA). It is chaired by the MOEYS Secretary of State and comprises 15 departments and institutes (MOEYS, 2006a). This appears to have been an effective mechanism for the mainstreaming of HIV. It involves key departments in HIV activities including the teacher training department. Its Achilles' Heel is that its operational budget is largely funded by international donors which, until funding arrives through the education sector budget, is likely to be unsustainable.

The South African Department of Education has prepared guidelines for educators (Department of Education, 2000). It is, however, not clear what specific use has been made of these, or what impact they may have had on teachers in schools. The guidelines include:

- questions educators ask about sexuality education;
- preventing disease transmission in schools;
- building an enabling environment and a culture of non-discrimination.

Case study: Cambodia and ICHA

ICHA was established in 1999 to strengthen the education sector response to HIV within the national programme. It has become responsible for:

- developing the MOEYS response within the national HIV strategic plan;
- educating in-school and out-of-school children and youth on HIV risk and how to protect themselves;
- mainstreaming HIV within the ministry.

ICHA's priority objectives are to:

- develop policies and systems to increase the ministry's capacity to respond to HIV and reduce its impact on the education system;
- provide nation-wide preventive education programme for students and out of school youth;
- train and raise awareness of MOEYS employees on prevention;
- reduce stigma and discrimination and include support to vulnerable children;
- progressively address sensitive issues (reproductive health, drugs and street children);
- develop curriculum and train teachers on how to teach HIV prevention and related topics in public schools and non-formal education settings (MOEYS, 2006a).

ICHA was reorganized in 2005 on the basis of a functional analysis to strengthen institutional arrangements to implement HIV programming in MOEYS. The new arrangements were put forward in *Proposals for strengthening the ICHA and proposal to introduce an output-based incentive scheme* (MOEYS, 2007). The resulting composition of ICHA is given below:

The *ICHA Policy Board* (IPB) is chaired by the Secretary of State for Education, Youth and Sports. Membership of the board includes two Directors of Directorates, the Director of the ICHA Secretariat, and Directors of 15 departments and institutes. Terms of reference for the Policy Board have been developed. Its function is to enable an integrated approach to policy and strategy development and programme management.

The *ICHA Technical Working Group* (TWG) is chaired by the Deputy Director General, the General Directorate of General Education, with the Director of the School Health Department (SHD) as Vice-Chair. It is the locus of technical and professional advice on HIV and leads the implementation of annual and quarterly action plans. The same 15 Departments of MOEYS are represented on the TWG (see *Table 7.2*). Terms of reference have been developed for the TWG.

Table 7.2 ICHA departments

Department	Specific HIV responsibility
ASEAN affairs and information	Media interventions
Audit	Financial management
Finance	Financial management
Higher education	HIV prevention
National Institute of Education	Teacher education at secondary level
Non-formal education	Out of school/adult HIV prevention
Pedagogical research	Curriculum development, monitoring and evaluation, research
Personnel	Workplace policy
Planning	Strategic planning
Primary education	HIV prevention
School health	HIV prevention and impact mitigation
Secondary education	HIV prevention
Student physical education	HIV prevention
Teacher training	Teacher education on HIV
Youth	HIV prevention

HIV focal points within technical departments. The members of the TWG are also designated as HIV focal point leaders within their departments. Focal points are responsible for preparing departmental action plans for approval and overseeing their implementation. Terms of reference have been developed for directors and ICHA focal points within technical departments.

The *ICHA Administrative Secretariat* has five full-time staff. It is located within the School Health Department, which has been allocated the responsibility of supporting ICHA. Terms of reference and job descriptions have been developed for the Secretariat. A key function is monitoring against the timetable for deliverables and to draw attention to action that needs to take place.

The *Department of Finance Programme Task Team*. Its responsibility is to undertake efficient and effective control of disbursement of programme funds. A *Financial Procedure Manual* has been prepared to ensure that activities are implemented efficiently and that disbursements keep up with the programme plans. It provides a clear standardized system for decision-making and approval for programme implementation. Guidelines have also been prepared for NGO bidding and contracting procedures.

In conclusion, Cambodia has developed an elaborate system for mainstreaming HIV in the education sector. It includes representation of the teacher-training department in policy-making and strategic planning. This approach has been judged to be effective in achieving its annual work plan objectives (MOEYS, 2006*b* and 2006*c*), but more multi-country research is needed in this area.

Decentralized MOE capacity

In education districts there needs to be similar capacity developed with emphasis on implementation, including monitoring and evaluation and co-ordination. The UNAIDS IATT on Education (2008) implicitly recommends that HIV sub-committees should be in place at provincial/district level, chaired by a senior education person. Currently, there appears to be no evidence available of the effectiveness of functioning entities for HIV management at decentralized levels of education systems. This is a large missing piece in the jigsaw.

