Educational planning and management in a world with AIDS

Volume

Setting the Scene

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Foreword

With the unrelenting spread of HIV, the AIDS epidemic has increasingly become a significant problem for the education sector. In the worst affected countries of East and Southern Africa there is a real danger that Education for All (EFA) goals will not be attained if the current degree of impact on the sector is not addressed. Even in countries that are not facing such a serious epidemic, as in West Africa, the Caribbean or countries of South-East Asia, increased levels of HIV prevalence are already affecting the internal capacity of education systems.

Ministries of education and other significant stakeholders have responded actively to the threats posed by the epidemic by developing sector-specific HIV and AIDS policies in some cases, and generally introducing prevention programmes and new courses in their curriculum. Nevertheless, education ministries in affected countries have expressed the need for additional support in addressing the management challenges that the pandemic imposes on their education systems. Increasingly, they recognize the urgent need to equip educational planners and managers with the requisite skills to address the impact of HIV and AIDS on the education sector. Existing techniques have to be adapted and new tools developed to prepare personnel to better manage and mitigate the impact of the pandemic.

The present series was developed to help build the conceptual, analytical and practical capacity of key staff to develop and implement effective responses in the education sector. It aims to increase access for a wide community of practitioners to information concerning planning and management in a world with HIV and AIDS; and to develop the capacity and skills of educational planners and managers to conceptualize and analyze the interaction between the epidemic and educational planning and management, as well as to plan and develop strategies to mitigate its impact.

The overall objectives of the set of modules are to:

- present the current epidemiological state of the HIV pandemic and its present and future impact;
- critically analyze the state of the pandemic in relation to its effect on the education sector and on the Education for All objectives;
- present selected planning and management techniques adapted to the new context of HIV and AIDS so as to ensure better quality of education and better utilization of the human and financial resources involved;
- identify strategies for improved institutional management, particularly in critical areas such as leadership, human resource management and information and financial management;
- provide a range of innovative experiences in integrating HIV and AIDS issues into educational planning and management.

By building on the expertise acquired by UNESCO's International Institute for Educational Planning (IIEP) and the EduSector AIDS Response Trust network (originally the Mobile Task Team [MTT] on the impact of HIV/AIDS on education) through their work in a variety of countries, the series provides the most up-to-date information available and lessons learned on successful approaches to educational planning and management in a world with AIDS.

The modules have been designed as self-study materials but they can also be used by training institutions in different courses and workshops. Most modules address the needs of planners and managers working at central or regional levels. Some, however, can be usefully read by policy-makers and directors of primary and secondary education. Others will help inspectors and administrators at local level address the issues that the epidemic raises for them in their day-to-day work.

Financial support for the development of modules and for the publication of the series at IIEP was provided by the UK Department for International Development (DFID) and the Joint United Nations Programme on HIV/AIDS (UNAIDS).

The Mobile Task Team (MTT) on the impact of HIV/AIDS on education, based at HEARD at the University of KwaZulu-Natal from 2000 to 2006, was funded by the United States Agency for International Development (USAID). The EduSector AIDS Response Trust, an independent, non-profit Trust was established to continue the work of the MTT in 2006.

The editing team for the series comprised Peter Badcock-Walters, and Michael Kelly for the MTT (now ESART), and Françoise Caillods, Lucy Teasdale and Barbara Tournier for the IIEP. The module authors are grateful to Miriam Jones for carefully editing each module. They are also grateful to Philippe Abbou-Avon of the IIEP Publications Unit for finalizing the layout of the series.

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Volume 1: Setting the Scene

Educational planning and management is an essential part of any education system, and in many countries, the planning needs are changing due to HIV and AIDS. In Volume 1, you are given the backdrop of how HIV and AIDS are unfolding in your schools and within the larger society. First you must understand the environments that HIV and AIDS are creating before your actions can be effective.

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Learner's guide

by B. Tournier

This set of training modules for educational planning and management in a world with AIDS is addressed primarily to staff of ministries of education and training institutions, including national, provincial and district level planners and managers. It is also intended for staff of United Nations organizations, donor agencies, and non-governmental organizations (NGOs) working to support ministries, associations and trade unions.

The series is available to all and can be downloaded at the following web address: www.unesco.org/iiep. The modules have been designed for use in training courses and workshops but they can also be used as self-study materials.

Background

HIV and AIDS are having a profound impact on the education sector in many regions of the world: widespread teacher and pupil absenteeism, decreasing enrolment rates and a growing number of orphans are increasingly threatening the attainment of Educational for All by 2015. It is within this context, that the series aims to heighten awareness of the educational management issues that the epidemic raises for the education sector and to impart practical planning techniques. Its objective is to build staff capacity to develop core competencies in policy analysis and design, as well as programme implementation and management that will effectively prevent further spread of HIV and mitigate the impact of AIDS in the education sector.

The project started in 2005 when IIEP and MTT (the Mobile Task Team on the Impact of HIV and AIDS on Education), now replaced by ESART, the Education Sector AIDS Response Trust, brought together the expertise of some 20 international experts to develop training modules that provide detailed guidance on educational planning and management specifically from the perspective of the AIDS epidemic. The modules were developed between 2005 and 2007; they were then reviewed, edited and enriched to produce the five volumes that now constitute the series.

Each situation is different

Examples are used throughout the modules to make them more interactive and relevant to the learner or trainer. A majority of these examples refer to highly impacted countries of southern Africa, but others are drawn from the Caribbean, where high HIV prevalence levels have frequently been documented. Each epidemiological situation is different: the epidemic affects a particular country differently depending on its traditions and culture, and on the specific educational and socio-economic problems it faces. Understanding this, the strategies and responses you adopt will need to be context-specific. The suggestions offered in this set of modules constitute a checklist of points for you to consider in any response to HIV and AIDS.

In some countries, different ministries are in charge of education in addition to the ministry of education. For example there may be a separate ministry of higher education, or a ministry for technical education. For clarity, we shall use the terms ministry of education when referring to all education ministries dealing with HIV and education matters.

Structure of the series

This series contains 22 modules, organized in five volumes. There are frequent cross-references between modules to allow trainers and learners to benefit from linkages between topics. HIV and AIDS fact sheets and an HIV and AIDS knowledge test can be found in Volume 1 to allow you to review the basic facts of HIV transmission and progression. At the end of all the volumes is a section of reference tools including a list of all the web sites and downloadable resources referred to in the modules, as well as an HIV and AIDS glossary.

The volumes

Not all modules will be of relevance or interest to each learner or trainer. Five core modules have been identified in Volume 1. It is recommended that you read and complete these before choosing the individual study route that best serves your professional and personal needs.

> Volume 1, *Setting the Scene,* gives the background to how HIV and AIDS are unfolding in the larger society and within schools. HIV and AIDS influence the demand for education, the resources available, as well as the quality of the education provided. The different modules should allow you to assess better the impact of HIV and AIDS on education and on development, and will allow you to understand the environment in which you are working before articulating a response.

> Volume 2, *Facilitating Policy,* helps you to understand how policies and structures within the ministry promote and sustain actions to reduce HIV-related problems in the workplace and in the education sector. Supporting policy development and implementation requires a detailed understanding the issues influencing people and organizations with regards to HIV and AIDS.

> In Volume 3, *Understanding Impact,* you will assess the need to gather new data to understand the impact of HIV and AIDS on the education system in order to inform policy-making. You will then learn different approaches to collecting and analyzing such data.

Volume 4, *Responding to the Epidemic,* will provide you with concrete tools to help you plan and implement specific actions to address the challenges you face responding to HIV and AIDS. It will prepare you prioritize your actions in key areas of the education sector.

The last volume in the series, **Volume 5**, *Costing, Monitoring and Managing,* focuses on costing and funding your planned response, monitoring its evolution and staying on target. The management checklist at the end provides you with a comprehensive framework to advocate, guide and inform the planning and management of your HIV and AIDS response.

The modules

Each module has the same internal structure, comprising the following sections:

- **Introductory remarks:** Each author begins the module by stating the aims and objectives of the module and making general introductory remarks. These are designed to give you an idea of the content of the module and how you might use it for training.

- **Questions for reflection:** This section is to get you thinking about what you know on the topic before launching into the module. As you read, the answers to these questions will become apparent. Some space is provided for you to write your answers, but use as much additional paper as necessary. **We recommend that you take time to reflect on these questions before you begin.**

- **Activities and Answers to activities:** The activities are an integral part of the modules and have been designed to test what you know as well as the new knowledge you have acquired. It is important that you actually do the exercises. Each activity is there for a specific reason and is an important part of the learning process.

  In each activity, space has been provided for you to write your answers and ideas, although you may prefer to make a note of your answers in another notebook. You will find the answers to the activities at the end of the module you are working on. However, in some cases, the activities and questions may require country-specific information and do not have a 'right' or 'wrong' answer (e.g. "Explain how your ministry advocates for the prevention of HIV"). As much as possible, sources are suggested where you could find this information.

- **Summary remarks/Lessons learned:** This section brings together the main ideas of the module and then summarizes the most important aspects that were presented and discussed.

- **Bibliographical references and resources:** Each author has listed the cited references and any additional resources appropriate to the module. In addition to the cited documents, some modules provide a list of web sites and useful resources.

Teaching the series: using the modules in training courses

As stated above, these modules are designed for use in training courses or for individual use.

Trainers are encouraged to adapt the materials to their specific context using examples from their own country. These examples can be usefully inserted in a presentation or lecture to illustrate points made in the module and to facilitate an active discussion with the learners. The objective is to assist learners to reflect on the situation in their own country and to engage them with the issue.

A number of activities can also be carried out in groups. The trainer can use answers provided at the back of the modules to add on to the group reports at the end of the exercise. In all cases, the trainer should prepare the answers in advance as they may require country-specific knowledge.

The bibliographic references can also provide useful reading lists for a particular course.

Your feedback

We hope that you will appreciate the modules and find them useful. Your feedback is important to us. Please send your feedback on any aspect of the series to:
hiv-aids-clearinghouse@iiep.unesco.org – it will be taken into account in future revisions of the series. We look forward to receiving your comments and suggestions for the future.

Enjoy your work!

List of abbreviations

ABC	Abstain, be faithful, use condoms
ACU	AIDS control unit
ADEA	Association for the Development of Education in Africa
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
BCC	Behaviour change communication
BRAC	Bangladesh Rural Advancement Committee
CA	Cooperating Agency
CAER	Consulting Assistance on Economic Reform
CBO	Community-based organization
CCM	Country Coordination Mechanisms (Global Fund)
CDC	Centers for Disease Control and Prevention
CRC	Convention on the Rights of the Child
CRS	Catholic Relief Services
DAC	Development Assistance Committee (OECD)
DEMMIS	District education management and monitoring information systems
DEO	District education office
DFID	Department for International Development
DHS	Department of Human Services
EAP	Employee assistance programmes
ECCE	Early childhood care and education
EDI	EFA Development Index
EdSida	Education et VIH/Sida
EFA	Education for All
EMIS	Education management information system
ESART	Education Sector AIDS Response Trust
FAO	Food and Agricultural Organization
FBO	Faith-based organization
FHI	Family Health International
FRESH	Focusing Resources on Effective School Health
FTI	Fast Track Initiative

GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People living with or Affected by HIV and AIDS
HAART	Highly active antiretroviral therapy
HAMU	HIV and AIDS Management Unit
HBC	Home-based care
HDN	Health and development networks
HFLE	Health and family life education
HIPC	Highly indebted poor countries
HIV	Human Immunodeficiency Virus
HR	Human resources
IBE	International Bureau of Education
ICASA	International Conference on HIV/AIDS and Sexually Transmitted Infections in Africa
ICASO	International Council of AIDS Service Organizations
IDU	Injecting drug user
IEC	Information, Education, and Communication
IFC	International Finance Corporation
IIEP	International Institute for Educational Planning
ILO	International Labour Organization
INSET	In-service education and training
IPPF	International Planned Parenthood Federation
KAPB	Knowledge, attitudes, practices and behaviour
M&E	Monitoring and evaluation
MAP	Multi-Country AIDS Program (World Bank)
MDG	Millennium Development Goals
MIS	Management information system
MLP	Medium-to-large-scale project
MoBESC	Ministry of Basic Education, Sport and Culture
MoE	Ministry of education
MoES	Ministry of Education and Sports
MoHETEC	Ministry of Higher Education, Training and Employment Creation
MSM	Men who have sex with men
MTEF	Medium-term expenditure framework
MTCT	Mother-to-child transmission
MTT	Mobile Task Team (MTT) on the Impact of HIV and AIDS on Education

NAC	National AIDS Council
NACA	National AIDS Co-ordinating Agency
NDP	National Development Plan
NFE	Non-formal education
NGO	Non-government organizations
NTFO	National Task Force on Orphans
OOSY	Out-of-school youth
OVC	Orphans and vulnerable children
PAF	Programme Acceleration Funds (UNAIDS)
PEAP	Poverty Eradication Action Plan
PEP	Post-Exposure Prophylaxis
PEPFAR	(US) President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission
PREP	Pre-exposure prophylaxis
PRSP	Poverty reduction strategy paper
PSI	Population Services International
PTA	Parent-teacher association
SACC	South African Church Council
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SGB	School governing body
SIDA	Swedish International Development Cooperation Agency
SMT	School management team
SP	Smaller project
SRF	Strategic response framework
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TB	Tuberculosis
TOR	Terms of reference
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS

UNICEF	United Nations Children's Fund
UP	Universal precautions
UPE	Universal primary education
USAID	United States Agency for International Development
VCCT	Voluntary (and confidential) counselling and testing
VCT	Voluntary (HIV) counselling and testing
VIPP	Visualization in participatory programmes
WCSDG	World Commission on the Social Dimensions of Globalization
WHO	World Health Organization
WV	World Vision

HIV and AIDS knowledge test

Adapted from UNAIDS

Before you begin, you may want to check your knowledge on HIV and AIDS. The answers are given on page 200. For more information, you can reference the HIV and AIDS fact sheets and the HIV and AIDS glossary located at the end of the volume on pages 189 and 195.

PART 1: Please answer the following questions by selecting the best answer. There is only one answer for each question.

1. Approximately how many people in the world are living with HIV?
   - A. 2,000,000
   - B. 12,000,000
   - C. 40,000,000

2. In what region can the largest number of people living with HIV currently be found?
   - A. Asia and the Pacific
   - B. Sub-Saharan Africa
   - C. Latin America and the Caribbean
   - D. North America
   - E. Central and Eastern Europe

3. What does the acronym HIV stand for?
   - A. Hemo-insufficiency virus
   - B. Human immunodeficiency virus
   - C. Human immobilization virus

4. What does the acronym AIDS stand for?
   - A. active immunological disease syndrome
   - B. acquired immune deficiency syndrome
   - C. acquired immunological derivative syndrome
   - D. acquired immunodeficiency syndrome

5. What is the main means of HIV transmission worldwide?
   - A. unprotected heterosexual sex
   - B. homosexual sex
   - C. intravenous drug use
   - D. mother-to-child transmission

6. Spread of HIV by sexual transmission can be prevented by:
   - A. abstinence
   - B. practising mutual monogamy with an uninfected partner
   - C. correct use of condoms
   - D. all of the above

7. Women are most likely to contract HIV through:
   - A. unprotected heterosexual sex
   - B. injecting drug use
   - C. contaminated blood

8. HIV can be contracted from:
   - A. condoms
   - B. kissing
   - C. mosquito bites
   - D. drinking from the same glass as an infected person
   - E. sharing a spoon with a person living with HIV
   - F. sharing a toothbrush with someone who is living with HIV
   - G. all of the above
   - H. none of the above

9. Risk of contracting HIV is increased by:
   - A. being infected with another sexually transmitted infection (STI)
   - B. having poor nutrition
   - C. having a cold

10. Pregnant women infected with HIV:
   - A. can reduce chances of transmitting HIV to her unborn child by maintaining a low viral load and staying in good health
   - B. can take medication to reduce the risk of mother-to-child transmission during childbirth
   - C. all of the above

11. List the four main body fluids that, when infected, may transmit HIV.

1.
2.
3.
4.

12. List the four main ways HIV is transmitted.

1.
2.
3.
4.

PART 2: Please state whether the statement is True or False.

1. If a person has HIV, they will always develop AIDS.

2. HIV is present in blood, sexual fluids and sweat.

3. Abstaining from (not having) sexual intercourse is an effective way to avoid being infected with HIV.

4. When a person has AIDS, his or her body cannot easily defend itself from infections.

5. A person can get the same sexually transmitted infection more than once.

6. There is a cure for AIDS.

7. If a pregnant woman has HIV, there is a still a chance she will not pass it to her baby.

8. A person can get HIV infection from sharing needles used to inject drugs.

9. Many people with sexually transmitted infections, including HIV, do not have symptoms.

10. HIV can be easily spread by using someone's personal belongings, such as a toothbrush or a razor.

11. A person can look at someone and tell if he or she is infected with HIV or has AIDS.

12. It is possible to avoid becoming infected with HIV by having sexual intercourse only once a month.

13. A condom, when used properly, provides excellent protection against sexually transmitted infections, and can prevent transmission of HIV.

14. An effective vaccine is available to protect people from HIV infection.

15. A person can be infected with HIV for 10 or more years without developing AIDS.

16. You can get HIV by kissing someone who has it.

17. A person can be infected with HIV by giving blood in an approved health facility.

18. Ear-piercing and tattooing with unsterilized instruments are possible ways of becoming infected with HIV.

19. A person can get HIV by being bitten by a mosquito.

20. A person can avoid getting HIV by eating well and exercising regularly.

Module 1.1

M.J. Kelly
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The impacts of HIV/AIDS on development

About the authors

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Desmond Cohen is an economist who was formerly Director of the HIV/AIDS and Development Programme of UNDP. He has worked in many countries in Africa for UN agencies on the impact of HIV and AIDS and has focused his work in recent years on the effects of HIV and AIDS on human resources and how to develop policies and programmes that sustain capacity in both the public and private sectors.

Module 1.1

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Aims

The aims of this module are to:

- alert you to the many social, cultural, economic and political factors that influence the spread and impact of HIV and AIDS;
- enable you to see the relevance for education of the interactions between the epidemic and the contextual factors within which it is embedded.

Objectives

At the end of this module you should be able to:

- present HIV and AIDS within a comprehensive socio-cultural and economic framework;
- identify relationships between HIV and AIDS on the one hand and other developmental issues in society on the other;
- distinguish between manifestations of the epidemic's impacts, its immediate causes, its underlying causes, and its structural causes;
- give examples of ways in which HIV and AIDS magnify the scale of the challenges that the socio-cultural and economic context poses for education.

Before you begin...

Questions for reflection

Take a few minutes to think about the questions below. You may find it helpful to make a note of your ideas in the spaces provided. As you work through the module, see how your ideas and observations compare with those of the author.

On what sectors, aside from that of health, do you think HIV and AIDS may be having a significant impact in society?

What reasons would you give for saying that AIDS is largely a disease associated with men or for saying that it is largely associated with women?

Are HIV and AIDS linked to poverty? If so, in what ways?

Does AIDS have an impact on economic growth?

In what ways does the education sector have an important role in fighting the impacts of HIV and AIDS on development?

Now look over your responses and identify those that might be of special relevance to education.

Module 1.1

Introductory remarks

The first published information on AIDS appeared in June 1981. Within a few years cases of the epidemic were being reported with increasing frequency in almost every part of the world. In view of what we now know about the length of time between HIV infection and the appearance of AIDS, it seems certain that widespread HIV infection must have been occurring some time during the 1970s, if not earlier. Quite understandably, the first attempts to deal with the new disease were almost entirely medical and epidemiological[1].

While the epidemiological approach addressed issues of human behaviour, it did not extend to other major contextual factors affecting the spread of HIV or its impact on society. Several years were to pass before it was recognized that HIV and AIDS affect the functioning of society at every level. Likewise several years passed before it came to be recognized that the way society operates, and the way it is structured, have major implications for the AIDS epidemic.

HIV and AIDS are a developmental issue that extends beyond medical and epidemiological concerns, and this has major implications for the response to the epidemic. Any response to the epidemic must take account of the contribution of society, and how society relates to successes and failures in dealing with the epidemic. The fact that the global response has so far had no more than very limited and partial success may be attributed in large part to a failure to pay adequate attention to this complex, two-way interaction: between the epidemic and society on the one hand, and between society and the epidemic on the other.

A sustainable and comprehensive response to HIV and AIDS is a complex matter. The response consists of three components, each of which needs to be present and functioning at the same time:

1. a broad based conceptual framework;
2. an empowering environment where relevant action can take place; and
3. an inclusive package of programmes dealing with prevention: care, support and treatment; and mitigation of the epidemic's negative impacts.

Working from an educational perspective, this module outlines a number of the social, cultural, economic and political factors that influence the spread and impact of HIV and AIDS. It also draws attention to the way interactions between the

[1] Medicine is the science of health in individuals. Epidemiology is study of the spread of disease in communities, nationally or internationally.

epidemic and the contextual factors within which it is embedded have relevance for the education sector.

1. The challenges posed by HIV and AIDS

HIV and AIDS confront us with two challenges:

- The disease: This is the medical and epidemiological condition of HIV infection and/or AIDS in individuals and communities.
- The developmental problem: This arises from the social and developmental impacts of widespread HIV infection, when infected individuals are found across a country or region.

The most immediate impacts of HIV and AIDS lie in the infection, illness or death of individuals. When infection becomes widespread in a community, it constitutes an epidemic. If the epidemic extends to several countries it is sometimes referred to as a 'pandemic'.

HIV infection, the likely ensuing illnesses and the possibility of a premature and distressing death have immediate and devastating consequences for the person concerned and for his/her immediate family. This impact at the individual level must never be overlooked. Behind all the statistics and reports of impacts on socio-economic situations are men, women and children, experiencing a heartbreaking mixture of fear and anxiety, physical pain and disability, isolation and rejection, loneliness and depression, anger and guilt. No matter how technical, theoretical or frequent your encounter with AIDS-related issues, never forget the individual human beings who are affected. Their personal situation motivates all of us to do what we can to understand the epidemic, to reduce its transmission, and to lessen its numerous impacts.

Figure 1 presents an organizing or conceptual framework for thinking about and addressing HIV and AIDS. It consists of five boxes. Box 2 represents the condition of living with HIV or AIDS.

Figure 1: Levels of causality for HIV and AIDS

1	Manifestations of the impacts of HIV and AIDS Increased personal and household poverty National economies growing more slowly than in a no-AIDS situation Depletion in the national pool of skills and capacities Increase in the scale of management problems Overstretching of health systems Debilitated education systems Social systems and networks overwhelmed Substantial reduction in size of the agricultural workforce Chronic food insecurity Environmental degradation (soils, crop diversity, fishing grounds, water resources) Decline in social capital Growing management and governance problems Changing cultural norms, practices and expectations Changing population structure Increase in single-parent, female-headed and child-headed households Large number of orphans and vulnerable children Increased burden of childcare on the elderly and grandparents Inadequate protection of human rights

2	AIDS deaths Opportunistic illnesses HIV infection

3	Immediate causes Unprotected sex with an infected person Mother-to-child transmission Transfusions of infected blood Sharing piercing or injecting equipment with an infected person

4	Underlying causes Permissiveness in sexual values and practices Ignorance Peer or social pressure Sexual abuse, violence and rape Commercial and transactional sex Substance abuse Personal poverty Low health and nutritional status Cultural practices

5	Structural causes Gender inequalities Poverty in society Joblessness Absence of recreational outlets Migration War and conflict North-south relations Corruption Structural adjustment and HIPC conditionalities

The first box in Figure 1 lists some of the ways in which HIV and AIDS impact on aspects of individual, social and economic life. We will be discussing some of these in the pages that follow. Note that there are many other impacts that are not

shown in this box. The first activity in this module invites you to think of some of these yourself.

Activity 1

Make a list of some impacts of HIV and AIDS at individual, household or society level other than those shown in Figure 1.

Some possible answers for this activity (and for the activities that will follow) are provided at the end of the module.

Boxes 3, 4 and 5 of Figure 1 are important for our understanding of the epidemic. If we could deal properly with the issues appearing in these boxes we would be successful in stopping further transmission of HIV. But so far we have not managed to do this. One reason is that we tend to focus very strongly on HIV/AIDS itself and on the immediate causes of HIV transmission. At the same time we may fail to take account of factors that are working at a deeper level. These are the underlying and structural causes that enable HIV and AIDS to spread (see Figure 2).

The immediate causes of HIV that appear in Figure 1 are like the surface roots of a tree. These roots are important but do not by themselves account for the vigorous life of the tree. Even if you cut away almost all the surface roots, a tree will continue to live because of the roots that go down deeper. The only way to kill the tree is to dig deep and cut all the roots. You must cut those spreading out fairly near the surface, or what Figure 1 calls the 'underlying causes'. But you must also cut the deep roots that go far down into the ground and enable the tree to survive even in the most difficult circumstances. These deep roots can be compared to the 'structural causes' that make it possible for HIV and AIDS to flourish. When people say that a multisectoral approach must guide the response to the AIDS epidemic, what they mean is that the response must address the causes of HIV and AIDS at all three levels – the immediate causes, the underlying causes, and the structural causes.

Important areas in the struggle with HIV and AIDS are a well-functioning, properly resourced health system, and an education system that ensures that every boy and girl can remain enrolled for several years in a school offering good quality education. Many governments with limited resources have found themselves strained or incapable of making the necessary investments in health and education. In the health arena, one outcome is clinics that do not have the medical supplies needed to treat sexually transmitted infections (STIs) or the opportunistic

illnesses of persons living with HIV and AIDS. An outcome for education is a ceiling on the number of people who may be employed, leading to schools (especially those in rural areas) not having enough teachers, or school developments being curtailed because additional teachers cannot be employed, even though large numbers of qualified teachers are without employment. The limitations that various conditions impose on both of these sectors constrain their ability to strengthen their positive response to HIV and AIDS, and the constraints contribute to the continued occurrence of the epidemic.

Figure 2: Contextualizing HIV and AIDS: underlying and structural causes

Source: UNAIDS, 2005.

Ignorance illustrates how factors that lead to HIV work their way up from below. As is often stressed, knowledge alone, when not accompanied by the adoption of safe practices, will not protect an individual from HIV infection, but ignorance can greatly increase individual risk. There is no way of telling by appearances alone whether or not a person is HIV-infected. A young person who is unaware of this and thinks that there will be bodily signs to show that an individual is infected is at heightened risk of a sexual encounter that could lead to HIV transmission. In addition, everybody needs to know how to protect themselves against HIV infection. Ignorance in this regard contributes to the possibility of being infected by HIV and hence is an underlying cause for the amount of infection that is occurring. The importance of proper knowledge also points out the benefits of teaching children about HIV and AIDS.

Activity 2 invites you to continue your personal reflections by trying to relate some of the other underlying and structural causes to HIV and AIDS.

Activity 2

Write a short paragraph to describe the way in which each of the following might contribute to the spread of HIV.

- Peer and social pressure
- Substance abuse
- Low health and nutritional status
- Joblessness
- War and conflict
- Corruption

Before you move on to the material that follows, make your own attempt at linking each of the causes or situations presented in the bottom two boxes of Figure 1 with the occurrence of HIV and AIDS and subsequently with the impacts of the epidemic on individuals, households or sectors of society. You will find help for this in books by Barnett and Whiteside (2002), Jackson (2002), and Weinreich and Benn (2004) that provide extensive background for our understanding of HIV and AIDS, its many levels of causality and its many impacts. These books are listed in the Bibliography towards the end of the module.

2. HIV, gender and culture

When we hear the word 'gender' we almost invariably think of something that concerns women. But gender refers to men as much as to women. Since gender is rooted in such aspects of culture as norms, customs and practices, this section of the module will examine, from female, male and cultural perspectives, the framework within which HIV/AIDS occurs.

The world has become increasingly aware of the female face of the AIDS epidemic. This is because of the steady annual increase in the proportion of women infected with HIV. This proportion has now risen to over 45 per cent. The feminization of HIV and AIDS is most pronounced in sub-Saharan Africa where an estimated 57 per cent of those infected at the end of 2005 were women. Indeed, in every country south of the Sahara, more than half of the infected are found to be women and girls.

This situation is likely to worsen. Infection rates among young women in the age-range 15-24 are considerably higher than those of young men of the same age. Globally there were an estimated 6.2 million young women living with HIV and AIDS at the end of 2003, compared with 3.8 million young men, and in Africa the estimates were 4.7 million young women and 1.5 million young men. As these young people grow into mature adults, the proportion of infected women in the older age groups will steadily rise.

HIV and AIDS have a disproportionately severe effect on women and girls for the following reasons:

- Physiological factors put them at higher risk of HIV infection. They have extensive, easily lacerated tissues in their vaginal area; they are exposed during sexual intercourse to a large volume of high-risk body fluids; sexually transmitted infections (STIs) may remain undetected. Because of poverty and/or early or frequent pregnancies, women and girls may experience a run-down health condition that in itself heightens their risk of infection.
- Women and girls are more vulnerable to HIV infection on social grounds. They have limited power to negotiate sex or the circumstances of sex. Though married and faithful, they remain vulnerable because their husbands may not be faithful or allow them to negotiate sex or condom use. Their male partners enjoy considerable economic as well as geographic freedom and mobility – factors that increase the possibility of infecting the spouse with HIV. Their male partners tend to be considerably older, and therefore possibly more sexually experienced. Across Africa male partners have been found to be on average six years older than the women with whom they have intercourse.
- Women and girls are more vulnerable to HIV infection on economic grounds. Economically they are subordinate to men, with less access to capital or credit. Frequently they receive inadequate financial support from their partner but have to apply their own ingenuity, labour and resources to maintaining the household. They bear most of the financial and caring

burden for young children and in some cases, can only ensure household and child survival through prostitution.

- Where AIDS care is needed, women and girls carry much of this burden. They take on responsibilities for the sick and orphans; they continue to provide care, attend to their household chores, and generate income even when they are personally infected or ailing; they receive inadequate support from social systems; they may be exposing themselves to situations of high-risk through caring for AIDS patients in the home; many suffer from burn-out or sicken and die at a young age.

The social, economic and care aspects of the vulnerability of girls and women to HIV infection are clearly related to cultural norms, expectations and practices governing womanhood. Equally, men are influenced by cultural beliefs, norms and practices governing manhood. Although the precise expression may differ from society to society, international experience shows that the following are usually true:

- *Every society has different sexual expectations for women and men.*

In heterosexual relationships, men and boys are almost always regarded as being in a stronger decision-making position than women and girls.

The majority of cultures ascribe to women a passive, subordinate role, particularly in the sexual sphere. Women are generally expected to be docile, submissive, accepting, unquestioning and faithful, and frequently it is regarded as preferable that they should not show themselves to be well-versed in sexual matters.

- *In many cultures, sexual experience and having many sexual partners are seen as matters of male prestige.*

It is taken for granted in many societies that boys should have many girlfriends, whereas a girl should 'stick to one boy'. These different sexual expectations put strong pressure on young people, whatever their sex, to act accordingly.

- *These 'macho' expectations put men and boys – and their sexual partners – at risk of HIV infection.*

Even though they are nearly universal, these norms and expectations are not inevitable. They have been constructed by the societies in which they occur and are transmitted through the socializing processes of society. Since they have been socially formed, they can be socially changed. Ministries of education, working with community, religious and other leaders, have a key role to play in bringing about positive transformations in the image and practice of what it means to be male and what it means to be female. Ministries have scope to work here with the media and the entertainment world so that gender perspectives that reflect more closely the fundamental equality of men and women begin to prevail. Achieving this change will be a long and slow task, but it is something that can be progressively improved on with each new generation of young people entering the education system. This process calls for a rights-based education that will foster lived acceptance that men and women are diverse, complementary and equal.

Activity 3

Try to obtain some primary school textbooks, say for grades 4 or 5 (or books for children). Read two or three chapters (or stories) and look at the illustrations. To what extent do the text and illustrations portray women and girls in more subordinate, passive roles while men and boys are shown as adopting active, leadership roles? Do you find much in the books that shows women and girls as either taking the lead or being at least as active and vigorous as boys and men? What gender message do you see being communicated by material like this?

