Educational planning and management in a world with AIDS

Volume

Responding to the Epidemic

United Nations Educational, Scientific and Cultural Organization

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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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Director
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Volume 4: Responding to the Epidemic

Volume 4 is a concrete tool to help you plan and implement specific actions to address the challenges you are facing with respect to HIV and AIDS. It will prepare you to develop a response in key areas of your education sector.

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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

E. Miedema

A curriculum response to HIV/AIDS

About the author

Esther Miedema is a former UNESCO Associate Expert of Education (Indonesia, the Philippines and Mozambique). Her main expertise is in education and social development, integration of sexual and reproductive health, and HIV and AIDS into basic education and teacher training curricula, and non-formal education.

Acknowledgements

This module explores some of the main planning implication of integrating HIV and AIDS education into the curriculum and builds on previous work done with IBE-UNESCO on HIV and AIDS and curriculum development. In exploring the various implications for planning and during the writing of the module in general, the inputs and feedback of the following people have been critical: Ms Françoise Caillods (Deputy Director, IIEP-UNESCO), Professor Michael Kelly (University of Zambia) and Ms Christine Panchaud (HIV/AIDS Programme Specialist, IBE-UNESCO). The module would not have been the same without their contributions and I am very grateful for their support.
I would also like to thank IIEP staff for their practical support to me during the writing of the module. A big thank you to all.

Module 4.1

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Aims

The aims of this module are to:

- provide an overview of current concepts relating to quality, curriculum-based sexual and reproductive health (SRH), HIV and AIDS education;
- provide an overview of the necessary steps in integrating HIV and AIDS-related education into a school curriculum, as well as the implications thereof for, among others, teacher training, community involvement, time allocation and assessment.

Objectives

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

- explain the need for integration of comprehensive SRH, HIV and AIDS education into the curriculum;
- describe some of the main 'characteristics' of quality SRH, HIV and AIDS education and some of the main shortcomings of current (SRH) HIV and AIDS teaching and learning and teacher training;
- identify some of the main planning implications of including SRH, HIV and AIDS education in the curriculum;
- describe what is meant by life skills and give examples of life skills that young people need to protect themselves from and cope with the impact of HIV and AIDS;
- list and provide a brief clarification of the broad planning steps involved in integrating HIV and AIDS education into the curriculum.

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.

What are the most important, core topics young people need to learn about in order to become competent in dealing with issues relating to sexual and reproductive health (SRH), HIV and AIDS?

Is SRH, HIV and AIDS education currently taught in primary and secondary schools in your country? If so, how has it been integrated into the curriculum?

Has teacher shortage and mortality (due to HIV and AIDS) affected the quality of teaching and learning, including teaching/learning about SRH, HIV and AIDS in your country? If so, how?

What steps need to be taken to ensure that all learners in both rural and urban areas have access to youth-friendly health services and information?

What steps need to be taken to involve community members in the development, design and monitoring of SRH, HIV and AIDS education?

What makes a school 'child-friendly' for both girls and boys? What needs to be done to make primary and secondary schools in your country more child-friendly for both girls and boys?

What kind of indicators relating to quality education can be incorporated in or linked to the education management information system (EMIS)

Module 4.1

.... A CURRICULUM REPSONSE TO HIV/AIDS

Introductory remarks

Every day thousands of children and young people all over the world are infected with HIV, the majority of whom are in sub-Saharan Africa. Over 14 million children have lost one or both of their parents to the disease. Hard won developmental gains and life expectancy are eroded and progress toward achieving Education for All (EFA) and the Millennium Development Goals (MDGs) is severely hampered. Ministries of education are becoming increasingly aware that, with no vaccine or cure for HIV and AIDS in sight, education can be an effective way to protect young people.

This module will look at ***SRH, HIV and AIDS education*** and how this can best be integrated in the formal school curriculum. The module concentrates on issues relating to teaching and learning about SRH, HIV and AIDS, the main question for educational policy-makers and planners always being what are the implications for policy and planning? And which resources are required to ensure that quality (SRH, HIV and AIDS) education is provided to all learners?

To start off with, the module will provide an overview of current findings regarding HIV/AIDS teaching and learning in schools; examples of good practices as well as some of the common shortcomings. The remainder of the module will build on the lessons learned described in this first section.

The first section will also focus on the core HIV and AIDS-related themes that should be addressed in an education programme. The core themes suggested in this module build on the four pillars of education (see UNESCO, 1996), i.e. learning to know, learning to do, learning to be and learning to live together. These four pillars provide a sound basis for developing the main themes of HIV and AIDS education. The issue of age and 'appropriate' learning on SRH, HIV and AIDS will also be discussed in this section, as well as possible opposition to SRH, HIV and AIDS education.

In the second part a description will be given of the different curricular approaches to integrating HIV/AIDS education in the regular curriculum. The different curricular approaches have different implications for planning and the user will be encouraged to consider some of the possible steps that need to be taken to ensure full integration of SRH, HIV and AIDS education according to a particular curricular approach.

Finally, the module will explore some of the implications for educational planners of integrating education on HIV and AIDS into the regular curriculum, such as the implications for teacher training and support (including peer education), time allocation, creation of child-friendly environments, learners' access to youth-friendly (health) services, and community involvement. Attached to the module is a tool developed by IBE-UNESCO that can be used to guide the 'diagnosis' of the current status of HIV/AIDS education. References of other relevant publications and tools are given in Appendix I.

It is important to note that although out-of-school youth are an extremely important target group, this module will not explicitly deal with non-formal SRH, HIV and AIDS education. Having said that, much of what applies to teaching-learning about SRH, HIV and AIDS within the formal curriculum can also be relevant to the (development of) the non-formal education (NFE) curriculum.

1. HIV/AIDS education

Current findings relating to HIV/AIDS teaching and learning; good practices and shortcomings

Various studies into the quality of HIV/AIDS education programmes have been carried out in recent years[1]. These studies look into how ministries of education, schools and teachers in a range of countries and continents address HIV/AIDS education. They describe the progress made, but also identify a range of common shortcomings related to the delivery of HIV and AIDS education. The *Deadly inertia* report provides an overview of the quality of delivery and content of HIV and AIDS education within the framework of the quality of education in general (Global Campaign for Education, 2004). The report makes a very important point, stating that "in practice [it] is impossible to teach children about HIV in classrooms that lack the essential ingredients for successful teaching and learning about any subject" (Global Campaign for Education, 2004: 5). In most of the 18 countries studied, it was found that classrooms were overcrowded and management systems under-resourced.

Box 1 below summarizes a number of shortcomings in the delivery of HIV and AIDS education as outlined in the above-mentioned reports.

Box 1 Examples of common shortcomings in the delivery of HIV/AIDS education

- HIV/AIDS education has been added to an already overcrowded curriculum.
- HIV/AIDS education is often added to the existing syllabus of a particular mandatory subject, but no provisions are made to make sure that HIV/AIDS education is taught or that learning outcomes are assessed in meaningful way.
- No specific time or far too little time is allocated to the teaching of the subject.
- Teachers are not adequately trained or supported to apply the necessary interactive pedagogical methods.
- Teaching and learning materials often are not available.

Source: IBE-UNESCO, 2006: tool 4.

Different studies, including those mentioned above, have also identified shortcomings relating to the contents of HIV and AIDS education.

[1] Examples include: Global Campaign on Education (2004), *Deadly inertia, a cross-country study of educational responses to HIV/AIDS*; IBE-UNESCO (2005), *The Quality Imperative, an assessment of the curricular response to HIV/AIDS in 35 countries*; and Action Aid (2003), *The sound of silence; difficulties in communicating on HIV/AIDS in schools*.

Box 2 Some common shortcomings relating to the content of HIV/AIDS education

- Teaching of HIV and AIDS is often selective; it does not address sexual and reproductive development or health, nor (sexual) relationships, negative or conflicting messages on condoms and practicing of safer sex.
- Education does not adequately challenge stigma and discrimination surrounding HIV and AIDS, which in turn strengthens the silence surrounding HIV/AIDS.
- Education on HIV and AIDS is often still too knowledge-based. Little attention is paid to the development of learners' abilities to deal with daily problems.
- Teaching-learning of life skills needs to be better understood in order to be better implemented.

Source: IBE-UNESCO, 2006: tool 4.

Although the work of educational planners has less to do with content and pedagogy *per se*, these educational aspects will have implications for planning. For example, SRH, HIV and AIDS education should be less knowledge-based than it currently is, and be taught using more interactive teaching-learning methods than are currently used. This has implications for teacher training and support/supervision – both in terms of content and time.