There is limited evidence of sub-national structures according to the *Global HIV/AIDS Readiness Survey* (UNAIDS IATT on Education, 2005). Seventy-six per cent of responding MOEs reported that they had set up sub-national implementing structures at provincial, regional, district and school levels. These appear to have more junior staff appointed to them. The absence of decentralized budgets may severely undermine the effectiveness of these structures. The *Global HIV/AIDS Readiness*

Survey reported that these budgets were lacking in 63 per cent of high prevalence countries with sub-national structures

It is instructive to note that MOEYS in Cambodia had not developed a decentralized management system to support ICHA activities at district level.

***Capacity in curriculum development centres/departments
(school health/life skills/HIV education)***

It is clearly important for MOEs to strengthen the technical capacity of personnel working in curriculum development in HIV and related areas. This may involve the further training of existing staff or the recruitment of new staff already experienced and qualified in HIV education curriculum development. There is considerable scope for regional sharing of experience and networking in this area.

The evidence gleaned from effective HIV education programmes (Kirby *et al.*, 2005 and 2006; Senderowitz and Kirby, 2006) suggests the following areas for capacity strengthening in curriculum development:

- research skills (e.g. needs assessment);
- management of multi-disciplinary curriculum development teams;
- syllabus development for HIV prevention and sexual health;
- teacher training skills (e.g. LSE);
- piloting skills;
- monitoring and evaluation;
- assessment of learning outcomes;
- resource centres on HIV-related curricula and associated references (including access to ICT).

***Capacity in teacher training institutions
(pre and in-service trainer training, research skills)***

TTCs are key to the future development of the teaching profession in general, and specifically on HIV education. TTCs need to respond to HIV in the following ways:

- develop and implement an HIV workplace policy (especially in generalized HIV epidemics);
- include costed HIV activities within the TTC strategic plan;
- establish an interdepartmental committee on HIV and AIDS (in generalized epidemics);

- train existing trainers or recruit new staff if necessary in content and pedagogical skills to become HIV education trainers for those teachers who will deliver the HIV curriculum in schools;
- mainstream HIV education in the training curriculum;
- strengthen human rights education;
- provide all teacher trainees with a life skills-based education programme for HIV prevention (in generalized HIV epidemics), otherwise integrate HIV in health education programmes;
- develop links with schools in HIV impacted areas (in generalized HIV epidemics);
- develop links with NGOs working at community level on HIV and networks of people living with HIV;
- develop capacity to address gender issues in education, especially those related to GBV, sexual harassment and abuse in schools;
- address all prevalent forms of stigma and discrimination in the training of all trainees;
- develop training capacity in counselling and support skills (in generalized HIV epidemics);
- establish resource centres on HIV and education (in generalized HIV epidemics);
- develop opportunities for continuous professional development, e.g. at Masters/MEd level for teachers involved in and committed to HIV education;
- strengthen monitoring and evaluation on training and teacher effectiveness.

Capacity in schools (school management boards, PTAs, school principals, nodal or focal teachers and peer educators)

The most important locus of capacity is arguably the school, as it is here that HIV education programmes are delivered. However, the education sector response to HIV requires investment in a multi-faceted set of areas for capacity building. It is important that the interests of the teaching profession be actively represented at all levels of the education system, from the centre down through the decentralized offices to the school itself.

The evidence base for effective approaches to capacity building for the HIV response in the education sector is weak and represents an agenda item for international research in this field.

There is little published research on how schools are building capacity to respond to HIV. This includes strategies to support teachers in HIV education, whole school activities, school policies on HIV, headmaster training, providing schools with better access to health facilities, and the implementation of workplace policies. More research is needed in this area.

An investigation into school leadership on HIV in Botswana (Ministry of Education, 2007) found through a baseline survey that:

- School heads and deputy heads in general are unaware and complacent in relation to HIV initiatives.
- There is a lack of performance indicators and ability to monitor the impact of initiatives and programmes, as well as the overall objective of reducing HIV infection rates.
- Eighty per cent of respondents are of the opinion that the support and guidance from the central government is inadequate, in terms of both financial and technical contribution. A needs and feasibility study was recommended to assist with defining roles and requirements.
- There is little or no knowledge among the schools about how to seek funding or assistance in a wider perspective such as church organizations, NGOs or regular donor organizations.

Clearly, much is to be done in Botswana, and presumably elsewhere in sub-Saharan Africa, in providing leadership on and managing HIV at school level.

The following capacity strengthening measures should be considered at school level:

- school leadership training on HIV for head teachers and senior staff;
- provision of guidelines and handbooks for schools on HIV policy implementation (and school health), including performance indicators for schools;
- establishment of school health committees (e.g. as in Jamaica and Namibia);
- strengthening school health education and access to health services;
- establishment of partnerships with PTAs and school committees on HIV policy and activities at school;

- orientation sessions for parents and guardians;
- a whole-school approach to HIV prevention and impact mitigation that pervades the school climate;
- a zero tolerance of GBV, sexual abuse and alcohol/substance abuse in the school, environment;
- linkages with NGOs, faith-based organizations working in the community on HIV and local networks of people living with HIV;
- strengthening of counselling and support staff (in generalized HIV epidemics);
- mainstreaming HIV prevention in co-curricular activities, including peer education activities (in generalized epidemics);
- encouraging teachers to break the silence on HIV (in generalized epidemics);
- monitoring the impact of HIV and AIDS on teaching and learning (in high prevalence epidemics), and addressing absenteeism and erratic teaching.