In addition to gender, cultural norms and practices are critical factors in the response to the AIDS epidemic. Some of these have been singled out as contributing to the spread of HIV infection:

- forced early marriage of young girls;
- tattooing and scarification carried out with non-sterilized equipment;
- widow inheritance;
- widow-cleansing;
- the belief that AIDS comes from a sorcerer's curse or the violation of a taboo.

Moreover, urbanization, migration, globalization and declines in cultural and social control have contributed to changes in the way people view sexual relationships. These changes have been speeded up by cultural relationships between the developing and developed world, with developing countries adopting many of the standards, norms and expressions of the developed countries, not always with beneficial consequences. In many respects, the AIDS epidemic is a product of globalization. Its spread became possible because of growing world interconnectedness through rapid transportation, international trade routes, and large-scale population flows.

Box 1 Excerpt from *On India's roads, cargo and a deadly passenger*

"India's entry into the global economy over the past 15 years may also be furthering the spread of AIDS. With rising incomes, men have more money for sex; poor women see selling sex as their only access to the new prosperity. Cities are drawing more migrants and prostitutes, and Western influences are liberalizing Indian sexual mores. In response, cultural protectionists are refusing to allow even the national conversation about AIDS to reflect this changing reality" (Waldman, 2005).

But there are numerous elements in traditional and cultural life that can contribute positively to the struggle against the epidemic. If anti-AIDS strategies and campaigns are to make headway, they must take serious account of these and capitalize on their potential. These positive elements include:

- the potential that initiation periods offer for sound sexual education;
- the fairly widespread practice of male circumcision (a factor that almost certainly helps to reduce HIV transmissibility);
- the knowledge and accessibility of herbal and traditional healers and their approach to an infected person as an integrated human being who is a member of a concerned community;
- the sense of family, community, solidarity and participation;
- respect for the sacredness of human life;
- perspectives that underline the role of sexual relationships in the formation and strengthening of kinships.

It is too simplistic to discredit the majority of cultural beliefs and practices as contributing to the spread of HIV. The truth is otherwise. Many of them can be powerful allies in the struggle against the epidemic. There is a need for more knowledge in this area and for approaches that are more sensitive to what the cultural context has to offer.

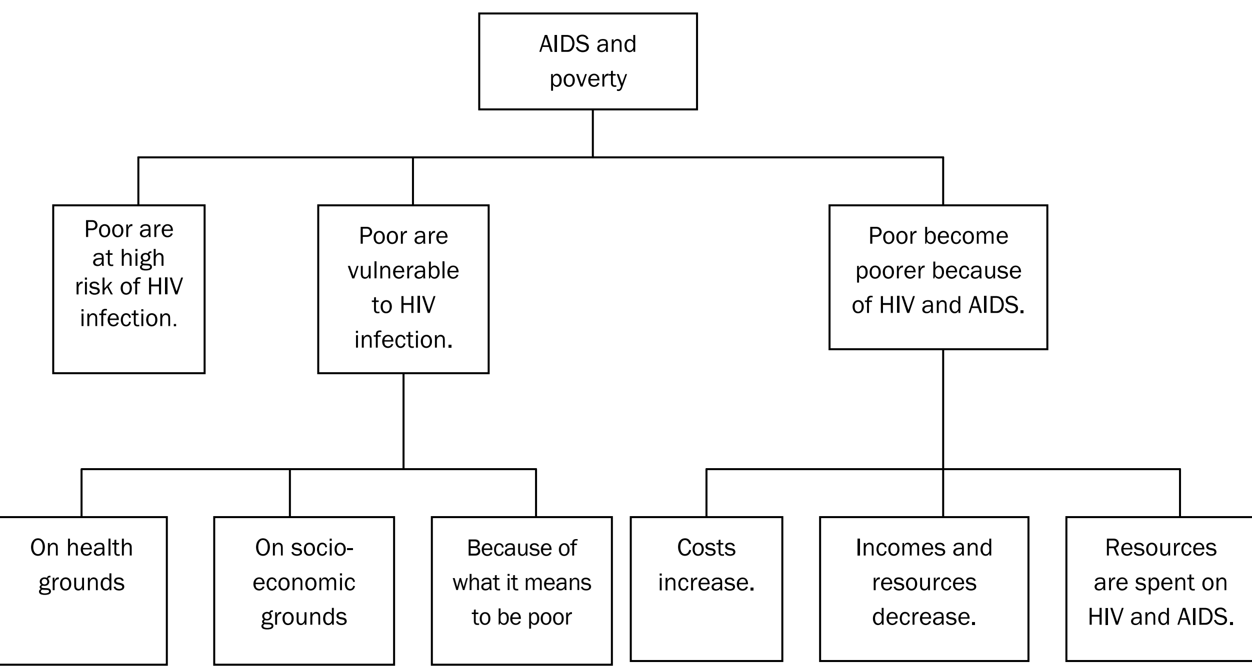
3. HIV/AIDS and poverty

Three facts are important for understanding the links between poverty and HIV/AIDS:

- **Poverty does not cause AIDS.** The cause of the disease is the human immuno-deficiency virus (HIV).
- **HIV/AIDS is not a disease of poor countries.** The disease first came to public attention in the United States, a very wealthy country, where it continues to infect more than a million individuals. Likewise, two of the wealthiest countries in Africa, Botswana and South Africa, are among the most severely affected countries in the world.
- **HIV/AIDS is not a disease of poor people.** Although across Africa, throughout Asia, in Latin America and in the Caribbean, there are countless individuals who are poor to the point of destitution, the great majority of these are not infected with HIV.

Nevertheless, HIV, AIDS and poverty are very closely intertwined. The poor are at higher risk of HIV infection. They are also more vulnerable to HIV infection. Furthermore, HIV and AIDS tend to make the poor poorer. These connections between HIV/AIDS and poverty are shown in Figure 3 and are developed below.

Figure 3 Ways in which HIV, AIDS and poverty relate to each other.



Individuals

The poor are at higher risk of HIV infection for the following reasons:

- It is less easy for the poor to access health services, and this in turn increases the possibility of their having untreated STIs, a factor that greatly increases the risk of HIV infection.
- Poor people are more likely not to have information about their personal HIV status or the status of their sexual partner.
- There is a greater possibility that the poor will engage in unprotected sexual activity because they cannot afford to buy condoms, do not have the facilities for storing them correctly, or they have sex in conditions that make it difficult to use them properly.
- Some poor people may have to sell sex for income, especially women and girls.

The poor are more vulnerable to HIV infection on health grounds because of:

- their poor health and low nutritional status;
- their limited access to health care;
- the non-availability of health services in places where the poor live;
- their inability to pay for treatment or afford the opportunity costs associated with health care;
- their increased exposure to other health hazards such as malaria, tuberculosis, or gastro-intestinal problems;
- the crowded and unsanitary conditions in which many of them are required to live, without access to safe water supplies.

Poor people also live under the following conditions:

- There is less scope in their lives for real choices affecting such areas as their work, where and how they live, what they will spend their money on, and how they will occupy themselves during their free time.
- They live under considerable pressure to meet immediate needs and have few incentives to delay gratification.
- The pressures they experience in meeting their daily living requirements make it unrealistic and difficult for the poor to be concerned about a disease that may not affect them until after many years have passed.

Households

In addition, AIDS makes the poor poorer because it reduces incomes and resources, increases costs, and makes it necessary to divert household resources to payments for medical, care and funeral costs. Household economies are affected by the loss of jobs, the inability to maintain existing levels of farm production or other output, the need to use up savings, the time that must be devoted to attending to the needs of the sick, the increased costs associated with caring for orphans, the selling-off of capital assets needed for production purposes,

high funeral costs, and the inability of family and other households to provide the same levels of support and assistance as in the past. The purchasing power of the market is affected because the disease reduces private incomes while increasing costs. There may also be a negative market effect when individuals die before they have finished paying for goods they have purchased.

The literature provides extensive evidence of these impacts and the way they can even cause households to disintegrate and family members to disperse. See for example, Barnett and Whiteside, (2002: chapter 7) and Jackson, (2002: 330-342). Three further examples can be cited here.

- A study of AIDS-affected households in Zambia showed that in two thirds of the families where the father had died, monthly disposable income fell by more than 80 per cent.
- In Ethiopia, AIDS-affected households were found to spend between 11.6 and 16.4 hours per week in agriculture, compared with a mean of 33.6 hours for non-AIDS-affected households.
- In Zimbabwe, a bedridden AIDS patient was estimated to cost the affected household an additional US$23-34 per month.

If you know a household in which a person is suffering from AIDS, keep its circumstances in the forefront of your mind as you do Activity 4.

Activity 4

Make a list of the ways in which the income and expenditure patterns of a household would be affected if one of its members developed AIDS. What strategies could the household adopt to cope with these changed circumstances?

4. AIDS, development and economic growth

The epidemic has a negative effect on economic growth because it cuts away at the necessary human, physical and social capital.

- The disease reduces the stock of human capital because it mostly affects adults in their economically productive years (those aged 15-49). Since significant development of human capital takes place at the household level, sickness and death of a household member, especially a parent, may leave the younger generation with nobody to pass on to them the necessary knowledge and skills. The readiness with which AIDS-affected families take children out of school causes further disruptions in basic human capital formation.
- HIV and AIDS lead to a reduction in physical capital because families have to draw immediately on savings, at both household and public levels. It also affects the incentive to save at household level. Earlier-than-planned-for pension payments and the early payment of terminal benefits steadily eat into private sector and national investments. A government's ability to save is constrained by increased expenditures arising from efforts to provide treatment and care for AIDS-related illnesses and to recruit and train public sector personnel to replace those lost to the disease.
- The epidemic reduces social capital – the norms, networks, institutional memories and understandings that promote the smooth working of society – because of the absence or premature deaths of those with the knowledge and experience needed for getting things done effectively and efficiently. As a result, governments may experience difficulty in providing basic social services, ensuring security, providing efficient economic management, and developing necessary regulatory and legal frameworks.

Subsistence agriculture

Consider the impact of the epidemic on agriculture. Agriculture is the main activity of a large proportion of the people in the world. This is especially the case in the developing countries of Africa and East and South-East Asia. The impacts of HIV and AIDS on agriculture put the lives and welfare of this vast number in jeopardy.

According to global estimates from the Food and Agricultural Organization (FAO), it is possible that by 2020 the disease will have claimed 26 per cent of the agricultural labour force in Namibia, 23 per cent in each of Botswana and Zimbabwe, 20 per cent in each of Mozambique and South Africa, and 17 per cent in Kenya, representing staggering losses of agricultural labour. Most of those who have died are women who make up as much as four fifths of the agricultural workforce. The loss of labour is exacerbated by the time allocated to caring for the sick, since caregivers have to stop working in the fields in order to carry out this function.

This labour loss has dramatic negative consequences.

- The impoverishment of rural households – average treatment and mourning costs are estimated to consume more than three times the average annual farm income.
- A shift from labour-intensive crops to those that are less demanding and often less nutritious.
- A decline in the area of land being cultivated, with remote fields often being left fallow.
- A decrease in the range of crops being cultivated, leading to a decline in plant diversity.
- Livestock and other farm assets being sold to pay the medical costs of AIDS treatment and palliative care or being used at funerals.
- Failure to transmit agricultural knowledge and skills among and between generations, households and communities.
- Increased reliance on the labour inputs of the elderly and the young (often the very young).
- A dominant need to give priority to immediate survival.

The final outcome is the production of less food and of foodstuffs that are less nutritious. The result is that the AIDS epidemic is leading to a chronic low-grade food crisis in many severely affected communities that are producers of their own foodstuffs.

The private sector

HIV and AIDS impact on the private sector by reducing productivity, increasing costs, diverting productive resources, and affecting the market for business products. During the asymptomatic phase of infection, an employee's status has no real consequence for a firm. Once an employee starts to become ill, the employer incurs a number of costs: increased absenteeism, reduced performance levels of the infected worker, additional burdens on the healthy workers, inexperience of replacement workers, increased medical and insurance costs, extensive recruitment and training costs, and payment of funerals and benefits. The transport and mining sectors are particularly vulnerable to these costs. Both sectors require people to work far from where they normally live and this places them at risk, and both sectors stand to lose highly-skilled and expensive employees.

In many parts of the developing world HIV and AIDS are also affecting the productivity and profitability of the commercial agricultural sector. As with mining and intensive factory production, the working conditions in the commercial agriculture and horticultural industries frequently place employees in situations that increase their vulnerability to HIV infection – away from their families, in low-paid or high-risk employment, living in single-sex overcrowded quarters, with few recreational outlets, and where the commitment to the long-term employment of unskilled workers is very limited. By accentuating the mobility of vulnerable individuals and failing to give them adequate care when in employment, the forces that promote large-scale mining, factory, agricultural and horticultural enterprises also contribute to the spread of the AIDS epidemic.

The purpose of the activity that follows is to encourage you to relate some of the issues that have been considered to what goes on in schools and colleges.

Activity 5

1. What steps can the education sector take to equip school children with the skills that many of them will need in the changing AIDS-affected agricultural environment?

2. How can the education sector better sensitize learners to the HIV risks and vulnerabilities that many of them will encounter in the multinational enterprises that dominate today's commercial and industrial world?

The public sector

The government of any country affected by HIV and AIDS is faced with difficult decisions, while at the same time being affected itself. Government is often one of the biggest employers in a country. Provision of services and the running of the administration require that a wide variety of people be employed across the country. This means that infections will occur within the civil service and the associated costs will be incurred. Reduced productivity, however, has different implications than in the private sector.

In the private sector, if an employee is not productive, this represents a cost to the organization. In the public sector, however, low productivity is a cost to the people requiring the service. HIV and AIDS therefore affect the ability of the state to deliver services. The severity of this reduced ability will be determined by the rates of infection and who it is that is affected, as the state is also likely to have critical posts within its civil service. The impact on the supply of service affects all aspects of government to a greater or lesser degree. The implications of the epidemic on demand, however, will vary across government sectors.

Health is the most obviously affected sector. The rise in illness and death associated with the epidemic increases the demand for health services at a time when health professionals are themselves affected. Again, it is the double impact of increased demand at a time of reduced supply. Governments have difficult decisions to make with regard to the health sector. Even if steps are taken to maintain supply by training additional staff to replace those lost, prioritizations will

have to occur. Health services in most countries heavily affected by HIV and AIDS were strained even before the increase in demand. If the capacity to meet the new demands is limited, decisions on who and what to treat will need to be made. The AIDS epidemic may, therefore, affect the health not only of those infected but also of others in the community.

If governments decide to respond to the increased demand, the manner in which they respond will have a variety of implications. If the decision is made to provide comprehensive treatment in the form of antiretroviral (ARV) drugs, the resource requirements are great. The time of doctors and nurses, the use of facilities, and the costs of the drugs and tests provided make the costs of implementation significant. These costs, however, should not be considered in isolation. Providing ARV will reduce the level of illness, thereby reducing the demand on other areas in the health system and thus freeing up resources. The intervention will, however, need to be financed. The means of financing may well have macro-economic implications. While these are issues that need to be considered, they are difficult to predict and will vary according to the initial economic position in which a country finds itself.

Other government sectors are similar to health in that they experience an increase in demand at the same time as a decrease in the ability to meet it. For example, welfare services, where they exist, face families requiring support as a result of illness or death and the demands of orphaned children or children living with, and possibly caring for, dying parents.

5. Implications for the education sector

Poverty, HIV and AIDS, and education

The close relationship between HIV and AIDS on the one hand and poverty on the other has several implications for education.

- Affected households are likely to have fewer disposable resources for spending on the education of their children.
- The need for children to work around the household and in its production activities may become so great that children are withdrawn from school or allowed to attend only erratically. Girls may be affected in this way more than boys.
- As a result, the provision of schooling should be tailored much more closely to the needs of the poor, in terms of what is taught, how it is taught and when it is taught.

Because of the many ways in which it makes people poorer, and because their poverty makes the poor more susceptible to HIV infection, there is a possibility that HIV and AIDS will become more heavily concentrated among the poor. But because they are less likely to have access to more education, the poor are the ones who will have greater difficulty to benefit from the 'social vaccine' of education. In other words, economic and social deprivation may combine to heighten the vulnerability of the poor to HIV infection. The possibility of this scenario presents educational policy-makers and programmers with the challenge of ensuring the access of every child, but especially the poor child, to good quality schooling for as many years as possible.

Supply and demand

Increased poverty will have an impact on the demand for education; that is, the number seeking education. In addition to the factors already enumerated, demand for education faces a decline in high HIV settings because HIV:

- reduces the fertility of infected women;
- cuts short the lives of others before they have had all the children they otherwise would have had; and
- infects some children born to infected mothers.

As a result, there are fewer children born and even fewer who survive to school-going age. This leads to a reduction in the demand on the education system.

The situation with regard to the demand for education does not mean that fewer teachers and other education personnel will have to be trained. In fact, the epidemic seems to lead to the opposite conclusion. Estimates suggest that, if education personnel have similar HIV prevalence to the general population, the loss of staff will far outstrip the reduction in demand. This means that simply to maintain the current standard of education would require an increase in training. Otherwise, the AIDS epidemic could lead to a decline in standards with resultant negative developmental consequences.

In the education sector, losses in human resources reduce the capacity of the sector to supply educational services while the impact of HIV and AIDS on other socio-economic sectors creates new and different demands for the services that the education sector supplies. The education sector does not exist in isolation from other productive sectors and will be both a cause of adjustment in other sectors as human resources in the education sector are lost and require replacement, and will also as a sector have to adjust its own objectives and capacities in the light of the impact of HIV and AIDS on other socio-economic sectors.

An effective response to the epidemic will be based on an understanding of the ways in which HIV and AIDS affect social and economic activity over time, given that the social and economic impact will differ between sectors, and these differences in impact will also intensify as the epidemic spreads.

Box 2 Case study: HIV and AIDS impact on the education sector labour force

Consider below a broad categorization of the impact of HIV and AIDS on the education sector labour force:

- Reduced labour supply in education with a different age and gender composition
- Loss of skilled and experienced staff of all categories including, professional and manual workers across the education system
- Disruption of educational activities and increased costs for the education system due to increased levels of staff absenteeism and morbidity and early retirement of experienced staff
- Stigmatization and discrimination against staff with HIV or AIDS and losses of staff performance as a result, with effects on system performance and on staff morale
- Increased labour costs for the education system as a whole due to reduced labour productivity, and higher costs due to healthcare expenditure, absenteeism and covering for workers that are sick, funeral costs, pension and other termination payments etc.
- Replacement of staff in all categories, either temporarily or permanently, thus increasing recruitment and training expenditures and associated with changing levels of system capacity through losses of experienced categories of human resources
- Changes in the quality as well as the quantity of services provided by the sector with consequent effects on the social and economic system which feeds-back into the performance of the education system as a whole.
- Losses of key human resource capacities at all levels of the education system, which reduces the capacity of the sector to manage and respond effectively to the complex human resource problems that HIV and AIDS generate.

Two important questions arise from the above:

- What are the most important ways in which attrition of human resources affects the capacity of the education sector to undertake the tasks that are expected of it?
- In what ways, and with what effects, have education sectors as service providers responded to the losses of human resources identified by broad categories above? For example, many of the ways in which schools are adjusting to losses of teachers due to AIDS, such as changes in class size, have effects on the quality of education that have other indirect impacts on labour productivity throughout the economy.

Summary remarks

The above discussions have traced some of the impacts of individual illness and death on government and the broader economy, highlighting the economic and developmental implications. HIV and AIDS touch on every facet of society. It cannot be viewed in isolation as either a medical problem or a behavioural problem.

Every response must take due account of the socio-economic context within which the epidemic occurs. Of particular importance are the poverty and gender dimensions. HIV/AIDS, poverty, and gender inequalities form a triplet whose members continually reinforce one another. HIV/AIDS boosts and is boosted by poverty and gender inequalities. Poverty boosts and is boosted by HIV/AIDS and gender inequalities. Gender inequalities boost and are boosted by HIV/AIDS and poverty. Ideally every intervention to deal with one of these three issues should include some intervention to respond to the other two. The complexity of the epidemic requires a multisectoral approach that takes account of the fact that many socio-economic and cultural factors determine the geographical, gender, age and socio-economic distribution of HIV in the population. Such factors also play a role in the impact of HIV and AIDS on individuals, families, communities and productive activities.

HIV/AIDS and its impacts may be likened to a succession of waves. The first wave that struck was that of HIV infection, but because the infection went unnoticed for many years, the world was not immediately aware of what had happened. The wave of AIDS illness and death has been more obvious. This continues to break upon the world with unrelenting force. There is also the wave of stigma and discrimination with its unfailing power to undermine the dignity of people. In recent years the world has become aware of further waves of the HIV/AIDS impact: the huge number of orphans and vulnerable children; the sometimes neglected population of grandparents and elderly people who look after orphans and the sick; and the undermining of food security and nutritional systems (which will in turn aggravate the risk of HIV infection and progression from HIV to AIDS). These emerging problems call for creative approaches.

When surveying the complex environment within which HIV and AIDS occur, the question repeatedly arises: what has the education sector done about this? What is it doing now? What could it be doing? For an educator, understanding the socio-cultural and socio-economic context of HIV and AIDS is not an end in itself. It is a call to action that will change the situation for the better.

Lessons learned

Lesson One: The importance of going beyond the symptoms

In addition to the obvious manifestations of HIV and AIDS and their immediate causes, there are many factors deep down in society, communities and individuals that facilitate the occurrence of HIV infection. The more thoroughly these are understood and taken into account, the greater the likelihood that responses to HIV and AIDS will be successful.

Lesson Two: Poverty does not cause HIV/AIDS, but the two are closely intertwined.

HIV infection is not confined to the poorest, even though the poor account for most of those infected in sub-Saharan Africa. The relationships between poverty and HIV are far from simple and direct and more complex forces are at work than just the effects of poverty alone.

Lesson Three: HIV and AIDS impact on the development and economic growth of a nation.

AIDS deepens poverty and increases inequalities at every level: household, community, regional and sectoral. The epidemic undermines efforts at poverty reduction, income and asset distribution, productivity and economic growth. AIDS has reversed progress towards international development goals because of the influence it has on all development targets.

Lesson Four: HIV and AIDS reduce governments' capacity to provide services and to respond to the disease.

By debilitating and killing large numbers of adults of working age, AIDS reduces the operational effectiveness of government institutions in high prevalence countries. This seriously undermines the ability of state institutions to provide their mandated services to the people, and in turn to respond to the increased demand for public services generated by the epidemic.

Lesson Five: HIV and AIDS raise questions about the role of education.

The education sector has the potential to address many of the issues that underlie the transmission of HIV and its numerous subsequent impacts. However, there is a need for much re-thinking if it is to be successful in playing its role in this regard.

Answers to activities

Activity 1

At the individual level, the epidemic undermines an individual's potential to lead a long and healthy life, to have access to education and knowledge, to be able to access the resources needed for maintaining a decent standard of living, and to take part in the life and activity of a dynamic community.

At the household level, the epidemic makes the poor poorer, leads to such impoverishment of households that they may disappear as units of society, results in the sale of productive assets to cater for income loss and increased outlays.

At society level, the epidemic leads to declines in productivity (in industry and agriculture because of sickness and death), rising production costs (because of increased medical and insurance costs and because of the costs of recruiting and training new workers), and uneasy relations within communities (because of stigma and discrimination).

Activity 2

Peer and social pressures: men and boys are often under pressure to display a macho image, while girls often feel the need to show their peers that they are in a 'good' relationship. Pressures like these can lead to behaviours that carry the risk of HIV infection.

The use of alcohol contributes in two ways to HIV transmission: first, it clouds the ability to think clearly and to exercise self-control, and thereby can lead to risky behaviour; second, the physical effects of alcohol on the body make an affected person more susceptible to HIV infection, and if the person is already HIV positive they make that person a more potent transmitter of the virus. Injecting drug users are also susceptible to infection in two ways: first, like alcohol, drugs cloud the ability to think clearly and exercise self-control; second, if injecting drug users share needles they can easily transmit the disease to one another through minute droplets of infected blood that remain in the needle after use.

A person whose health or nutritional status is low is more susceptible to HIV infection than a person who is in good health or well nourished. In addition, there is a higher concentration of HIV in the body fluids of an infected person who is under-nourished or whose diet does not contain the necessary micronutrients, and hence that person is a more powerful transmitter of the HIV virus.

Joblessness is closely allied to poverty and poor nutritional status and contributes to the spread of HIV through this route. In addition, those without jobs may not see much hope for themselves in the future and hence may take risks that they would not take if they had secure jobs and reasonable incomes. They may feel that it is pointless trying to protect themselves against a disease that will not make its effects felt for several years when they do not have the income or resources to ensure that they can live a humanly decent life in the years in between.

Points to consider here are the way war and conflict cause severe disruptions to the civilian population; the way they lead to inability to treat ordinary sicknesses, or

cause increased hunger and poverty; the use of rape as an instrument of war; the high levels of HIV in armed forces, especially those who are engaged in active combat; the break-up of households; the refugee streams to which conflicts give rise, especially among women and children.

Corruption promotes the spread of HIV and AIDS because it takes away resources that were intended to go to the relief of those who are infected, to programmes for prevention, or for responding to the needs of orphans and vulnerable children. Corruption may also mean that there is little effective leadership in the struggle against the disease or that leadership is entrusted to those who are less committed. Corruption may also result in policies being adopted, not because they promise to be the most effective, but because they are the ones to which most resources are attached (with the opportunities for unlawful personal profit that this provides).

Activity 3

Income might drop because of inability to work or to carry out farming activities. Income might also drop because attending to a sick person occupies so much of the time of the one generating the income (e.g. a female marketer who cannot devote as much time as otherwise to her work of petty trading).

Expenditure might rise because of the need to buy special items for the person who has AIDS – better food, soft drinks, soothing creams, tablets for headaches, medicines for an upset stomach, extra soap and bleach for washing bed clothes, extra fuel for boiling water to help keep the person and the surroundings clean, etc. Expenditure might also rise because of the costs of visiting a clinic – possibly clinic fees, but also the costs of transport to and from the clinic, the cost of the time spent at the clinic (which is time taken away from other productive work), the costs of medicines that may not be not covered by schemes for free antiretrovirals (e.g. antibiotic creams for thrush).

Coping strategies would include using savings; borrowing from relatives, friends or even moneylenders; selling capital assets (e.g. radio, TV, bicycle, oxen), getting help from community and faith-based organizations. More radical coping strategies would include encouraging female members of the family to go into prostitution, arranging an early marriage for a daughter (so as to obtain the 'bride price' or lobola), taking children out of school to work on the farm or in other income-generating activities.

Activity 4

Books that were published 10 or 15 years ago may show girls and women as teachers, nurses, house servants, cooks, clothes washers, etc. They appear in the background, playing roles that are important but not as prominent as many of those that are shown for men and boys: pilots, doctors, lawyers, drivers, school managers, business executives, sportsmen. More modern books may reflect the changes that are occurring in the way the different sexes are represented, but although this movement is making progress, many texts continue to represent women and girls as occupying 'inferior' positions while men and boys discharge the more 'superior' roles.

The gender message that came across in the older style books was that women and girls were subordinate to men and boys. The newer style books show greater equality between the sexes and indicate how important it is that pupils be made aware of this from the time they commence school.

Activity 5

Possible steps would include: integrating practical agricultural and horticultural education more firmly into the curriculum; developing a school agricultural plot (and not just a school garden) that pupils would manage in co-operation with the community; arranging for demonstrations from successful community farmers; arranging for department of agriculture extension workers to participate in the development of pupils' agricultural skills; bringing the school closer to the community.

By analyzing the connection between globalization (as practiced) and the spread of HIV and AIDS, pointing out how the ease of transport in today's world has contributed to the spread of the disease and how a multinational's lack of accountability to a local community leaves the livelihoods of that community dependent on decisions made elsewhere (and often in a far-off country) in which they do not participate and over which they have no influence.

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Module 1.2

M.J. Kelly

The HIV/AIDS challenge to education

About the author

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Module 1.2

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Aims

The aims of this module are to:

- alert you to the wide variety of challenges that HIV and AIDS pose to a formal education system; and
- enable you to recognize these challenges within a unifying conceptual framework.

Objectives

At the end of this module you should be able to:

- describe ways in which HIV and AIDS affect the context within which education systems function;
- explain how the epidemic affects the ability of education systems to function;
- identify ways in which education systems are changing in response to HIV and AIDS;
- evaluate the need for further education system changes in response to the epidemic;
- present an organizing framework for the interaction between HIV and AIDS and education.

Before you begin…

Questions for reflection

Take a few minutes to think about the questions below. You may find it helpful to make a note of your ideas in the spaces provided. As you work through the module see how your ideas and observations compare with those of the author.

Identify some areas where the education ministry in your country has changed its management structures or procedures because of HIV and AIDS.

Identify any changes that have taken place in the staffing and organization of schools and educational institutions as a result of HIV and AIDS.

In what ways has the school curriculum in your country been changed to take account of HIV and AIDS?

How (if at all) has AIDS had an effect on the number of teachers in schools and the time they can give to actual teaching?

How (if at all) is the AIDS epidemic making it more difficult for the education ministry and schools to do their job?

Module 1.2

Introductory remarks

HIV and AIDS are a new concern for education. Although the World Declaration on Education for All, adopted at the Jomtien Conference in March 1990, embodied worldwide consensus on a renewed global commitment to meeting the basic learning needs of all children, youths and adults, it mentioned neither HIV/AIDS nor orphans. It was only during the 1990s that awareness developed on the implications of the epidemic for education. Recognition that education could also be a significant player in the response to the epidemic grew even more slowly. Both aspects came to the fore at the World Education Forum held in Dakar in April 2000. Acknowledging that HIV and AIDS constitute one of the biggest threats to the global education agenda, the Forum considered:

- the impact of the epidemic on the education sector; and
- how HIV/AIDS-specific education can have a beneficial impact on the prevalence of infection.

At the close of its deliberations, the Forum committed itself in the Dakar Framework for Action to implement as a matter of urgency education programmes and actions to combat the AIDS epidemic. The developments at Dakar bring out three points that lie at the heart of this module (see overleaf).

This module will address these three issues and, more specifically, will examine how HIV and AIDS affect:

- the context within which education systems function;
- the way in which education systems function;
- what society expects from an education system.

A comprehensive response to this threefold challenge implies the need for an education sector to move to a systemic approach. This module outlines the fundamentals of what this entails, while more detailed consideration is given in Module 2.1, *Developing and implementing HIV/AIDS policy in education.*

Box 1 Excerpts from the Dakar Framework for Action

It is only in this century that education is coming to grips with HIV/AIDS, and because the area is so new there is still much experimentation, trial and error learning, and there are many pilot programmes being tested. The science of 'HIV/AIDS and Education'is still in its infancy. HIV/AIDS is a new disease that is only slowly being understood. Similarly, education's appropriate response is only slowly being understood. It will certainly require adjustment as more is learned about the disease and about the way education systems chose to respond to it.

The epidemic has major impacts on the education sector. Specifically, it greatly enlarges the scale of existing management and systemic problems, while at the same time it undermines the capacity to deal with these problems. As was said at Dakar, "what HIV/AIDS does to the human body, it also does to institutions. It undermines those institutions that protect us" (UNESCO, 2000: 22). This negative impact of the epidemic on education is systemic. It affects education in the way in which it is organized and managed as a system. Hence the system in its turn has the responsibility to fight back and protect its functioning so that it can successfully deliver educational services in the way that is expected.

Society has confidence in the ability of the education sector to help it in its struggle with HIV/AIDS. It recognizes that the struggle to overcome the epidemic is one that every sector must engage in. However, because of education's role in the formation of the young, society expects the sector to do something exceptional in helping it confront the epidemic.

1. The impacts of HIV and AIDS on the context for education

HIV and AIDS are transforming the environment in which education systems function. Major HIV- and AIDS-related changes have occurred and continue to occur in the economic, social, cultural and health situations of families and communities. These changes affect not only learners and educators but also education systems themselves.