Where possible, ministries of education should aim to continue to improve the delivery and content of HIV/AIDS teaching and learning. Other than reviewing the delivery and content of HIV/AIDS-related education and comparing these to the 'attention points' highlighted above, ministries of education can also build on the increasing body of knowledge on what does work, i.e. what are the main characteristics of effective HIV and AIDS education. Some of these characteristics are listed in Box 3 below.

Box 3 Characteristics of effective HIV/AIDS education

- Focus on life skills aimed at reducing risk-tasking behaviours, particularly by delaying first sexual intercourse and encouraging protected intercourse.
- Concentrate on personalizing risk through active participation of learners by using appropriate role-playing and interactive discussions.
- Provide clear messages on sexual activity and discuss in a straightforward manner the possible results of unprotected sex, and in equally clear terms provide comprehensive information on the ways to avoid such an outcome.
- Explain where to turn for help, support and services (such as peers, school staff and facilities, and outside facilities).
- Provide occasions to model and practice communication and refusal skills useful for self-protection and to build self-confidence.

- Address pressure from peers and society. Reinforce values, norms and peer-group support for resisting pressure, both at school and in the community.
- Provide sufficient time for classroom work and interactive teaching methods such as role-playing and group discussions.
- Select teachers and peers who believe in the programme and provide systematic training and support.
- Start at the earliest possible age with adapted messages and teaching methods, and certainly before the onset of sexual activity.

Source: IBE-UNESCO, 2005a.

The final goal of SRH, HIV and AIDS education is to enable learners to become SRH, HIV and AIDS competent, i.e. to be able to apply relevant skills, knowledge and demonstrate 'healthy' attitudes to take positive actions to protect themselves, promote their own and other's well-being and health, and develop and maintain positive social relationships.

Activity 1

Using the examples of shortcomings and characteristics of good SRH, HIV and AIDS education listed in the boxes above, analyze 2-3 shortcomings and/or characteristics of quality education relating to the delivery of education which are most relevant to your country. List the necessary steps to respond to these shortcomings or that work towards achieving the selected characteristic of quality SRH, HIV and AIDS education.

The lessons learned regarding current shortcomings as well as the findings on characteristics of quality HIV and AIDS education form the starting point for the following sections. To begin with, we will look more closely at the contents of HIV and AIDS education. In Chapters 2 and 3 more attention will be paid to the delivery

of education on HIV and AIDS and the implications for teacher training, assessment and textbook development.

Core topics to be addressed

The four pillars of education – learning to know, to do, to be and to live together – can be seen as forming the founding blocks for education throughout life. These four pillars are also highly relevant for (developing) education on SRH, HIV and AIDS. For example, learners need to learn the correct information (***learning to know***), how to use the correct information and skills (***learning to do***), value/respect others, irrespective of their status, gender, etc. (***learning to live together***), and how to deal with and value themselves (***learning to be***).

As mentioned above, the overall aim of SRH, HIV and AIDS-related teaching and learning is to build the competencies of learners to apply relevant skills and knowledge and demonstrate 'healthy' attitudes to take positive actions to protect themselves and others from the spread and impact of HIV and AIDS, to promote overall health, wellbeing and positive social relationships. To help learners to become competent in coping with HIV and AIDS, teaching-learning should focus on the four core themes described below. These are the themes that are recommended for integration into the curriculum to jointly form a comprehensive SRH, HIV and AIDS education programme.

Box 4 Core HIV and AIDS teaching-learning themes

1. Basic knowledge on health, SRH, STIs, HIV and AIDS, and care and treatment.This thematic topic is aimed at the development of basic knowledge on health, SRH, HIV and AIDS as well as important information processing skills.

2. Human rights, stigma and discrimination

   Stigma and discrimination greatly increase the silence and fear surrounding HIV and AIDS as well as the suffering of people with/affected by HIV/AIDS. This core topic should focus on, among others, teaching learners about children's and human rights – as applying to themselves and others, irrespective of their HIV/AIDS status.

3. Relationships and gender issues

   Increasingly, the HIV/AIDS epidemic is feminizing, with women accounting for more than half of HIV-positive adults worldwide. Gender inequity and general power discrepancies in relationships increase the risk of HIV infection as well as the impact of HIV and AIDS. The main expected learning outcome of this third topic would be the development of a critical understanding of the different vulnerabilities and risks men and women face, the equal rights of men and women. Equal participation of boys and girls in this module is essential.

4. Life skills

   Though learners are expected to learn a range of skills through the other three thematic topics described above, it is recommended to include a fourth theme in the HIV and AIDS teaching-learning programme which pays attention to a specific set of additional life skills.

   Life skills are generally defined as abilities that help promote mental well-being and competence in young people as they face the realities of life. Life skills are taught with the aim to empower people to take positive actions to protect themselves and to promote health and positive social relationships. Examples of life skills are skills in problem-solving, critical thinking, decision-making, negotiation, as well as 'skills' such as self-awareness, empathy, and coping with stress and emotions.

   Life skills requiring additional attention in SRH, HIV and AIDS education can be organized into three categories:

   a) Critical thinking skills, including self- and social awareness, setting goals and solving problems;

   b) Social skills, including building positive relationships, challenging gender stereotypes, stigma and (sexual) violence, coping with loss and stress; and

   c) Communication and negotiation skills, such as being able to voice one's concerns and needs, being able to say 'no' and to have that respected.

Source: IBE-UNESCO, 2006: tool 4; UNESCO Bangkok, no date.

With regard to life skills, it has to be noted that there still remains much to be clarified and defined in the area of life skills education. ‘Open’ questions include the kind of skills that different groups of children and young people actually need, for example besides life skills such as ‘effective communication’, orphans and other vulnerable children may also need to learn basic entrepreneurial and/or vocational skills. Other issues to be clarified are how young people best learn different skills, which pedagogical approaches and assessment methods are most appropriate to support learning of life skills, and what the implications are for teacher training and support. Monitoring and evaluation of (life skills) education can serve to inform future policy and programming.

Adaptation to different age groups

Existing education programmes on SRH, HIV and AIDS are often not age specific. Either the age group is not well defined or the programme and accompanying materials are designed for too large an age group despite the fact that literacy levels and learning needs differ per age group. At the same time, it has to be kept in mind that in developing countries there may be a very wide range of ages in any one class. This places additional demands on teachers – and thus on teacher training and support.

HIV/AIDS education programmes need to be developed in a spiral way; increasing the levels of complexity and detail as pupils climb up the educational ladder. It goes without saying that the information required by a young learner at primary school is different from that required by an adolescent at secondary school level.

Education on SRH, HIV and AIDS should start as early as possible, and in any case before the average age of sexual debut. SRH, HIV and AIDS teaching-learning should be provided until at least the end of compulsory schooling, but preferably longer, i.e. until the end of secondary school and during tertiary education. Deciding at which age to start education on prevention, care, treatment and mitigation of sexually transmitted infections (STIs), HIV and AIDS can be guided by, for example, information on the average national age of onset of sexual activity.

Activity 2

Review recent research into the average age of sexual debut in your country. Compare this with the average age of school debut and school completion or drop-out. Based on these indications of the age of sexual debut, at what age should education on SRH, HIV and AIDS begin in your country?

Opposition to change

Often those responsible for providing HIV/AIDS education encounter opposition from, for example, learners' parents, other teachers, school principals and church leaders. Many people believe that teaching youngsters about sexual health and sexuality will encourage promiscuity and sexual experimentation. Studies from around the world show, however, that young people who have been provided with correct information and have learned relevant skills actually delay sexual debut. In addition, when they do start having sexual relationships they are more likely to practice safer sex. It is important to accept that adolescence is a time when many young people will experiment with sex and that equipping them with information and skills is crucial if they are to protect themselves and others.

The issue of opposition to curricular change was addressed during the UNESCO Bangkok workshop on Building Capacities of Curriculum Specialists for Educational Reform (see Lao, 2002). The participants (directors and curriculum specialists from 11 countries in East, South-East Asia and Mekong sub-regions) considered it was possible to anticipate and address some forms of resistance to curricular change and delivery. They formulated the following three key recommendations for addressing opposition.

I. Clearly define and communicate on the role of stakeholders in the process of consultation on curricular change.

It was considered impossible to consult all stakeholders on every issue. For this reason, sometimes consultations should be about informing stakeholders on what the reform will be about, without necessarily asking for their input.