Capacity in teachers' unions

Dialogue with the representative of teachers is an important facet of education reform. If teachers do not back proposed educational change it is unlikely to take root and be sustained (Vaillant, 2005). In the case of the education response to HIV, teachers' unions appear to be an obvious and essential partner for MOEs in policy formulation and implementation. Teachers' unions need to assume responsibility for their share of the social issues concerning education.

Teachers' unions need to build technical capacity to respond to HIV and to ensure that their members' various needs in this regard are addressed. Some teachers' unions have appointed national HIV co-ordinators (for example the South African Democratic Teachers' Union) and are in the process of building institutional capacity. Support for this has been provided to teachers' unions by a partnership comprising Education International, WHO and EDC in countries in the Caribbean region, and also in 15 countries in sub-Saharan Africa. A strong focus of this programme has been to assist unions in providing training to prevent HIV infection and related discrimination through schools. This includes teachers being supported to examine their own vulnerability to infection, their own knowledge about HIV and how it is spread, and their attitudes towards helping others avoid infection. Resources have been

developed to support the implementation of the programme, including the following:

South Africa: SADTU has developed its own trainer training manual for HIV (SADTU, 2004) to equip its union leaders, staff and members to be able to work in an integrated team to provide training to fellow educators, learners and community members. It addresses HIV as a workplace issue, but goes beyond this in its scope.

Kenya: The Kenya National Union of Teachers (KNUT) had developed its own workplace policy for teachers (KNUT, undated). There is a risk that this may cause problems in implementation as the MOE also has a workplace policy. An abundance of policies has the capacity to sow confusion. The Zambia National Union of Teachers (ZNUT) also has a draft HIV policy which covers workplace issues.

KNUT and the American Federation of Teachers Educational Foundation (AFT-EF) formed a partnership in the Prevention and Treatment Access Programme to strengthen the capacity of the 230,000-member KNUT to implement effective HIV interventions for Kenyan teachers and other stakeholders in the education sector. The evaluation team noted that assessing the contribution of the project towards reducing teacher vulnerability to HIV was problematic and constituted a big challenge to the programme managers and implementers (Abagi and Kirby, 2007). The following factors were adduced:

- There was no baseline prepared before project interventions, thus there were no data which could be used for assessment.
- Specific indicators for measuring teachers' vulnerability to HIV infection were not defined and made available to the districts and schools.
- Although teachers' awareness and knowledge about HIV have been enhanced, voluntary testing by teachers is still very low.
- There is no data either at school or district level on who has been tested. The majority of teachers do not know their HIV status.
- Stigma and lack of confidentiality associated with HIV are still widespread. Thus, many teachers have not come out into the open to declare their status.
- To reduce teacher vulnerability to HIV through school-based interventions is a long-term objective and problematic to assess after only 12 months or less. This objective seemed to have been too ambitious.

Guyana: Since the EFAIDS-supported HIV Prevention Programme was begun in 2004 by the Guyana Teachers' Union (GTU), 985 teachers have been trained in 300 different schools (Van der Pijl, 2007). For each semester, the GTU National HIV/AIDS Committee prepares a schedule for training workshops in the different regions. Before the workshops take place, the Regional Education Offices are informed that a workshop will take place in their region, and letters are sent to schools to invite head teachers to send a delegate. The GTU aims at organizing the workshops in as many different regions as possible so that many different schools are reached. The programme is based on skills-based health or life skills education.

The workshops provide clear information on HIV prevention and EFA goals, and train the teachers to use participatory teaching methods. Teachers are encouraged to join the union. The teachers were reportedly very enthusiastic about the workshops and request to participate more often in them. They see the workshops as being very informative and show great motivation to disseminate the information they have received to others.

However, to strengthen the programme in the long-term, a more structural approach by the GTU was considered necessary. There was a lack of a standard selection procedure for teachers to participate in the workshops. Their head teacher either chose them or they had volunteered. It was concluded that if the head teacher does not support the implementation of the programme or the teacher does not have the authority or the ability to be the school focal point and coach the other teachers to implement health education in the programme, than training this particular teacher repeatedly does not seem to be very effective. It was found that although teachers were trained in a qualitative three-day workshop, the majority of them did not organize structured events in their schools. This would appear to be a disappointing outcome.