The economic context for education has been affected at every level

- Nationally, severely affected countries record slower economic growth than in an AIDS-free situation.
- At the business and industrial level, enterprises are experiencing serious losses in the workforce, higher costs, smaller markets, and reduced profitability.
- Households and families are encountering higher expenditures, reduced incomes, and in many cases increased poverty.
- All levels are being affected by the diversion of resources to health costs, reduced investments and savings, the loss of skills, and fewer economically productive young or middle-aged individuals to support the elderly and the very young.

Cumulatively, these effects result in the availability of fewer financial resources, irrespective of their source, for education. The public sector's investment in education is less than it would be in an AIDS-free situation. The private sector has fewer resources at its disposal. Survival is the first concern of households and families, with educational expenditures not ranking high on their list of priorities.

The AIDS epidemic has had major impacts on the social climate in which education systems operate:

- The composition of households is changing; more and more are headed by women or are lacking the presence of an adult.
- The epidemic is creating an ever-increasing number of orphans and vulnerable children.
- The silence, misunderstandings, isolation, stigma and discrimination that surround the epidemic have clouded social relationships with uneasiness and suspicion.
- Communities feel under pressure to provide support for affected families, especially those that care for the sick.
- A growing burden of childcare is being entrusted to grandparents and the elderly, and as traditional safety nets collapse there is an increase in the mobility of people in search of assistance and employment.

The AIDS epidemic is also bringing changes in a number of cultural areas. Although there is still much reluctance to talk about sexuality, the topic is not as taboo as in the past. One outcome is a heightening of expectations that schools will offer

HIV/AIDS and sexuality education to their students. Determined efforts are being made to end practices that favour HIV transmission, such as female genital mutilation, wife inheritance and widow cleansing. Because funerals have become so frequent, the time and resources spent on them are being reduced, while in some places burial rites have become shorter.

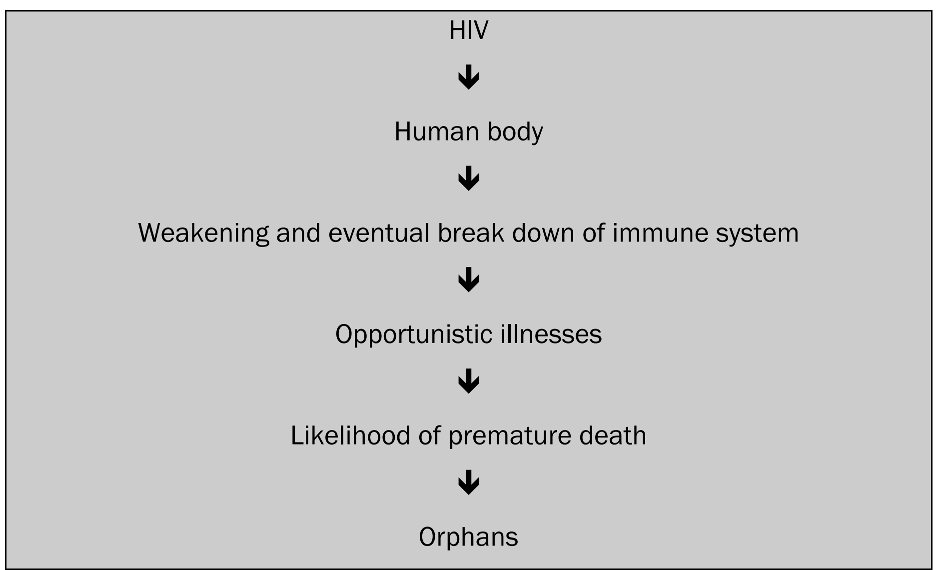
Many of the health impacts are more apparent. In severely affected areas many suffer from extensive, chronic illness, with the situation being made worse in many cases by inadequate healthcare systems. A very high proportion of hospital beds are occupied by patients with AIDS – up to two thirds in many institutions. AIDS-related spending on health services has increased at national and household levels. There is an increasing focus on gaining access to antiretroviral and other life-sustaining drugs.

The epidemic is causing a gradual transformation of the entire social environment, affecting all sectors. However, the education sector is unique in the way that it encompasses a vast number of learners and educators, with a great prevalence of young people who, because of their age, are especially vulnerable to HIV infection. This makes the education sector more vulnerable than other sectors to HIV and AIDS. It also heightens the need for it to be more responsive to the way the epidemic is changing the context for educational provision.

2. HIV and AIDS constitute a systemic problem for education

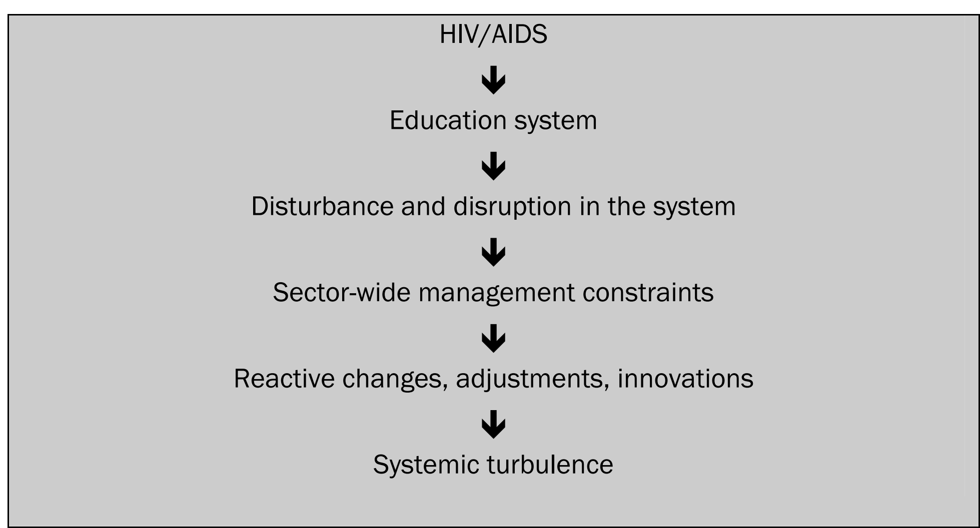
There is a striking similarity between the way in which HIV/AIDS weakens and destroys the human body (Figure 1) and the way in which it undermines an education system (Figure 2).

Figure 1 The course of HIV/AIDS in the human body



When the virus enters the human body, the infection attacks the entire immune system, slowly destroying it. After a considerable period of time, the body is overcome by illnesses that its debilitated immune system is not able to fight. In the absence of antiretroviral treatment, premature death is probable, often resulting in children being left orphaned.

Figure 2 The impact of HIV/AIDS on an education system



Similarly, the effect of HIV and AIDS on education in a seriously affected country is that it compromises the functioning of the entire education system. It magnifies the scale of existing management and systemic problems, as well as creating new ones. An example of an existing problem is ensuring the staffing of schools in rural areas; something that becomes more difficult when AIDS makes it necessary to ensure that every teacher who is ill is posted within reasonable distance of a suitable health facility. A new problem might be developing the learning materials for HIV preventive education as a new area in the curriculum (see Module 4.1, *A curriculum response to HIV/AIDS*).

Because of the way it exhausts human resources, AIDS makes it more difficult to deal appropriately not only with issues originating from the epidemic itself, but even with ongoing routine matters. Managing these constraints leads in turn to a number of reactive changes, adjustments and innovations, all of which in their turn result in considerable turbulence across the system (Figure 2). Because of HIV and AIDS, changes have occurred in the way the system functions and operates. If infection and illness are extensive, these changes may be of such magnitude that the system might experience difficulty in pursuing and attaining its essential goals. This is happening in many countries where the AIDS epidemic is making it that much more difficult to attain the Millennium Development Goals (MDGs) and those of Education for All (EFA).

3. The impacts of HIV and AIDS on an education system

Essentially, an education system seeks to put in place arrangements that ensure that learners learn and educators teach in an environment that supports learning. In countries affected by the epidemic, HIV and AIDS have an increasingly negative impact on these three major areas: They affect learners, educators and the learning environment. The impact in any or all of these areas may be sufficient to make learning difficult, or even impossible; impede teaching; and create an environment that is not conducive to the provision of good quality education. Further, the epidemic has progressive major financial implications for the education sector and can have a significant negative impact on educational management and planning.

AIDS and the demand for education

Many developing countries are still struggling to meet the EFA goal of providing basic education for all. In a perverse way, AIDS makes this task easier because fewer children will be born, and some who are born will die young because of the HIV virus transmitted to them by their parents. On the other hand, HIV and AIDS make the achievement of EFA goals more difficult because children from affected families may not be able to make use of the available opportunities for schooling. This is very frequently because of school-related costs. Although recent years have seen several countries introduce free primary education, the reality is that those attending school continue to bear some costs. These may consist in parent-teacher association levies, or the cost of a school uniform and educational materials or supplies that must be provided for the school. In addition, there is always an opportunity cost for those attending school – a cost that may be so significant that it will prevent those from poor households from attending school. Through the increasing dependence on child labour that it has created, AIDS has greatly increased these opportunity costs, especially for girls.

These circumstances lead to three possible situations for children:

- non-attendance at school;
- highly irregular, ‘stop-start’ school attendance;
- non-completion of school.

In each case, children do not have access to sustained basic learning opportunities. They are deprived of their human right to education and, as Module 1.3, *Education for All in the context of HIV/AIDS* shows, they are denied the protection against HIV infection that a school education can provide.

The demand for education is also affected in various ways by the enormous and growing problem of orphans. At the end of 2003, children under the age of 18 who had lost one or both parents to AIDS were estimated to constitute 10-19 per cent of all children in the countries of eastern and southern Africa. The financial problems that many of these children experience in school participation may be aggravated by their sense of emotional loss and the psycho-social distress of the

disruption in their lives. But although orphaning is associated in many countries with low rates of school attendance, situations occur where the proportion of orphans attending primary school is as high as that of non-orphaned children. In almost all countries, however, young people left without one or both parents may experience unusual difficulty in accessing secondary and tertiary education. They find that the support that was extended to them as young children becomes less readily available as they grow older.

As you have by now read a considerable amount of information, it would be good at this point to reflect on what you have read in relation to situations with which you are familiar. The activity that follows will help you do this. Please make sure that you do work through this activity. It will help you to come to a richer understanding of the impacts of the epidemic on education. Guidance to where you might look for answers is given towards the end of this module.

Activity 1

How AIDS affects the demand for education.

Working at either national, sub-national (provincial, district or zone) or school level, try to find the information that will answer the questions below, and use this information to inform your own understanding of the impact of AIDS on the demand for education.

Are all children entering primary school? If not, what are some of the reasons for this?

Are they entering at the prescribed age?

Are all children completing primary school?

Is drop-out increasing? If so, what are some of the reasons for this?

What is the drop-out pattern for girls?

And for orphans?

Do children who have left school re-enter again at an older age?

Is there much movement of children from one school to another? What are the reasons for such movement?

Are there signs of families being broken up or migrating in search of employment?

Do orphaned young people in your area or country have greater access to secondary and tertiary education than other young people?

AIDS and the supply of education

HIV and AIDS make it more difficult for an education system to ensure that there is a teacher in every class because:

- teachers and other educators are dying in increasing numbers and at comparatively young ages, and it takes time before they can be replaced;
- teachers who are ill are often unavoidably absent, and there is nobody to take over the affected classes;
- household sicknesses and family and community funerals are leading to increases in teacher absenteeism;
- rural posting of teachers is becoming more difficult because teachers who know they are HIV positive want to be posted near health facilities, most of which tend to be in towns or at the larger administrative centres; and
- teachers leave teaching to take up employment (often more lucrative) in other areas where AIDS has created vacancies.

However, teachers are not the only ones affected. The epidemic affects personnel in other parts of the education system in similar ways. HIV prevalence among managers, planners, professional staff and support staff is likely to be as high as in comparable groups in the general population. The effects mount up to a severe depletion in the social capital available to the system – the norms, networks, institutional memories, understandings and working arrangements that sustain its smooth functioning and make it possible for it to maintain its daily operations. Deprived of this social capital, systemic ability to address the difficulties experienced in schools is weakened. Simultaneously, the problem of addressing its internal needs becomes of greater concern to the system, thereby further constraining its ability to respond to what is happening in schools and institutions.

Cost is an important factor in the supply of education. The AIDS epidemic affects the costs of education in various ways, such as the following:

- The additional training and posting costs for replacement teachers and other staff.
- Payments of salaries to absent or sick personnel.
- The loss of the training costs invested in teachers and students who die young.
- Frequent payments of death and funeral benefits.
- Premature payment of terminal benefits.
- The costs of ensuring orphans' and other vulnerable children’s access to education.
- The costs of teacher training in the relatively new curriculum area of HIV preventive education, and the development and dissemination of the necessary materials.
- Additional management costs for the establishment of HIV and AIDS units or AIDS-in-the-workplace training programmes.

Time is a further factor in ensuring that the supply of education responds to known and envisaged needs. Two very different areas are worth noting.

First is that educational managers are being required to give an increasing proportion of their time to responding to HIV and AIDS. Sometimes this may take

them away from their other duties for prolonged periods as they participate in training sessions or workshops. In addition, HIV and AIDS make demands on their time through additional meetings, preparation for and follow-up of such meetings, epidemic-related paperwork, and responding to the concerns of colleagues. Relentlessly, the epidemic increases their burdens and jams up systemic capacity to address both ongoing and new issues.

Second, schools, particularly those in rural areas, look to their communities to provide labour and inputs for school maintenance and development. The epidemic is reducing community capacity to do so. Because of the loss of community members to AIDS, those who are not infected find that they must give more time to maintaining their own levels of production, working on behalf of those who are ill, or assisting the families of those who have died. They no longer have time to participate in usual self-help activities for the benefit of the school.

HIV and AIDS and the quality of education

Following a long period when the focus tended to be on quantity and numerical expansion, education systems are increasingly focusing on quality, by which they measure the level of their success. In this approach, central goals for every system are to ensure student learning achievements and appropriate personal formation. The ultimate aim of education systems and institutions can be stated even more briefly: to prepare every learner for a better future.

Since the likelihood of a better future depends to some extent on the quality of learning, it will help you at this stage to reflect on what this means and how it can be undermined by HIV and AIDS. That is the purpose of the next activity which should help to expand your understanding of quality in education. Signposts to the answers follow immediately in the text (and are repeated towards the end of this module).

Activity 2

How HIV and AIDS affect the quality of education.

Before you read further, make a note of any ways in which you think HIV and AIDS might constrain the achievement of quality in education.

HIV and AIDS obstruct every learner's access to a better future. In the context of the epidemic, the learning achievement and personal formation of students are threatened by the following factors:

- Frequent teacher absenteeism, with classes being left for days, even weeks, to learn on their own.
- Shortages of teachers in specialized areas such as mathematics or science.
- Increased reliance on less qualified teachers.
- Learners are frequently absent, participate intermittently or drop out.
- A concern for the sick at home takes attention away from teaching and learning.
- Frequent periods of grief and mourning in schools, families and communities.
- Unhappiness and fear of stigmatization and ostracism on the part of both teachers and learners who have been affected by the epidemic.
- Uncertainty and anxiety in the relations between learners and teachers (who may be caricatured by the community as those responsible for the introduction of HIV).
- Teachers' uneasiness and concern about their personal HIV status.

These problems are accompanied by limited resources, generalized poverty, a sense of inappropriateness of the curriculum to real life, a lack of connection between the world of the school and the world of work, and some doubt about the value of school education when it seems likely that many will die young because of AIDS.

On the other hand, however, it is also necessary to recognize that the introduction of HIV preventive education and life skills programmes may drive schools to work more purposefully for the personal formation of learners (see also Module 4.2, *Teacher formation and development in the context of HIV/AIDS*). Further, a number of these programmes are set in a rights-based framework and value highly learning to live together in a society that shows respect for every human being. Good programmes of this nature can assist learners in the formation of desirable values. This brings out one of the anomalies arising from HIV and AIDS: that, notwithstanding the devastation and suffering it brings, it can also set the stage for outcomes that are highly desirable in their own right.

AIDS and the management of education

The management challenges and inadequacies that education systems encounter have not all originated with AIDS; they existed long before the advent of the epidemic. But in almost every case, HIV and AIDS are making them worse. They are also creating new problems.

Areas of particular concern include the following:

- Human resource planning and management in an environment of morbidity, mortality and considerable uncertainty (see Module 3.4, *Projecting education supply and demand in an HIV/AIDS context*).
- Resource mobilization and financial flows, so that the funds allocated to dealing with the problems caused by HIV and AIDS are spent efficiently and effectively.
- HIV and AIDS issues in the workplace.
- Building capacity in response to personnel losses and fostering the ability to generate new approaches, skills and capacities that will enable the system to cope with the impacts of the epidemic.
- Devising and establishing an HIV- and AIDS-informed educational management information system (EMIS).
- Promoting and harmonizing donor and partner involvement in such a way as to develop ownership of a system-driven response to the epidemic.
- Learning from experience through rigorous and regular monitoring and evaluation.

An overarching management concern is to mainstream HIV and AIDS within the system so that it caters in a long-term and sustainable way for the three key themes of:

1. prevention;
2. care, support and treatment; and
3. impact mitigation, encompassing both workplace issues and management of the response.

Responding to this concern requires that the short-term programmatic issues identified earlier in this section be set within the long-term systemic framework of a comprehensive, prioritized plan of action (see, for example, Kenya (2004). Developing such a plan necessitates an evaluation of the impact of the epidemic on the education system and the system's preparedness to respond, identification of the form that the system response will take, and providing for the necessary monitoring, evaluation and reporting. Clearly, such a process and subsequent implementation make extensive demands on the management capacity of an education system. But in going through the process, management capacity is itself built up, as both Namibia and Kenya experienced as they developed prioritized plans of action for the education sector's response to HIV and AIDS.

This is a good time to stop reading for a while. It is suggested that you try to work through the next activity, and that you do so conscientiously as this will greatly improve your understanding of what has been discussed so far.

Activity 3

Issues to be included in a comprehensive HIV and AIDS plan

Try to identify some of the major issues that an education system should address within the framework of a comprehensive plan of action for dealing with HIV and AIDS.

Guidance on where to look for further ideas is provided towards the end of this module.

AIDS and the process of education

The process of education refers to all that goes on in a school or educational institution. In addition to everything that is officially and formally provided, it also includes the numerous unofficial activities that take place, as well as the many interactions occurring between the members of the educational community. It further encompasses the institutional culture – that ill-defined but all-embracing ethos of a school or college, its way of prescribing 'how things are done here' and of separating those who belong from those who do not. The module uses the word 'process' in preference to 'curriculum' because of the tendency to associate curriculum with formal classroom teaching and learning experiences.

HIV and AIDS affect many aspects of institutional culture and activities. In school and college settings, the influence of the epidemic manifests itself in the following ways:

- More express institutional concern about the values it communicates and the practices it allows.
- HIV- and AIDS-related changes in rules, regulations and sanctions.

- More randomized teaching and learning, because of the periodic absence of teachers or the irregular attendance of learners.
- New teaching and learning areas catering for preventive and sexual health education and psycho-social life-skills.
- The training of teachers and tutors to deal with these new topics.
- Teaching methodologies that are more interactive and student-centred.
- Social interactions that are affected by the frequency of illness, death, funerals, caring for the sick, stigma, isolation, and orphanhood.
- A focus on AIDS-related co-curricular activities, clubs, information, announcements and other expressions of the school's organizational culture.

Take some minutes now to work on the fourth and final activity.

Activity 4

The pros and cons of school boarding facilities

In many developing countries, students live on the school premises or make private arrangements in boarding facilities near the school. Moreover, in some societies parents are particularly keen that there be school boarding facilities for girls. Make a list of the arguments for and against school boarding in circumstances of high HIV prevalence:

For:

Against:

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4. HIV and AIDS affect what society expects from its education systems

HIV and AIDS present educators with the challenge and the opportunity to improve and reform the existing system and to transform education. Although calamitous in many respects, the impacts of the epidemic do not necessarily lead to a developmental dead end. Instead, the epidemic presents a challenging opportunity for growth, reform and development.

In many severely affected countries, vigorous responses to the AIDS epidemic are revitalizing communities with a renewed sense of purpose, accomplishment and cohesion. Developments that are being spurred by the epidemic are found also in education. For instance, the AIDS situation is leading to greater efforts to find ways to put an end to gender inequalities, in education as elsewhere. Likewise it has created a greater sense of urgency in efforts to attain the EFA goals.

The challenge to education is to use the opportunity that the AIDS crisis presents to rethink and redesign many of its approaches to these and similar issues. Education systems have long been a prisoner of their past, with much stress on the academic. Because of the way AIDS consumes productive human resources and breaks the chain of transmission of skills from one generation to the next, the epidemic calls for a critical rethinking of this and other aspects of education provision. Thus a comprehensive education sector response to HIV and AIDS will embody opportunities for progress and reform in such areas as:

- greater involvement of the community;
- improving instructional practice;
- more interactive student-centred learning;
- greater focus on the acquisition of productive skills;
- managing the challenge of equity in favour of the poor, girls, rural children and those with special educational needs;
- decentralization in reality as well as in intent;
- enhanced and more mutually beneficial relationships between education ministries and teachers;
- deeper and more effective partnerships;
- improved information about the system through the application of a needs-based education management information system (see for more information Module 3.2, *HIV/AIDS challenges for education information systems*).
- In addition, society expects its education systems to use the resources at their disposal to halt the spread of HIV and AIDS; be involved in an appropriate way in care, support, and treatment; and work with other partners to mitigate the negative effects of the epidemic.
- In education, as in other domains where AIDS is prevalent, things cannot continue running as usual. The AIDS epidemic challenges every education system to plan and provide the kind of education that will prepare children and youths to live responsibly, productively, creatively and happily, and give them hope in the world they face – a world that has changed very radically

since the time when most of the current education systems were designed. A major responsibility for educational authorities is to analyze the consequences of the epidemic in order to adapt educational structures and provision to be more relevant to the needs of an HIV- and AIDS-affected environment.

Summary remarks

Because HIV and AIDS did not become known in the world until the last quarter of the twentieth century, understanding how it impacts on education is an area that is new and developing. Knowledge is growing rapidly, but there is still much to learn. Impact assessments commissioned by education ministries provide the basis for much that is known about the way the epidemic affects education. The understandings arising from these studies are complemented by other country, sectoral and sub-sectoral investigations and analyses. Although there are differences between countries, the impact assessments and other studies bring out a number of features that constitute the challenge of HIV and AIDS to education (see Box 2 below).

Box 2 The challenge of HIV and AIDS to education

- The epidemic is resulting in significant changes in the economic, social, cultural and health environments in which education systems operate.
- The epidemic is having major sectoral impacts in terms of the demand for education, the supply of teachers and other educational personnel, the costs of providing education, the management of education, the process of education, and the quality of education.
- Education systems have a central role to play in responding to the epidemic. The epidemic is providing opportunities that challenge education systems to initiate reforms, and is stimulating them to move in directions that in themselves are good and desirable.

The majority of the observed impacts on the education sector are negative. These are occurring in an environment that is being restructured by the AIDS epidemic. This restructured environment is experiencing deeper and more extensive poverty, a wide range of economic problems, increased health concerns, and a transformation of many social structures. It is not possible to separate education from all of these or to say with absolute certainty that AIDS is responsible for one outcome, poverty for another, health for yet another, and so forth. But what is certain is that the features of the changing society that HIV and AIDS are creating conspire with the direct impacts of the epidemic to compromise the ability of education systems to deliver education in the quantity and quality that society expects.

Figure 3 overleaf presents a simple structure for conceptualizing the challenges that HIV and AIDS pose for education.

Figure 3 What HIV and AIDS do to an education system

HIV and AIDS affect :

The context for education

- Economic
- Social
- Cultural
- Health

The functioning of an education system

- Demand
- Supply and costs
- Management and process
- Quality

Expectations for education

- Contribute to preventing the spread of HIV and AIDS
- Greater community involvement
- Improved institutional practices in the classroom
- Attainment of equity goals
- Renewed stress on the acquisition of productive skills
- Improved information about the system

When the HIV virus is present in the human body, it inhibits the ability of the immune system to respond to what would in normal circumstances be manageable illnesses. When the virus is present in education, it inhibits the ability of the system to deliver what in normal circumstances would be achievable outcomes. The 2002 Education for All Monitoring Report identified one tangible aspect of this situation: “countries where HIV/AIDS prevalence is high are experiencing severe problems in maintaining progress towards the attainment of the EFA goals” (UNESCO, 2002: 147). A further aspect of grave concern is the way that factors arising from the AIDS epidemic combine with other forces to inhibit actual learning achievement and thereby lowers the quality of the education provided.

Finally, it should be noted that the preceding pages have analyzed the AIDS and education situation as it manifests itself in severely affected countries. It is unlikely that all of these impacts will be experienced in countries where HIV prevalence is low. But the global history of HIV and AIDS shows that HIV levels can increase with dramatic rapidity, as happened in South Africa in the period 1990-1999. With large-scale failure in global prevention measures, the situation in countries with low prevalence levels could deteriorate quickly. Therefore, such countries need to be ready to respond to the epidemic’s potential to cause a variety of problems for their education systems, which could compromise their ability to function.

Lessons learned

Lesson One: HIV and AIDS put education systems under stress.

The epidemic adds wide-ranging new dimensions to the problems that education systems already confront and enlarges their scale, as well as adding new problems. In many systems, demand, supply, cost and other problems existed long before the advent of HIV and AIDS. The epidemic did not create these problems, but it has aggravated them and at the same time has added new ones.

Lesson Two: There is a need to be alert to the impacts of HIV and AIDS in every facet of educational provision.

The impacts of HIV and AIDS are not confined to teachers or to schools; they are to be found throughout the system. They can occur at every educational level, from pre-school to university. They can affect management, professional and administrative functions just as easily as teaching and learning. Concentrating on one facet while excluding the others will fail to give the whole picture. It is important to consider how the epidemic affects schools and how they should respond. But it is equally important to consider how the epidemic affects the integrated management of the system and how it should respond.

Lesson Three: The impacts of HIV and AIDS on education cannot all be measured.

Difficult as it may be to obtain the data, it is theoretically possible to enumerate the impacts of HIV and AIDS in terms of such factors as teacher morbidity and mortality, non-attendance rates, drop-out rates or numbers of orphans, one or both of whose parents have died from AIDS. It is not possible to quantify in the same way the trauma that HIV and AIDS cause to infected and affected individuals, the sense of loss and disruption that an orphan experiences when a parent dies, or the tensions experienced by a female employee with three major tasks on her hands: performing satisfactorily as an employee, managing a household, and caring for a spouse or relative who has AIDS. These impacts, which cannot always be measured, may be as detrimental to the functioning of an education system as those that are more easily measurable.

Lesson Four: HIV and AIDS affect education as a system.

HIV infects cells in the body’s immune system and undermines the system’s ability to protect the entire body. Similarly, the disease enters education through the large number of individuals within the system, and by infecting them undermines the education system’s ability to deliver its mandated services. This systemic problem requires a response that sees HIV and AIDS as a long-term systemic management problem that calls for a comprehensive, prioritized plan of action.

Lesson Five: Knowledge about the impacts of HIV and AIDS on education is still in its infancy, pointing to the need for more research, further investigations, and continued analysis.

Although much progress has been made, information on the way the AIDS epidemic affects education systems is still quite limited. There is a need for more knowledge and improved understanding. Practical research is required to extend the body of knowledge and to serve as a basis for response measures. But the need for better information should not inadvertently delay or derail action. Further, investigations should address issues that are likely to make a substantial difference to understanding, policy and action. In addition to the insights that would come from purpose-designed studies, knowledge gaps in this area could also be bridged by strengthening routine management information systems and adjusting them to take account of the epidemic's intrusion into the education system.

Answers to activities

Activity 1

These data will be country specific, but some of the answers may be found in the EFA Global Monitoring Report (UNESCO, 2004) or on the UNESCO Institute of Statistics website at www.uis.unesco.org.

Activity 2

Below are some are some of the ways in which HIV and AIDS can affect educational quality; the list is not comprehensive:

- Frequent teacher absenteeism, with classes being left for days, even weeks, to learn on their own.
- Shortages of teachers in specialized areas such as mathematics or science.
- Increased reliance on less qualified teachers.
- Learners are frequently absent, participate intermittently or drop out.
- A concern for the sick at home takes attention away from teaching and learning.
- Frequent periods of grief and mourning in schools, families and communities.
- Unhappiness and fear of stigmatization and ostracism on the part of both teachers and learners who have been affected by HIV or AIDS.
- Uncertainty and anxiety in the relations between learners and teachers (who may be caricatured by the community as those responsible for the introduction of HIV).
- Teachers' uneasiness and concern about their personal HIV status.

Activity 3

You may want to compare your ideas with those set out in Kenya's Education Sector policy on HIV and AIDS (Kenya, 2004).

Activity 4

You may find it interesting to compare your ideas with the findings of Zimba and Nuujomo-Kalomo, 2002 (for full reference see Bibliography).

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Module

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Education for All in the context of HIV/AIDS

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Module 1.3

EDUCATION FOR ALL IN THE
CONTEXT OF HIV/AIDS

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Aims

The aims of this module are to:

- present users with an overview of the Education for All (EFA) initiative;
- introduce the six goals identified in the Dakar Framework for Action, as well as the education-related Millennium Development Goals (MDGs);
- discuss how their implementation is threatened by the pandemic; and
- illustrate how the strategies implemented within their framework can assist in curbing the spread of HIV and the impact of AIDS.

The ultimate aim of this module is to demonstrate that the fight against HIV and AIDS and efforts to promote EFA are intimately linked.

Objectives

At the end of this module, you should be able to:

- demonstrate knowledge and understanding of Education for All and its various objectives as listed in the Dakar Framework for Action and the Millennium Development Goals;
- appreciate the impact of HIV and AIDS on the implementation of EFA and explain how HIV and AIDS are an EFA issue;
- explain how strategies for EFA can ensure HIV prevention and slow the spread of the virus among children, youth and adults;
- identify EFA strategies and interventions that can assist in increasing learning opportunities for infected and affected children and youth.

Before you begin…

Questions for reflection

Take a few minutes to think about the questions below. You may find it helpful to make a note of your ideas in the spaces provided. As you work through the module, see how your ideas and observations compare with those of the author.

Do you know what Education for All is? Can you name two of the EFA goals?

Why is Education for All important to a country's development? Does your country have an EFA Action Plan or a sector plan emphasizing EFA?

Identify some ways in which HIV and AIDS may be affecting progress towards EFA in your country.

Can you envisage how implementing Education for All can curb the spread of HIV and AIDS?

Name some interventions and policies that can help increase access of the poorest and disadvantaged groups to quality education in your country, and that could benefit AIDS-infected and -affected children.

You will find answers to these questions in the rest of the module. More information on EFA, including your country's plan for EFA, can be found on the following web sites:

http://portal.unesco.org/education/en/ev.php-URL_ID=43009&URL_DO=DO_TOPIC&URL_SECTION=201.html

www.unesco.org/education/efa/db/index_national_plans.shtml

Module 1.3

Introductory remarks

In the absence of a cure, education is the best protection against HIV. Several studies have shown that a complete basic education can equip children with the cognitive skills and necessary knowledge to make an informed choice and bring about healthier behaviour. Educated children – and educated girls in particular – know more than other children about how they can become infected and how they can protect themselves. The more educated and better informed they are, the more likely they are to refuse risky practices and to resist pressure and intimidation by adults. Education is not a substitute for treatment, nor does it replace any other prevention campaign. But informing children and providing them with advice before they become sexually active is a means of stopping the spread of the epidemic.

Yet Education for All (EFA) is far from being a reality. Some 100 million children all over the world are still out of school, 55 per cent of whom are girls. Although substantial progress has been made, several countries are at risk of not achieving the goal of universal primary education (UPE) by 2015 unless aggressive financial plans and policies are put underway. In Africa, where HIV prevalence is the highest in the world, enrolment ratios are amongst the lowest at primary and secondary education levels, particularly among girls and disadvantaged groups. Sub-Saharan Africa is home to most of the out-of-school children. Should UPE become a reality there would be fewer youngsters and young adults infected every year.