Agreement on all issues by all stakeholders will also be extremely difficult. Ministries of education will have to strike a balance between teaching-learning content that is relevant to learners – i.e. enables them to deal with real life problems – and that which is supported by the community.

II. Engage stakeholders through the curriculum development process

The most efficient consultation was found to be one that engaged stakeholders throughout the curriculum development process, and not only at the beginning.

Involving local authorities and other stakeholders in a participatory manner throughout the process was considered not to ensure continuity and transparency, but also implied that sufficient time was made available to consult all relevant stakeholders.

Involving stakeholders during the implementation of curricular change is also important, for example in the design and implementation of teacher training and monitoring of SRH, HIV and AIDS teaching and learning.

III. Communicate and market policy changes

When a public is misinformed or insufficiently informed, this can lead to a lack of understanding of the changes and eventually to resistance. It is therefore important to communicate on (plans for) curricular change through several sources and to a variety of stakeholders, including those that are sceptical of the proposed changes.

Box 5 Dealing with opposition – policy and planning recommendations

- Guidelines on the involvement of key actors and stakeholders during development, implementation, monitoring and evaluation of SRH, HIV and AIDS education are developed.
- Involvement of various actors and stakeholders and the adequacy of the guidelines are monitored.

Activity 3

Set up a tentative list of stakeholders that should be involved in the development and delivery of SRH, HIV and AIDS-related education within the regular curriculum.

2. Integrating education on HIV and AIDS in the regular curriculum

A great many countries have integrated SRH, HIV and AIDS education into the national curriculum. The lessons learned regarding HIV and AIDS teaching and learning mentioned at the beginning of this module include those related to the manner in which the topic has been integrated into the (existing) curriculum. This section will build on these lessons learned.

The section begins with a brief description of 'curricular frameworks', which ideally, provide a basis for curricular development. This is followed by a description of the possible curricular approaches to integrating SRH, HIV and AIDS education into an existing curriculum and examples of the principal factors that can affect integration, as well as educational policy-making and planning. Finally, we will look into some of the main implications of integration and the choice of curricular approach for educational policy makers and planners.

Curriculum framework

Though curriculum frameworks can vary significantly between countries, most clarify the structure of the planned curriculum, i.e. the teaching-learning aims, contents and methods. Most frameworks describe the following aspects:

- Context
- Statement of national education policies
- Overall learning objectives and/or outcomes
- Structure of the education system and learning areas
- Standards of required resources
- Teaching methodology
- Assessment of teaching-learning outcomes

A country's curriculum framework should provide the necessary background for reflection on and decisions relating to curricular innovation, such as the integration of a new subject.

A curriculum framework is not a static document, however. During the process of curricular innovation a ministry of education may find it necessary to adapt the framework to new contextual factors and teaching-learning needs.

Approaches to integrating HIV and AIDS education into the curriculum

Though different countries may use different terms to describe a particular curricular approach, it has been found that SRH, HIV and AIDS education is usually integrated using one of the five curricular approaches described in Box 6 below.

Box 6 Curricular approaches

SRH, HIV and AIDS education can be included in the curriculum:

a. as a stand-alone subject:

The topic SRH, HIV and AIDS is clearly labelled and earmarked in the school timetable. It addresses all relevant issues relating to SRH, HIV and AIDS education.

An example of a country that uses this approach: Benin.

b. integrated in one main carrier subject:

Teaching and learning of most of the relevant material is addressed in one main carrier subject, e.g. social science.

Examples of countries that use this approach: Brunei, Chile, China, Colombia, Nigeria, South Africa and Vietnam.

c. as a cross-curricular subject:

SRH, HIV and AIDS education is integrated in a limited number of subjects (in no more than 1/3 of the total number of subjects in the curriculum). These subjects bear a close affinity with the topic and teaching-learning on SRH, HIV and AIDS within these few subjects is clearly defined and divided.

Examples of countries that use this approach: Cambodia, Brazil, Malawi, Malaysia, and Mozambique.

d. infused through the curriculum:

Teaching-learning on SRH, HIV and AIDS is included across a broad range of subjects (in more than 1/3 of the total number of subjects in the curriculum). This approach has generally been found to be less effective than the other approaches.

Examples of countries that use this approach: Botswana and Kenya.

e. as an extra-curricular topic:

Extra-curricular activities are activities that schools arrange outside the regular curriculum. Extra-curricular activities often offer greater opportunity for more active interaction between learners, teachers and the community. On the downside, because extra-curricular activities are less structured, they are often irregular. In addition, because outcomes are generally not assessed or credited, teachers may be less motivated to devote time to facilitating these activities, in particular when overtime is not compensated.

Examples of countries that use this approach: Botswana, Bahamas, Indonesia.

Source: IBE-UNESCO, 2006: tool 5; IBE-UNESCO, 2005a: Appendix B.

Factors affecting the choice of curricular approach

Which curricular approach to the integration of SRH, HIV and AIDS education is most feasible and relevant in a particular context depends on a number of factors, which also have implications for planning. Main factors affecting integration include:

1. The possibilities to integrate HIV and AIDS education depend on the stage of curriculum reform or innovation in a country. For example, if a ministry of education is in the process of reviewing the overall primary education curriculum, then the inclusion of the subject SRH, HIV and AIDS will generally have fewer specific implications; teacher training, textbook development etc. are likely to be done in light of the overall reform, and development of SRH, HIV and AIDS education can therefore be carried out as part of the general process.

   N.B. At any stage of curriculum reform/innovation it may be necessary to budget resources for technical assistance or gaining access to technical resources to develop the contents of SRH, HIV and AIDS education, including teacher training. Examples may include involving a teacher and/or curriculum development specialist from a neighbouring country with experience in delivering/designing SRH, HIV and AIDS education, or finding good models of SRH, HIV and AIDS teacher training and teacher/learner materials.

2. Centralized or decentralized curriculum design: at what level is curriculum designed and/or what degree of flexibility exists to adapt content to the local context? These issues will also have implications for policy-making and (financial) planning, for example deciding in which subject SRH, HIV and AIDS education will be integrated may need to be done at higher (policy-making) levels in the ministry of education. Education delivery may also be (partly) decentralized, in which case one will need to reflect on the implications for planners at different levels of the system.

Despite the general recognition of the importance of enabling young people to protect themselves from HIV and AIDS and, therefore, the importance of HIV and AIDS education, opinions vary widely about the best way of including the subject in the curriculum. Curricula are often overloaded already, which pleads against the introduction of a new subject. For this reason, and because they are less disruptive of existing arrangements, the integration approach is often advocated. Experience shows, however, that behavioural skill development and internalization of values require practice and extended open discussion. No matter what kind of curricular approach is used, dedicated and scheduled time is therefore needed. Despite the fact that the different curricular approaches all have certain advantages, it has been found that "**explicit and officially timetabled approaches of the separate subject type or modifications of it are widely recommended based on the failure of the infusion or integration approaches**" (UNESCO Bangkok and IBE, 2005).

3. Implications of integrating HIV/AIDS education into the regular curriculum

Teacher training and support

Inadequate teacher training and support is one of the primary reasons why delivery and possible impact of HIV and AIDS education has been hampered. SRH, HIV and AIDS are topics that people generally find difficult to discuss, especially with young people and children. Teachers are no exception.

Learners need to see the relevance of learning about HIV and AIDS for their own lives. This is an important reason why learning about these subjects requires active and participatory teaching-learning methods. These methods are new to a great many teachers. Many – if not most – teachers use classical, teacher driven pedagogical approaches, especially when they need to manage large and/or multi-grade classrooms.

When the curriculum is overcrowded, teachers will also be less inclined or able to take the time to facilitate active learning activities on SRH, HIV and AIDS. The subject may be skipped altogether if there is no specific time allocation and if it is not made examinable. It has been found that teachers with a solid understanding of the subject content are better able to teach in a participatory, learner-centred manner (IBE-UNESCO, 2006: tool 4).

The curricular approach chosen will affect teacher training. It will, for example, affect the number of (new and practising) teachers that will need to be trained, as well as the content of the (pre- and in-service) training. If a stand-alone subject or main carrier subject approach is used to integrate HIV and AIDS education into the curriculum, then fewer teachers will need to be trained than would be the case if a cross-curricular approach were used. If a cross-curricular approach is used, (trainee) teachers of the selected disciplines will need to learn how they can enable learners to establish linkages between the lessons learned across the selected carrier subjects.