Teachers' unions should be encouraged to develop codes of practice with respect to HIV and AIDS which include tackling the issue of stigma and discrimination among their members. An action plan to tackle stigma and discrimination within or by the union could be developed. The Teachers' Union of Malawi has developed a Statement of Professional Ethics and Code of Conduct for Teachers. The acid test will be implementation in a context where the union is challenged by limited human and financial resources (OSISA and ActionAid International, 2006).

7.7 Curriculum content and process

The curriculum for HIV is a policy issue and one for strategic developmental action. It needs to address both the vulnerability and risks of the learner (UNAIDS IATT on Education, 2003). To develop a relevant and appropriate curriculum, there needs to be a comprehensive knowledge base on HIV-related vulnerability and risk behaviours of children and young people within the education system. It also needs to include an assessment of the motivation, knowledge, attitudes and skills of the teachers who would deliver the HIV-related curriculum.

Capacity needs to be built to develop an appropriate skills-based curriculum on HIV at primary, secondary and tertiary levels of the system, as required by the education sector response. It is recommended that HIV education should be integrated into a wider skills-based health programme including nutrition and hygiene issues as envisaged in the FRESH framework (Focusing Resources on Effective School Health) which was developed jointly by UNESCO, WHO, UNICEF, Education International and the World Bank in 2000. Stand-alone HIV education programmes tend to be stigmatized and unpopular. If there is a lack of such a school health programme, the development of any HIV curriculum may be more problematic.

The HIV curriculum content should address age, gender and culturally appropriate HIV prevention methods, and promote non-discriminatory behaviours and attitudes towards people living with HIV. It should address gender inequality and power issues including violence and non-consensual sex, and stigma and discrimination. The curriculum should also address access to health services and treatment-related issues which fall under treatment education. Good quality teaching and learning materials need to be developed and used at all levels in the education system. The provision of good quality teacher training to implement the curriculum as designed is an essential component of the response.

A key issue is the place of HIV education in the national curriculum. This is generally a difficult undertaking given the prevalence of overcrowded curricula across the world, and there is often little, if any, space for additional content. The preferred approach is to mainstream HIV into existing curricula. There appear to be advantages to integrating HIV into examinable subjects, as this seems to ensure that it will be taught. HIV curriculum mainstreaming, however, has several interpretations ranging from integration of HIV into a single carrier subject to diffusion across a

wide range of subjects. The choice of mainstreaming strategy will have implications for teacher preparation and support. Another key issue is how to ensure appropriate and relevant content for HIV prevention, which may potentially include the risks of multiple concurrent sexual partners, men who have sex with men, injecting drug use and sex work (including clients), issues that are difficult for education systems to address.

The HIV curriculum needs to be planned and developed in accordance with the approach that is taken with the national curriculum framework. Objectives, learning outcomes and standards need to be set for HIV education. It is recognized that objectives assist the planning process for teachers and they can provide the foundation for effective structured teaching (Marsh, 2004). Objectives can also assist the teacher and the students in focussing on what will be assessed. Teachers and their unions should be involved in the design of curricula, teaching and learning materials (UNESCO, 2006e).

Introducing such a new HIV curriculum requires a strategic and managed approach to implementation. School principals have a key role to play in providing leadership for educational change. Attention needs to be focused on the quality of teachers and how they perform. Teacher preparation for implementing any new HIV curriculum is clearly likely to be of critical importance and needs to be planned strategically. How teacher effectiveness can be promoted is clearly critical to the success of the new curriculum. Any proposed intervention that is beyond the technical capacity or vested interests of the teaching force is probably doomed to failure.

In summary, the key issues in developing and implementing the HIV curriculum include consideration of:

- mainstreaming of HIV in the core curriculum;
- the characteristics of effective HIV education programmes;
- the characteristics of effective teachers and schools more generally;
- the current constraints on educational participation and quality;
- gender issues including gender-based violence;
- current and predicted impacts of HIV on children their families and communities;
- the local manifestations of stigma and discrimination.

7.8 Complementary approaches to HIV prevention

It is reasonable to propose that a curriculum-based approach to HIV needs to be complemented by co-curricular actions, though this is under-researched and not evidence-based. The picture is confused by research and publications that conflate curricular and co-curricular interventions within the school-based education response to HIV.

Complementary approaches to curriculum-based HIV prevention programmes typically involve the co-curriculum. These include peer education programmes, school anti-AIDS clubs, MOE IEC strategies and the promotion of youth friendly health services for STI treatment, VCT and condom distribution. They can include structured syllabus-based programmes such as the Adolescence Education Programme (AEP) in India, LSHE in Cambodia and *My Future is My Choice* in Namibia.

Curriculum-based interventions may be more intensive and more structured than non curriculum-based interventions (Kirby *et al.*, 2006). However, in some cases the reverse may be the case, especially where HIV is weakly diffused across the curriculum and there is a syllabus-based co-curricular programme being implemented. Co-curricular based interventions may include a wide variety of activities including school health fairs, debates, dramas during school assemblies, use of posters or leaflets and rallies for World AIDS Day. Some of these activities are easier to implement, as they require less investment in teacher training, although their impact is unproven.