Realizing the importance of education for economic and human development, the international community committed itself to attaining EFA in 2015. The present module examines the different goals set out in EFA. It then focuses on how the HIV/AIDS epidemic is affecting progress towards these goals. HIV/AIDS reduces the resources available to education and has an impact on the system and on learners in many different ways. The module then moves on to describe how EFA can help mitigate the pandemic. Ministries of education have representatives in almost every village in each of the countries and their teachers can deliver prevention messages to large numbers of the uninfected population; to children and youths, and also their parents. The more youngsters that are educated and convinced of the need to protect themselves, the more the spread of the virus can be controlled.

By strongly emphasizing access to quality education for all children and youth, promoting appropriate learning opportunities for youngsters and adults, introducing life skills in educational programmes, and advocating gender equality in education HIV-prevention messages can be widely taught and effectively reinforced. At the same time, protecting the education system and maintaining its efficiency is essential for EFA and for fighting HIV and AIDS. Ministries of education must see HIV and AIDS as an EFA issue. The requisite skills, resources, capacity development and confidence-building must be made available to teachers and administrators everywhere if this strategy is to succeed.

1. EFA timeline

1990

The World Conference on Education for All convened by UNESCO, the World Bank, UNICEF and UNDP takes place in Jomtien, Thailand in March 1990. During this conference, delegates from 150 countries and 155 organizations reaffirm the right of all people to education and adopt the World Declaration on Education for All: Meeting Basic Learning Needs. The participants commit themselves to universalizing primary education and to massively reducing illiteracy rates by the end of the decade.

2000

These same countries and organizations attend the World Education Forum ten years later in Dakar, Senegal. The 1,100 participants restate their commitment to the goals of the World Declaration on Education for All and commit themselves to achieving the six goals listed in the Dakar Framework for Action, including free primary education of good quality by 2015.

In the same year, the member states of the United Nations establish the Millennium Development Goals (MDGs) during a General Assembly or Millennium Summit in September.

2001

Two specific strategies particularly relevant to HIV and AIDS are developed within the framework of EFA.

The flagship on the impact of HIV/AIDS on education aims at implementing, as a matter of urgency, education programmes and actions to combat the HIV/AIDS pandemic. It is based on a statement made in Dakar that "To achieve EFA goals will necessitate putting HIV/AIDS as the highest priority in the most affected countries, with strong, sustained political commitment; mainstreaming HIV/AIDS perspectives in all aspects of policy; redesigning teacher training and curricula; and significantly enhancing resources to these efforts" (Expanded Commentary on the Dakar Framework for Action, Strategy 7).

Another programme, called FRESH (Focusing Resources on Effective School Health) is launched, aimed at promoting child-friendly schools and quality EFA by broadening the scope of school health programmes and improving their effectiveness; and identifying and addressing health-related problems that interfere with enrolment, attendance and learning.

2002

The EFA Fast Track Initiative (FTI) is developed to accelerate progress in achieving the shared Education for All and Millennium Development Goals of universal completion of quality primary education. FTI forms partnerships between donor organizations and beneficiary countries to support commitment and adherence to the goals.

Countries can apply for FTI funds once they produce a poverty reduction strategy paper (PRSP) and a credible national education sector plan. Once these plans are accepted by local development partners, countries receive funding to support their efforts towards UPE within the broad context of EFA and the second and third Millennium Development Goals. Reference to an HIV and AIDS strategy is an explicit condition for a country's submission if they are to be accepted (EFA FTI Secretariat, 2005).

2003

The EFA Development Index (EDI) is introduced as part of the EFA Global Monitoring Report to aid countries in assessing progress towards the goals and to create a common scale for all countries.

2005

Eighteen countries have education sector plans endorsed and can apply for FTI funds. Many countries around the world show progress in enrolling more students in schools, and also in increasing the enrolment of girls. Yet progress is still slow. Some countries still face challenges, such as HIV and AIDS that risk throwing them off course.

2. EFA and the Millennium Development Goals

The World Declaration on Education for All, adopted in Jomtien and reaffirmed in Dakar in 2000, called on a learning environment in which everybody would have the chance to acquire the basic elements that serve as a foundation for further learning and enable full participation in society. This was considered necessary for essentially three reasons: First, education is a basic human right; second, it is a critical tool to empower those who suffer from multiple disadvantages, giving them access to self-respect, to the means to avoid illness, sustaining livelihood and enjoying peaceful relations; and last, but not least, education has been proven to increase productivity and to promote growth and other development objectives.

Recognizing that economic growth was not in itself sufficient to reduce poverty and to promote human development, the Millennium Summit in September 2000 made an international commitment to work towards eliminating poverty and to promote sustained development. It identified a number of Millennium Development Goals, three of which are of particular relevance to education, gender equality and HIV/AIDS.

These international commitments create a universal blueprint to guide the decisions of governments, donors and ministries of education when prioritizing the allocation of funds and resources, including to the education sector. Ministry of education staff and planners should understand each of the EFA goals in order to effectively design an EFA action plan or a sector plan that concentrates on aspects of the goals and provides sound reasoning as to how the plan will accelerate progress to reach these goals.

In the next section, we present the EFA goals and MDGs within the context of HIV and AIDS.

Activity 1

Before we begin looking at the EFA goals and MDGs, take a minute to write down the goals that you know about. Then write down how AIDS could affect your country's ability to achieve them.

Understanding the EFA goals in the context of HIV

The six goals expressed in the Dakar Framework for Action are the following:

- Expanding and improving comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children.
- Ensuring that by 2015 all children, particularly girls, children in difficult circumstances and those belonging to ethnic minorities, have access to and complete free and compulsory primary education of good quality.
- Ensuring that the learning needs of all young people and adults are met through equitable access to appropriate learning and life skills programmes.
- Achieving a 50 per cent improvement in levels of adult literacy by 2015, especially for women, and equitable access to basic and continuing education for all adults.
- Eliminating gender disparities in primary and secondary education by 2005, and achieving gender equality in education by 2015, with a focus on ensuring girls' full and equal access to and achievement in basic education of good quality.
- Improving all 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.

A brief description of each goal is followed by how this goal seems particularly relevant in a context of HIV.

Goal 1: Expanding and improving comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children.

"Learning starts at birth. This calls for early childhood care and initial education" (World Declaration on Education for All, 1990). Early childhood care and education (ECCE) refers to the range of programmes aimed at the physical, cognitive and social development of children from birth until age six or seven, just before they should enter primary school. ECCE programmes adopting a holistic approach to the development of a child have important positive effects on future learning and development possibilities. The benefits of quality ECCE continue well beyond initial education, setting the foundation for lifelong learning. ECCE can be delivered in many forms, such as government programmes, home care programmes and NGO and community initiatives. Factors that influence attendance in ECCE programmes include the education level of mothers, proximity to urban centres, and parents' income and work status. Except in a handful of countries, early childhood care and education programmes are not well developed in sub-Saharan Africa, where they often concern fewer than 10 per cent of the relevant age group (UNESCO, 2005).

These programmes would be particularly helpful for low-income and disadvantaged children, among them HIV/AIDS-infected and -affected children. These children would be among those who would benefit most from the activities that support children's psychosocial development, but also from the systems of care, health and nutrition that are often attached to them. Indeed, malnutrition during the first two to three years of life can damage the physical growth and brain development of the child for ever. Participating in ECCE is an opportunity for infected and affected children to receive the attention they deserve. Parents living with HIV, however,

might be forced to neglect early childhood care and education due to reduced resources or constraints on their own health.

Goal 2: Ensuring that by 2015 all children, particularly girls, children in difficult circumstances and those belonging to ethnic minorities, have access to complete free and compulsory primary education of good quality.

Goal 2 of EFA requires that governments prioritize access to schools for all children, particularly children in difficult circumstances, such as AIDS orphans. Education is a human right, yet some 100 million children are still not enrolled in primary schools, 55 per cent of whom are girls. Most out-of-school children live in the rural areas of developing countries; most of them in sub-Saharan Africa. Education is not yet available for all and "primary school fees, a major barrier to access, are still collected in 89 countries out of 103 surveyed" (UNESCO, 2005: headline message).

Enrolment and completion rates are the key indicators for measuring progress towards this goal. The gross enrolment rate (GER) is the number of students at a given level of school, regardless of age, as a proportion of the number of children in the same age group. The net enrolment rate (NER) is the proportion of the relevant age group enrolled in the level of education concerned. It excludes all pupils/students who are too young or too old for the education level concerned. These are both presented as percentages. Unlike the GER, the NER cannot exceed 100 per cent. The completion rate is the proportion of children of the relevant age groups who complete a full cycle of primary education. In 2003, only 59 per cent of the relevant age group was finishing primary education in Africa. This means that not only are many children deprived of access to primary schools, but a large number drop out before completing the first cycle and will more than likely remain illiterate. The graph below shows that completing six to nine years of basic education is necessary in most African countries before an adult considers him- or herself literate. Hence, having attended school does not necessarily mean that an individual has acquired all the cognitive skills that are normally expected from schooling. This is due in part to the low quality of the education provided – a problem we shall return to below.

Figure 1: Proportion of adults aged 22-44 who consider themselves literate according to their number of years of studies in Africa.

Source: calculations by the pole de Dakar and the World Bank on the basis of countries' household surveys.

Goal 3: Ensuring that the learning needs of all young people and adults are met through equitable access to appropriate learning and life skills programmes.

EFA is sometimes understood as being synonymous with achieving primary education for all, but this is not the case. The Dakar Framework also emphasizes learning for young people and adults that will enable them to live safer, healthier, and more economically and socially productive lives. Adult education and life skills programmes can encompass many different disciplines, from health education and citizenship education to practical or entrepreneurship education that allows youngsters in or out of school to make a living. These are provided in a myriad of formal, informal and non-formal education programmes. Youngsters, adults and children who were denied learning opportunities or dropped out of school early can particularly benefit from education and training programmes that aim at increasing employability and income-generation capacities as well as at building individuals' and communities' capacities for sustainable livelihoods. Box 1 contains examples of education programmes that use technical and vocational training to improve livelihoods, health and incomes, but also incorporate an aspect of literacy training.

Box 1 Lifelong learning in Africa and Asia

Junior Farmer Field and Life Schools for orphaned children aged 12-18 in Kenya, Mozambique, Namibia and Zambia

Established by FAO, NGOs, UN agencies and local institutions, these specially designed rural schools teach orphans traditional and modern agricultural techniques as well as providing business skills and life skills training. Children also learn about HIV/AIDS and gender sensitivity and the schools also provide psychological and social support.

The programme for skills development for youth and adults (EQJA) in Senegal

This programme aims at providing practical and literacy skills to youngsters who have been denied literacy opportunities with a view to promoting equity and socio-economic integration. It focuses on several groups, among them females working in the food and agricultural sector, youngsters in Koranic schools, and apprentices in the informal sector. It calls on a variety of trainers, including teachers and local artisans. It draws on a network of partners across sectors, including craftspeople, and representatives of local authority associations and donors.

Bangladesh Rural Advancement Committee (BRAC)

This NGO uses micro-credit as well as education and health to provide sustainable community development. The BRAC programme incorporates micro-credit lending with technical and vocational education programmes. Borrowers are also required to have health check-ups when taking out a new loan, and they are required to keep their children in school throughout their programme participation.

Goal 4: Achieving a 50 per cent improvement in levels of adult literacy by 2015, especially for women, and equitable access to basic and continuing education for all adults.

About one fifth of the world adult population is still illiterate (UNESCO, 2005). Illiteracy is significantly associated with extreme poverty. Addressing the literacy challenge is crucial for economic and social development, as it is for empowerment and increased political participation. Goal 4 addresses the need for adults to develop basic skills: reading and writing, numeracy and other life skills such as technical and practical knowledge or legal information useful to sustaining a livelihood and participating in society. Literacy, defined as the capacity to read, write and calculate, is the foundation for other life skills. Literate youngsters and adults are better able to read documents, posters, leaflets and newspapers that are useful for them in their day-to-day life. It has been found, for example, that in parts of Zambia illiterate women are not coming forward for anti-retroviral therapy because there are forms to be filled and signed. Elsewhere illiterates are refused access to vocational training that could help them to make a living. How often illiterate adults miss opportunities such as these we do not know, but it should no longer happen.

Goal 5: Eliminating gender disparities in primary and secondary education by 2005, and achieving gender equality in education by 2015, with a focus on ensuring girls' full and equal access to and achievement in basic education of good quality.

It is widely recognized that gender disparities fuel AIDS. Girls are more vulnerable to HIV infection than boys. They are more subject to pressure and intimidation by adults in search of safe sex. The proportion of girls among infected youngsters is much higher than that of boys. At the same time, education of women and girls contributes in many different ways to social and economic development. Educated mothers have fewer children, they are more prone to send their children to school and they contribute better to their family's health and nutrition. Educated girls are more likely to be empowered and to resist pressures for unwanted sex; they tend to marry later and this reduces the chances of early infection. Over the past ten years, countries have seen increasing numbers of girls attending school. The gender parity index (GPI), i.e. the ratio between boys' and girls' school enrolment rates, has increased globally over the past ten years, and many of the improvements were seen in developing countries.

Another aspect of Goal 5 is the representation of women in different sectors of society, which is seen as a measure of gender equality. It has been agreed that any society in which women and girls do not actively participate cannot be considered satisfactory. In the education sector it had been shown that female teachers can encourage parents to send their daughters to school and thus facilitate girls' access to education. Employing women as teachers enables them to be sensitive to the needs of girls.

The overwhelming importance of girls' education in a context of HIV and AIDS will be discussed later in this module.

Goal 6: Improving all 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.

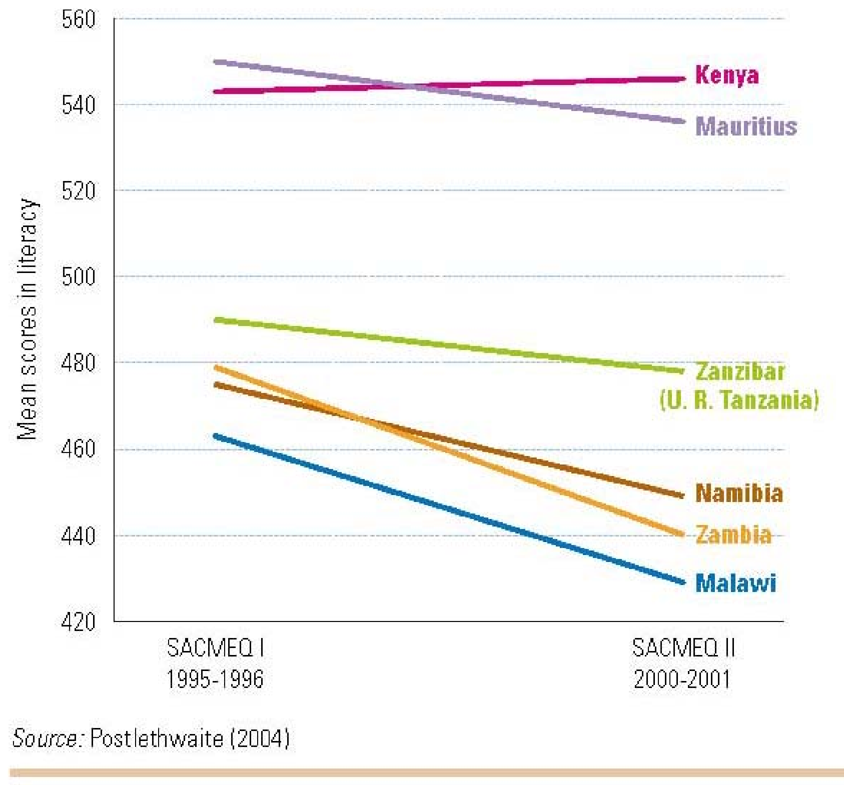
With all the energy and support for increasing access, educational quality is sometimes overlooked. As enrolment increases, schools become overcrowded, class size increases to unacceptable levels, and untrained teachers are recruited and do not receive adequate support within the school. Goal 6 reminds us that there can be no such compromise. There is no point in enrolling children unless learning occurs. It is increased learning – not increased access – that can lead to all the benefits expected from more education.

HIV and AIDS can undermine the functioning of the education system and seriously compromise quality (a point that we will return to below). In the five years between 1995 and 2000, learning achievements in some countries of Southern Africa declined significantly (see Figure 2). How much of this decline is due to deterioration of teaching conditions after massive expansion of the system following in particular the introduction of free primary education and how much of it is due to HIV/AIDS is not known, but it is it likely that HIV/AIDS played a significant role in this trend.

Quality is an important aspect of any education system. If parents do not think their children are benefiting from a relevant education, they will be less inclined to send

them to school. Without relevant and quality education, the efforts of governments to enrol all children in school will be wasted.

Figure 2 Changes in literacy scores between SACMEQ I and SACMEQ II in six African countries



Source: Postlethwaite (2004)

The EFA Development Index (EDI)

In order to assess global progress toward the goals, countries and agencies agreed at the Dakar Forum to use common indicators to summarize the progress of countries and to create a common scale by which to measure global progress. The use of certain indicators, such as the net enrolment ratios and completion ratios, were advertised as being better indicators of progress.

The EFA Monitoring Report introduced the EFA Development Index, or the EDI, which is a composite of four indicators that measure four of the six goals:

Table 1 Indicators for the EDI

Indicator	Measures	Goal
Net enrolment rate (NER)	Universal primary education (UPE)	2
Adult literacy rate (aged 15 and older)	Adult literacy	4
Gender parity index (GPI)*	Gender	5
Survival rate to grade 5	School quality	6

* The GPI indicator for a given country is the mean of the GPI for primary school and the GPI for secondary school gross enrolment ratios and the adult literacy rate.

Calculating a country's EDI involves calculating the arithmetical mean of the observed values for each of the indicators in Table 1. The EDI value falls between 0 and 1, 1 being the achievement of EFA.

The Millennium Development Goals

The MDGs were set by the member states of the United Nations during the Millennium General Assembly which met in September of 2000. The MDGs focus on the overall objectives of development and poverty reduction, of which education and health are essential components. Of the eight goals, three directly concern education and HIV/AIDS. They are underlined below.

- *Goal 1*: Eradicate extreme poverty and hunger: To halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day.
- *Goal 2*: Achieve universal primary education: To ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling. This goal is similar to EFA goal 2.
- *Goal 3*: Promote gender equality and empower women: To eliminate gender disparity in primary and secondary education preferably by 2005, and to all levels of education no later than 2015. This goal is similar to EFA goal 5.
- *Goal 4*: Reduce child mortality: To reduce by two thirds, between 1990 and 2015, the under-five mortality rate.
- *Goal 5*: Improve maternal health: To reduce by three quarters, between 1990 and 2015, the maternal mortality ratio. Goal 5 is related to HIV/AIDS as regards mother-to-child transmission.

- *Goal 6*: Combat HIV/AIDS, malaria and other diseases: To halt and begin to reverse the spread of HIV/AIDS; to halt and begin to reverse the incidence of malaria and other major diseases. Reducing the spread of HIV/AIDS and other major diseases will increase the health of populations and produce stable environments for children and adults to access education and information and to progress.
- *Goal 7*: Ensure environmental stability: Reverse the loss of environmental resources.
- *Goal 8*: Develop a global partnership for development: Address the special needs of the least developed countries.

Meeting these eight goals by 2015 represents an enormous challenge, and implementing them will require leadership, resources and, last but not least, management capacity. As your ministry develops education sector plans and education and HIV/AIDS strategies, references to the MDGs will allow you to see education in a larger perspective: the education goals cannot be achieved unless other goals are.

3. HIV and AIDS as an obstacle to attaining EFA

As was shown in Module 1.2, *The HIV/AIDS challenge to education*, the education sector is hit by HIV and AIDS from all sides.

- As the country's economic growth slows down, and as competing demand on existing resources – particularly from the health sector – increases, the resources available for education are less than they would have been.
- On the other hand, the replacement of teachers, the cost of health interventions, including in some countries provision of anti-retroviral therapy, the production of materials, participation in funerals, and the additional support to be given to affected pupils lead to an increase in education costs.
- Teachers and administrators are in the group where the most AIDS deaths occur. They are not more likely than other educated adults to be infected[2], but attrition rates due to AIDS – in addition to existing problems of attrition – may seriously compromise the system. As administrators at central, regional and local levels get sick and die or leave the education system to replace professionals that are lacking in other areas of the economy, HIV and AIDS threaten the capacity of ministries of education to function adequately and to provide bureaucratic support to schools.
- The impact of teachers' sickness is also high on schools' operation and teaching activities. As the sickness progresses, infected teachers become increasingly ill and tired. Their absences become more frequent and prolonged. Absent teachers are most often not replaced: either their classes are merged with others or the students are left unattended. Teachers are also affected by HIV and AIDS in their homes and communities, and may suffer from stress and the pressures of providing care to their own extended families. All in all, HIV and AIDS have the effect of reducing the length of the school year and the time allocated to covering the required syllabus. As instructional time declines, quality and learning deteriorate.
- Learners themselves are threatened by the epidemic and are less likely to attend school. When the income-earning member of the family falls sick and stops working, the family's income declines. Household resources are strained to pay for medicines for sick family members or to support relatives, and education becomes too expensive for most families. They can no longer buy textbooks and materials. Nor can they pay fees of any kind. In addition, a lack of resources impacts on food security and may significantly reduce access to the levels of nutrition required to support effective learning.
- The situation worsens when one or both parents die. Children may be placed in a foster family, which does not necessarily have the resources to continue paying for their schooling, or they become heads of households and must start earning a living. In addition to being traumatized by the loss of one parent, HIV-infected and -affected children are at risk of falling into poverty or utter poverty. They attend school irregularly and eventually drop out before they become literate.

[2] Evidence from research into teacher attrition and mortality in South Africa shows that HIV prevalence rates amongst teachers may be at the same level or even lower than the general population in equivalent age-bands (Badcock-Walters et al., 2005). Other studies on other countries show similar findings (Boler, 2004).

As affected families become too poor to pay for the numerous expenses that schooling incurs, as children have to work to complement the family income and eventually have to drop out, and as quality deteriorates and average learning achievements decline, EFA is in great danger. Progress toward EFA will slow down or, in the worst cases, earlier achievements may be reversed.

4. EFA and HIV prevention

As mentioned above, the best protection against the rising prevalence of HIV in society is education at all levels and the cognitive skills and understanding this provides.

The impact of education on HIV

By promoting access to quality education for children and youngsters, and literacy and practical training for adults, the following can be said:

- Children and young adults will be equipped with the competence to read and write and thus continue to learn throughout their lives. They will be equipped with important skills such as critical thinking and the ability to process and evaluate information. Some data suggest that "receiving at least a primary school education can halve young people's risk of contracting HIV even if they are never exposed to specific AIDS education programs in the classroom" ... "Literate women are three times more likely to know that a healthy-looking person can have HIV and four times more likely to know the main ways of avoiding AIDS" (Global Campaign for Education, 2004: 4).
- The prevention messages can be taught in schools and complement whatever information children hear by other means; i.e. through the radio and other media in particular. The questions planners and educators must answer are how can preventive education be organized so as to be most effective? What should be focused upon to provide more and better education? Should preventive messages be introduced in all subjects, or should HIV/AIDS education be treated as a separate subject? Recent research indicates that the latter would be more effective. HIV/AIDS courses can be provided as part of the formal curriculum or after classes in AIDS clubs, be taught by teachers, health personnel or peers. These questions will be dealt with in Module 4.1, *A curriculum response to HIV/AIDS,* and Module 4.2, *Teacher formation and development in the context of HIV/AIDS.* It is nevertheless necessary to emphasize that preventive education is to be introduced as early as possible and certainly from primary education level. Peer education and AIDS clubs are particularly effective, provided there is adequate and appropriate support material available and a common message developed through training. Peers and teachers must also receive specific prevention education and training programmes.
- Literacy programmes and non-formal education for out-of-school youth and adults will inform mothers, parents and adults on the risks of HIV and how to protect themselves. Research has shown that women who have participated in literacy programmes have a better knowledge of health and family issues and are more likely to adopt preventive health measures. They are also more likely to know their rights and to protect themselves and their families. HIV/AIDS information and preventive education must reach all those who are sexually active, including the many youngsters and adults who have never attended school or dropped out early. UN agencies and NGOs found that the most successful programmes integrate literacy and life skills into training programmes designed to improve livelihoods. In this way, beneficiaries see the immediate benefits and results of participation. Some adults may already

be infected and the education offered will provide them with advice and inform them on their rights and responsibilities.

Of course there is no absolute guarantee that increased knowledge will change behaviour. But the chances that changes in behaviour will occur are higher if the messages come from different sources and converge; if school prevention education complements what the media are saying and what other prevention programmes of other ministries and NGOs may convey; and if certain cultural practices can be challenged. In some countries, data from the Health and Demographic Survey show in fact an ambiguous relation between the rate of HIV infection and the education level in the overall population (young and old people together). Secondary school graduates in South Africa, for example, appear to have a higher chance of being HIV-infected than uneducated people; urban people have a higher rate of infection than people living in rural areas. This is very likely due to the fact that more educated persons and people living in urban areas are more likely to migrate and travel than uneducated or rural persons; they are more likely to be separated from their families and to engage in risky relations. Many of them have been infected before having heard or read about HIV/AIDS. Teachers are a case in point. Earlier statistics showed that the proportion of HIV-infected teachers was higher than in the rest of the adult population; more recent statistics show that the reverse is now the case.

EFA and promoting girls' education

Just as important, "education is crucial to give the most vulnerable members in society – especially young women – the status, the independence and confidence they need to assert themselves so that they can act on what they know about staying safe" (Global Campaign for Education, 2004 :4).

EFA has girls' education and empowerment as one of its major objectives. The majority of cultures around the world do not empower women and girls to get an education and to become active members of society. Traditional cultures of male dominance and the socially accepted submissive position of women make it difficult to be assertive without fear of the repercussions or abuse as a result. The education of women is not a priority in such circumstances. Furthermore, many women do not have access to health services or sexual health training.

These attitudes, coupled with a lack of education, can make a woman unlikely to know how to protect herself from unwanted sex or afraid to demand condom use. Uneducated girls may not know the risks they are facing by engaging in risky behaviour. Furthermore, they often do not have the power to refuse sex. Girls are discriminated against, threatened with violence and sometimes raped. These young girls can also be courted by older men hoping to find a partner whom they believe has little chance of having been infected with HIV. In some cases, girls may be courted by their own teachers and give in to them in the hope of getting good grades (the so-called 'sexually transmitted grades' phenomenon).

EFA is an instrument that can contribute to empowering women and producing active members of society. Research has shown that the more educated the parents, especially the mother, the more support a girl will receive to attend school. Finally, several studies have shown that the more educated the young girl, the more informed she is on HIV and AIDS and how to protect herself.

Simply increasing access will not achieve gender equality. The education provided must be of high quality and must empower young girls. Schools need to become child-friendly, safe environments. When developing plans and policies to promote environments and societies supporting the education of girls as well as boys, ministries should keep in mind the following:

- Establish policies that do not tolerate school violence and follow through when prosecuting perpetrators.
- Include messages about teacher conduct in teacher training courses. Teachers must model the behaviours of equality and respect that we wish our children to practice.
- Train teachers to use education programmes that promote critical thinking, decision-making and communication.
- Provide teachers with access to information concerning HIV/AIDS and sexuality so that they feel comfortable discussing the subject with other adults as well as students.
- Encourage discussions in classrooms, where students can speak freely about their views on gender roles and HIV/AIDS.
- Promote the establishment of anti-AIDS clubs for pupils, and for teachers as well.

Box 2 **Extract from a speech of The United Nations Secretary General's Special Envoy for HIV/Aids in Africa, Stephen Lewis, to a conference on UN Reform and Human Rights at Harvard Law School in February 2006.**

> “How can we ever explain the fact that the funeral parlours and graveyards of Africa are filled with the bodies of young women in their late teens, 20s and 30s? … How can we ever explain the fact that fewer than 10 per cent of pregnant women in Africa have access to prevention of mother-to-child transmission in the year 2006? How can we ever explain the fact that fewer than 10 per cent of the women in Africa know their HIV status in the year 2006? How can we ever explain the fact that grandmothers, aged, impoverished and failing, have become the last resort of orphan support in 2006? How can we ever explain the fact that young girls in a number of high-prevalence countries still don't have knowledge of how the virus is transmitted? How can we ever explain the fact that laws against sexual violence and marital rape, and laws to embody property rights and inheritance rights, are still not a part of the legislative fabric of several countries at the epicentre of the pandemic in 2006? … How can we ever explain the fact that the women of Africa carry the continent on their backs, and reel under the burden of care, unacknowledged and uncompensated, while the world looks on with eyes of glass.”

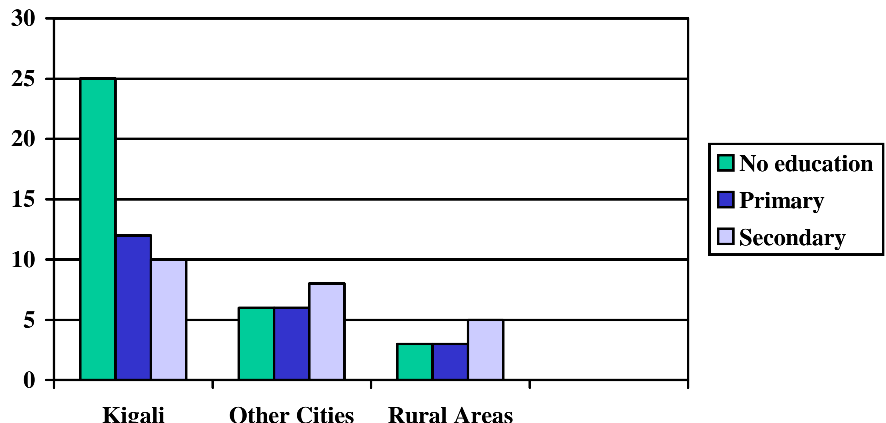
Activity 2

Figure 3 below illustrates data from the Rwanda Health and Demographic Survey on HIV prevalence by place of residence and educational level.

1. Comment on the difference in the infection rates according to whether people live in Kigali, in other cities or in rural areas. Are you surprised to find that people living in Kigali have a higher chance of being infected than in other cities, or in rural areas? Why/why not?

2. Comment on the difference in the infection rates of people living in Kigali according to their educational level. Are you surprised by the difference in infection rates? Why/why not?

Figure 3 HIV infection rates of women in Rwanda by urban and rural areas and by educational attainment, 2003.



5. Using EFA to overcome the impact of AIDS

The following section gives examples of how governments can prioritize actions to promote attainment of EFA, and how this will help mitigate the impact of HIV and AIDS by allocating more resources to education, by training teachers better and faster, and by taking different initiatives that will help educate infected and affected children and youngsters.

Increasing the resources available for education

To achieve EFA, more funds are being mobilized for education at national and international levels. International funds are increasingly mobilized in the framework of the Fast Track Initiative (FTI). In the latter framework, a compact agreement is reached between the recipient countries and donors according to which, on one hand, countries agree to develop an education sector plan and to spend a larger share of their budget on education and on primary education in particular. Funding agencies, on the other hand, commit themselves to mobilizing more resources, making them more predictable and more co-ordinated. Much remains to be done to increase funding, and lack of funds is not the only problem. But on the whole, low-income countries spent a lot more on education in 2002 than they did in 1990. Government spending on education as a proportion of GDP increased from 3.1 per cent in 1990 to 4 per cent in 2000 and 4.3 per cent in 2002. The international community also has started mobilizing itself. The downward trend noted in official development assistance (ODA) as a proportion of national income until the year 2000 has been reversed, and development assistance increased by 23 per cent between 2000 and 2002. Following the commitments made in the G8 meeting in 2005, ODA should continue to increase until 2010. Aid to education and aid to Africa in particular is expected to double. Let us hope that these commitments will be put into practice[3].

Beyond securing more funds, the challenge will be for countries to design the right policies and to strengthen their capacities to use such funds and effectively manage their education systems.