It goes without saying that both pre- and in-service teacher training on SRH, HIV and AIDS education needs to be comprehensive. It is recommended that where possible educators with 'desirable' characteristics be selected for teaching SRH, HIV and AIDS, i.e. teachers who are willing and able to discuss these topics in an open manner, who are trusted by learners (in the case of in-service training), etc.

Pre- and in-service teacher training should cover the same core themes that are addressed in SRH, HIV and AIDS education and should include ample time for trainees to try out participatory teaching methods and facilitate 'active learning'. Training on relevant assessment methods is also critical, both in pre- and in-service training.

During training, (trainee) teachers will also need to become familiar with the teaching-learning materials designed for SRH, HIV and AIDS education. For example, they may need to learn how to use teaching-learning tools designed for role-plays, student fieldwork, case studies and games.

Finally, where pre-service training will need to focus on enabling trainees to teach the HIV and AIDS-related curriculum, in-service training will need to focus on enabling teachers to teach the modified curriculum, i.e. following integration of SRH,

HIV and AIDS education. During in-service training, teachers will therefore need to learn, for example, which changes have been made to the old curriculum, what the implications of these changes are for the teaching of the old curriculum, and what the implications are for assessment/examination.

The success of curricular change largely depends on teachers and the extent to which they understand and support the changes. For the reasons highlighted above, it is important that the implications of curricular change for teacher training be thought through carefully and that teachers be active partners in the consultation process on curricular change. Because teachers may encounter resistance to their teaching on SRH, HIV and AIDS from both colleagues and the community, it is important that they be supported by the school principal and key community members. These actors should therefore also take part in the consultation process as well as in (a number of) teacher training sessions.

Peer education

In addition to training and use of teachers to facilitate learning about SRH, HIV and AIDS, some countries also make use of peer educators. Peer education here refers to young people imparting information to others of a similar age group, background, culture and/or social status. Studies suggest that "people are more likely to hear and personalize messages, and thus to change their attitudes and behaviors, if they believe the messenger is similar to them and faces the same concerns and pressures. … Peer education can support young people in developing positive group norms and in making healthy decisions about sex" (Mason, 2003: 1).

Peer education can best be used to complement rather than substitute teacher facilitated education. Peer education can be used during both intra- as well as extra-curricular activities. However, factors relating to the curriculum (does the curriculum allow for the use of peer-led education?), teaching-learning climate and available resources (e.g. to train and support peer educators) will effectively shape how peer education is used in schools.

Like teachers, successful peer educators require quality training and support!

Teacher wellbeing

As is explained in the IIEP/ESART Module 4.4 on *HIV/AIDS care, support and treatment for education staff*, there are many reasons why a ministry of education should establish and implement a workplace or 'wellness' programme. Antiretroviral therapy (ART) and highly active antiretroviral therapy (HAART) are not yet widely available, and education sector staff living with HIV will therefore experience "evermore frequent illnesses and will become progressively incapacitated" (IIEP Module 4.4 - *HIV/AIDS care, support and treatment for education staff*:6). HIV/AIDS has profound psychosocial implications, which, if not managed appropriately, "can be as debilitating as the physical effects of the disease".

"HIV/AIDS has negatively affected the quality of teacher education. It has led to the absenteeism of both the students and their lecturers from colleges due to illness or funeral attendance. The death of the lectures and their students in colleges due to HIV/AIDS has lead to a cumulative loss of skilled labour and potential skilled labour" (IBE-UNESCO, 2004: Zimbabwe).

The wellbeing of teachers has a profound effect on the quality of their work, i.e. teaching practice and, subsequently, the teaching-learning environment. For

teachers to be effective, it is therefore critical that the impact of HIV and AIDS on teachers is prevented and mitigated as effectively as possible.

Preparation and distribution of teaching-learning materials

The choice of curricular approach and the availability of relevant teaching-learning materials, i.e. teacher training manuals, teacher handbooks, pedagogical aids and learner materials, will determine the resources that will need to be allocated to this 'expenditure post'. It will be necessary to assess the availability and quality of existing materials and what the costs of updating these might be. Key questions include: in how many subjects will teaching about SRH, HIV and AIDS take place? Are local languages used to teach about SRH, HIV and AIDS? If so, how many different sets of the same type of material will need to be developed (e.g. in how many different languages will the material for teaching learners in grade x of primary education need to be printed)? What is the capacity of national publishers to publish good quality materials at a competitive price? How can materials best be distributed and when?

Time allocation

An important shortcoming of much of the education on SRH, HIV and AIDS is that there is not specific time allocation and that teaching-learning on the subject is fragmented and irregular. It is important when integrating SRH, HIV and AIDS education into the curriculum that a specific amount of time be allocated to the subject and that it be clearly scheduled in the school timetable.

Deciding on the time that will be allocated to HIV and AIDS education can be guided by the following considerations:

- Participatory teaching-learning methods, which are strongly recommended to teach this subject, require more time than classical teaching methods, whether peer educators are used to facilitate some of the teaching-learning on the subject or not as they may require more time as they get used to their new roles.
- Whether or not some sub-themes are covered in other school subjects, e.g. children's rights and human rights.
- The amount of time that education authorities are willing to spend on the subject, taking into account that the curriculum is often already overloaded and that, should time be taken off other subjects, subject specialists will need to be convinced of the importance of HIV and AIDS education.

The IBE-UNESCO Curriculum Manual on HIV and AIDS education provides guidelines for the minimum time required to complete the four different thematic modules during an average school year (160 days or 32 weeks). It is important to note that this minimum time should not be seen as time added to the existing curriculum and school calendar, but as part of the curriculum.

Service provision

In order for education on SRH, HIV and AIDS to be effective, it is important that learners have access to youth-friendly health services, information and counselling. Young people in both urban and rural areas should either be able to access these services in schools themselves or in a youth-friendly centre close by.

The FRESH programme provides a range of tools to support the provision of school health programmes. This set includes a tool to guide the provision of (school-based) youth-friendly services. Should these services be provided in schools, a number of issues need to be considered and planned for. Some of the main points for consideration are listed in Box 7. If these are not provided in schools, ministries of education will need to work closely with, for example, ministries of health and youth to verify whether the services learners have access to are youth-friendly.

Box 7 Characteristics of youth-friendly services

I. Provider characteristics

- *Specially trained staff*
- *Respect for young people and students*
- *Privacy and confidentiality honoured*
- *Adequate time for client and provider interaction*
- *Peer counsellors available*

II. Health facility characteristics

- *Separate space and special times set aside*
- *Convenient hours*
- *Adequate space and sufficient privacy*
- *Comfortable surroundings*

III. Programme design characteristics

- *Youth involvement in design and continuing feedback*
- *Drop-in clients welcomed, and appointments arranged rapidly*
- *No overcrowding and short waiting times*
- *Affordable fees*
- *Communication on available services by trusted adults and peers*
- *Wide range of services available*
- *Necessary referrals available*
- *Educational material available on site and to take*

Source: UNESCO, 2004b.

Community involvement

The involvement of the community in curriculum design and delivery is not only important in light of preventing opposition to HIV and AIDS education, but also as a general way of building support for education on this topic and harmonize communication taking place in schools, families and communities. If messages on HIV transmission and prevention are contradicted in the community, this can greatly undermine the effectiveness of education. As much as possible, a ministry of education will need to build partnerships with relevant actors and stakeholders so as to create and maintain broad support for its (new) education programme.

In part 1 of this module under the heading 'opposition issues', a number of recommendations are mentioned which can guide the basic planning of community involvement in HIV and AIDS education development and delivery. Planners will need to reserve resources for continued involvement of the different actors and stakeholders, e.g. through regular national, provincial and local forums.

Appendix 2 contains a tool for the planning of public participation, taken from the Education for Sustainable Development Toolkit (see McKeown, 2002, www.esdtoolkit.org). The tool can serve as a guide in determining the public participation needs of a community. The planning tool is based on five steps in which "planners determine the type of project and the reason for public participation, identify the goals of the process, answer questions about the process, select a process, and follow up with evaluation of the process" McKeown, 2002: 56 on www.esdtoolkit.org). The tool looks at three main types of projects, namely fact finding, setting goals, and implementation, and describes the kinds of public participation that work well for each of the five steps.

Schools that provide a child-friendly environment

Access to quality education is essential to preventing and mitigating HIV and AIDS. For SRH, HIV and AIDS education to be effective however, is it equally important that a school environment be child-friendly, that it "models equality and fairness, and protects the rights of all children equally" (UNICEF, 2004: 10).