The evidence base for the effectiveness of co-curricular-based programmes included in peer-led approaches is considerably weaker than for adult-led curriculum-based interventions. The co-curriculum is under-researched, neglected and often misunderstood. Co-curricular interventions can be a vehicle for introducing innovative approaches to education into the system and should be considered more an essential component of the education mainstream. They may also provide greater flexibility and enable the inclusion of more local content. It is likely that many of the characteristics of effective curriculum programmes will be broadly applicable to co-curricular programmes, but this needs to be tested.

Peer education has been advocated as an alternative or an adjunct to teacher-led education activities (UNAIDS, 1999). Peer education acknowledges that behaviour is shaped and constrained by

collectively negotiated peer identities rather than by individual choice (Campbell, 2003). It is therefore potentially a valuable complement to individual-focused and typically information-based education. Not all programmes are successful and more research is needed to establish the characteristics of effective peer education interventions in education settings and the communities they serve.

It is widely asserted that adolescent peer educators will be able to relate more closely than teachers or other adults to their peers. They are, however, less likely than adults to be more knowledgeable on HIV or related issues and less likely to have the skills needed to teach curricular activities (Irvin, 2000). Regular annual student turnover has raised doubts about the sustainability and cost-effectiveness of using peer educators (James-Traore *et al.*, 2002). Peer education is rarely used alone in HIV-prevention efforts, but is one strategy in a school-wide or community-wide effort. For example, it often complements skills-based health education led by teachers, condom promotion, youth-friendly health services and local media campaigns. Experience shows that the presence of a teacher or adult co-ordinator improves the quality and general flow of programmes. Where peer education is being implemented in schools, it is important for teachers to be trained in how to work effectively with peer educators to enable them to accomplish their objectives. This represents an additional component for teacher training programmes.

There is limited evidence of the effectiveness of peer education programmes. A recent review of the research on youth peer education programmes identifies the following challenges (Adamchak, 2006):

- Motivation and individual capacity cannot be assumed.
- Youth require more training and supervision than adults.
- Youth may not be able to challenge peers to develop critical thinking or to change social or cultural norms.
- Youth may not have skills to avert stigma associated with speaking out on sensitive topics.
- Youth may lack the maturity, skills and knowledge to respond to challenges from their peers or the community.
- The role of peer leader may create social distance, be perceived as being favoured by teachers or programme staff, or alter peer relationships.
- Retention is limited, and turnover occurs as youth age.
- Sustainability may be challenged by reliance on volunteer labour.

In-school peer educators are being used in some programmes as outreach workers to educate out-of-school youth on HIV and related issues. This is a relatively un-researched and therefore unproven approach. It is not yet sufficiently clear that what additionality will be provided by peer education and that the benefits obtained will be cost effective. The costs can be substantial if they include training for teachers on how to support peer education and for the peer educators themselves, together with the teaching and learning resources they require. More research on coverage and effectiveness is therefore required in a range of contexts and peer education programmes.

The justification for including a peer education approach will be strongest in high HIV prevalence settings, where a significant number of young people are likely to be vulnerable to HIV infection and the risks are clear. It is less evident that peer education will be cost-effective in low HIV prevalence settings.

7.9 Teacher training and support

Competent and skilled HIV educators need to be developed through pre-service and in-service training to teach a skills-based approach to HIV prevention. This requires the adoption of participatory teaching methods and classroom management skills, a major challenge in education systems that retain didactic teacher-centred pedagogy and where class sizes are large. Enhancing teachers' content knowledge of HIV is an important facet of teacher training, as is developing confidence to handle sensitive and taboo topics with comfort in the classroom. Teacher motivation and commitment to the programme are critically important factors in programme success.

In-service training tends to be the vehicle for introducing knowledge and skills to serving teachers for HIV education. HIV education, relevant to the national epidemic, needs to be given appropriately high priority in initial teacher education as an integral component in the curriculum for the professional preparation of all new teachers. Specific training in participatory pedagogy will need to be given to those that will become classroom teachers of HIV education. Pre-service training will allow the young teacher to take on new skills and knowledge for HIV education before exposure to the conservative teaching system. Materials for HIV teacher education will need to be developed. Resource centres for HIV education can usefully be set up in teacher training colleges. Teacher

trainers typically also require professional training in HIV education. They require opportunities to obtain relevant qualifications to professionalize the field.

Clear policies are needed to support teachers in effectively addressing HIV at school (UNESCO, 2006e). Guidelines for teachers on HIV in schools and all education institutions need to be prepared and disseminated, and also to be used. Suitable teaching and learning materials need to be provided in adequate numbers to schools so that participatory teaching activities can be undertaken. Without these, the only resource at the teacher's disposal in resource-poor settings is the blackboard and the likely recourse to 'chalk and talk'. User-friendly teacher guides should be available to support the implementation of the curriculum.