Training and supporting large numbers of teachers in school

In order to reach the Education for All objectives and enrol 100 per cent of school-age children by 2015, large numbers of teachers will have to be recruited and trained. According to some estimates, more than 1.3 million teachers will have to be recruited between 2000 and 2015 in sub-Saharan Africa.

Recent research results have challenged the effectiveness of the present model of initial teacher training: it is long, expensive, and yet does not appear to have a significant impact on teacher practices and knowledge. Most teachers continue to teach using the methods that their own teachers practiced when they were in primary and secondary schools and that they see being practiced in many teacher

3 The Fast Track Initiative is helping an increasing number of countries but is still very limited.

training colleges, even today – frontal methods which do not encourage interaction or individualized teaching. In view of the high cost of traditional teacher training and the need to train large numbers of teachers, a new model of teacher training is emerging which combines short pre-service training with coaching and mentoring at school level and/or with distance education (Dembélé, 2003; PASEC, 2002; Lewin and Stuart, 2003). Similarly, in-service teacher training as currently practised does not have much of an impact either. Hence, continuous in-service training of teachers is encouraged as part of a holistic model of continuing professional development and support for whole school development.

Box 3 Training large numbers of teachers

> The new primary teacher preparation programme in Guinea combines initial training with practice in associate schools. In the crash programme, teachers are trained in three phases: three months of coursework at the teacher training college, followed by nine months of supervised student teaching with full responsibility for a classroom in selected associated schools, and finally three months of further coursework at the teacher training college (TTC). The regular programme consists of two phases: nine months of coursework at the TTC, interspersed with three periods of practicum teaching followed by nine months of teaching with full responsibility for a class.

In countries where a significant number of teachers are infected by HIV and AIDS and their professional lifespan as teachers is shortening, a faster and cheaper way of training teachers is an option to be considered. The new mode of teacher training seems therefore particularly appropriate. Teachers also need to be regularly updated and supported in schools on several subjects including preventive education.

Activity 3

What policies are in place in your country to facilitate the recruitment of trained teachers in general and at school level in particular? What are the practices used in terms of replacing absent teachers? Have these been changed recently?

Facilitating the education of poor and vulnerable groups

Children and youngsters affected by HIV/AIDS are at a disadvantage with regard to schooling because not only are they likely to suffer from the psychological trauma associated with the sickness of their parent, they also have to suffer from a decline in family and nutritional resources. When a family member living with HIV is confronted with AIDS, the family income declines and more resources are used to buy medicines. Hence, children and youngsters in affected families suffer from the following circumstances:

- They have difficulty in paying fees and other expenses that schooling entails – contribution to parent-teacher associations, uniforms, textbooks, stationery, transport costs, examination fees.
- They may have to work to support their family.
- They live in greater poverty and suffer from malnutrition.
- They no longer have support for their studies.

In the context of EFA, several countries have adopted specific measures to encourage the participation of poor and vulnerable children. These should benefit AIDS-affected children and they concern the following:

Abolishing school fees

Numerous low-income countries continue to charge tuition and other fees at primary level. These fees are sometimes legal and sometimes illegal; that is, the schools continue to raise fees when not enough funds are allocated by the central or local government to cover their expenses. Some countries apply targeted exemptions on school charges (e.g. for girls and/or orphans), but unless the missing funds are compensated by other sources, anecdotal evidence suggests that these exemptions may lead to some schools excluding the children concerned. It can also lead to stigmatization in the case of AIDS orphans.

Realizing that families were spending an inordinate proportion of their income on education and that this was deterring them from sending their children to school, several countries have suppressed all school fees at primary level. The first country to do this was Malawi in 1991. Uganda was the next country to do so (1997), followed by Cameroon (1999), Lesotho (2000), Tanzania (2001), Zambia (2002), Madagascar and Kenya (2003), etc. More countries followed in 2004 (Benin, Mozambique) and 2005. The impact of this measure on enrolment has been obvious and overwhelming. In Malawi, gross enrolment ratios increased from 89 per cent to 133 per cent in one year. In Uganda, enrolment rose by 2.3 million children in one year. This led to greater equity as poor children benefited largely. Unfortunately, the end result has in some cases been a dramatic deterioration in teaching conditions when there were not enough teachers to teach the pupils, no classrooms to accommodate them or no textbooks. Also, not all costs have been suppressed: other charges, such as textbooks, stationery, meals, examination fees, etc., remained. Hence, the poorest children continue to drop out and be out of school.

Increasing the quality of education through various measures such as:

- changing the curriculum and making it more relevant;
- introducing teaching in the mother tongue;
- improving teacher training programmes;
- distributing free textbooks for every child;
- introducing support mechanisms to teachers and head teachers;
- breaking the isolation of teachers and organizing clusters;
- giving more responsibility to head teachers and increasing accountability to communities.

Many innovative programmes exist; too many to mention. Obviously, the greatest incentive for children to go to school is when learning is enjoyable and when what they learn is relevant to their situation and to that of their families and communities.

Different measures introducing greater flexibility in school timetables and calendar

As a result of greater community involvement, decentralization, and more diversified sources of financing, formal education has become somewhat more diversified and less rigid than it once was. Following decentralization some flexibility has been introduced, for example in the school calendar and timetable of certain schools in Mali, Senegal and Guinea to take into account specific climatic conditions, or in the curriculum. The involvement of communities in community schools also allows adaptation to local needs.

Organizing school meals and food programmes

Several countries in Africa and elsewhere in the world organize food programmes with the support of NGOs and international organizations such as the World Food Programme. They are meant to provide incentives to encourage parents to send their children to school, partly compensating the opportunity cost of child labour, as well as to fight child hunger while at school and facilitate concentration and learning. The effect of school meals on access and attendance rates has been demonstrated. The sooner food is provided to children – preferably before they reach the age of three – the better, hence the importance of ECCE programmes, but also the need to complement school meals with take-home rations that benefit the whole family.

Giving scholarships to the children most in need

This is another measure meant to encourage parents to send their children to school and compensate for the income foregone.

Large scale scholarships schemes at primary and secondary levels are quite frequent outside Africa: i.e. in Asia and Latin America. Increasingly, stipends are given directly to families, as long as their children stay in school, to cover school charges and other living expenses. In some cases the scholarship schemes become social funds with an educational orientation, such as the '*Bolsa Escola*'

and ‘*Bolsa Familia*’ in Brazil, or other cash-transfer programmes elsewhere in Latin America. These programmes appear to be quite effective in increasing school attendance of low-income groups, but they require a fairly able administration to administer the scheme.

In certain countries, NGOs have been successful in obtaining grants to fund a child’s education. This has shown an improvement in the enrolment of orphans in schools (see Box 4). Such schemes must be carefully devised and implemented so as to avoid stigmatization of orphans and vulnerable children (OVC), robbery, and even attack of the beneficiaries by parents of 'unaffected children', etc.

Box 4 Supporting HIV/AIDS-affected children

Mukuru Promotion Centre: A rehabilitation centre set up in the Mukuru slums of Nairobi, Kenya. The centre has four schools that cater for children and youth from the slums, as well as street children and AIDS orphans. The schools serve primary-school-age children who are unable to pay school fees. There are also health services and life skills projects, as well as skills training programmes in carpentry and masonry.
Community-Based Options for Protection and Empowerment (COPE), implemented by Save the Children Federation Inc. This programme helps villages to set up committees to monitor orphans and provide assistance.

Encouraging non-formal education as a substitute or complement to formal education

Education does not have to be viewed in the traditional way, i.e. in a school building with a teacher standing at the front of the classroom. Indeed, many successful education programmes fall into a category commonly referred to as non-formal education (NFE). They tend to respond better to the diversity of needs – be they social, economic or cultural – of OVC.

Several NFE programmes exist within the framework of EFA that provide supplementary support services within schools to specific groups of disadvantaged children. In countries such as Tanzania and Uganda, a strong NGO and community network presence supports the education of AIDS orphans. There are many examples such as community volunteers making regular visits to provide assistance with housework, donations of food, or even some counselling support to children heading households or families supporting people sick with AIDS.

Other NFE programmes develop learning opportunities parallel to the formal education system to tackle the needs of the most vulnerable groups who would have difficulty regularly attending a full day in a formal school in view of their specific personal or family circumstances. Some programmes are organized in non-formal settings for shorter hours; others provide accelerated courses (Box 5); others combine literacy courses with vocational skills and train youngsters on how to make a living (see Box 1 above).

Box 5 Flexibility in schools

> Adapting school schedules to suit the timeframes of girls or young people who have dropped out to care for family members can be a practical solution to increasing education. BRAC (formerly Bangladesh Rural Advancement Committee) schools schedule classes in two-hour blocks six times a week to accommodate the needs of girls and other community members.
> Community schools in Zambia offer the same education content as traditional primary schools in four years instead of seven. Their curriculum is recognized and therefore upon completion youngsters may be allowed to re-enter the formal education system. In addition to the normal curriculum, the course emphasizes life skills and health education.
> The Undugu Society of Kenya is a well-established institution that endeavours to address the plight of street children through non-formal education and training. The programme is designed to teach children basic literacy, numeracy and survival skills, and to give them a heightened sense of their own worth. The curriculum condenses the regular primary syllabus in three years of basic learning. The learners do not wear a uniform, they receive free textbooks and are provided with free lunch. After the basic education cycle, learners can attend Undugu vocational centres.

Activity 4

What is the policy in your country regarding fees at primary and local secondary levels? What policy exists to support poor and vulnerable children who cannot pay fees or other school-related charges?

Activity 5

Do you know of any innovative approaches existing in your country that could be expanded to meet the needs of AIDS orphans?

Summary remarks

HIV and AIDS have been challenging countries' progress to Education for All for the past ten years. A significant proportion of the children in the lowest income groups still do not have access to education or drop out before completing primary education. The quality of education has declined and the costs of education remain high.

It is important for ministries of education to see HIV and AIDS as an EFA issue. Similarly, when planning for Education for All, policy makers and managers in ministries of education have to plan certain activities and programmes which will help limit the spreading of HIV and mitigate its impact. EFA and other international declarations were designed in part to help countries prioritize agendas and focus resources. Programmes and interventions must make sure that professional teachers are trained to deliver quality education for all, including HIV prevention, and that they are deployed where they are most needed. These programmes must also focus on the neediest of students and families to ensure that all children enrol and stay in school. To do this, the school system must address the needs of OVC affected by HIV/AIDS. Ministries of education should in particular:

- partner with community organizations and local NGOs that help children to remain in school;
- support community actions that fulfil the basic needs of out-of-school children and orphans. Child-friendly centres, like the one in Kenya (Box 4), provide stability and security for children, and improve access to schools;
- focus on the needs of all vulnerable and educationally marginalized children, not just on those of HIV-affected children or AIDS orphans. Children from impoverished or disjointed families can be as disadvantaged as orphans, if not more so. Besides, any special attention may further stigmatize them;
- provide foster families with financial incentives and non-monetary support for assuming care of orphan children. For example, counselling and traumatic support services can be helpful to the orphans and would give children and families a chance to properly grieve over their loss;
- subsidize school fees and increase government grants for schools where large number of OVC are enrolled. Well-targeted school feeding programmes can also helpfully complement abolition of fee policies.

Lessons learned

Lesson One

HIV/AIDS must be looked at in the context of EFA. If left unchecked, it will slow or even reverse a country's progress towards meeting the universally agreed EFA goals.

Lesson Two

Equally, EFA and other sector plans must integrate measures to prevent the spread of HIV /AIDS so that adequate response strategies are found to support progress.

Lesson Three

EFA goals and MDGs should be referred to when developing an HIV/AIDS education strategy; and vice versa, HIV/AIDS is to be included in a country's education sector plan and EFA action plan.

Lesson Four

Several of the measures introduced in the framework of EFA will make it easier for educationally marginalized children, including AIDS orphans, to continue their studies up to the end of basic education. These include free primary education; decentralization of management and financing responsibilities to local authorities and schools, allowing greater flexibility in schools' timetables and in the local recruitment of teachers to replace missing ones; organization of scholarship schemes and nutrition programmes; and a variety of non-formal initiatives including community-led initiatives to support students after school.

Lesson Five

Before developing HIV-prevention programmes, ensure that a preliminary overview is taken of activities that may already be taking place in order to work with them.

Lesson Six

Just as literacy programmes are more effective when combined with micro-credit, rural development or health programmes, developing HIV-prevention programmes as a part of a larger multi-sectoral initiative can be successful when training young people and adults.

Answers to activities

Activity 1

Answers will be specific to your country.

Activity 2

Question 1

The HIV-infection rates of women are much higher in Kigali than in other cities and strikingly more than in rural areas. This is probably linked to populations' movements. Many people who live in Kigali do not originate from Kigali. Prostitution is also much more developed in the capital city than elsewhere, not to mention the violence and rapes that occurred during the genocide. The likelihood of having been infected by HIV is lower for those living in rural areas.

Question 2

The population most at risk amongst women is the uneducated in Kigali. The rate of infection of these women is extremely high: among them are a lot of poor and marginal people, and probably also prostitutes. Obviously those who have completed primary and secondary education in Kigali know better how to protect themselves.

The rates of infection of women living in other cities and especially in rural areas are much lower. There the education level seems to make little difference: whether one has received some primary education or not seems to make no difference at all; while, quite paradoxically, having studied in secondary education would increase one's chances of being infected. More information would be required to be sure, including on the number of cases concerned. There may be so few cases that the difference cannot be considered statistically significant. Many may have been infected before they heard of the danger of HIV and the way it is transmitted.

Activity 3

Answers will be specific to your country.

Activity 4

Answers will be specific to your country.

Activity 5

Answers will be specific to your country.

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Module 1.4

R. Smart

HIV/AIDS-related stigma and discrimination

About the author

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Module 1.4

HIV/AIDS-RELATED STIGMA AND DISCRIMINATION

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Aims

The aim of this module is to enable you to recognize AIDS-related stigma and discrimination and to equip you with strategies to challenge and reduce these within the education sector. In the first part we define stigma and discrimination; we discuss its causes and state how it affects populations. In the second part we look at stigma and discrimination within the education sector, and how the problem should be seen as a human rights issue. Then we examine AIDS-related stigma and discrimination in the workplace or at the ministry level and then within schools. In the final section we discuss how prevention programmes can be developed to effectively diminish stigma and discrimination.

Objectives

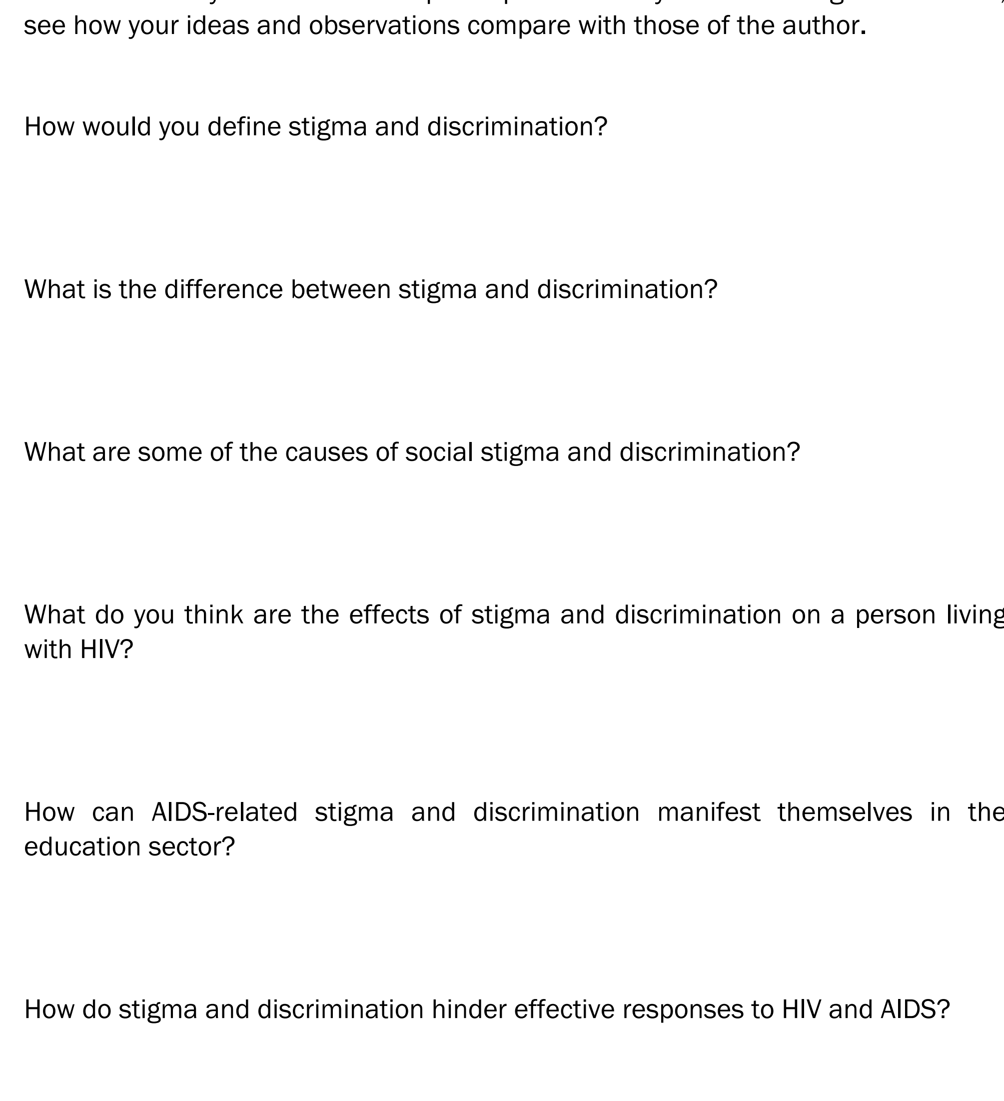
At the end of the module you should be able to:

- define stigma and discrimination;
- explain the causes, effects and consequences of stigma and discrimination;
- describe different forms of stigma and discrimination;
- apply a rights-based approach for confronting and reducing discrimination;
- understand how stigma poses obstacles to education and prevention programmes;
- explain strategies and practical actions to challenge and reduce AIDS-related stigma and discrimination in education systems.

Before you begin…

Questions for reflection

Take a few minutes to think about the questions below. You may find it helpful to make a note of your ideas in the spaces provided. As you work through the module, see how your ideas and observations compare with those of the author.



How would you define stigma and discrimination?

What is the difference between stigma and discrimination?

What are some of the causes of social stigma and discrimination?

What do you think are the effects of stigma and discrimination on a person living with HIV?

How can AIDS-related stigma and discrimination manifest themselves in the education sector?

How do stigma and discrimination hinder effective responses to HIV and AIDS?

Module 1.4

.... HIV/AIDS-RELATED STIGMA AND DISCRIMINATION

Introductory remarks

At the end of 2004, 39.4 million people were living with HIV, and during that year 3.1 million died from AIDS-related illnesses. Since the onset of the disease in the early 1980s, HIV and AIDS have triggered responses of fear, denial, stigma and discrimination, often targeted at those groups seen as the most affected (injecting drug users, sex workers, etc.). In some cases, people living with HIV have been rejected by their loved ones and their communities, unfairly treated in the workplace, and denied access to education and health services – this holds true for the industrialized as well as the developing nations. AIDS-related stigma can take many forms – rejecting, isolating, blaming and shaming, and we are all involved in stigmatizing even if we don't realize it.

Box 1 Quote from UNFPA Executive Director on World AIDS Day 2003

> *"After two decades ... the global AIDS epidemic shows no signs of abating ... Among the main reasons ... is the persistence of stigma and discrimination against those infected. This outrageous violation of basic human rights drives the disease underground, crippling efforts for prevention and care."*

Fear of discrimination often discourages people from seeking treatment or from disclosing their HIV status, which makes prevention and management of the disease very difficult. The stigma attached to HIV and AIDS extends into the next generation, placing a heavy emotional burden on those left behind. It is especially hard for children who may already be grieving a parent or family member.

AIDS-related stigma and discrimination remains one of the biggest barriers to effectively managing the AIDS epidemic. Within the education sector, children are refused access to school because they come from an AIDS-affected household. Teachers can be dismissed because of their HIV status.

Box 2 Quote from Archbishop Njongonkulu Ndungane

> *"Stigma is the unfair, uneducated and unholy disgrace we have allowed to develop around the disease. Stigma destroys self-esteem, destroys families, disrupts communities and takes away all hope for future generations."*

Stopping the stigma and discrimination against people and marginalized groups who are affected by HIV and AIDS is as important as developing a vaccine itself. Education plays a key role in diminishing stigma and discrimination. Strategies to address stigma are critical for HIV prevention and education programmes and must extend into communities to be effective. As we have seen with gender issues, stigma reduction should also be mainstreamed into every aspect of education policies, programmes and practices.

1. Definitions of stigma and discrimination

Box 3 Quote from Regional Consultation on Stigma and HIV/AIDS in East and Southern Africa (2001)

> *"HIV/AIDS-related stigma is a real or perceived negative response to a person or persons by individuals, communities or society. It is characterized by rejection, denial, discrediting, disregarding, underrating, and social distance. It frequently leads to discrimination, and violation of human rights."*

There are a number of definitions of stigma and discrimination which can help us to understand these complex issues.

Stigma: The holding of derogatory social attitudes or cognitive beliefs, a powerful and discrediting social label that radically changes the way individuals view themselves or the way they are viewed by others.

Discrimination: An action based on a pre-existing stigma; a display of hostile or discriminatory behaviour towards members of a group, on account of their membership to that group.

Disclosure: Refers to a process that results in a person living with HIV deciding to give others information about their status (and perhaps then also talking openly about living with HIV or AIDS). Disclosure is a positive response that has many benefits but it is made very difficult, or indeed impossible, in situations where stigma and discrimination are present. The benefits of disclosure could include:

- improved emotional and physical health through increased acceptance of status;
- better access to healthcare services and support;
- more opportunities to learn about HIV and AIDS;
- being able to enter into important discussions, e.g. about safer sex;
- becoming equipped to influence others to avoid infection;
- removing the mystery and silence surrounding HIV and AIDS;
- enabling others to show love and care.

These benefits in turn contribute to reducing stigma and discrimination. This cause and effect cycle where disclosure is compromised because of stigma needs to be broken before any real progress in terms of HIV prevention, treatment, care and support, and impact mitigation can take place.

Box 4 Extract from Siyam'kela: HIV/AIDS-related stigma: A literature review

> *"Stigma has been identified as a complex, diverse and deeply rooted phenomenon that is dynamic in different cultural settings. As a collective social process rather than a mere reflection of an individual's subjective behaviour, it operates by producing and reproducing social structures of power, hierarchy, class and exclusion and by transforming difference (class, race, ethnicity, health status, sexual orientation and gender) into inequality" (POLICY Project, 2003a: 2).*

Activity 1

The language of HIV and AIDS

1. In your local language(s), make a note of what word(s) best capture the concepts of stigma and discrimination.

2. Now list words in your local language(s) that are used for HIV and AIDS and what connotations these words have – positive vs. negative, implying certain behaviours, reinforcing silence as opposed to openness, etc.

3. Now make notes on how language about HIV and AIDS can fuel stigma and discrimination.

2. Causes and types of stigma and the language used

The causes of AIDS-related stigma are multiple and include the following:

- Ignorance or insufficient knowledge, as well as misbeliefs and fears about HIV and AIDS.
- Moral judgements about people and assumptions about their sexual behaviour.
- Associations with 'illicit' sex and/or drugs.
- Fear of death and disease.
- Links with religion and the belief that AIDS is a punishment from God.

Self-stigma is, for example, self-hatred, shame, blame etc. Self-stigma refers to the process whereby people living with HIV impose feelings of difference, inferiority and unworthiness on themselves.

Box 5 Quote from stigma-aids e-forum

"The way I saw myself fundamentally changed within a matter of minutes. I thought that I was marked, different from everyone else. I felt dirty, ashamed, guilty (although I wasn't sure why I felt guilty; it just felt like an appropriate response)."

Felt stigma are perceptions or feelings towards a group, such as people living with HIV, who are different in some respect.

Enacted stigmas are actions fuelled by stigma and which are commonly referred to as **discrimination.**

Self-stigma

Manifestations of self-stigma include:

- feelings of shame, dejection, self-doubt, guilt, self-blame and inferiority;
- feeling that the person deserves to be in that particular situation;
- loss of self-esteem and confidence;
- social withdrawal and isolation;
- no longer dining with or expressing physical affection towards partners and family members;
- self-exclusion from services and opportunities, and refusing help that is offered;

- stopping work in the belief that one is no longer capable or worthy of employment;
- high levels of stress and anxiety;fear of disclosure;
- denial;

Self-stigma is worse when an individual:

- is first diagnosed (especially with no or limited emotional support at the time of diagnosis);
- has a limited support system;
- already feels minimal self worth (this includes when dual or multiple stigmas are present);
- has preconceived irrational or mythical beliefs about HIV and AIDS.

Overcoming self-stigma is assisted through:

- early referral to peer support;
- good quality pre-, post-test and on-going counselling;
- disclosure of HIV status to loved ones;
- encouragement to remain a productive member of the community;
- information about HIV and AIDS;
- access to antiretroviral treatment for those in need of medication;
- respect for the rights of all people diagnosed as being HIV positive;
- training and employment of positive persons.

Box 6 Extract from Siyam'kela: Measuring HIV/AIDS-related stigma – preliminary indicators

> "Fear and moral judgement are considered to be the root sources of HIV/AIDS stigma. HIV/AIDS is associated with many different fears. People may fear the casual transmission of the virus, the loss of productivity of people living with HIV, that resources may be wasted on people living with HIV, living with the disease, or imminent death.
>
> Similarly, moral judgement may cause stigma. people living with HIV are often seen as self-blaming and convinced that they deserve it because the transmission of the virus is linked to stigmatised behaviour, which allows people to understand HIV/AIDS in terms of the concept of blame. It is important to note that HIV/AIDS stigma can be experienced not only by people living with HIV/AIDS but also by people who are suspected to be living with HIV/AIDS ..." (POLICY Project, 2003b: 4).

Felt stigma

Stigma can be blatant or subtle, but it is always value-laden and compromises the human rights of those affected. Stigma is characterized by denial, ignorance and fear. Other features of stigma include:

- pointing out or labelling differences – "they are different from us";
- separating 'us' and 'them' – leading to avoidance, shunning, isolation and rejection;
- stereotyping;
- attributing differences to negative behaviour – "his sickness is caused by sinful or promiscuous behaviour";
- loss of status;
- overt abuse (may occur).

Enacted stigma

The effects of stigma are wide-ranging and may include actions taken by the person concerned in response to the stigma, and actions taken against the person concerned, which are discriminatory. Felt and enacted stigma can take many forms such as:

- physical and social isolation from family, friends and community;
- being kicked out of one's family, house, rented accommodation, school, and community groups;
- gossip, name-calling and insults;
- judging, blaming and condemnation;
- loss of rights and decision-making power;
- stigma by association – e.g. the whole family is affected by the stigma;
- stigma by looks/appearance/type of occupation;
- loss of employment;
- impaired access to treatment and care;
- dropping out of school;
- depression, suicide, alcoholism;
- avoiding getting tested for HIV;
- break-up of relationships;
- violence;
- loss of perceived ‘manhood’ or ‘womanhood’.

Box 7 Extract from Love - and death - in the time of AIDS

"Love in the time of AIDS meant embracing death together for a married couple in West Bengal as the duo preferred to end their miseries instead of dying a little of humiliation everyday. (...) Probir and Basanti Sarkar were a happy couple since their love marriage four years ago. But in an infection apparently caused by blood transfusion, Basanti was recently found to be HIV positive. The ordeal began with friends, neighbours and even family members socially boycotting them after she was diagnosed as HIV positive. (...)It was alleged that Basanti was even prevented from boarding a cycle rickshaw by some neighbours because of her infection and no one wanted to provide the couple with a vehicle for taking her to hospital for admission. Probir, who was not infected, could not bear to see his wife living as a social outcast and after Basanti's discharge from hospital they took the drastic step. Thursday night after dinner, Probir gave his wife half a glass of poison and after he was sure that she had died, he hanged himself" (Indo-Asian News Service Kolkata, September 10th, 2005).

Box 8 Extract from stigma aids e-forum

"In 2001, the Tanzanian media published a story of a primary school girl who was HIV-positive and as a result was forced by the school authorities to wear a red ribbon to show her sero-status as a warning to other pupils. The story became the best seller but it was soon forgotten and there was no serious media follow up on measures taken against the headmaster or on the feelings of the girl after she was stigmatised in this most inhuman manner. The media only concentrated on the sensational part of this gross violation of human rights and did not even mention that it was stigmatisation – a discrepancy in reporting that reflects a serious problem in Tanzanian media involvement on AIDS issues" (HDN Key Correspondent Report, June 7th 2001).

Powerful metaphors related to HIV and AIDS reinforce stigma and re-affirm social inequalities, thus rendering already stigmatized groups even more stigmatized. Words like 'promiscuous' and 'risky' assign shame and blame and underline a moral tone that reinforces the notion of 'them' and 'us'. Words such as 'victim', 'AIDS carrier' and 'sufferer' stigmatize people living with HIV and create images of powerlessness. Prejudices are perpetuated by media portrayals of HIV-infected persons as helpless and hopeless. This media reporting compounds irrational fears and prejudices associated with HIV and AIDS by using the language of guilt versus innocence, and the metaphors of war and plague.

The impact of stigma is mediated by gender and its impact is experienced more by women than men. This is rooted in the current social constructions of sexuality and sexual relations. In many cultures, where women are frequently perceived as vectors of illness, AIDS is seen as a woman's disease. And, women may be blamed by their partners, families or community for not raising their HIV-positive son or daughter 'properly'. Similarly, children may experience stigma related to their own HIV status or because they live in an AIDS-affected household. The latter is very common and is known as 'secondary stigmatization' or 'stigma by association'. These children may:

- be perceived as 'innocent victims';
- be neglected/abused by their new 'parents';
- grow up without trust and love;
- become street kids;
- become introverted, or experience difficulty handling grief;
- experience depression, or loss of hope and a 'sense of future';
- be isolated by friends;
- effectively lose their childhood, as they are forced to accept adult responsibilities;
- not have access to school or any form of education.

3. Consequences of stigma and discrimination for programmes

Stigma and discrimination impede both willingness and ability to adopt HIV preventive behaviour, to access treatment and to provide care and support for people living with HIV.

- Fear of stigma impedes prevention efforts, including discussions of safer sex and preventing mother-to-child transmission. Because of the separation between 'us' and 'them', people avoid confronting their own risk and adopting preventive behaviours.
- Utilization of voluntary counselling and HIV testing (VCT) services and disclosure of HIV status are constrained because of the anticipated stigma and the actual experiences of people living with HIV.
- Resources like medicine, transport to health services, food and other amenities may be withheld because of a perception that people living with HIV are hopeless cases and will die anyway.

These represent just some of the barriers created by stigma. On the positive side, the process of disentangling stigma reveals many opportunities for interventions.

Box 9 Extract from Disentangling HIV and AIDS stigma in Ethiopia, Tanzania and Zambia

There are five critical elements that programmes need to address:

- creating greater recognition of stigma and discrimination;
- fostering in-depth, applied knowledge about all aspects of HIV and AIDS through a participatory and interactive process;
- providing safe spaces to discuss the values of and beliefs about sex, morality and death that underlie stigma;
- finding common language to talk about stigma; and
- ensuring a central, contextually-appropriate and ethically-responsible role for people with HIV and AIDS.

Source: Nyblade et al., 2003.

Box 10 Example of a workplace programme – from Positive Action at Work (Nairobi)

Positive Action at Work was launched on 29 November 2004 by the Kenya HIV/AIDS Business Council and the UK's National AIDS Trust. Positive Action at work seeks to address stigma as a barrier to successful implementation of comprehensive workplace HIV/AIDS programmes by using positive images in HIV awareness and education and by encouraging the discussion of prejudice and social exclusion.

Materials, developed with peer educators, are available on www.gsk.com/positiveaction/at-work.htm.

4. Policies and laws: human rights and education

At sectoral, national and international levels, policies, laws, and conventions can either enable access to services and to exercising rights, or they can inadvertently perpetuate discrimination and stigmatization.