Box 8 Characteristics of a child-friendly school

- Gender-sensitive for both girls and boys,
- Protects children; there is no corporal punishment, no child labour and no physical, sexual or mental harassment,
- Involves all children, families and communities; it is particularly sensitive to and protective of the most vulnerable children,
- Healthy; has safe water and adequate sanitation, with separate toilet facilities for girls and boys.

Source: UNICEF, 2004.

Ensuring that schools meet these standards will require resources, not only to establish and implement, for example, teacher conduct policies and build separate toilet facilities for girls and boys, but also to monitor whether schools meet these standards. Ministries of education will need to incorporate and budget for developing child-friendly schools in strategic and (annual) work plans.

Assessment

Assessment of teaching and learning is done for different reasons. It may be done to give feedback to learners and teachers on learners' progress or report on learner progress to parents, caregivers and school management. It can also be done in the process of awarding national qualifications and accreditation of individuals, and/or to evaluate the education system itself. No matter what the

purpose however, assessment can both positively and negatively affect learning, pedagogy and the curriculum. As was mentioned earlier, the absence of assessment of teaching and learning was considered a general shortcoming of current HIV and AIDS education; mandatory (summative) examination of teaching and learning should be done to ensure that teachers and learners take the subject SRH, HIV and AIDS seriously. Making the subject examinable can also strongly increase the likelihood that it is taught as has been mandated by the curriculum. To assess learner progress, it is best to have a balanced assessment package including both formative and summative assessment. Teacher training needs include training in conducting different types of assessment.

Besides assessing learner outcomes, ministries of education will also need to monitor the quality of delivery and coverage of HIV and AIDS education and related services (e.g. counselling, access to youth-friendly health services and information), and the quality and coverage of teacher training and support. Monitoring the quality and coverage of teachers' pre-service and in-service training and implementation of SRH, HIV and AIDS education in schools is important for planners as it will enable them to adjust resource allocation so as to enable the system to meet the targets set in the ministry's strategic/annual work plans.

The following are some examples of issues that need to be monitored annually when implementing SRH, HIV and AIDS education programmes. Some issues are not directly related to the teaching-learning process itself, such as clean and safe sanitary facilities. These matters are, however, strongly related to the success of education (on HIV and AIDS) and need to be included in the assessment process.

Issues to monitor include:

- Number of male/female trainee teachers educated in SRH, HIV and AIDS (pre- and in-service);
- Number of male/female trainee teachers trained facilitating SRH, HIV and AIDS education, i.e. active, learner-centred teaching-learning pedagogies (pre- and in-service);
- Active involvement of community members in SRH, HIV and AIDS education (e.g. involvement to be measured through parent-teacher meetings, involvement of community members in (extra-curricular) teaching);
- Frequency of supervision sessions for male/female SRH, HIV and AIDS teachers;
- Frequency of refresher trainings for male/female SRH, HIV and AIDS teachers;
- Number of male/female learners who received SRH, HIV and AIDS education (e.g. male/female attendance of lessons and, in case a school works in shifts, provision of SRH, HIV and AIDS education during different shifts);
- Number of hours spent teaching SRH, HIV/AIDS education per school year (does this meet the requirements as stipulated in the curriculum?);
- Number of SRH, HIV and AIDS education activities conducted in out-of-school settings;
- Number of schools in rural and urban areas with a trained male/female counsellor;
- Number of learners counselled per school/district, number of follow-up sessions;

- Number of schools in rural and urban areas with separate, clean and safe sanitary facilities for female and male learners;
- Number of vulnerable children supported who continue attending school (grants to orphans and vulnerable children (OVC), for example exemption from payment of school fees);
- Number of male/female teachers in urban/rural areas who attended an orientation session on HIV and AIDS and workplace policy and/or received reader-friendly information on work place policies.

Ideally, monitoring and evaluation of learning outcomes as well as the issues mentioned above should be linked to or integrated in the overall education management information system (EMIS) (where this has not yet been done). Please see Module 3.2 on *HIV/AIDS challenges for education information systems* for further information. In addition, some of the issues mentioned above may be measured through and/or complemented by qualitative research on, among others, the impact of HIV/AIDS on education (see Module 3.3 on *Qualitative research on education and HIV/AIDS*).

Activity 4

The ministry of education in your country is in the process of deciding which curricular approach to use to integrate SRH, HIV and AIDS education into the regular curriculum for both primary and secondary levels. Based on what you have read above and reflecting on what you know about the present curricular structure in your country, what would you consider to be the main policy-making and planning implications of the stand-alone subject and cross-curricular approach?

What are the advantages and main challenges of the two different curricular approaches with regard to policy-making and planning?

Summary remarks

The aim of this module was to provide the reader with an overview of:

- the characteristics of quality SRH, HIV and AIDS education;
- the approaches to integrating SRH, HIV and AIDS education into a school curriculum; and
- the implications of integration of SRH, HIV and AIDS education for teacher training, textbook development and assessment/examination methods.

The module was based on the lessons learned from evaluation reports on current HIV and AIDS education around the world. These evaluations identify a range of important shortcomings that have contributed to the piecemeal implementation of HIV and AIDS education. In sum, it has been found that implementation of HIV/AIDS education fails in the following key areas:

- Content: teaching is not comprehensive, e.g. the realities of sexual transmission are not covered and stigma and discrimination are not adequately addressed.
- Delivery: HIV and AIDS education is not fully integrated into curricula, and implementation therefore remains piecemeal.
- Training: the Global Campaign for Education found that in only three of the 18 countries "had Ministries of Education made systematic attempts to train teachers about HIV and AIDS" (Global Campaign for Education, 2004: 5).
- Materials: insufficient quantities of (good) materials are reaching schools.

By paying particular attention to the lessons learned from experience of HIV and AIDS education around the world in the development/revision of strategic plans and (annual) work plans, educational planners can make a critical contribution to the improvement of HIV and AIDS education.

Lessons learned

Lesson One

Education on HIV and AIDS is often still too knowledge-based (for example see IBE-UNESCO, 2005 and Global Campaign for Education, 2004). More attention needs to be paid to the development of learners' abilities to deal with daily problems and (risky) situations relating to and affecting their wellbeing and health. At the same time, more study needs to be done into the teaching-learning of life skills in order to better understand how the learning of life skills can be facilitated. Teacher training needs to be comprehensive and last sufficient time to ensure that teachers are able to facilitate the learning of skills through participatory pedagogic methods and not only facts through, for example, rote learning. Resources are also needed to monitor the teaching and learning of life skills so that teaching-learning practices can be improved.

Lesson Two

Studies have demonstrated that where SRH, HIV and AIDS education is not fully integrated into the curriculum, teaching and learning may fall short due to incomplete delivery (for example see IBE-UNESCO, 2005). To ensure effective implementation, it is recommended that:

- SRH, HIV and AIDS education be fully integrated into the national curriculum of primary and secondary level schooling, i.e. that a specific amount of time be allocated to the subject and that the teaching-learning outcomes be assessed and accredited.
- teacher training courses be designed to be in line with and meet the challenges that the chosen curricular approach can present.

Lesson Three

Community commitment to and involvement in HIV and AIDS education is of critical importance. This involvement is essential not only as a means to prevent opposition to education on SRH, HIV and AIDS, but also to work towards harmonization of messages learners hear in school and those that are disseminated in the community (for example see Kirby et al., 2005 and Global Campaign for Education, 2004).

- In order to gain and maintain understanding and support of the public and other important (education sector) actors for SRH, HIV and AIDS education, national guidelines on the involvement and informing of relevant stakeholders during the process of development, implementation and monitoring of SRH, HIV and AIDS-related education should be established and followed up on. Resources (human, financial, technical) need to be reserved to make community involvement possible.

Lesson Four

The lack of (adequately) trained teachers has severely hampered the implementation of quality HIV and AIDS education (for example Global Campaign for Education (2004). Training of and support for teachers are essential building blocks in the MoE's response to

the HIV/AIDS epidemic. Therefore, it is recommended that sufficient resources be allocated to ensure that:

- all trainee teachers receive comprehensive training on SRH, HIV and AIDS. Also in the case of teacher training, outcomes should be made examinable and accredited;
- guidelines are designed for selection of SRH, HIV and AIDS teachers and, where relevant peer educators (including those that will facilitate extra-curricular activities);
- courses on participatory teaching methodologies and relevant (formative and summative*) assessment methods are incorporated into pre- and in-service teacher training programmes.