Teachers' unions should be involved in supporting HIV education efforts where this is appropriate. It would appear to be particularly important for all teachers to receive comprehensive HIV education as apart of their initial training in high prevalence settings. An evidence base needs to be developed to demonstrate how unions can be effective in this field.

Teachers need to be provided with professional support for HIV prevention education. Teacher performance in implementation should be supported within the school and by the inspectorate, head teachers and colleagues. A whole school approach is the most effective (UNESCO, 2006e). Support also needs to be provided by the PTA or the school committee. Performance should be monitored and quality assured.

Box 3 presents a framework for investigating pre-service teacher training and HIV education, developed by Ramos (2007).

Box 3. Framework for investigating pre-service teacher training and HIV education

Teacher training college environment

- Is the teacher training college being responsive to the professional needs of future teachers?
- Does the college have adequate support from the MOE and district level decision-makers?
- Is there a budget for HIV-related capacity building and regular activities?

- Does the college have an HIV workplace policy to ensure the rights and safety of staff?
- Does the college leadership talk openly about HIV in public fora?

HIV programme conceptualization

- Has the college dedicated teacher educators (lecturers) to take ownership for the programme, and is it conceived as a subject area in its own right?
- Has the programme been conceptualized under a wider strategic framework?

Curriculum integration and curriculum content

- How has HIV been integrated into the curriculum?
- Is it examinable?
- Did stakeholders participate in the development of the curricula (people living with HIV) etc?
- Are learning materials widely available and do they contain local knowledge, facts and experiences?

Teaching methodology

- Are student teachers being taught participatory and new teaching methods, and are teacher educators competent in new teaching methods?

Linkages

- Are the college HIV programmes (teachings and other activities) linked to community health services?

College strategic planning

- Does the college include HIV interventions in its institutional planning?

Staffing

- Does the college have appropriate staff (experienced, qualified and committed) to manage HIV-related teacher training and activities?

Source: Adapted from Ramos (2007).

Some conclusions on improving teacher effectiveness on HIV

- The wider crisis in teacher education and classroom practice needs to be addressed with HIV mainstreaming.
- Improving the effectiveness of teachers in HIV education needs to draw upon the wider sectoral experience of improving teacher and school effectiveness.
- Attention needs to be given to developing sustainable interventions to strengthen teaching skills, professional characteristics and the classroom climate.
- School leadership on HIV is of critical importance.
- The characteristics of effective sex and HIV education programmes should inform programme development.
- A balanced approach for HIV education involving appropriate integration into the curriculum and co-curriculum appears to be the most promising.
- Mainstreaming HIV education in initial and in-service teacher education is essential.
- More research is required on HIV education and LSE.

7.10 Impact prevention and mitigation

At the same time as education was identified as an important means of HIV prevention, the impacts, both short and long term, of HIV on education systems were also identified through the sickness and deaths of those infected. In terms of demand, supply and process, the impacts were recognized as presenting particular problems for the planning, financing and management of education and for the achievement of the primary task of teaching basic knowledge and skills (Shaeffer, 1994). HIV leads to impacts on the demand for education through its effects on children, the supply of education through its effects on education personnel and the quality of education on offer as a result of the interaction of impact on both demand and supply.

As in the case of HIV prevention education, coherent MOE responses to the growing impact on the education sector have been slow in coming. Governments have been slow to grasp the scale of the impact of HIV on development. Predictably, the most severe impacts have been experienced in those countries where the highest rates of HIV infection have been found. In general the impacts have been most serious in sub-Saharan Africa and in eastern and southern Africa in particular. One

of the most significant features of the human impact of HIV in Africa is that it is concentrated in the working age population.

Patterns of employment, in particular the migration and mobility of workers, play an important role in facilitating the transmission of HIV (Cohen, 2002). The deployment of teachers to remote areas may increase their vulnerability to HIV infection. Research is required to develop a better understanding of such vulnerability factors and how they affect teachers. Education ministries may therefore need to assess their deployment policies in the context of national HIV epidemics.

(a) The impact of HIV on teachers

The impact of HIV on human capital, affecting the coverage and quality of service delivery, means that governments in countries with a generalized HIV epidemic will need to pay attention to the supply of education and to measuring human resource attrition. The identified impacts on service delivery, especially teachers, arising from HIV in such contexts include the following (Kelly, 2000, Badcock Walters, 2002):

- *Absenteeism from a range of causes:* This may include sickness, resulting in reduced productivity, reduced contact time and quality of teaching; funeral attendance and associated family trauma; and caring for sick relatives.
- *Vacancies:* These arise from the loss of trained teachers through mortality. Posts may become vacant for long periods.
- *Costs:* Costs to the MOE may include sickness benefits, funeral costs, recruitment costs, and teacher training costs as well as additional management costs for HIV workplace policy implementation (Kelly, 2006).