Enabling and protective policies and laws

Most countries have now enacted policies and laws to protect the rights and freedom of people living with HIV and to safeguard them from discrimination. Much of this legislation has sought to ensure their rights to education, employment, privacy and confidentiality, as well as rights to access information, treatment and support.

In relation to education, the Convention on the Rights of the Child (CRC) commits signatory nations to strive to:

- make primary education compulsory and available free to all;
- encourage the development of different forms of secondary education; and
- take measures to encourage regular attendance at school.

Similarly, the Millennium Development Goals (MDGs) aim at:

- Universal primary education (UPE) by 2015: that all children, boys and girls alike, be able to complete a full course of primary education; and
- achieving gender equality: that girls and boys have equal access to all levels of education.

The AIDS epidemic represents a major challenge to the realization of these goals, not least because stigma creates enormous barriers to access to education and to gender equality, but also because this stigma and discrimination can create obstacles to prevention programmes in schools and in the workplace. As rights-based institutions, schools should play a major role in protecting pupils and teachers against discrimination.

Discriminatory and stigmatizing laws and policies

In many countries, stigmatization is expressed through laws and policies directed at those living with HIV that claim to protect 'the general population'. Examples of such discriminatory legislation include limitations on international travel and migration, compulsory screening and testing for HIV, compulsory notification of AIDS cases, prohibition of people living with HIV from certain occupations, and even isolation of people living with HIV from the general population.

Box 11 Comment from stigma-aids e-forum

"While nearly a million HIV-positive American citizens enjoy the freedom to leave and travel outside their country, the United States government prohibits HIV-positive individuals from other countries entry to the United States! Without a doubt, this ban is the most blatant display of discrimination against HIV-positive people to date! This ban continues to fuel discrimination, while a worldwide community strives to stop the stigma and discrimination surrounding HIV and AIDS!" (Bradford McIntyre, Canada).

In most cases discriminatory practises, such as the compulsory screening of 'risk groups', both further the stigmatization of these groups and create a false sense of security among individuals who are not considered members of such groups or who are at high-risk of contracting HIV. Conversely, enabling programmes and laws can have an *unintended* discriminatory effect on the beneficiaries rather than an enabling one. For example, healthcare workers may perpetuate stigma during treatment, counselling and care of people living with HIV. In an education-related example, in spite of the many national and international subsidies and support programmes to support orphans' education, children in Uganda were unhappy being singled out as orphans and said they felt ridiculed at school because of their subsidized uniforms or other forms of monetary assistance that made their status easily recognized (Munaaba, Owor et al., 2004).

Box 12 Inadvertently perpetuating stigma

"Socially excluded groups are often at great risk for discrimination. During interviews in Botswana, Uganda and Malawi, children orphaned by HIV/AIDS reported several cases of discrimination. Some children claimed they were sent home from school due to unpaid school fees, or untidy uniforms and some said they did not go for fear of being teased or unaccepted" (Bennell, Hyde and Swainson, 2002).

5. Confronting stigma and discrimination in the education sector

There are many forms of AIDS-related stigma and discrimination occurring in schools and ministries of education across the world, with perhaps the most prominent discrimination being termination of employment or refusal to offer employment based on an employee's actual or assumed HIV status. Other discriminatory practices involve:

- unequal training and/or promotion opportunities based on HIV status;
- inconsistent or absent practices to deal with instances of AIDS-related discrimination;
- breaches of confidentiality regarding an employee's HIV status.

Box 13 Examples from stigma-aids e-forum

My colleague told me he hated HIV, and people with HIV, because when they came to his desk he had to disinfect everything.

Someone suggested we should not recruit new staff from Africa because they'd all have HIV and die.

A staff member asked why someone was having their contract renewed since he was dying (in fact, although this person had HIV he was extremely healthy).

People in my team made jokes about AIDS assuming that nobody in the room had HIV.

Some people suggested we test everyone and put them into separate vehicles when we travel so that if there is an accident the 'innocent negative' staff won't be put at risk.

Team members suggested that people who are living with HIV were only hired because we felt sorry for them - implying they were not competent.

Box 14: 'Debbie' speaking to the National AIDS Trust, UK, 2002.

"My foster son, Michael, aged 8, was born HIV-positive and diagnosed with AIDS at the age of eight months. I took him into our family home, in a small village in the southwest of England. At first relations with the local school were wonderful and Michael thrived there. Only the head teacher and Michael's personal class assistant knew of his illness. Then someone broke the confidentiality and told a parent that Michael had AIDS. That parent, of course, told all the others. This caused such panic and hostility that we were forced to move out of the area. The risk is to Michael and us, his family. Mob rule is dangerous. Ignorance about HIV means that people are frightened. And frightened people do not behave rationally. We could well be driven out of our home yet again."

Activity 2

Stigma and discrimination in the education sector

A. Consider how stigma and discrimination impact on HIV prevention, treatment, care and support, and impact mitigation programmes in your country for:

1. pupils.

2. teachers and other education sector employees.

B. Now select one impact on HIV prevention, one on treatment, care and support and one on impact mitigation and discuss possible interventions to prevent or reduce the impact.

C. Can you think of other barriers that stigma produces within the education sector, such as how stigma can affect the following:

1. the implementation of a policy of universal primary education; or
2. the morale and productivity of an infected teacher; or
3. the learning environment of children from an affected community?

Effects of stigma and discrimination in the education sector

The effects of stigma and discrimination in the education sector can be very disruptive. For example:

- they can negatively affect teacher morale;
- they can result in reduced productivity (e.g. teacher absence);
- they can compromise employee health, in instances where stigma constitutes a barrier to access to treatment and care;
- they can result in the loss of human resources if infected employees leave;
- they will undermine HIV prevention programmes.

Local-level discrimination in the education sector

At the school level and in communities, children living in AIDS-affected households can be sent away from school, refused access to services and robbed of their property. We will discuss stigma and discrimination within the classroom further in this module.

Strategies

Education sector strategies to address stigma and discrimination in the workplace should include the following:

- Conducting an HIV and AIDS policy analysis to assess the extent to which policies address (or perhaps reinforce) AIDS-related stigma and discrimination.
- Informing all teachers, staff and employees of AIDS-related stigma mitigation policies and practices, so that there is widespread understanding of the consequences of discriminatory behaviour.
- Targeting prevention programmes specifically at school employees and staff in addition to programmes for students.
- Mainstreaming AIDS-related stigma mitigation policies into other functions, such as communication strategies and strategic plans.
- Protecting the rights of all employees who are infected or assumed to be infected with HIV and acting decisively when cases of stigma and discrimination do occur.
- Encouraging sensitivity and understanding among co-workers regarding AIDS issues.
- Encouraging HIV-infected teachers to disclose their status within a safe, accepting and supportive environment.
- Providing managers at all levels with clear guidance on which they can base managerial decisions when confronted with issues relating to HIV and AIDS.
- Ensuring that mechanisms are in place to protect the confidentiality of information related to teacher and staff health, including their HIV status.
- Involving people living with HIV in all workplace HIV and AIDS activities, as well as inviting them to share their experiences with parents and students.
- Encouraging school staff to form networks and associations with people living with HIV to promote acceptance and understanding.
- Monitoring the implementation of AIDS policies, including the stigma mitigation aspects of these policies, and monitor interventions for their sensitivity in relation to stigma.

Leadership within the education sector

HIV and AIDS leadership and visible and vocal commitment have enormous potential to address stigma and discrimination. These should be evident in three areas:

1. **Internally** – leadership on AIDS issues within the sector, the organization, and the school.
2. **Externally** – leadership with other stakeholders.
3. **Personally** – acting as a role model, for example by demonstrating solidarity with people living with HIV or getting tested for HIV.

Activity 3

Provision for AIDS-related stigma reduction in annual operational plans

Develop an objective that could be one of the objectives in the annual operational plan of your ministry and that clearly states the desired outcome in terms of a stigma-free working and learning environment.

Select some of the stigma reduction workplace strategies that would be appropriate in your ministry or at school.

Then, using a simple work-plan template that consists of the headings in the example table below, develop a work plan for one year that includes the step-by-step activities that relate to the selected strategies. For example, what are the steps necessary to undertake analysis of a stigma reduction policy?

ACTIVITY	TIME FRAME	RESPONSIBLE UNIT OR PERSON	OUTPUT/ OUTCOME

6. Education as a tool to counter stigma and discrimination in the classroom

Education has a key role in lessening stigma and discrimination. It can affect change where the law cannot, such as in families and among friends. Furthermore, people working in education are ideally placed to pass on information that challenges the stigma related to HIV and AIDS.

UNAIDS differentiates three types of education to promote HIV prevention and awareness:

- Public education: Information provided to the general public to increase knowledge of the disease. Can be done through media campaigns, newsletters.
- Professional education: By changing the attitudes of respected professionals, this can have positive effects on the behaviours and attitudes of others around them. An example would be workplace interventions within your ministry.
- Targeted or focused education: This refers to education programmes tailored to specific communities and groups, such as teen groups, workplace groups, religious groups or women's groups.

Box 15 Extract from the Conference on HIV/AIDS and the Education Sector

> "My name is Mpho from the North West Province (South Africa), and I'm seventeen years old. I believe that teachers can have a huge impact on the lives of learners who are affected and infected by AIDS. I lost my mother and a sister in 1999 and in 2000 I was raped by my father. A year later I discovered that I'm HIV positive. The first person who knew about this was a teacher and the attitude that she had is the cause of my positive living in life" (South Africa Department of Education, 2002: 10).

Prevention programmes must take into account the messages students are receiving from the community and at home. If not, the fears and misunderstandings that create stigma and cause discrimination will be perpetuated. If education is the best means of stopping the spread of HIV, these prevention programmes must successfully break this cycle.

Box 16 Addressing stigma and discrimination through education

An effective way to address stigma and discrimination is through training and educating people and children about HIV and AIDS and about the causes and effects of stigmatization and discrimination. Below are some examples of education programmes that were effective in diminishing stigmatization.

Prevention in schools through peer education

HIV/AIDS life skills day camps (Tanzania)

Designed by Global Service Corps and based in Arusha, these camps provide a framework for secondary school students to learn about HIV/AIDS, prevention, relationships and sexuality in a fun, creative, and ultimately sustainable manner. A primary goal of the camp is for the participants to form health clubs in their respective schools to share their knowledge of HIV/AIDS with the rest of the school. This way the discussion of HIV/AIDS can be continued throughout the year.

Peer education and theatre

Tabor Wegagen Anti-AIDS Association (Ethiopia)

A programme established in conjunction with UNICEF over six years ago by a group of young people who came together to inform their peers about HIV and AIDS. Using the principles of peer education, the groups share information on HIV prevention and also engage in sensitization activities, such as theatre, to diminish stigma and discrimination.

Activity 4

Stigma and discrimination at school

A) First read the three questions from a Save the Children UK study. Concentrate on how stigma impacts on the education and well-being of these children. Focus on who is stigmatized and by whom; where within the learning environment; and why – the context and causes.

1. "They are laughing outside of the class. They laughing at the fact that her mother has AIDS. She is angry and going away. She feels angry and she also feels like beating them but she knows they will report her at the office."

2. "You are afraid the teachers will tell all the other children at assembly. Then other children will start playing cruelly with you and tease you that your mother has got AIDS. Just like the one that I share a seat with. She shifted and sat somewhere else in the class after I told her. Then she went to tell the class teacher."

3. "Sometimes they'll chase us back home if we don't have exercises (books). They say they will chase us away, it is not their problem."

B) Now consider what a school could do to (a) prevent situations of stigma and discrimination from occurring and (b) to respond if they do occur. Make a note of your ideas below.

Summary remarks

Stigma and discrimination are pervasive and destructive, and need to be recognized as significant obstacles to any effective education sector response to HIV and AIDS. Stigma is a systematic process that reinforces existing divisions in society. Discrimination can take away a person's rights. They are, however, difficult to tackle due to their dynamic nature; changing both when an individual progresses from HIV to AIDS and as the epidemic evolves in a learning community. Understanding the causes and consequences of stigma, as well as the different forms of stigma, can offer opportunities to challenge and reduce stigma and discrimination. There are a number of practical actions that an education sector or institution can take to create a caring, enabling, supportive and stigma-free environment, the benefits of which will rapidly become apparent.

Lessons learned

Lesson One

Stigma and discrimination are different but interrelated phenomena involving negative attitudes about a person or group of persons, and the actions resulting from the holding of these negative attitudes.

Lesson Two

Stigmatization and discriminatory behaviour are hampering Education for All and Millennium Development Goals.

Lesson Three

Failure to understand the types, features and effects of stigma will jeopardize HIV prevention programmes.

Lesson Four

Education has a key role in diminishing discrimination and supporting the rights of all children.

Lesson Five

Stigma is an obstacle to successful prevention programmes and policies. These programmes and policies can unintentionally reinforce stigma and discrimination.

Lesson Six

Education sectors should define the strategies to challenge and reduce stigma – in learning situations and throughout the sector – and should ensure that these become an integral part of their overall AIDS response.

Answers to activities

Activity 1

There is no one answer to this activity and you may want to discuss your answers with a colleague or mentor. Alternatively, referring to the section 'Causes and types of stigma and the language used' might be useful. You may also want to try to analyze the language in one or two media articles about AIDS and decide if it is 'enabling' or 'discriminatory'. The two essays now published as a book, *Illness as metaphor and AIDS and its metaphors* (Sontag, 2001), also give some interesting insights into the language we use when talking about illness and more especially AIDS. See also *Presentation of self in everyday life* (Goffman, 1990)

Activity 2

- Teachers, other staff and pupils may not take personal protective action, despite receiving consistent correct prevention messages, as a result of perceiving AIDS to be a 'problem of those other people'.
- Infected staff may resist accessing treatment for fear of being identified as infected and being stigmatized as a result. Affected families may not apply for fee exemptions for their children for fear of being labelled.

Activity 3

- Supervisors and managers could attend sessions that focus on managing situations of stigma and discrimination against staff who are infected (or perceived to be infected).
- Policies, practices, protocols, etc. could be reviewed to ensure that they do not, even inadvertently, reinforce stigma.
- A person living with HIV, who is open about his/her status, could be given opportunities to interact with groups to open the debate and challenge some of the myths and misconceptions that feed stigma.

Activity 4

- Invite schools, teachers and other staff to provide pupils from affected families with uniforms, lunches, books, etc. so that they are the same as all other pupils (as being different often feeds stigma).
- Help address stigma by ensuring access to education for all members of society, including orphans, girls and youth.
- Affirm and show visible support for pupils and teachers who are infected or affected (i.e. becoming a positive role model) will challenge stigma.
- Make schools 'safe places' where discrimination is not tolerated and where information is given to continue awareness.
- Have established referral procedures in place for teachers as well as clearly defined roles with respect to social and health workers to access the services needed to support vulnerable children.

- Be sure to consider human rights as the basis for education and prevention campaigns against HIV and AIDS.
- Participate in wider community-based activities that challenge stigma and discrimination. Children and communities need to be involved in the decision-making process when developing support programmes for poor and vulnerable children.
- Involve people living with HIV in school and community activities to promote a greater understanding of their situation and to diminish stigma and misconceptions about how HIV is spread.
- Consider your schools' activities within the context of the community and/or related NGO activities within your country.
- Institute forms of participatory training for pupils, teachers and education sector staff. Use peer groups which have been proven effective.
- Take early and decisive action to address instances of discrimination.

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Module

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Leadership against HIV/AIDS in education

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Module 1.5

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Aims

The aims of this module are to:

- highlight the paramount importance of good leadership in the fight against HIV and AIDS in education;
- present you with examples of leadership to enable you to understand the concept of leadership and the qualities that make a good leader;
- identify skills and resources needed to lead and advocate effectively;
- show the value of leadership and advocacy when motivating peers and subordinates to mobilize effective responses to HIV and AIDS in the education sector.

Objectives

At the end of this module you should be able to:

- understand why leadership is important when addressing HIV and AIDS impacts on the education sector;
- recognize the traits and skills of an effective leader;
- assess your own leadership abilities and identify areas for improvement;
- understand your own potential for leadership within your community or family life, at work and among your peers;
- develop an HIV and AIDS advocacy strategy at your level within the institution or within your community.

Before you begin...

Questions for reflection

Take a few minutes to think about the questions below. You may find it helpful to make a note of your ideas in the spaces provided. As you work through the module, see how your ideas and observations compare with those of the author.

Who was the best leader you ever had? What made him/her a good leader?

Who was the worst leader you ever had? What did he/she do wrong?

Can you think of any examples of how effective leadership has helped tackle HIV and AIDS

a) in your workplace?

b) in schools?

c) in communities?

What is advocacy and what forms can it take?

How can advocacy help in promoting awareness and prevention of HIV and AIDS?

Module 1.5

. . . . LEADERSHIP AGAINST HIV/AIDS IN EDUCATION

Introductory remarks

Enabling the education sector to respond effectively to the HIV and AIDS epidemic requires special efforts in policy design, curriculum development, teacher training and management. Overcoming the obstacles to mobilizing responses against HIV and AIDS at all levels of the education sector underscores the need for effective leadership and leadership development.

This module aims to provide practical guidance to staff from senior levels of ministries of education down to the school level on how to develop their own leadership skills, so that necessary changes in work environments and practice can be implemented. The basic premise of this module is that leadership is essential to the success of responses to HIV and AIDS in the education sector; that while some people seem to be natural or born leaders, effective leadership can be learned and developed in each of us. The content of this module is based on the following principles:

- No significant institutional changes or innovations are achieved and sustained without strong leadership, commitment and advocacy for change.
- Mainstreaming HIV and AIDS in the education sector cannot be accomplished without leadership and open communication to promote the vision and transform it into action and institutional change.
- Individual leadership and skills can be learned and developed at all levels of the education sector.
- Advocacy, communication, negotiation and partnerships are essential tools for effective leadership.

This module is intended to provide insights into good leadership and the qualities that make up a good leader. It provides practical guidance to staff from ministries of education down to the school level on how to recognize their own potential as leaders and how to develop their own leadership skills. It highlights ways that you can develop your own leadership style in order to influence positive changes in your institution, family or community life, and to acknowledge and confront the impact of HIV and AIDS.

This module should be studied in conjunction with Module 1.2, *The HIV/AIDS challenge to education* in this volume, with Module 2.3, *HIV/AIDS in the educational workplace,* in volume 2; Module 4.5, *School level response to HIV/AIDS* in volume 4, and Module 5.3, *Project design and monitoring,* in volume 5.

1. Leadership

The meaning of leadership

Leadership is about questioning the *status quo*, challenging the process, giving direction, introducing innovations, and bringing about change. It is about seeing over the horizon, visualizing the final destination, and making something happen. It is about changing the way things are (UNAIDS, 2001). It is also inducing others to act effectively .

The importance of leadership in development is well known. All countries that have made considerable progress in education, and more generally in economic development, have benefited from strong and inspired political leadership. At a micro level, such as the school level, the importance of a good head teacher in triggering change, motivating his colleagues and promoting quality is increasingly recognized.

Leadership starts with identifying the right problems, having a vision of what the country – or the institution – can become and the changes that are required to go in the right direction. But having a vision is not enough. Leadership is also about inspiring others to take action. It implies guidance towards a particular goal. Effective leaders have an impact on the way their constituencies see and respond to the new challenges in their environment. Understanding what different members of their constituencies are feeling and what motivates them, effective leaders can inspire people and move them in certain directions.

Box 1: Example of an extraordinary vision: that of Martin Luther King, Jr.

> "I have a dream that one day this nation will rise up and live out the true meaning of its creed: 'We hold these truths to be self-evident, that all men are created equal.' I have a dream that one day on the red hills of Georgia, the sons of former slaves and the sons of former slave owners will be able to sit down together at the table of brotherhood. I have a dream that my four little children will one day live in a nation where they will not be judged by the color of their skin but by the content of their character. I have a dream today!"
> Extract from a speech that Martin Luther King, Jr. delivered on 28th August 1963 at the Lincoln Memorial in Washington, D.C.

Leadership is often assimilated to power and authority. When someone is given power and authority, he or she is expected to be a leader. Not everyone who has power however is an effective leader. But some of the skills required in the act of leading can be learnt (such as the skills of identifying problems, problem-solving, personnel management, communication, organizational design).

Many believe that one is born as a leader, and those who become leaders (at different levels) are those who have the ability to lead. They have different innate characteristics and skills: charisma, sense of initiative, ability to inspire,

communicate and move people. But again it is increasingly recognized that the act of leading can be taught and learnt.

Leadership is not reserved to those with power and authority, not even to those in a position with assigned responsibility. Anyone – with certain traits and skills – can be a leader at his/her level and can influence others positively to take action and to make and sustain change.

Leadership is particularly needed in an HIV and AIDS context. In the struggle against HIV and AIDS, leaders have to use their capacity to influence their constituents in a positive way – to create a national, social environment that curbs the spread of the pandemic and cares for people living with HIV.

Box 2: Examples of effective leadership

Examples of successful innovations and sustained reforms all illustrate the essential role of leadership. Setting an example, risk-taking, and being a pioneer are examples of leadership. In the political arena, the transition of South Africa from apartheid to democracy came about thanks to the leadership of Nelson Mandela and many of his allies and supporters.

Nelson Mandela has also shown courageous leadership in the area of HIV and AIDS. In January 2005, former President Mandela announced that his only remaining son, Makgatho Mandela, had just died at age 54 of AIDS-related causes, two years after his wife, Zondi, died of pneumonia. Mandela's announcement defied the taboos and silence about the AIDS epidemic.

This 1986 Nobel Peace Prize winner encouraged people to speak out about HIV and AIDS, saying "Let's not hide it because the only way to make it a normal disease, such as tuberculosis, as cancer, is to always openly say that someone died due to HIV/AIDS".

Qualities that make an effective leader

As mentioned earlier, leadership is about setting a vision and establishing goals. It is about courage and persistence, a refusal to take no for an answer when it comes to introducing change. Successful leaders are usually thick-skinned and have generally had to overcome numerous set-backs and suffered criticism -- and even condemnation -- for going against established practices and theories.

True leadership is associated with qualities such as creativity, innovation, energy, patience, and perseverance. At the same time a leader must master the skills of listening, empathizing, communicating, and supporting and promoting others. There are many characteristics of a leader, just as there are different types of leadership. In *The Art of War*, by Sun Tzu, written 2,500 years ago, the qualifications required to lead effectively were the following:

- Self-discipline, the statement of rules for the leader and the group.
- Empathy – or, as we would say now, emotional intelligence -- in order to know others' needs.
- Responsibility, in relation to your own decisions and actions.
- Co-operation, in the work designated to achieve common goals.
- Example, to show the right way with attitudes.

This list remains valid. Yet the wide literature on the subject has extended the number of qualities required. Effective leaders:

- sustain their own mental health (especially through a balance of work and play);
- show courage, determination, decisiveness, innovation, trustworthiness, initiative, a readiness to seize opportunities, self-confidence, and energy;
- possess the drive to meet an internal standard of excellence;
- show accurate self-awareness and self-assessment (or a realistic evaluation of their strengths and limitations);
- are willing to engage in personal change;
- take responsibility for personal behaviours and actions;
- are able to follow where appropriate (instead of lead);
- have the ability to communicate effectively and empathize with others;
- are able to develop relationships with others based on trust and open communication;

In addition, leaders must have a fairly high degree of technical and intellectual competence in their own domain without necessarily having to be geniuses. They should strive to stay current with relevant trends and issues, and be comfortable working in complex environments.

Of course all leaders do not have to master all these skills. In any case the national culture and history strongly influence the leadership style, expectation and performance. Some societies are more likely to accept strong leadership than others. Different organizations have different leadership styles and cultures as well. This has to be taken into consideration.

Remember, a leader does not necessarily hold a high position. Leaders can be *ordinary* people with creative ideas and a willingness to go outside the beaten path to implement the policy and achieve the goals set. The following people can all be considered effective leaders at their respective level:

- A district officer who successfully promotes a policy supporting access of OVC to education;
- A school principal who ensure that schools are safe places where children want to be and where they really learn something worthwhile;
- A school principal who seeks to identify children who have never enrolled, the reasons for this and what can be done with the help of the community to encourage them to go to school;
- A school principal who establishes a school committee to determine the content and methods of HIV education;
- Members of parent-teacher associations that mobilize funds to replace the unpaid contribution of orphans and vulnerable children;
- A university student who starts an association to spread awareness about HIV and AIDS.

These people may not be known to many outside their communities, and they may not hold powerful positions, but they can still bring about positive change in their environments and institutions.

A question to you is how could you, at your level, be a leader and contribute to the struggle against HIV and AIDS?

The difference between leadership and management

In the field of organizational change, the terms ‘leadership’ and ‘management’ are sometimes used loosely and even interchangeably. However, although there is an overlap between management and leadership in organizational contexts, the two terms are conceptually and operationally distinct. One way to remember the difference is to say that leadership is commonly stated to be about doing the right thing, and management is about doing things right. Leaders might develop vision, influence creation of a coalition or teams that understand and accept the vision and strategies, and energize people to overcome barriers. In contrast, managers might develop a strategy, list detailed steps and timetables for results, allocate necessary resources, build up delegation structures, develop procedures for guidance and methods for monitoring, and strive to change organizational structure. An effective leader is more likely to empathize with people, develop a vision that mobilizes people, and have a charismatic personality than a manager, but he may also need to be supported by a manager. Holman considers that “leadership and management are different facets of leader-manager behaviour that are usually present to varying extents and integrated within an individual” (Holman, 2003).

Discovering the potential to lead

As mentioned above, effective leadership depends on specific traits and personal characteristics and abilities. The act of leading also implies a certain number of tasks to be performed. Mastering leadership is a skill like any other; it just takes time and a true commitment to bettering one's self, assuming or developing the qualities that make up a leader, and acquiring specific competencies.

Research shows that leadership skills and traits can be learnt, and if already present they can be improved through practice, training and other developmental activities. Hopefully, reading this module should make you think about how you can work on some of the required traits and develop some of the necessary leadership skills. You must first assess your own capabilities, but also your weaknesses.

Activity 1

Develop your positive traits

In the table below, look at the list of positive and negative traits, and answer the following questions:

Table 1

Positive Traits	Negative traits
Innovative	Over-cautious
Creative	Unimaginative
Focused	Scattered
Open-minded	Authoritarian
Supportive	Humiliating
Self-assured	Insecure
Generous	Arrogant
Unpretentious	Vain
Trustworthy	Corrupt

- Which traits appear most important to you at the top of your organization?

- Which traits appear most important to you at your level of your organization?

- Which ones correspond best to you?

- Which positive traits correspond least to you, and hence which one should you develop?

Let us focus now on specific leaderships skills. The following points synthesize some of the most commonly cited roles, activities, abilities and skills of leaders operating in the context of organizational change (each of the terms is explained in Activity 2):

- Change agent and motivator
- Visionary and direction-setter
- Alliance broker/team builder
- Analytical and creative thinker
- Skilled communicator and guide
- Virtue and integrity

Activity 2

How effective a leader are you?

Read the list of six characteristics of a successful leader below. Rate yourself on each characteristic, using the following scale from 1 to 5.

1 = no experience or ability

2 = little experience or ability

3 = average experience or ability

4 = considerable experience or ability

5 = very high level of experience and ability

Ability to act as a change agent and motivator: Think of how you have been able to achieve innovations in your office, school or community by inspiring or motivating colleagues, friends, neighbours, community members, etc. How successful are you in 'selling' your ideas or views? When you encounter opposition from others to doing things differently, do you persist with your efforts or do you give up easily?

SCORE_____

Visionary and direction-setter: Identify at least one instance when you felt strongly about a problem situation and clearly outlined a course of action. How well were you able to articulate your vision of the problem and the solution to others? How well were you able to define a strategy to achieve the vision?

SCORE_____

Alliance broker/team builder: Think of a situation in which there were antagonisms or strong divergence in opinions in your workplace. Did you take the initiative to propose a strategy and convince others to support you? How did you overcome doubts and opposition to your ideas? If this skill is difficult for you, why is it so, in your opinion?

SCORE_____

Analytical and creative thinker: When confronted with a dilemma or a problem, how effective are you in identifying underlying causes? How often or how well do you come up with alternative solutions that others may not have identified? Do you find that others generally welcome your analyses and solutions to problems?

SCORE_____

Skilled communicator and guide: Do you consider yourself articulate and convincing? Are you better at oral or written communication? What feedback have

you had from colleagues about your speaking or writing skills? How comfortable are you speaking in public and chairing meetings? When given the opportunity, do you volunteer to head committees or organize meetings, or do you shy away from taking charge? How do you deal with people who are antagonistic to your point of view? Do you prefer diplomacy or confrontation?

SCORE_____

Virtue and integrity: How do you rate yourself at 'practicing what you preach'? How are you viewed in your workplace and community? Do friends and colleagues tend to look up to you? Do they come to you for advice? If people have doubts about you, how do you overcome these negative reactions?

SCORE_____

Now, calculate your total score and turn to Answers to activities section on page 175 to see how effective *you* are as a leader.

Moving from thought to action in the struggle against HIV and AIDS and making it happen

While the above-mentioned abilities are essential for designing a vision and introducing change, different steps are to be followed and these have to be planned. Furthermore, the planned actions have to take place in a proper sequence.

The following eight procedures for managing change illustrate steps in preparing for, implementing and consolidating change. While applicable to the change process in many fields, we will explore how they can be used by educational leaders in an AIDS environment. As you will see, setting a vision, motivating groups, gaining trust, establishing effective communication and promoting strategic planning are the essential steps in this process for change.

1. Assessing the problem and urging others to take action – Examine the situational realities; identify and discuss the extent of the problem, and assess possible opportunities. With regard to HIV and AIDS, there is an urgency to take action. A good leader should understand that it is necessary to promote action. It is also important that he/she understand the attitudes and feelings of his/her staff concerning existing issues before planning interventions.

2. Developing a vision and a strategy – Create a vision and develop strategies to achieve that vision. As stated earlier, changing the status quo requires visualizing the final destination and making something happen. To reduce HIV and AIDS impacts on education sectors, you will need to develop such a vision and strategy, and you must be able to see what you would like to achieve.

3. Communicating the new vision –Inform all those concerned of the new vision and the strategies to be put in place: why and how. The role proper communication plays in the success of your project cannot be overlooked, and this applies even more so when considering how to promote awareness and sensitivities towards people living with HIV or affected by AIDS. Communication reinforces the ideas that are motivating the change, and can bring others to support the cause.

4. Creating a coalition – Look for partners and allies. Assemble a group motivated enough to lead the change; facilitate team work within the group. For many countries in Africa as well as elsewhere, HIV and AIDS remain taboo subjects. The more you can motivate your team to be open about HIV and AIDS and to reduce stigma and discrimination, the more you will increase chances for change.

5. Empowering broad-based action – Identify the obstacles, their causes and try to remove them. For example, try to understand teacher reluctance to teach HIV prevention in schools, or the reluctance to be tested. Do not be afraid to support risk-taking and unconventional ideas or actions.

6. Creating short-term wins – Recognize the achievements (the wins) and reward the people who made these possible. Plan their introduction or scaling up. Remember that HIV and AIDS are problems to be treated over the long term, but they also need short-term wins, or actions, such as giving all teachers training in preventive education, or providing all ministry staff with workplace support policies.

7. **Consolidating gains and producing more change** – Highlight successes in changing systems, structures and policies. Hire, promote and develop people who can implement the new vision; constantly review and reinvigorate the process with new projects, themes and change agents.

8. **Anchoring new approaches in the wider culture** – When we say 'culture' we mean the culture of people, the culture of your organization, school or community. If it is normal that everyone attend a funeral for a colleague, perhaps ministries could draw up work schedules by which not every employee (not every teacher in a school) attends the funeral, or by which some employees return to work while others stay at the funeral for the entire day. If there is little discussion over HIV within the office, organize regular meetings or put up sign boards to post messages. This will lead to more effective management and better quality of the service. It will show the connections between new behaviours and organizational success.

Activity 3

Understanding the organizational context for change

Take a few moments to think about the questions below and make a note of your answers.

Part 1: Attitudes of personnel within the institution where you work.