Lesson Five

Monitoring and evaluation of the delivery and impact of HIV and AIDS education is critical to its success (see IBE-UNESCO, 2005). The absence of assessment of teaching and learning is considered a general shortcoming of current HIV and AIDS education. Pre- and in-service teacher training should include training on assessment methods.

The success of HIV and AIDS education also largely depends on assessment of, among others:

- the involvement of relevant actors during the process of development, implementation and evaluation of SRH, HIV and AIDS education;
- coverage and quality of teacher training and support;
- access to youth-friendly (health) services and information in and/or close to the school.

The guidelines should specify, among others, the frequency of monitoring and evaluation, reporting and use of monitoring and evaluation findings for the adjustment of programmes/approaches. Monitoring and evaluation of HIV and AIDS teaching-learning indicators should be done within the framework of the overall ministry of education data collection system (EMIS). Guidelines on use of relevant, complimentary data from, for example, the ministry of health, universities and non-governmental organizations should be included.

Answers to activities

Answers to questions

Question 1

Please refer to subheading 2 in section 1 *Core topics.* If there are additional topics that are particularly important in your country, i.e. relating to sexual and reproductive health, HIV and AIDS, please add these or make special mention of them under the heading of one of the core themes. For example, if female genital cutting and/or male circumcision is a relevant topic in your country this topic should be addressed (e.g. under the core theme 'relationships and gender issues'), not only – in case of female genital cutting – as a human rights topic, but also from a health perspective.

Question 2

Please refer to box 6 to assess what are the main curricular approaches that are used to integrate (new) subject matter into a curriculum to verify which approach best matches the one used in your country (refer also to the curriculum framework and/or HIV and AIDS Education strategy).

Question 3

Impacts of teacher absenteeism and mortality on the quality of teaching/learning (on SRH, HIV and AIDS) can differ per country, but some common impacts are:

- HIV and AIDS lead to absenteeism of teachers due to illness, caring for sick relatives or funeral attendance;
- less experienced younger teachers, volunteers and untrained teachers are recruited in response to the teacher shortage;
- the psychosocial impact of HIV and AIDS on teachers as a result of (repeated) periods of grief and mourning, the loss of friends and family, and the mental and financial burden that is forced upon them can lead to poorer teaching performance.

Question 4

Short-term solutions can include the use of retired teachers, volunteers from the community, grade 12 (i.e. final year of secondary school) school-leavers as relief teachers. The number of shifts per school day can be increased or multi-grade classes can be created. Finally, having substitutes on stand-by and giving extra lessons on Saturdays can serve as short-term stop-gap measures[2].

It is important to note that these measures could be implemented to respond to a crisis situation as bringing in under/unqualified teachers can contribute to a loss of quality of teaching/learning. More long-term solutions therefore need to be found.

Examples of more long-term solutions are:

[2] The short-term and long-term solutions are mainly based on the findings of the IBE-UNESCO Capacity-Building Seminar 'HIV/AIDS, Teacher Shortage and Curriculum Renewal in the Southern Africa Region' (November 2003, Swaziland).

Teacher training

Re-organization of teacher training in order to have teachers in the field after a shorter training period, either by shortening altogether pre-service training or by reorganizing pre-service training to have trainees teaching sooner (for example in Malawi: 16 weeks training, 10 weeks in the field, 16 weeks training). The use of information technologies to complement teacher instruction is another solution that has been mentioned in Namibia. In Swaziland, a part-time diploma programme may be introduced for unqualified personnel who are already in the classroom.

Provision of Anti-retroviral therapy (ART)

Provision of antiretroviral treatment to teachers could also greatly reduce the rise in death rates and cumulative loss of teachers. A projection presented by Namibia shows that providing ART to HIV-positive teachers will keep many of them from falling sick, and ultimately reduce significantly mortality related to AIDS.

Data collection, stigmatization and review of sick-leave plans

Better data on teacher attrition and absenteeism is critical to planning. However, it has to be taken into account that teachers who are sick are often reluctant to declare it officially. Important reasons why teachers can be averse to taking official sick leave are stigmatization, existing sick-leave schemes and the fear of loosing one's salary once the permitted sick-leave (usually six months) period is over. Stigma and discrimination in the workplace and sick leave schemes for (HIV-positive) teachers are, therefore, two critical issues that need to be tackled.

Question 5

I. Provider characteristics

- *Specially trained staff:*

  - Training of selected staff, e.g. by ministry of health trainers and/or NGO staff

  - Recruitment of trained staff

  - Definition of tasks and responsibilities of staff, clarification of functions and services versus other school functions.

- *Privacy and confidentiality respected:*

  - Elaboration of school and youth services policy on confidentiality of learners and teachers.

- *Respect for young people and students and adequate time for client and* provider interaction:

Question 6

As is described in the section on opposition on pages 10–11, there are three basic 'steps' that need to be taken to involve community members and other relevant actors in the process of curricular design and delivery. These can be further broken down into activities, for example:

I. Clearly define and communicate on the role of stakeholders in the process of consultation on curricular change.

- Develop guidelines on the involvement of key actors and stakeholders during development, implementation, monitoring and evaluation of SRH, HIV and AIDS education (these guidelines should be linked to or

integrated in the overall documentation of the implementation strategy for the curricular innovation that is planned.

- Carry out a stakeholder analysis to explore who is affected by and/or can influence the process and outcome of curricular change/SRH, HIV and AIDS education to determine which actors or representatives thereof need to be involved in the curricular change process.
- Ensure that all relevant stakeholders (within and outside the ministry of education) are informed of the intention of integrating SRH, HIV and AIDS education into the curriculum and that involvement of community members and other important actors is considered key to the process.

II. Engage stakeholders throughout the curriculum development process

- To sustain the involvement of stakeholders, ask them to volunteer for different aspects of the project through task forces, committees, etc.
- Ensure that volunteers maintain communication with other actors (e.g. by circulating committee schedules and reports).

III. Communicate policy changes

- Disseminate regular progress reports, which, because they contain stakeholder input and opinions, acknowledge that they were heard.
- Make these reports widely available to the public through newspapers, popular local publications, and Internet to further validate the opinions, as well as the time and energy that stakeholders have spent in the process.
- Monitor the process and outcomes of the stakeholder involvement. Have the goals of the involvement been achieved?

Question 7

Box 8 mentions a number of characteristics of child friendly schools. To answer this question one can look into the possible policy-making and planning measures to take in order to 'realize' these characteristics. For example:

- School is gender-sensitive for both girls and boys:

➢ Develop policies to promote inclusion and equity in the school environment by guaranteeing the continuing education of pregnant or parenting girls, and address issues such as abuse, discrimination and harassment by staff and among learners.

➢ Policies aimed at getting and keeping girls in school should be developed and implemented in co-operation with children, families and communities.

➢ Separate and clean sanitary facilities in all schools can help towards ensuring that girls keep going to school when they are menstruating,

Question 8

Please refer to the text box on page 18 for examples of factors relating to quality of education which need to be monitored and which should ideally be linked to the EMIS.

Answers to activities

Activity 1

Example:

Delivery: characteristic of quality education (see Box 3):

*"Provide [*learners*] occasions to model, practice communication and refusal skills useful for self-protection and to build self-confidence."*

This characteristic of quality education has implications for teacher training and classroom delivery. Leading questions may be: to what extent does current pre- and in-service teacher training cover the teaching-learning of various communication skills? Do trainee teachers get sufficient time and support to practise the necessary teaching skills? Are trainee teachers assessed and credited in these areas? There are also important implications relating to classroom delivery, e.g. what is the current learner-teacher ratio? How does this compare with international benchmarks relating to acceptable and optimal pupil-teacher ratios, in particular when applying active and participatory teaching-learning methods (40:1 is considered the minimal acceptable norm for pupil:trained teacher ratio and 1:20 as the best acceptable [Education International, 2002])?

Activity 2

Answers to this activity depend on average age of sexual debut for females and males. It is important to remember that education on SRH, HIV and AIDS should start <u>before</u> the onset of sexual debut.

Activity 3

The involvement of educational and non-educational stakeholders during the different stages of curriculum design and delivery varies from country to country. During the process of consultation the following groups of people can be involved: curriculum specialists, area experts, teachers, learners, school principals, textbook producers, teacher unions, academics, as well as representatives of parents, business, trade and industry, religious groups, and local government units.