In severe generalized HIV epidemics, MOEs need to respond to the losses of human capital by taking measures to manage the impact of HIV and mobilize its partners such as teachers' organizations in this endeavour. In the case of education systems, teachers' unions are key organizations that can be mobilized in partnership to help address both the impact of HIV and also HIV prevention.

The most noticeable impact on the system in high impact contexts is the permanent loss of teachers through death, employment change, retirement or chronic illness. HIV tends to exacerbate existing attrition rates. A less direct form of impact is temporary teacher loss through illness or occasional and compassionate leave to attend funerals of

colleagues or family members. Temporary absences will be harder to measure than permanent loss and since teacher attendance records are often neglected, this form of impact may be underestimated (Badcock Walters *et al.*, 2002). These constitute dimensions of the impact of HIV on the supply of education which also includes the losses of education managers, teacher educators and other key staff.

The impacts identified above may be comprehensively mitigated by governments ensuring access to ART for all teachers who need it as part of a general approach to providing universal access. The recent expansion of access to ART, through initiatives such as the WHO Three by Five initiative and the US Presidents Emergency Fund for AIDS Relief (PEPFAR), has important implications for the supply of teachers. Ensuring that teachers have access to treatment is an important area for policy development and capacity building. ART can prolong life and productive service in the classroom. It will be a cost-effective solution to teacher absenteeism through HIV-related illness and loss through early mortality.

Key interventions:

- education policy (workplace issues) formulated, disseminated and implemented;
- assessing current and future impacts of HIV on the education sector;
- developing costed strategies in the ESP to prevent or mitigate predicted impacts on the teaching stock;
- HIV mainstreamed in human resource management functions (generalized epidemic);
- monitoring and addressing teacher attrition and absenteeism from all causes;
- establishing information systems at decentralized levels to monitor absenteeism, attrition and death;
- assess the feasibility of establishing a system to provide relief teachers (high prevalence epidemics);
- pre- and in-service training on HIV impact on education (generalized epidemics);
- school leadership training on HIV impact at school (generalized epidemics);
- support for infected and affected staff;

- engaging with teachers' unions to help protect teachers from HIV impacts;
- access to treatment (high prevalence epidemics).

(b) The impact of HIV on children

The impact of HIV on children has been comprehensively described including the ability of children orphaned or made vulnerable by HIV to continue to access and benefit from education. There are a number of ways in which HIV impacts on educational opportunities for children. In school, children who are either infected with or affected by HIV face possible discrimination by fellow pupils and by teachers. There is the reduced ability of affected families to pay for school fees, uniforms, books and shoes, the increased demand for child work at home or in the workplace and the need for children to provide care for sick members of the household. In HIV-affected households there may be a lower expected return on the investment in children's schooling (Grainger *et al.*, 2001). The learning capacity of children affected by HIV may be compromised, including by poor nutrition, hunger, trauma and emotional distress (Kelly, 2005). Teachers often report that orphaned children are 'listless, excessively reserved and do not play or laugh as much as other children.'

It is of critical importance to make schools more responsive to the needs of children infected with and affected by HIV and enable them to continue their education despite the challenges they face at home or in the community (USAID, 2003). Human Rights Watch (2005) recommends the development of best practices for schools. Possible strategies identified include the training teachers or guidance counsellors to address bereavement issues, supporting school-based peer support groups, keeping schools open at night, liaising with community-based organizations to identify the most vulnerable children, and sensitizing teachers to the needs of HIV-affected children. The World Bank *OVC Toolkit for Sub-Saharan Africa* advocates developing school-based psychosocial counselling services (World Bank, 2004a).

The evidence base for effective education policy and programme responses to HIV-affected children is slim and represents an important research agenda.

Finally, teachers are duty-bearers. It follows that appropriate interventions which support their ability to fulfil the rights of children in

the school setting, who are infected with and affected by HIV, should be considered by MOEs.

Key interventions:

- education sector policy (on sexual abuse and violence, rights of orphans and vulnerable children);
- establishing school mechanisms to protect pupils;
- developing and disseminating guidelines on dealing with children infected with and affected by HIV, or other vulnerable groups;
- trainer training on child rights;
- pre and in-service training (generalized epidemics);
- school leadership training on orphans and vulnerable children (generalized epidemics);
- tackling stigma and discrimination through whole school approach;
- strengthening school-based psycho-social services;
- school linkages with social protection services (generalized epidemics).

(c) Responding to stigma and discrimination

The stigma and discrimination that children infected with and affected by HIV face in school settings has been widely documented, for example in Jamaica, India and in sub-Saharan Africa. It leads to discriminatory acts that can culminate in exclusion from education. In Rwanda, for example, children from families living with HIV are reportedly prevented from associating with or playing with others at secondary school (Perkins and Mulyanga, 2005). The practice of isolating such students is apparently common though it is not sanctioned by the school authorities. Verbal abuse in various forms by other students is also reported. A study of HIV infected and affected children in South Africa found that most of the stories of discrimination at school related to other learners rather than teachers (Save the Children, 2001). Through such HIV-related stigmatization at school, educational inequity and the vulnerability of the children targeted are exacerbated.