1. How does the staff in your institution (school, ministry, training institute, etc.) view its strengths and weaknesses in terms of its responsiveness to the challenges posed by the HIV/AIDS epidemic? What differences are there between men and women, senior and subordinate staff?

2. To what degree do the staff feel that the epidemic concerns them and their work? Do they believe that the situation of their unit, department or school etc. is improving or getting worse? What differences are there between men and women, senior and subordinate staff?

3. Do the staff trust their leaders and have a sense of loyalty towards them?

Part 2: Information for members of the institution.

1. Is there a policy on HIV/AIDS for the ministry and the education sector? Has it been implemented? If so, do staff know about it?

2. Do the staff have access to the information they need to protect themselves from infection or know where to go for counselling, testing and treatment?

Activity 4

Analyzing the actions of a leader: Putting a vision into place at institutional level

Read the example below in Box 3, and then answer the questions on the following page:

Box 3: Being a Leader!

Charles came back from the HIV and AIDS training with lots of excitement and energy. He now understood how to put in place an HIV and AIDS programme within his department to teach his co-workers about HIV transmission, to lessen stigma and to put in place a workplace policy.

When he came back to the Ministry, he went to his superior and discussed his experiences and his ideas. His superior was favourable to the implementation, but told Charles he could not give him any funds and that he could not liberate time during the work week.

Charles called a meeting and began telling everyone how he was going to implement the project. He wanted them to be open about their views towards HIV and AIDS, and suggested that they should all be tested to start an open work environment.

After one month, Charles noticed that people were not coming to meetings, no one had been tested and that, generally speaking, things had not changed. He became discouraged: “why do people not care about HIV and AIDS?” he thought, “This is such an important issue”.

One day during lunch he spoke to a colleague who seemed a bit more interested in the subject, and with whom he felt he could speak openly. He explained his frustrations that no one was taking his initiative seriously. His colleague told him that the other colleagues felt that they did not need to learn about HIV transmission; that they were afraid to be tested and that implementing the programme took too much time and they had no incentive to do it since they were not getting paid to do it. He said that they also felt that Charles was just showing off, and that he was trying to receive praise from the Minister.

This surprised Charles. He had not even thought about these things! He had been so encouraged by his own training that he thought everyone else would be too. In his eagerness, he overlooked an important part of leading such a change. He did not speak to colleagues to get their ideas on the subject, and to understand how such programmes could affect them.

What lessons do you derive from this example? Answer the following questions.

1. Did Charles act as a good leader? Why or why not?

2. Why did no one join his vision?

3. What could Charles have done differently?

Activity 5

Developing an *action planning matrix* to strengthen leadership skills

Action planning is a technique that provides a framework for setting goals and scheduling tasks needed to achieve the goals. An action planning matrix identifies the tasks to be accomplished in order to reach a certain goal. It encompasses the co-operation and support required (co-operation of subordinates, peers, superiors or mentors), the human and financial resources needed to carry out each step, and the time frame.

Think of a project which you could introduce in your institution/organization and which will enable you to strengthen your leadership abilities. If your work situation does not allow for you to make important decisions or take major initiatives, then think of a project, or take a leadership role on an issue that concerns your community or any other organization to which you belong. Remember, this issue or initiative for which you choose to take a leadership role does not have to be on a grand scale. Rather, choose an issue about which you have *strong feelings*, as you will need to take initiatives, build alliances and organize team efforts to achieve your goal. Keep a diary of your efforts. If possible, identify a friend, colleague or mentor with whom you can discuss problems and progress in your action plan. Where possible, develop your action plan around an HIV/AIDS issue.

After setting your goal (or vision), develop a work plan in which you describe how you will design and implement appropriate activities related to each of the action points. Refer to the eights points on page 161 to help you come up with specific actions to plan your project. Use the action planning matrix on the following pages to help you organize your thoughts.

Action planning matrix

Name of project: ....

Goal or vision: ....

Task (Under each heading below, state the main issue or problem for each task)	Internal collaborators (Who within your organization could you speak with to help you?)	External collaborators (Who exterior to your organization could you seek to help you?)	Resource needs (human & financial)	Time frames
Assessing the problem, establishing the urgency and urging others to act				
Developing a vision and strategy				
Communicating the new vision				

Creating a coalition				
Empowering broad-based action				
Creating short-term wins				
Consolidating gains and producing more change				
Sustainability: anchoring new approaches in the culture				

2. Advocacy

What is advocacy?

Advocacy is a key instrument for leaders to bring about change. It is an umbrella term for (often unorganized and modest) activism related to a particular agenda. Advocacy is the act of pleading for or supporting; the work of advocating; intercession. Advocacy is to urge or support with vigorous arguments, especially in a public setting. It can also take place through 'buttonholing and lobbying' or pressuring individuals and small groups in private settings on a one-to-one basis.

Public advocacy

Both leaders and ordinary citizens play public advocacy roles in different ways. Politicians and activists of many kinds commonly use the written word and vivid images to advocate for a cause.

Box 4: Advocacy through a press release

> The South African Council of Churches (SACC) has issued a strong statement in support of the continued public distribution of condoms to control HIV transmission. In the press release, dated 4 February 2005, Rev. Dr. Molefe Tsele, the General Secretary of SACC, "expressed shock and dismay at continuing assertions that condoms 'don't work' as a means of preventing the spread of HIV."
> Aidsmap News, 14 February 2005

Printed messages (written messages)

A leader who is a public official or an officer in an organization such as a labour union can use written means to advocate, such as press releases, e-mail messages to large lists of addressees, web-sites, leaflets, brochures and flyers distributed to the public.

Private citizens can write letters to the editors of newspapers, publish articles, set up web-sites, wear badges, such as the AIDS red ribbon pin, or T-shirts printed with advocacy messages such as "HIV exists," or paste bumper stickers on cars with statements like "Elect Mr. X to Parliament". Because of the discrimination suffered by people living with HIV, many activist groups around the world have used these methods to sensitize the public or pressure politicians to pass laws protecting the rights of people living with HIV or provide better access to counselling, testing and care.

Other forms of public written advocacy are the circulation of petitions. This means is frequently used to include an issue as an item in a referendum. Placards, posters, leaflets and banners are commonly used by political parties, social movements or individuals to advocate for a cause such as civil rights for oppressed groups or a withdrawal of troops from an occupied area.

Speaking and activism

Further examples of public advocacy include giving speeches. These can be informal and personal, such as those given by individuals who stand on a box at Speaker's Corner in Hyde Park, London, and advocate their favourite cause, or it can be formal, for example a speech given by a world leader at the United Nations General Assembly, and broadcast live on television and radio to many parts of the world.

Box 5: Advocacy through a speech

> Friends, from my own experience – reinforced in recent weeks by my impressions of the vast humanitarian crisis unfolding in much of southern Africa – tells me three things. Firstly, that we need to reinvigorate the Global Movement for Children on the African continent. Secondly, that we cannot act on behalf of children in Africa without directly, honestly and boldly addressing HIV/AIDS. And thirdly, that traditional African strengths such as the extended family and community structures are collapsing under the weight of HIV/AIDS. Let me be frank: families and communities in many parts of Africa are no longer coping. In my opinion, leadership is key in changing all this, in agitating, leading and mobilising this movement for children.
> Carol Bellamy, former UNICEF Executive Director at the Africa Leadership Consultation

Be a model for change!

Personal involvement and actions are as effective as a strong statement about an issue or a cause, particularly if one is a head teacher, inspector or senior official in a ministry of education. When others see commitment and courage in leaders, they often try to emulate it. In Britain, the late Princess Diana did much to de-stigmatize HIV and AIDS when she made public visits to patients dying of AIDS-related causes in hospitals. Nelson Mandela, when visiting villages in his native South Africa, asked that all the sick, handicapped or mentally handicapped children be brought to the table to enjoy a meal with him. The community, generally ashamed of such children, was surprised, but then individuals and parents became proud to see their children and family members eating with Nelson Mandela.

In a local school, a principal can play a valuable role in fighting stigma and discrimination by personally going to visit a teacher or pupil living with HIV who is out of school sick. Sharing a meal with a person living with HIV also makes a strong positive statement, as does setting up a tutoring programme for orphans and other vulnerable children (OVC). Think about how you can be a model for change in your own environment.

Individuals and small groups can use a variety of approaches to advocate policy changes on HIV and AIDS issues. Below are some additional key actions you can take to advocate for HIV and AIDS awareness and action.

- *Talk about AIDS:* Raising AIDS issues at meetings and conferences can be a starting point to breaking down the barriers to discussing AIDS. If you are a head teacher, you have several options for advocating HIV and AIDS issues. For example, when you go to the District Education Office (DEO) to attend a meeting of your peers on school management issues, you have an excellent opportunity to mention the problems caused by teacher absenteeism, sick leave and death. You can ask the other head teachers how they deal with the problem, or you may ask them to act as a group in requesting the DEO to clarify ministry policy on the issues you raise. Similarly, if you are a ministry staff member, you can bring up the issue of sick leave or funeral attendance when workplace issues concerning HIV and AIDS trainings are discussed. Being a leader means not being ashamed to speak about such things, and facing the difficulties and problems in the community, even if it means talking about HIV and AIDS in your places of work, schools and communities.

- *Engage new leaders and partners in HIV and AIDS work.* If you are an HIV/AIDS focal point in your ministry of education, take the initiative of sensitizing leaders in the sector about the impmplications of HIV and AIDS for their work. For example, try having a meeting with the senior staff of the inspectorate to help them explore the ways that the AIDS epidemic affects their work and how their work can have an impact on preventing and mitigating the spread of HIV and AIDS. The inspection function is important in supporting curriculum innovations (including those on HIV and AIDS) as well as ensuring the quality of teaching and teacher management, all of which are sensitive to the AIDS impact.

- *Target parliamentarians and policy-makers about AIDS issues.* Among the most valuable allies to cultivate in mobilizing against AIDS are legislative bodies and policy-makers. Stigma and discrimination can be more easily overcome if members of parliament speak out on AIDS issues in parliament and in their districts. Policy-makers can review personnel regulations that may be working against persons living with HIV or AIDS and devise alternative measures that are more supportive. For example, many people who die of AIDS-related causes do not want the cause of death to be known because it may prevent the payment of death benefits or life insurance to relatives.

- *Lobby and buttonhole.* Discrete forms of advocacy are known as lobbying and buttonholing. Interest groups pushing for a new policy of some sort of change or initiative will often meet legislators, civic, religious or educational leaders one-on-one or in small private groups. Lobbyists and advocates of civic or private interests will often seek out a few key influential persons to ‘bring on board’ their initiative.

Box 6: NGOs play an advocacy role in increasing resources for HIV/AIDS

> Brazilian civil society and AIDS NGOs played a role in lobbying Congress and the President's Office to overcome resistance within the Ministry to the World Bank loans for AIDS, and launched simultaneous street demonstrations in sixteen states in 1999 to secure additional funding for AIDS treatment despite the recent devaluation and financial crisis. Although several government programs had suffered budget cuts in 1998, and although in the original proposal from the Ministry of Finance the largest cut was to fall on health care, the AIDS budget was not cut and in fact listed in the "essential" programs to be protected..... The number of Brazilian AIDS NGOs multiplied after the World Bank loan earmarked a stream of money to civil society for outreach, support, and prevention efforts; and their numbers in turn increased the visibility and political strength of the AIDS community in Brazil.
> Gauri and Lieberman, 2004

- *Work through the media to raise AIDS issues.* If you are interviewed about your job, your school or your ministry by a journalist, take the opportunity to mention the ways in which your work is affected by HIV and AIDS. You need to create more public awareness about the issues, and thereby more support for solutions. Thus, the broadcast and printed media are important allies in developing solutions to the threats posed by HIV and AIDS.

- *Mark World AIDS Day to plan events.* 1st December is World AIDS Day and presents an excellent opportunity for advocacy at different levels, from the central ministry to teacher training colleges and primary schools. It is highly recommended to involve parliamentarians or the media.

Activity 6

World AIDS Day as an advocacy opportunity

1st December is World AIDS Day. It is an excellent opportunity for advocacy at different levels. Involving parliamentarians, religious leaders and NGOs, as well as making use of the media, is highly recommended. Imagine you are a head teacher and form a committee to plan the World AIDS Day activities at your school or within your community.

1. To whom would you and the committee go for technical advice on formulating messages about HIV and AIDS for teachers, pupils, parents and members of the community?

2. How could the event be managed and funded?

3. What are dynamic and appropriate ways of involving teachers, pupils and people from the community?

Summary remarks

The experience of politics, institutional governance, social reform movements to innovate show clearly the importance of leadership and advocacy in achieving goals. The example of Nelson Mandela illustrates the importance of leadership and advocacy in bringing about change and reform. However, leaders are not necessarily celebrities or high-level officials. Leaders are also people motivating change within their schools, families, offices, neighbourhoods and communities.

Leadership skills can be learned, and developed. Characteristics such as being a change agent, a direction setter, or a team builder

Because of the silence, stigma and discrimination surrounding HIV and AIDS, there are tremendous barriers to mainstreaming them into the operations of the education sector. Overcoming these obstacles requires forceful, committed and sustained leadership and advocacy.

Lessons learned

Lesson One

While often an innate quality in people, leadership skills and competencies can be learned and developed.

Lesson Two

Leadership is about the capacity to question the *status quo* when it is unacceptable. It implies confronting problems, communicating a vision on where to go, identifying and removing obstacles to change, having the capacity to redefine organizational goals, and modifying organizational culture. Effective leadership motivates people and makes them all want to achieve high objectives.

Lesson Three

Leadership is relational. An effective leader has to listen to others, understand their concerns, their worries and their motivations, before defining his or her strategy. She/he has to form alliances in action. Leadership is to be, to know and to do.

Lesson Four

Advocacy and communication skills are essential tools of all leaders. It is through advocacy and communication that one can be a model for change.

Lesson Five

Leadership is not only exercised at the top. Everybody can exercise leadership at his or her own level (in one's family, community, church, organization). Everyone should take responsibility for what happens where they are rather than wait for a proper decision to be made at the top level and for resources to be made available. This mobilization is essential in the response to HIV and AIDS.

Answers to activities

A regional workshop on HIV and AIDS was held by IIEP for division chiefs in a ministry of education in Eastern Africa. The answers to activities 2, 3 and 5 are taken from the discussions and outputs of this workshop. Though your answers will differ from those below, this information could be useful.

Activity 1

The answers for activity 1 will be different for everyone and will surely vary according to your personal experiences, but also according to the country and the culture. The best way to answer these questions is to be your own judge. It is also recommended that you discuss these answers with others in your group.

Activity 2

The answers below for activity 2 were provided by a District Education Office, who herself did the activity.

Ability to act as a change agent and motivator: I feel that there are too many statutory and resource limitations to my being a major change agent. However, I am good at motivating my office staff and the head teachers in my district. I make periodic visits to schools and hold meetings for head teachers to share experiences. I encourage them to innovate at the school level. As far as HIV and AIDS go, I encourage my head teachers to hold school assemblies on AIDS and set up anti-AIDS clubs. This works, as these are extra-curricular initiatives. On the other hand, I have not pushed for inclusion of AIDS in the curriculum; even though some NGOs have offered to provide books, the Ministry has not provided guidelines on including AIDS in the curriculum. Furthermore, most of the parents feel that sex should not be discussed in the classroom.
SCORE 3

Visionary and direction-setter: I see myself essentially as a competent administrator. I value fairness and accountability, but I am not a visionary. Policy is set at the ministerial level. I cannot create new policies or tell the Ministry what to do. I find ways of implementing policies within my means.
SCORE 1

Alliance broker/team builder: I am good at getting things done. When I don't have the staff or resources to do something, I look for assistance elsewhere. For example, I have developed a co-operative arrangement with the heads of several other district services. Thus, when the Agricultural Extension Service is going to send a Land Rover to remote areas where there is no bus service, I arrange for one of my primary education advisers to go along and visit schools in the villages. The agricultural extension agents provide valuable help to school gardens in my district. The larger ones contribute produce to our school lunch programme. I am an advocate of agricultural education and have successfully lobbied the Ministry of Education to increase its support for the agricultural training college in our district.
SCORE 4

Analytical and creative thinker: I know the policies of our Ministry well. I once studied law and developed good analytical skills. These have helped make me a successful administrator. We have problems with growing teacher absenteeism and requests for sick leave. I have obtained a grant from the district office of the National AIDS Commission to hire substitute teachers or to bring back retired teachers to fill in for sick colleagues.
SCORE 4

Skilled communicator and guide: I am not good at speeches and I don't like to show off. I prefer quiet diplomacy to confrontation in solving problems. I'm not comfortable with politicians. It's difficult for me to speak out on AIDS issues, even though some teachers have been driven away from their schools by unsympathetic and prejudiced head teachers. I have sent notes to the Director of Primary Education about the issue, but not much progress has been made.
SCORE 2

Virtue and integrity: Despite temptations, I manage my budget very carefully, as it is for the good of my staff and our schools. I have to say no to requests for favours of various kinds, including having grades changed so that a student can avoid repeating a year. I always turn down offers of cash for such favours. I am respected for my firmness.
SCORE 5

Analysis:
With a score of 19 out of a total possible of 30, The District Education Officer (DEO) is a *moderately effective* leader. She is brilliant as a trustworthy person (SCORE 5) and people will follow her example, as she is admired for her integrity. She must learn to leverage more support for change initiatives with this strength. Our DEO is also a good problem solver and alliance builder. However, she falls short on visioning (SCORE 1) and public advocacy (SCORE 2). However, with encouragement and support she can turn these weaknesses into strengths.

Activity 3

Below you will find a matrix that displays the answers given by the workshop participants according to the units where they worked.

Part 1: Attitudes

Section or Unit	Responsiveness of institution to HIV/AIDS	Extent to which the staff felt concerned by HIV and AIDS	Do the staff trust their leaders
Office of the Minister and the Permanent Secretary	The MoE sends a representative to monthly meetings of the National AIDS Commission (NAC). We get much pressure from outside groups to do more about HIV/AIDS. We hear little from the staff, either senior or junior, about HIV/AIDS.	There is no clear impact of HIV/AIDS on the staff of our cabinet. However, a number of secretaries and drivers ask for time off to take care of sick family members. The Minister's driver died of tuberculosis at age 31 six months ago.	The Minister and Permanent Secretary feel that the staff are loyal and that senior management has their best interests at heart. The Minister's approval of extended 'compassionate leave' for staff who have sick relatives was very well received by all staff.
Division of Personnel	Our biggest problem is support staff who are sick. We are better at tracking staff attrition. Death is now the leading cause of leaving employment. Women more affected than men.	Little impact on my division. Most impact is felt at the school level, where requests for successive periods of sick leave have increased by 30% in the last 5 years. Female primary school teachers are the most affected.	Staff were reluctant to do research on causes of attrition. Some feared that the real reason was to detect 'phantom teachers' who were being paid a salary. My efforts are viewed with suspicion by some staff, especially junior level men.

Division of Finance and Administration	We have increased death benefits for the bereaved, which was well received by junior staff. I have hired temporary staff to process payments when regular staff are off sick.	We have lost mainly support staff, such as cleaners and lower level clerks. More men than women. Overall, workload has increased and delays in transactions are more frequent.	My staff at the Ministry is loyal. However, we have problems with the DEOs who are using vehicles and teacher in-service training funds for funerals, sometimes for persons who are not MoE staff!
Division of Primary Education	The ministry is not doing enough. My staff represents 85% of MoE employees and many face hardship caused by HIV/AIDS. Female teachers seem to be the most affected.	I am overwhelmed with requests for transfers, particularly rural teachers wanting to come to the capital or major towns.	My staff is loyal but the Teachers Union is hostile. When I couldn't find posts for 540 teachers seeking transfers, the Union organized a strike.
Office of the Chief Inspector	I have been told to strengthen in-service training for primary teachers on HIV/AIDS. Unfortunately, there are no specific guidelines.	I am frustrated because many IST workshops and inspection visits are curtailed because DEOs are using resources budgeted for these purposes to fund funerals.	The staff in the field are angry. I have been blamed for the lack of resources. I would welcome support to develop the confidence of my field staff.

Part 2 Information: These responses will vary by country.

Activity 4

Charles did have a vision and he was motivated to see it through. He was ready to take a chance and to lead a new project in order to change a situation he felt strongly about. However, he had been so enthusiastic about his own training that he thought everyone else would be too. In his eagerness, he overlooked an important part of leading such a change. He did not speak to colleagues to get their ideas on the subject, and to understand how such programs could affect them. He did not make them feel part of something. He failed to create a sufficiently powerful guiding coalition.

Having emotional intelligence is one important aspect of a strong leader. Emotional Intelligence is the ability to empathize or relate to others by understanding their position on an issue and working with them to enable them to see the vision and to move ahead.

Activity 5

Action Planning Matrix *(as taken from the IIEP regional training course in Eastern Africa. The team chose the project concerning the development of a workplace policy)*

Name of project or vision: Developing an HIV/AIDS in the Work Place Policy

Task (State main issue or problem for each task)	Internal Collaborators	External Collaborators	Resource Needs (Human & financial)	Time Frames
Establishing a sense of urgency Teachers are increasingly absent, taking repeated sick leave before dying. I will collect data on attrition over the past decade to share with major stakeholders. Goal: create an awareness campaign before working on workplace policy.	Teachers' Union, Director of Human Resources and EMIS specialist in the MoE. District Education Officers. The Inspectorate. Boards of Governors	ILO, Ministry of Civil Service, Ministry of Health, National AIDS Commission (NAC).	A full-time consultant, three research assistants, a secretary. $4,500 grant requested from NAC.	3 weeks of interviews and symposia with teachers living with HIV, and those on sick leave; presentations on school closings due to lack of teachers. TV, radio news. Launch a poster contest on HIV/AIDS in primary and secondary schools. Total: 2 months
Creating a guiding coalition Identify MoE directors willing to take a proactive stance on HIV/AIDS prevention and mitigation; agree to support workplace policy. Link with external collaborators to develop a workplace policy action plan for the Ministry and the schools.	Director of Finance; Chief Inspector of Schools; Deputy Commissioner for Primary Education	Head of social services committee of NAC; 3 HIV+ teachers, Deputy Chair, National Teachers' Union; Director of Benefits, Civil Service Commission, ILO	$1,000 in travel, secretarial and meeting costs.	1 month

Developing a vision and strategy Meet with internal and external collaborators, including teachers living with HIV, to determine what the workplace policy should cover.	Director of Finance; Chief Inspector of Schools; Deputy Commissioner for Primary Education	Head of Social Services Committee of NAC; 3 HIV+ teachers, Deputy Chair, National Teachers' Union; Director of Benefits, Civil Service Commission, ILO	$500 in travel, secretarial and meeting costs.	3-5 meetings over 2 weeks.
Communicating the new vision Overcome silence, stigma about HIV/AIDS; create understanding of the epidemic as a workplace issue.	Director of Finance; Chief Inspector of Schools; Deputy Commissioner for Primary Education	Representatives of print and broadcast media. 3 HIV+ teachers, Deputy Chair, National Teachers' Union; Director of benefits, Civil Service Commission, ILO; ministry personnel.	$500 in travel, secretarial and meeting costs.	3_5 meetings over 2 weeks Programme of radio, TV and newspaper features about workplace policy.. ministry personnel sponsor debate in parliament about HIV/AIDS and workplace policy issues (1 week).
Empowering broad-based action Enact legal framework of workplace policy	Director of Finance; Chief Inspector of Schools; Deputy Commissioner for Primary Education	ministry personnel, Teachers Union. NGO specialized in VCT, care for people living with HIV.	$1, 500 in reception, lobbying and dissemination workshop costs.	1 month to enact legislation 2 months to disseminate text via Teachers' Union workshops

Creating short-term wins Establish and run workplace policy in pilot schools, DEO and selected units of MoE	Director of Finance; Chief Inspector of Schools; Deputy Commissioner for Primary Education	Teachers' Union, NGO specialized in VCT, care for people living with HIV.	$5,000 for VCT and treatment costs of teachers and staff living with HIV.	6 months pilot.
Consolidating gains and producing more change Assess lessons learned about workplace policy during pilot phase; respond constructively to criticism and opposition	Director of Finance; Chief Inspector of Schools; Deputy Commissioner for Primary Education. Committee of staff and teachers living with HIV.	Teachers Union, NGO specialized in VCT, care for people living with HIV.	$1,500 for evaluation survey in MoE and pilot DEO and schools.	2 months.
Sustainability: anchoring new approaches in the culture Disseminate workplace policy throughout MoE and districts.	Director of Finance; Chief Inspector of Schools; Deputy Commissioner for Primary Education. Committee of staff and teachers living with HIV.	Teachers' Union, NGO specialized in VCT, care for people living with HIV.	$15,000 for VCT and treatment costs of teachers and staff living with HIV	On-going: 12 months and beyond.

Activity 6

Guidance on formulating messages about HIV and AIDS can be obtained from the National AIDS Commission, which often has district-level offices. NGOs specialized in voluntary counselling and testing are also good sources of information. The ministry of education may have an HIV/AIDS co-ordination unit which could also provide materials. Local offices of the World Health Organization and UNAIDS are other possible sources. If you have Internet access, there are web-sites from which information can be downloaded. Here are a few:

- UNICEF:
  www.unicef.org/voy/
- Kenya AIDS Information Project
  www.kaippg.org/
- Africa Alive Youth AIDS Prevention Initiative
  www.africaalive.org/youthaids.htm
- Oxfam HIV/AIDS Prevention, Treatment and Care for young people
  www.iyp.oxfam.org/campaign/preliminary_findings/hiv_and_aids_prevention.asp

Planning and managing a World AIDS Day event is time-consuming. A committee of teachers, parents and community volunteers will be needed. Your National AIDS Commission and certain NGOs may have funds for such events. Alternatively, plan on raising money through school fairs, sporting events or asking local businesses and churches to contribute funds. Solicit your PTA or board of governors for assistance.

You may want to hold a school assembly to launch the idea of marking World AIDS Day with speakers from NGOs working on AIDS issues. Try to involve sympathetic religious and community leaders as well. After the assembly, ask a senior teacher to be the chair of the organizing committee. Ask for volunteers among faculty and students.

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Useful links

Web sites:

Association for Qualitative Research/ Association pour la recherche qualitative:
www.recherche-qualitative.qc.ca

Bill and Melinda Gates Foundation:
www.gatesfoundation.org/default.htm

Catholic Relief Services:
www.crs.org

Centers for Disease Control and Prevention:
www.cdc.gov

The Department for International Development (DFID):
www.dfid.gov.uk

Eldis:
www.eldis.org/go/topics/resource-guides/hiv-and-aids

Family Health International:
www.fhi.org

Family Health International: Youth Area:
www.fhi.org/en/Youth/YouthNet/ProgramsAreas/Peer+Education.htm

Food and Agriculture Organization:
www.fao.org

GTZ: German Development Agency:
www.gtz.de/en/

Global Campaign for Education:
www.campaignforeducation.org

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM):
www.theglobalfund.org/en/

Global Service Corps:
www.globalservicecorps.org

The Henry J. Kaiser Family Foundation:
www.kff.org/hivaids/

International Bureau of Education:
www.ibe.unesco.org/

IBE-UNESCO Programme for HIV & AIDS education:
www.ibe.unesco.org/HIVAids.htm

International Institute for Educational Planning:
www.unesco.org/iiep

International Institute for qualitative methodology:
www.uofaweb.ualberta.ca/iiqm/

HIV/AIDS Impact on Education Clearinghouse:
hivaidsclearinghouse.unesco.org/ev_en.php

Kenya HIV/AIDS Business Council & UK National AIDS Trust. Positive action at work:
www.gsk.com/positiveaction/pa-at-work.htm

Mobile Task Team (MMT) on the Impact of HIV/AIDS on Education:
www.mttaids.com

OECD Co-operation Directorate:
www.oecd.org/linklist/0,3435,en_2649_33721_1797105_1_1_1_1,00.html.

Population Services International Youth AIDS:
http://projects.psi.org/site/PageServer?pagename=home_homepageindex

The Policy Project
www.policyproject.com

The United States President's Emergency Plan for AIDS Relief:
www.pepfar.gov/c22629.htm

UNAIDS Joint United Nations Program on HIV/AIDS:
www.unaids.org

UNESCO EFA Background documents and information:
www.unesco.org/education/efa/ed_for_all/background/background_documents.shtml

www.unesco.org/education/efa/know_sharing/flagship_initiatives/hiv_education.shtml

www.unesco.org/education/efa/index.shtml

UNESCO Institute of Statistics website:
www.uis.unesco.org

United Nations Millennium Development Goals:
www.un.org/millenniumgoals

UNICEF United Nations Children's Fund:
www.unicef.org

UNICEF Life skills:
www.unicef.org/lifeskills

UNAIDS Joint United Nations Program on HIV/AIDS:
www.unaids.org

United States Agency for International Development: USAID:
www.usaid.gov/

School Health:
www.schoolsandhealth.org/HIV-AIDS&Education.htm

World Bank EFA Fast Track Initiative:
www.fasttrackinitiative.org/

World Bank Multi-Country HIV/AIDS Program for Africa (MAP):
http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/EXTAFRHEANUTPOP/EXTAFRREGTOPHIVAIDS/0,,contentMDK:20415735~menuPK:1001234~pagePK:34004173~piPK:34003707~theSitePK:717148,00.html

World Economic Forum:
www.weforum.org/globalhealth

World Health Organization:
www.who.int/en/

World Vision
www.worldvision.org/

HIV and AIDS fact sheets

Fact sheet No. 1: A global overview

Global summary of the AIDS epidemic

Number of people living with HIV in 2006	Total 39.5 million
(Adults: 37.2 million; Women: 17.7 million; Children under 15 years: 2.3 million)	
People newly infected with HIV in 2006	Total 4.3 million
(Adults: 3.8 million; Children under 15 years: 530 000)	
AIDS deaths in 2006	Total 2.9 million
(Adults: 2.6 million; Children under 15 years: 380 000)	
Orphans due to AIDS in 2006:	Total 15.2 million

UNAIDS/WHO "AIDS Epidemic Update: December 2006

GLOBAL SITUATION

Although inadequate surveillance makes it difficult to discern the precise impact, patterns and trends of the epidemic, according, to UNAIDS, sub-Saharan Africa continues to bear the brunt of the global epidemic. Two thirds (63%) of all adults and children with HIV globally live in sub-Saharan Africa, with its epicentre in southern Africa, making it almost 25 million people living with HIV in sub-Saharan Africa.

In the past two years, the number of people living with HIV increased in every region in the world. The most striking increases have occurred in East Asia and in Eastern Europe and Central Asia, where the number of people living with HIV in 2006 was over one fifth (21%) higher than in 2004.

In Asia, national HIV infection levels are highest in South-East Asia, where combinations of unprotected paid sex and unprotected sex between men, along with unsafe injecting drug use, are the largest risk factors for HIV infection, with the highest levels of HIV prevalence in India and China.

Latin America's epidemics remain fairly stable, with Brazil continuing to set the example with its effective prevention and treatment programmes keeping the epidemic under control. The epidemics in Eastern Europe and Central Asia, though still relatively young, are nevertheless continuing to grow (UNAIDS, 2006).

Fact sheet No. 2: HIV, AIDS and the immune system

HIV stands for the Human Immunodeficiency Virus. HIV is the virus that causes AIDS, this virus is found in blood and bodily fluids of someone said to be living with HIV. HIV weakens the body's immune system and if untreated will result in AIDS.

AIDS stands for Acquired Immune Deficiency Syndrome. AIDS is a range of medical conditions that occurs when a person's immune system is seriously weakened by HIV, to the point where the immune system can no longer protect the body from illness and the person develops any number of opportunistic infections and diseases.

HIV affects the body by slowly attacking the immune system. The immune system is the body's defence system that fights off infection and disease by micro-organisms (bacteria and viruses).

Amongst the cells that make up the immune system is one called a CD4 lymphocyte, or a T4 Helper cell. These cells send signals to the immune system that an invader or bacteria has entered the body and must be destroyed.