For more detailed information on the different stages of curricular design and which stakeholders can be involved, please refer to the UNESCO Bangkok and IBE-UNESCO publication *Leading and Facilitating Change, A resource pack for capacity building* (2005).

Activity 4

The answers given below are general implications, advantages and challenges, i.e. they may vary from country to country.

Stand-alone subject:

Teacher training: A stand-alone subject can basically be taught by one teacher per school. However, if the school is very large (e.g. has multiple grades and shifts), it may be necessary to train (and recruit) more than one teacher per school. It will have to be decided whether a new teacher will be appointed to teach this subject or whether suitable teachers can be identified at the school level (preferably by learners). If the latter is done, the workload of the selected teachers will need to be

reviewed and it is likely that in most cases these teachers will need to be relieved of their other (teaching) tasks.

Material development and distribution: Specific materials will need to be developed for the stand-alone subject, i.e. teacher training materials; teacher handbooks, teaching aids (including, for example, making condoms available to teachers and (older) learners), and learner materials for different grades. HIV and AIDS strategic plans and (workplace) policies should be distributed to all teachers.

Cross-curricular approach:

Teacher training: If SRH, HIV and AIDS education is integrated into, for example, social science and biology, in-service training will need to be geared toward teachers currently teaching these two topics. Pre-service training on SRH, HIV and AIDS education will need to be given to all trainee biology and social science teachers.

Material development and distribution: Additional materials will need to be developed to guide teaching and learning on SRH, HIV and AIDS within biology and social science. As with a stand-alone subject, teacher handbooks, learner books etc. will need to be developed. Syllabi for biology and social science will need to be reviewed; integrating the teaching on SRH, HIV and AIDS will require making space for the new teaching-learning contents (by removing certain other less urgent lessons/sub-topics).

Examples of the general advantages and challenges of the two different curricular approaches are given below.

Box 9 Examples of the advantages and main challenges of SRH, HIV and AIDS being taught as a stand-alone and cross-curricular subject

Curricular approach	Advantages	Challenges
Stand-alone subject	* It is possible to recruit and train suitable teachers. * It can be cost-effective as there are a limited number of teachers to train and support, and a limited number of textbooks to develop and distribute. * Monitoring of the quality of education is simplified.	* It is critical that the subject be made mandatory otherwise there may be a risk that teachers will not take the time to teach it. * The start up costs can be quite high due to the need for training of specialized teachers.
Cross-curricular subject	* In principle this approach allows for a sharing of responsibility between teachers for delivering the various aspects relating to the topic.	* The cross-curricular approach involves training larger number of teachers as well as development and distribution of a large number of textbooks. * Monitoring of the quality of education is more complicated.

Source: IBE-UNESCO, 2006: tool 5.

Bibliographical references and additional resource materials

Documents

Boler, T.; Adoss, R.; Ibrahim, A.; Shaw, M. 2003. *The sound of silence; difficulties in communicating on HIV/AIDS in schools*. London: ActionAid.

Boler, T.; Aggleton, P. 2005. *Life skills based education for HIV prevention: a critical analysis*. London: Save the Children and ActionAid International. www.actionaid.org/assets/pdf/life_skills_new_small_version.pdf

Education International. 2002. *Educational International Quarterly*, Volume VIII, 3-4,Double Issue, September-December, Belgium.

Fountain, S.; Gillespie, A. 2003. *Assessment strategies for skills-based health education with focus on HIV prevention and related issues*. New York: UNICEF. www.unicef.org/lifeskills/index_10489.html

Global Campaign for Education. 2004. *Deadly inertia? A cross-country study of educational responses to HIV/AIDS.* www.campaignforeducation.org/resources/Nov2005/ENGLISHdeadlyinertia.pdf

IBE-UNESCO. 2004. Executive report on the Capacity-Building Seminar *HIV/AIDS, Teacher Shortage and Curriculum Renewal in the Southern Africa Region* (November 2003, Swaziland). Geneva: IBE-UNESCO.

IBE-UNESCO. 2005a. *The quality imperative; Assessment of curricular response in 35 countries for the EFA monitoring report 2005*. Geneva.

IBE-UNESCO. 2005b. *HIV/AIDS teaching-learning materials appraisal tools*, Geneva: IBE-UNESCO.

IBE-UNESCO. 2006. *Manual for integrating HIV and AIDS education in school curricula.* Geneva: IBE-UNESCO

Kelly, M.J. 2000. *Planning for education in the context of HIV/AIDS.* Paris: IIEP-UNESCO.

Kirby, D.; Laris, B.A.; Rolleri, L. 2005. *Impact of sex and HIV education programs on sexual behaviors of youth in developing and developed countries.* Working Paper 2. Research Triangle Park, NC: Family Health International. www.fhi.org/NR/rdonlyres/e4al5tcjjlldpzwcaxy7ou23nqowdd2xwiznkarhhnptxto4252pgco54yf4cw7j5acujorebfvpug/sexedworkingpaperfinalenyt.pdf

Mason, H. 2003. *Peer education: Promoting healthy behaviors*. Washington, DC: Advocates for Youth. http://www.advocatesforyouth.org/PUBLICATIONS/factsheet/fspeered.pdf

McKeown, R. 2002. *Education for sustainable development toolkit.* www.esdtoolkit.org

Ministry of Health of Jamaica. 2004. Youth.now: *Adolescent sexual decision-making counselling protocol* http://pdf.dec.org/pdf_docs/PNADC076.pdf.

UNESCO. 1996. *Learning, the treasure within*. Report to UNESCO of the International Commission on Education for the Twenty-first Century. Paris: UNESCO.

UNESCO Bangkok. (no date). *Life skills on adolescent reproductive health: Package of lessons and curriculum materials*. www.unescobkk.org/index.php?id=1599&type=98

UNESCO. 2004a. *Quality education and HIV/AIDS.* Paris: UNESCO

UNESCO. 2004b. *Characteristics of Youth-Friendly Services*. FRESH Tools for Effective School Health. Paris. UNESCO. http://portal.unesco.org/education/fr/ev.php-URL_ID=37084&URL_DO=DO_TOPIC&URL_SECTION=201.html

UNESCO Bangkok and IBE-UNESCO. 2003. *Building the capacities of curriculum specialists for educational reform*, Final Report of the Regional Seminar, Vientiane, 9-13 September 2002.

UNESCO Bangkok and IBE-UNESCO. 2005. *Leading and facilitating change; A resource pack for capacity building. A resource pack for capacity building. Discussion paper 1*. Bangkok. UNESCO.

UNICEF. 2002. *HIV/AIDS education: a gender perspective.* New York: UNICEF. http://portal.unesco.org/education/en/ev.php-URL_ID=25673&URL_DO=DO_PRINTPAGE&URL_SECTION=201.html

UNICEF. 2004. *Girls, HIV/AIDS and education*. New York: UNICEF. www.unicef.org/publications/index_25047.html

WHO. 2003. Information Series on School Health. *Skills-based health education including life skills: An important component of a Child-Friendly/Health-Promoting School*. Geneva: WHO. www.who.int/school_youth_health/media/en/sch_skills4health_03.pdf

Appendix 1

Impact of sex and HIV education programs on sexual behaviors of youth in developing and developed countries.

By: Kirby, D. Laris, B.A. and Rolleri, L. (2005), Family Health International

The above mentioned publication summarizes a review of 83 evaluations of sex and HIV education programmes that are based on a written curriculum and are implemented among groups of youth in school, clinic, or community settings in developing and developed countries. The review analysed the impact programmes had on sexual risk-taking behaviours among young people. It addressed two central research questions:

1) What are the effects, if any, of curriculum-based sex and HIV education programmes on young people's sexual risk behaviours, STI and pregnancy rates, and mediating factors such as knowledge and attitudes that affect those behaviours?

2) What are common characteristics of the curricula-based programs that were effective in changing sexual risk behaviours?

Analysis of curricula that were found to be effective led to the identification of 17 common characteristics of the curricula and their implementation. Five of the 17 characteristics relate to the development of the curriculum; eight involve the curriculum itself; and four describe the implementation of the curriculum. The common characteristics are summarised in the box below.