Addressing the stigmatization of children and adults living with HIV or affected by HIV is an area where education and teachers in particular can make a significant contribution to the multi-sectoral approach that is required to tackle this particular social phenomenon (discussed in *Section 2.3*). Teachers have a potentially powerful role in combating

HIV-related stigma and discrimination among the children they teach, the community they serve and the profession in which they belong. In high HIV prevalence settings, teachers are likely to be in contact with children affected by HIV and have a clear duty to ensure that their own actions are not only non-stigmatizing and non-discriminatory towards them in the school environment, but also that they seek to shape the values and behaviours of others in the same direction. Thus, training on addressing HIV-related stigma and discrimination needs to be integrated into pre and in-service teacher education.

The experiences of teachers living with HIV illustrates how they are also stigmatized and discriminated against. Teachers' unions have a key role to play in protecting the rights of their members. The Trinidad and Tobago Teachers' Union has developed a policy handbook which addresses the rights of teachers to help tackle stigma and discrimination (UNESCO, 2006*e*).

Strategies for success include tackling gender and racial stereotypes and efforts should be made to counter prejudice against any minorities that are discriminated against. LSE and counselling to help HIV infected and affected children should be promoted to help children cope with stigma (Parker and Aggleton, 2002). Workplace policies for the education sector should include zero tolerance for HIV-related stigma and discrimination. Involving people living with HIV is also important in making HIV real and human.

The fact that teachers are both rights-holders and duty-bearers makes addressing stigma and discrimination so important for the profession. They need to be empowered to protect those in their charge, as well as be protected from those that would victimize them. It is a critical issue for teacher education in countries with significant HIV epidemics.

The education sector can help prevent HIV-related stigma and discrimination through teacher training and curriculum-based teaching and learning. The rights of education staff and children living with HIV or affected by AIDS can be supported through workplace policies and anti-discrimination legislation. The results of a review of HIV education programmes in Africa provide evidence that attitudes toward people living with HIV can be changed with school-based programmes (Gallant and Maticka-Tyndale, 2004). Similar findings were obtained in India (Catalyst Management Services, 2003; Swasti, 2004).

UNAIDS (2007c) recommends that schools create awareness of stigma and discrimination, the harm they cause and the benefits of reducing them through participatory teaching and learning. Myths and misconceptions about HIV and AIDS need to be addressed. Contact strategies involving direct or indirect contact between schools and people living with HIV help dispel myths and humanize the disease.

Key interventions include:

- an education sector policy on HIV (including stigma and discrimination);
- costed activities in the education sector policy;
- training of senior leadership on HIV (including stigma and discrimination);
- including training on stigma and discrimination in pre- and in-service training programmes;
- including sessions on stigma and discrimination in the HIV curriculum;
- addressing stigma and discrimination in the school co-curriculum;
- using innovative methods, e.g. theatre for development, music, dance, painting and films;
- contact strategies with networks of people living with HIV;
- peer support for infected and affected teachers;
- increasing access to services.

7.11 Beyond heroes and villains

This book has been an odyssey into the world of HIV, education and the teaching profession. The general findings suggest that a stronger focus on equipping, empowering and protecting the teaching profession is required to enable effective teaching and learning about HIV to take place in schools.

The strategies that are required to enhance teacher effectiveness are clear enough. The question is whether governments and their development partners have the requisite commitment and vision to enable this to happen. The evidence of past practice affords no complacency.

Resources need to be targeted better in the education sector to bring about improved results in teaching and learning. This requires *inter alia* a more focused approach to the sustainable development of teacher education and in school leadership and management. Only through

better policies, sector strategies and grassroots action will the villains be rooted out. The real blame, however, lies not so much with the teachers, but with the way in which scarce resources are used in the education sector with insufficient attention to improving the quality of service delivery. Decaying infrastructure corrodes values. Neglect and lack of accountability provide opportunity for the unacceptable.

HIV in many contexts is just one additional issue among many. It should not be neglected or unnecessarily downplayed. A contextually appropriate mainstreaming approach is required. In the high HIV prevalence settings of southern Africa the impacts are appalling and require an intensified response in the education sector.

HIV is likely to be around for many generations to come. There is no cure on the horizon at present. The pertinence of HIV education remains, and all young people have a right to information and related services. The social issues that create vulnerability and risk to HIV create other problems in society, including sexual health, violence and crime, gender inequality, family breakdown and poverty. HIV education provides an opportunity to contribute towards addressing some deeply entrenched social issues and prepares young people to live in an increasingly challenging world. We divorce education from social reality at our peril.

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