HIV attaches to the surface of the CD4 lymphocyte and eventually destroys the cell. The cells are thus not able to protect the body from invading bacteria or viruses. Over time this leads to a progressive and finally a profound impairment of the immune system, resulting in the infected person becoming susceptible to infections and diseases such as tuberculosis, malaria or cancer. This is when a person is said to be diagnosed as having AIDS.

In adults, the typical course from HIV infection to AIDS is as follows:

- Window Period: About 6 weeks to 3 months after becoming infected. A person develops antibodies to HIV and the body tries to defend itself. At this time some people will experience a flu-like illness.
- Incubation Period: This is the time between infection and the development of disease symptoms associated with AIDS. The length of this period is different for everyone but it can take many years. On average, it usually takes from 7-20 years before AIDS symptoms will show up, depending on treatment. A person can live with HIV during this period for a very long time.
- Honeymoon Period: This is the time between the end of the window period and the end of the incubation period. During this period the person is living in relative harmony with the virus. The may have a few symptoms, but they do not look sick. During this time the antibody load is high and the viral load is low.
- AIDS: If a person is not receiving treatment or fortifying their immune system through good nutrition and health, the immune system eventually becomes overcome by HIV and cannot fight off infections. Following that almost all (if not all) infected persons progress to AIDS, the terminal phase of the illness.

Fact sheet No. 3: Transmission and Prevention

TRANSMISSION
HIV is a weak virus that cannot survive outside the human body. It can survive only in bodily fluids. Although present in all body fluids, HIV is only present in sufficient concentrations to be transmitted and cause infection in the following four types of fluids:

1. blood
2. vaginal fluids
3. semen
4. breast milk

Rule of Thumb: In order to HIV to be transmitted there must be infected fluid and a port of entry into the body.

A portal of entry is the way that HIV enters the body. This is either through a cut, sore, or opening in the skin or through the soft tissue called .mucous membrane, located in the vagina, the tip of the penis, the anus, the mouth, the eyes, or the inside of the nose.

HIV can only be transmitted from an infected person to another person by the following routes:

- Sexual intercourse (vaginal, anal or oral) - this is the most frequent mode of transmission
- Contact with infected blood, semen, cervical or vaginal fluids - in situations where the infected body fluid is able to enter a person's body
- From an infected mother to her child - during pregnancy or childbirth, or from breastfeeding

Anyone who has had unprotected sex, shares unclean instruments or uses dirty syringes is at risk of contracting HIV regardless of race, religion or sexual orientation.

ACTIVITIES THAT CANNOT TRANSMIT HIV
- Being near a person with HIV
- Sharing a drinking cup with a person with HIV
- Hugging a person with HIV
- Kissing a person with HIV when blood is not present
- Shaking hands with a person with HIV
- Proper use of a condom during sex

THERE IS NO RISK OF HIV TRANSMISSION FROM EVERYDAY CONTACT WITH AN INFECTED PERSON EITHER AT WORK OR SOCIALLY.

PREVENTION
The major route of HIV transmission is unprotected sex. The safest form of prevention is thus abstinence. However, in many instances, this is neither realistic nor desirable. Options such as limiting the number of sexual partners and/or using barrier methods, such as male and female condoms can reduce the risk.

Fact sheet No. 4: Testing and counselling

TESTING

The commonly used test for HIV infection tests for antibodies to HIV, it does not test directly for the presence of the virus. The period between infection with HIV and seroconversion (when the body develops antibodies) is called the 'window period'. During this time the HIV antibody test will not detect the infection, even though the person is infected and infectious.

HIV antibody testing is done for the following reasons:

- To screen donated blood and blood products, tissues, organs, sperm and ova.
- For epidemiological surveillance of HIV prevalence (usually anonymous and unlinked testing).
- To diagnose HIV infection.

ELISA

Usually HIV antibody testing is done using an ELISA test (Enzyme Linked ImmunoSorbent Assay). The test can be done on a number of body fluids, but is most often done using blood. The ideal testing process involves two tests, if the first is positive. This re-testing, using a different test allows for the positive test to be confirmed and excludes the possibility that the first test was perhaps a false positive.

Pre- and post-test counselling are universally regarded as necessary accompaniments to all HIV testing where the person concerned will receive his or her test result. The 3 'C's' are the standards for ethical HIV antibody testing:

- Informed Consent
- Counselling
- Confidentiality

COUNSELLING

HIV counselling is defined as a confidential dialogue between a client and a counsellor aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS.

Pre and post-test counselling

Counselling at the time of having an HIV antibody test has two main functions: prevention and support. It allows those tested to adopt preventive measures, change their behaviour and inform others. For those who are positive, counselling serves to help them learn to live with the virus, and to access care and support at an early stage.

Fact sheet No. 5: Treatment and Care

Treatment, care and support needs are very different at different stages of HIV infection and these can be very difficult for the families of the infected persons. The primary objectives therefore are:

1. for the infected person	-	to reduce suffering and improve quality of life
	-	to provide appropriate treatment of acute intercurrent infections
2. for families	-	to render practical support
	-	to lend bereavement support

The points at which a person who is HIV infected will require treatment and care may include:

- treatment for sexually transmitted infections
- treatment of opportunistic infections (tuberculosis, malaria, pneumonia)
- prophylaxis for opportunistic infections
- palliative care
- antiretroviral therapy (ART)

Positive living

Although there is no cure for HIV or AIDS, there are many treatments available and things you can do to stay healthy. This means taking control of aspects of your life such as maintaining your health. Ways that you can do this include maintaining:

- General Health: nutrition, rest, exercise, avoiding infections, avoiding drugs and alcohol. Studies have shown that these things strengthen our immune system.
- Psychological well-being: having a positive attitude, building self esteem, counseling, reducing stress.
- Spiritual well-being: having faith or a belief system, prayer, or meditation.
- Social well-being: having spousal or family support, peer support, a social system that protects one from discrimination, continuing productive work or advocacy. Studies have shown that women with breast cancer who were involved in support groups lived twice as long as those who were not.
- Physical well-being: at least three types of medical interventions:
    1. Treatments to strengthen the immune system which could include traditional remedies like herbs and acupuncture, and so forth.
    2. Treatment to prevent or alleviate symptoms and cure opportunistic infections like TB, pneumonia, diarrhea, skin conditions, and so forth.
    3. Anti.retroviral therapy and protease inhibitors such as AZT, D4T, Indinavir, Nevirapine often not available in some countries except for treatments to reduce risk of mother-to-child transmission.

Nutrition

Good nutrition is very important if you are living with HIV. Nutrition is not a replacement for ART, but it can help a person stay healthy for longer, delaying the time when they will require ART and, once ART is started, good nutrition enhances the benefits of ART.

References

Peace Corps. 2001. *Life Skills Manual.* Washington, D.C. Peace Corps.

Joint United Nations Program on HIV/AIDS (UNAIDS) and World Health Organization (WHO). 2006. *AIDS Epidemic Update: December 2006.* Geneva. UNAIDS.

HIV and AIDS glossary

by L. Teasdale

The terms below are defined within the context of these modules.

Advocacy: Influencing outcomes - including public policy and resource allocation decisions within political, economic, and social systems and institutions - that directly affect people's lives.

Affected by HIV and AIDS: HIV and AIDS have impacts on the lives of those who are not necessarily infected themselves but who have friends or family members that are living with HIV. They may have to deal with similar negative consequences, for example stigma and discrimination, exclusion from social services, etc.

Affected persons: Persons whose lives are changed in any way by HIV and/or AIDS due to infection and/or the broader impact of the epidemic.

Age mixing: Sexual relations between individuals who differ considerably in age, typically between an older man and a younger woman, although the reverse occurs. Diseases can be treated, but there is no treatment for the immune system deficiency. AIDS is the most severe phase of HIV-related disease.

AIDS: The Acquired Immune Deficiency Syndrome is a range of medical conditions that occurs when a person's immune system is seriously weakened by HIV, the Human Immunodeficiency Virus, to the point where the person develops any number of diseases and cancers.

Antibodies: Immunoglobulin, or y-shaped protein molecules in the blood used by the body's immune system to identify and neutralize foreign objects such as bacteria and viruses. During full-blown AIDS, the antibodies produced against the virus fail to protect against it.

Antigen: Foreign substance which stimulates the production of antibodies when introduced into a living organism.

Antiretroviral drugs (ARV): Drugs that suppress the activity or replication of retroviruses, primarily HIV. Antiretroviral drugs reduce a person's viral load, thus helping to maintain the health of the patient. However, antiretroviral drugs cannot eradicate HIV entirely from the body. They are not a cure for HIV or AIDS.

Asymptomatic: Infected by a disease agent but exhibiting no visible or medical symptoms.

Bacteria: Microbes composed of single cells that reproduce by division. Bacteria are responsible for a large number of diseases. Bacteria can live independently, in contrast with viruses, which can only survive within the living cells that they infect.

Baseline study: A study that documents the existing state of an environment to serve as a reference point against which future changes to that environment can be measured

Care, treatment and support: Services provided to educators and learners infected or affected by HIV.

Clinical trial: A clinical trial is a study that tries to improve current treatment or find new treatments for diseases, or to evaluate the comparative efficacy of two or more medicines. Drugs are tested on people, under strictly controlled conditions.

Combination therapy: A course of antiretroviral treatment that involves two or more ARVs in combination.

Concentrated epidemic: An epidemic is considered concentrated when less than one per cent of the wider population but more than five per cent of any key population practising high risk behaviours is infected, while, at the same time, prevalence among women attending urban antenatal clinics is still less than 5 percent.

Condom: One device used to prevent the transmission of sexual fluid between bodies, and used to prevent pregnancy and the transmission of disease, HIV and sexually transmitted infections. Consistent, correct use of condoms significantly reduces the risk of transmission of HIV and other STDs. Both male and female condoms exist. The male condom is a strong soft transparent polyurethane device which a man can wear on his penis before sexual intercourse. The female condom is also a strong soft transparent polyurethane sheath inserted in the vagina before sexual intercourse.

Confidentiality: The right of every person, employee or job applicant to have their medical information, including HIV status, kept private.

Counselling*:* A confidential dialogue between a client and a trained counsellor aimed at enabling the client to cope with stress and take personal decisions related to HIV and AIDS.

Diagnosis: The determination of the existence of a disease or condition.

Discriminate: Make a distinction in the treatment of different categories of people or things, especially unjustly or prejudicially against people on grounds of race, sex, social status, age, HIV status etc.

Discrimination: The acting out of prejudices against people on grounds of race, colour, sex, social status, age, HIV status etc; an unjust or prejudicial distinction.

Empowerment: Acts of enabling the target population to take more control over their daily lives. The term 'empowerment' is often used in connection with marginalized groups, such as women, homosexuals, sex workers, and HIV infected persons.

Epidemic: A widespread outbreak of an infectious disease where many people are infected at the same time. An epidemic is *nascent* when HIV prevalence is less than 1 percent in all known subpopulations presumed to practice high-risk behaviour for which information is available. An epidemic is *concentrated* when less than one per cent of the wider population but more than five per cent of any so-called 'high-risk group' is infected but prevalence among women attending urban antenatal clinics is still less than 1 percent. An epidemic is *generalized* when HIV is firmly established in the population and has spread far beyond the original subpopulations presumed to be practising high-risk behaviour, which are now heavily infected and when prevalence among women attending urban antenatal clinics is consistently one percent or more.

Heterosexual: A person sexually attracted to or practising sex with persons of the opposite sex.

High-risk behaviour: Activities that put individuals at greater risk of exposing themselves to a particular infection. In association with HIV transmission, high-risk activities include unprotected sexual intercourse and sharing of needles and syringes.

Highly active antiretroviral therapy (HAART): A combination of three or more antiretroviral drugs that most effectively inhibit HIV replication, allowing the immune system to recover its ability to produce white blood cells to respond to opportunistic infections.

HIV: Human Immunodeficiency Virus, the virus that causes AIDS, this virus weakens the body's immune system and which if untreated may result in AIDS.

HIV testing: Any laboratory procedure – such as blood or saliva testing – done on an individual to determine the presence or absence of HIV antibodies. An HIV positive result means that the HIV antibodies have been found in the blood test and that the person has been exposed to HIV and is presumably infected with the virus.

Homosexual: A person sexually attracted to or practising sex with persons of the same sex.

Immune system: The body's defence system that prevents and fights off infections.

Incidence (HIV): The number of new cases occurring in a given population over a certain period of time. The terms prevalence and incidence should not be confused. Incidence only applies to the number of new cases, while the term prevalence applies to all cases old and new.

Incubation period: The period of time between entry of the infecting pathogen, or antigen (in the case of HIV and AIDS, this is HIV) into the body and the first symptoms of the disease (or AIDS).

Informed consent: The voluntary agreement of a person to undergo or be subjected to a procedure based on full information, whether such permission is written, or expressed indirectly.

Life skills: Refers to a large group of psycho-social and interpersonal skills which can help people make informed decisions, communicate effectively, and develop coping and self-management skills that may help them lead a healthy and productive life.

Log frame or logical framework: A matrix that provides a summary of what a project aims to achieve and how, and what its main assumptions are. It brings together in one place a statement of all the key components of a project. It presents them in a systematic, concise and coherent way, thus clarifying and exposing the logic of how the project is expected to work. It provides a basis for monitoring an evaluation by identifying indicators of success, and means of assessment.

Maternal antibodies: In an infant, these are antibodies that have been passively acquired from the mother during the pregnancy. Because maternal antibodies to HIV continue to circulate in the infant's blood up to the age of 15-18 months, it is difficult to determine whether the infant is infected.

Mother-to-Child Transmission (MTCT): Process by which a pregnant woman can pass HIV to her child. This occurs in three ways, 1) during pregnancy 2) during childbirth 3) through breast milk. The chances of HIV being passed in any of these ways if the mother is in good health or taking HIV treatment is quite low.

Micro-organism: Any organism that can only be seen with a microscope; bacteria, fungi, and viruses are examples of micro-organisms.

Orphan: According to UNAIDS, WHO and UNICEF an orphan is a child who has lost one or both parents before reaching the age of 18 years. A double orphan is a child who has lost both parents before the age of 18 years. A single orphan is a child who has lost either his or her mother or father before reaching the age of 18.

Opportunistic infection: An infection that does not ordinarily cause disease, but that causes disease in a person whose immune system has been weakened by HIV. Examples include tuberculosis, pneumonia, Herpes simplex viruses and candidiasis.

Palliative care: Care that promotes the quality of life for people living with AIDS, by the provision of holistic care, good pain and symptom management, spiritual, physical and psychosocial care for clients and care for the families into and during the bereavement period should death occur.

Pandemic: An epidemic that affects multiple geographic areas at the same time.

Pathogen: An agent such as a virus or bacteria that causes disease.

Peer education: A teaching-learning methodology that enables specific groups of people to learn from one another and thereby develop, strengthen, and empower them to take action or to play an active role in influencing policies and programs

Plasma: The fluid portion of the blood.

Post-exposure prophylaxis (PEP): As it relates to HIV disease, is a potentially preventative treatment using antiretroviral drugs to treat individuals within 72 hours of a high-risk exposure (e.g. needle stick injury, unprotected sex, rape, needle sharing etc.) to prevent HIV infection. PEP significantly reduces the risk of HIV infection, but it is not 100% effective.

Post-test counselling: The process of providing risk-reduction information and emotional support, at the time that the test result is released, to a person who is submitted to HIV testing.

Pre-exposure prophylaxis (PREP): The process of taking antiretrovirals before engaging in behaviour(s) that place one at risk for HIV infection. The effectiveness of this is still unproven.

Pre-test counselling: The process of providing an individual with information on the biomedical aspects of HIV and AIDS and emotional support for any psychological implications of undergoing HIV testing and the test result itself before he/she is subject to the test.

Prevalence (or HIV prevalence): Prevalence itself refers to a rate (a measure of the proportion of people in a population infected with a particular disease at a given time). For HIV, the prevalence rate is the percentage of the population between the ages of 15 and 49 who are HIV infected. The terms prevalence and incidence should not be confused. Incidence only applies to the number of new cases, occurring in a given population over a certain period of time, while the term prevalence applies to all cases old and new.

Prevention of mother-to-child transmission (of HIV): Interventions such as preventing unwanted pregnancies, improved antenatal care and management of labour, providing antiretroviral drugs during pregnancy and/or labour, modifying feeding practices for newborns and provision of antiretroviral therapy to newborns – all of which aim to reduce the risk of HIV transmission from an infected mother to her child.

Prophylaxis for opportunistic infections: Treatments that will prevent the development of conditions associated with HIV disease such as fungal infections and types of pneumonia.

Rape: Sexual intercourse with an individual without his or her consent.

Retrovirus: An RNA virus (a virus composed not of DNA but of RNA). Retroviruses are a type of virus that can insert its genetic material into a host cell's DNA. Retroviruses have an enzyme called reverse transcriptase that gives them the unique property of transcribing RNA (their RNA) into DNA. HIV is a retrovirus.

Safer sex: Sexual practices that reduce or eliminate the exchange of body fluids that can transmit HIV e.g. through consistent and correct condom use.

Serological testing: Testing of a sample of blood serum.

Seronegative: Showing negative results in a serological test.

Seroprevalence: Number of persons in a population who tested positive for a specific disease based on serology (blood serum) specimens.

Seropositive: Showing the presence of a certain antibody in the blood sample, or showing positive results in a serological test. A person who is seropositive for HIV antibody is considered infected with the HIV virus.

Sex worker: A sex worker has sex with other persons with a conscious motive of acquiring money, goods, or favours, in order to make a fulltime or part-time living for her/himself or for others.

Sexual debut: The age at which a person first engages in sexual intercourse.

Sexually Transmitted Infections (STIs): Infections that can be transmitted through sexual intercourse or genital contact such as gonorrhoea, chlamydia and syphilis. In many cases HIV is a sexually transmitted infection. Untreated STIs can cause serious health problems in men and women. A person with symptoms of STIs (ulcers, sores, or discharge) 5-10 times more likely to transmit HIV.

Sexually transmitted infection management: Comprehensive care of a person with an STI-related syndrome or with a positive test for one or more STIs.

Socio-behavioural interventions: Educational programmes designed to encourage individuals to change their behaviour to reduce their exposure to HIV infections in order to reduce or prevent the possibility of HIV infection.

Stigma: A process through which an individual attaches a negative social label of disgrace, shame, prejudice or rejection to another because that person is different in a way that the individual finds the stigmatized person undesirable or disturbing.

Stigmatize: Holding discrediting or derogatory attitudes towards another on the basis of some feature that distinguish the other such as colour, race, and HIV status.

Symptom: Sign in the body that indicates health or a disease.

Symptomatic: With symptoms

Sugar Daddy/Mommy Syndrome: Comparatively well-off older men/women who pay special attention (e.g. give presents) to younger women/men in return for sexual favours.

T- Cells: A type of white blood cell. One type of T cell (T4 Lymphocytes, also called T4 Helper cells) is especially apt to be infected by HIV. By injuring and destroying these cells HIV damages the overall ability of the immune system to reduce the reproduction of the virus in the blood or to fight opportunistic diseases. A healthy person will usually have more than 1,200 T-cells in a certain measure of blood, but when HIV progresses to AIDS the number of T-cells drops below 200.

Treatment education: Education that engages individuals and communities to learn about anti retroviral therapy so that they understand the full range of issues and options involved. It provides information on drug regimen and encourages people to know their HIV status.

Tuberculosis (TB): Tuberculosis is a bacterial infection that is most often found in the lungs (pulmonary TB) but can spread to other parts of the body (extrapulmonary TB). TB in the lungs is easily spread to other people through coughing or laughing. Treatment is often successful, though the process is long. Treatment time averages between 6 and 9 months.TB is the most common opportunistic infection and the most frequent cause of death in people living with HIV in Africa.

Universal precautions: A practice, or set of precautions to be followed in any situation where there is risk of exposure to infected bodily fluids, such as blood, like wearing protective gloves, goggles and shields, or carefully handling potentially contaminated medical instruments.

Vaccine: A substance that contains antigenic or pathogenic components, either weakened, dead, or synthetic, from an infectious organism which is injected into the body in order to produce antibodies to disease or to the antigenic components.

Viral load: The amount of virus present in the blood. HIV viral load indicates the extent to which HIV is reproducing in the body. Higher numbers mean more of the virus is present in the body.

Virus: Infectious agents responsible for numerous diseases in all living beings. They are extremely small particles, and in contrast to bacteria, can only survive and multiply within a living cell at the expense of that cell.

Voluntary counselling and testing: HIV testing done on an individual who, after having undergone pre-test counselling, willingly submits himself/herself to such a test.

Workplace policy: A guiding statement of principles and intent taking applicable to all staff and personnel of an institution. This can often be part of a larger sectoral policy.

HIV and AIDS knowledge test answers

The purpose of the knowledge test is to be sure you have the basics of HIV transmission. This test is in no way intended to replace the specialized information provided by WHO and UNAIDS. Should additionally clarifications be sought, please refer to the websites of these two organizations.

PART 1.

1. Approximately how many people in the world are living with HIV?
   A. 2,000,000
   B. 12,000,000
   C. 40,000,000

Answer: C. According to the Global UNAIDS/WHO AIDS Epidemic Update: December 2006, the number of people living with HIV is approximately 39,500,000, or 40,000,000.

2. In what region can the largest number of people living with HIV currently be found?
   A. Asia and the Pacific
   B. Sub-Saharan Africa
   C. Latin America and the Caribbean
   D. North America
   E. Central and Eastern Europe

Answer: B. In Africa south of the Sahara desert, an estimated 2.8 million adults and children became infected with HIV during 2006, bringing the total number of people living with HIV in Africa at year's end to 24.7 million. Over the same period, millions of Africans infected in earlier years began experiencing ill health, and 2.3 million people at a more advanced stage of infection died of HIV-related illness.

3. What does the acronym HIV stand for?
   A. Hemo-insufficiency virus
   B. Human immunodeficiency virus
   C. Human immobilization virus

Answer: B. HIV stands for Human Immunodeficiency Virus. HIV is the virus that causes AIDS, this virus weakens the body's immune system and which if untreated may result in AIDS.

4. What does the acronym AIDS stand for?
   A. active immunological disease syndrome
   B. acquired immune deficiency syndrome
   C. acquired immunological derivative syndrome
   D. acquired immunodeficiency syndrome

Answer: B. AIDS stands for Acquired Immune Deficiency Syndrome. AIDS is a range of medical conditions that occurs when a person's immune system is seriously weakened by HIV to the point where the person develops any number of diseases and cancers.

5. What is the main means of HIV transmission worldwide?
   A. unprotected heterosexual sex
   B. homosexual sex
   C. intravenous drug use
   D. mother-to-child transmission

Answer: A. Though all of the answers above can transmit the virus, the most common means of transmission of HIV in the world today is through unprotected heterosexual sex.

6. Spread of HIV by sexual transmission can be prevented by:
   A. abstinence
   B. practising mutual monogamy with an uninfected partner
   C. correct use of condoms
   D. all of the above

Answer: D. Abstinence is the only 100% effective way to prevent HIV transmission, though proper use of condoms and staying faithful with your partner, (once you have both been tested for HIV) are also effective ways of preventing the transmission of HIV.

7. Women are most likely to contract HIV through:
   A. unprotected heterosexual sex
   B. injecting drug use
   C. contaminated blood

Answer: A. In many cultures, women are at a higher risk of contracting HIV through unprotected sex than men. This is due to physical reasons, but also due to the social factors that keep them submissive to men.
Biological reasons that make women more vulnerable to HIV infection through sexual intercourse include:

1. Women receive greater quantities of possibly infected fluids during a sexual encounter.

2. Women have a surface area of mucous membrane (portal of entry) that is greater in size than men's.

3. Very young women have more risk of infection during sex both because the cells in the vagina in underdeveloped women are more likely to receive the virus, and because tearing may cause bleeding which increases the risk of infection.

4. If a woman has been circumcised or uses natural substances to dry out her vagina, the smaller or drier area may rupture more easily during sex.

8. HIV can be contracted from:
   A. condoms
   B. kissing
   C. mosquito bites
   D. drinking from the same glass as an infected person
   E. sharing a spoon with a person living with HIV
   F. sharing a toothbrush with someone who is living with HIV
   G. all of the above
   H. none of the above

Answer: H. The HIV can only be transmitted by an infecting fluid and a portal of entry into the body. A portal of entry is the way that HIV enters the body. This is either through a cut, sore, or opening in the skin or through the soft tissue called .mucous membrane, located in the vagina, the tip of the penis, the anus, the mouth, the eyes, or the nose.

HIV is not an airborne, water-borne or food-borne virus, and does not survive for very long outside the human body. Therefore ordinary social contact such as kissing, shaking hands, coughing and sharing cutlery does not result in the virus being passed from one person to another.

There is no way to catch HIV by being near a person with HIV, or by sharing their cups or bathrooms, or by hugging them or kissing them when blood or a contaminated fluid is not present. There are no documented cases of HIV transmission through sharing toothbrushes. This practice could only present a risk if there was blood present on the toothbrush.

9. Risk of contracting HIV is increased by:
  A. being infected with another sexually transmitted infection (STI)
  B. having poor nutrition
  C. having a cold

> Answer: A. In general, a genital sore or ulcer as in syphilis, chancroid, or herpes expands the portal of entry. Having a discharge, as in gonorrhea or chlamydia, means that more white blood cells are present. Since white blood cells are hosts for HIV, it means that more virus can be transmitted or received when the discharge is present. Quick and proper treatment of STDs and immediate referral of partners can be important strategies for HIV prevention. Often women do not have apparent symptoms of sexually transmitted diseases, so check.ups and partner referrals are very important. But men, too, may occasionally not have symptoms, even of gonorrhea; so, it is important that the man seek treatment.

10. Pregnant women infected with HIV:
  A. can reduce chances of transmitting HIV to her unborn child by maintaining a low viral load and staying in good health
  B. can take medication to reduce the risk of mother-to-child transmission during childbirth
  C. all of the above

> Answer: C. An HIV-infected pregnant woman can pass the virus on to her unborn baby either before or during birth. HIV can also be passed on during breastfeeding. If a woman knows that she is infected with HIV, there are drugs she can take to greatly reduce the chances of her child becoming infected. Other ways to lower the risk include choosing to have a caesarean section delivery and not breastfeeding or breastfeeding for only the first six months of the child's life.

11. List the four main body fluids that, when infected, may transmit HIV.

> 1. Vaginal fluids
> 2. Semen
> 3. Breast milk
> 4. Blood (using infected instruments for cutting, or sharing infected needles for drug use)

12. List the four main ways HIV is transmitted.

> 1. Mother-to-child transmission
> 2. Sharing needles for injections (drug use) or using contaminated instruments
> 3. Blood transfusion
> 4. Unprotected sexual intercourse

PART 2: *the answers to part 2 can be found below. For more explanations, please refer to the HIV and AIDS fact sheets and glossary on pages 189 and 195.*

1. If a person has HIV, they will always develop AIDS.

(False)

2. HIV is present in blood, sexual fluids and sweat.

(False: not present in sweat.)

3. Abstaining from (not having) sexual intercourse is an effective way to avoid being infected with HIV.

(True)

4. When a person has AIDS, his or her body cannot easily defend itself from infections.

(True)

5. A person can get the same sexually transmitted infection more than once.

(True)

6. There is a cure for AIDS.
(False)

7. If a pregnant woman has HIV, there is a still a chance she will not pass it to her baby.
(True)

8. A person can get HIV infection from sharing needles used to inject drugs.
(True)

9. Many people with sexually transmitted infections, including HIV, do not have symptoms.
(True)

10. HIV can be easily spread by using someone's personal belongings, such as a toothbrush or a razor.
(False)

11. A person can look at someone and tell if he or she is infected with HIV or has AIDS.
(False)

12. It is possible to avoid becoming infected with HIV by having sexual intercourse only once a month.
(False)

13. A condom, when used properly, provides excellent protection against sexually transmitted infections, and can prevent transmission of HIV.
(True)

14. An effective vaccine is available to protect people from HIV infection.
(False)

15. A person can be infected with HIV for 10 or more years without developing AIDS.
(True)

16. You can get HIV by kissing someone who has it.
(False)

17. A person can be infected with HIV by giving blood in an approved health facility.
(False)

18. Ear-piercing and tattooing with unsterilized instruments are possible ways of becoming infected with HIV.
(True)

19. A person can get HIV by being bitten by a mosquito.
(False)

20. A person can avoid getting HIV by eating well and exercising regularly.
(False)

The series

Wide-ranging professional competence is needed for responding to HIV and AIDS in the education sector. To make the best use of this series, it is recommended that the following order be respected. However, as each volume deals with its own specific theme, they can also be used independently of one another.

Volume 1: Setting the Scene

1.1 The impacts of HIV/AIDS on development
M. J. Kelly, C. Desmond, D. Cohen

1.2 The HIV/AIDS challenge to education
M. J. Kelly

1.3 Education for All in the context of HIV/AIDS
F. Caillods, T. Bukow

1.4 HIV/AIDS-related stigma and discrimination
R. Smart

1.5 Leadership against HIV/AIDS in education
E. Allemano, F. Caillods, T. Bukow

Volume 2: Facilitating Policy

2.1 Developing and implementing HIV/AIDS policy in education
P. Badcock-Walters

2.2 HIV/AIDS management structures in education
R. Smart

2.3 HIV/AIDS in the educational workplace
D. Chetty

Volume 3: Understanding Impact

3.1 Analyzing the impact of HIV/AIDS in the education sector
A. Kinghorn

3.2 HIV/AIDS challenges for education information systems
W. Heard, P. Badcock-Walters.

3.3 Qualitative research on education and HIV/AIDS
O. Akpaka

3.4 Projecting education supply and demand in an HIV/AIDS context
P. Dias Da Graça

Volume 4: Responding to the Epidemic

- 4.1 A curriculum response to HIV/AIDS
  E. Miedema
- 4.2 Teacher formation and development in the context of HIV/AIDS
  M. J. Kelly
- 4.3 An education policy framework for orphans and vulnerable children
  R. Smart, W. Heard, M. J. Kelly
- 4.4 HIV/AIDS care, support and treatment for education staff
  R. Smart
- 4.5 School level response to HIV/AIDS
  S. Johnson
- 4.6 The higher education response to HIV/AIDS
  M. Crewe, C. Nzioka

Volume 5: Costing, Monitoring and Managing

- 5.1 Costing the implications of HIV/AIDS in education
  M. Gorgens
- 5.2 Funding the response to HIV/AIDS in education
  P. Mukwashi
- 5.3 Project design and monitoring
  P. Mukwashi
- 5.4 Mitigating the HIV/AIDS impact on education: a management checklist
  P. Badcock-Walters

The present series was jointly developed by UNESCO's International Institute for Educational Planning (IIEP) and the EduSector AIDS Response Trust (ESART) to alert educational planners, managers and personnel to the challenges that HIV and AIDS represent for the education sector, and to equip them with the skills necessary to address these challenges.

By bringing together the unique expertise of both organizations, the series provides a comprehensive guide to developing effective responses to HIV and AIDS in the education sector. The extensive range of topics covered, from impact analysis to policy formulation, articulation of a response, fund mobilization and management checklist, constitute an invaluable resource for all those interested in understanding the processes of managing and implementing strategies to combat HIV and AIDS.

Accessible to all, the modules are designed to be used in various learning situations, from independent study to face-to-face training. They can be accessed on the Internet web site: www.unesco.org/iiep Developed as living documents, they will be revisited and revised as needed. Users are encouraged to send their comments and suggestions (hiv-aids-clearinghouse@iiep.unesco.org).

The contributors

The International Institute for Educational Planning is a specialised organ of UNESCO created to help build the capacity of countries to design educational policies and implement coherent plans for their education systems, and to establish the institutional framework by which education is managed and progress monitored.

The EduSector AIDS Response Trust (ESART) is an independent, non-profit organisation established to continue the work of the Mobile Task Team (MTT), originally based at HEARD, University of KwaZulu-Natal from 2000 to 2006, and supported by USAID. ESART is designed to help empower African ministries of education and their development partners, to develop sector-wide HIV&AIDS policy and prioritized implementation plans to systemically manage and mitigate impact.