Curriculum development process
1. Involved multiple people with different backgrounds in theory, research and sex/HIV education to develop the curriculum
2. Used a logic model to develop the curriculum that specified the health goals, the behaviours affecting those health goals, the risk and protective factors affecting those behaviours, and the activities addressing those risk and protective factors
3. Assessed relevant needs and assets of the target group
4. Designed activities consistent with community values and available resources (e.g. staff time, staff skills, facility space and supplies)
5. Pilot-tested the program
Curriculum content
6. Created a safe social space for youth to participate
7. Focused on clear health goals – the prevention of HIV/STIs and/or pregnancy
8. Focused narrowly on specific behaviours leading to these health goals (e.g. abstaining from sex or using condoms or other contraceptives), gave clear messages about these behaviours, and addressed situations that might lead to them and how to avoid them
9. Addressed multiple sexual psychosocial risk and protective factors affecting sexual behaviours (e.g. knowledge, perceived risks, values, attitudes, perceived norms and self-efficacy)
10. Included multiple activities to change each of the targeted risk and protective factors
11. Employed instructionally sound teaching methods that actively involved the participants, that helped participants personalize the information, and that were designed to change each group of risk and protective factors
12. Employed activities, instructional methods and behavioural messages that were appropriate to the youth's culture, developmental age and sexual experience
13. Covered topics in a logical sequence
Curriculum implementation
14. Whenever possible, selected educators with desired characteristics and then trained them
15. Secured at least minimal support from appropriate authorities such as ministries of health, school districts or community organizations
16. If needed, implemented activities to recruit youth and overcome barriers to their involvement (e.g. publicized the program, offered food or obtained consent)
17. Implemented virtually all activities with reasonable fidelity

Appendix 2

Planning public participation

Type of Project	**Step 1:** Reason for public participation	**Step 2:** Identify goals of the process	**Step 3:** Answer questions about the process				**Step 4:** Public participation processes	**Step 5:** Evaluate the process
			Q1: Who are participant ?	**Q2:** What type of interaction is appropriate?	**Q3:** Amount of public influence?	**Q4:** What is government agency's role?		
Fact Finding - To gather the best information and ideas from many sources.	The public shares local knowledge and creative thinking with government agency.	Increase information and creativity related to a specific project.	Everyone. Take steps to ensure wide represent-ation of socio-economic groups.	Information sharing. Emphasize two-way exchange: citizens hear what agencies are doing; agencies hear what citizens think of their plans, and listen to alternative plans.	Depends on quality of contributions.	High control. Agency defines what information is needed and how it will be used.	• Public comments. • Surveys • Public meetings. • Informal consultations. • Public notice and comment procedures. • Public hearings.	• Did better information contribute to better decisions? • Did participation processes increase information and ideas on the issue?
Setting goals - People reflect on what they want for the community	The public represents a broad range of values.	Identify and incorporate public values into decisions	Interested citizens.	Deliberation. Emphasize more intensive exchange, using well-reasoned arguments and group problem-solving.	Discuss and debate competing values; form collective vision; make recommendatio ns to agency.	Moderate control. Agency allows deliber-ations to evolve without overt control.	• Small-group discussions. • Series of workshops. • Citizen advisory committees. • Citizen juries. • Mediations. • Negotiations.	• Were goals created? • If there was conflict, was it resolved? • If there was a need for more trust, was trust increased?
Implementation - Implement the project and reduce conflict and mistrust that could impede implementation	Groups are directly affected by the project; groups will play strong role in implement-ation.	Reduce conflict; build trust; implement decisions	Interest groups.	Deliberation. Emphasize creative problem-solving; participants have access to the best information and analysis.	High influence; forge agreements among themselves about implementation responsibilities.	Low control. Agency provides technical resources and assurance to back the participants' agreement.	• Small-group discussions. • Series of workshops. • Citizen advisory committees. • Citizen juries. • Mediations. • Negotiations.	• Were decisions implemented? • If there was conflict, was it resolved? • If there was a need for more trust, was trust increased?

Source: McKeown, 2002. (Adapted from Beierle and Cayford, 2002. *Democracy in Practice: Public Participation in Environmental Decisions.* Resources for the Future).

Appendix 3

IBE-UNESCO
Diagnosis tool of current curriculum situation

Level of schooling: Primary level/*specify age-groups:*____________

<table>
<tr><th>Dimensions of HIV and AIDS education</th><th colspan="2">Current situation</th><th>Diagnosis – What could / should be changed? What is good?</th></tr>
<tr><td>HIV and AIDS education included in the curriculum</td><td colspan="2">□ Yes
□ No</td><td></td></tr>
<tr><td>Curricular approach</td><td colspan="2">□ Stand alone
□ One carrier subject
□ Cross-curricular
□ Infused
□ Extra-curricular
Comments:</td><td></td></tr>
<tr><td>Goals</td><td colspan="2">Quote curriculum :</td><td></td></tr>
<tr><td>Total time per school year <u>specifically</u> allocated to HIV/AIDS in each related disciplines</td><td>Disciplines
D1:
D2:
D3:
D4:
D5.</td><td>hours/year</td><td></td></tr>
<tr><td>Learning material available</td><td colspan="2">Provide list :</td><td></td></tr>
<tr><td>Teaching material available</td><td colspan="2">Provide list :</td><td></td></tr>
<tr><td>Teachers/staff in charge of HIV and AIDS education</td><td colspan="2">List:</td><td></td></tr>
<tr><td>Teacher/staff training</td><td colspan="2">□ In-service
Describe :

□ Pre-service
Describe :</td><td></td></tr>
<tr><td>Status of HIV and AIDS education</td><td colspan="2">□ Compulsory
□ Assessed
□ Examinable
Comments :</td><td></td></tr>
</table>

IBE-UNESCO

Diagnosis tool of current curriculum situation

Level of schooling: Secondary level*/specify age-groups:*____________

Dimensions of HIV and AIDS education	Current situation		Diagnosis – What could / should be changed? What is good?
HIV and AIDS education included in the curriculum	□ Yes □ No		
Curricular approach	□ Stand alone □ One carrier subject □ Cross-curricular □ Infused □ Extra-curricular *Comments:*		
Goals	*Quote curriculum :*		
Total time per school year <u>specifically</u> allocated to HIV/AIDS in each related disciplines	*Disciplines* D1: D2: D3: D4: D5.	*hours/year*	
Learning material available	*Provide list :*		
Teaching material available	*Provide list :*		
Teachers/staff in charge of HIV and AIDS education	*List:*		
Teacher/staff training	□ In-service *Describe :* □ Pre-service *Describe :*		
Status of HIV and AIDS education	□ Compulsory □ Assessed □ Examinable *Comments :*		

Appendix 4

Glossary

Assessment

Formative assessment is generally defined as a means to provide feedback to the teacher and learners regarding present understanding and skill development of learners. Formative assessment is considered an integral part of classroom teaching, which provides necessary inputs for both the teacher and learner to modify and enhance the teaching-learning process.

Formative assessment can make use of both formal and informal assessment procedures.

Summative assessment is used to evaluate learning achieved at different times during the school year(s) for the purposes of reporting to parents, other teachers, learners themselves, and other interested parties, including school boards or accreditors of national qualifications.
Source: IBE-UNESCO, 2006.

Module 4.2

M.J. Kelly

Teacher formation and development in the context of HIV/AIDS

About the author

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Module 4.2

.... .TEACHER FORMATION AND DEVELOPMENT
IN THE CONTEXT OF HIV/AIDS

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8. Teaching methodology
9. Counselling and care
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Summary remarks

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Aims

The aims of this module are to:

- clarify what is meant by teacher formation and development;
- show why teacher formation and development should deal with HIV and AIDS and issues arising from the AIDS pandemic;
- highlight the actions that must be taken for the integration of these areas in programmes of teacher education and development;
- outline the broad areas in which teacher educators and teachers need to develop HIV competence;
- draw attention to the potential of management and institutional factors within the teacher development setting to facilitate or inhibit the control of HIV and AIDS.

Objectives

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

- identify the challenges that HIV and AIDS pose for teachers and tutors in their capacity as educators;
- explain why teacher formation and development programmes should incorporate issues relating to HIV and AIDS;
- specify the principal elements of a comprehensive education programme for addressing HIV and AIDS;
- identify school management areas relating to HIV and AIDS that should be included in teacher formation and development programmes;
- outline the broad planning steps involved in ensuring that prospective teachers become AIDS-competent;
- plan, in a meaningful way, for the inclusion of HIV and AIDS issues in on-going teacher development programmes;
- identify potential HIV and AIDS hazards facing members of the teaching profession and ways of avoiding these.

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.

What do you think is meant by 'teacher formation and development'? In what ways does teacher formation differ from teacher training?

Why should HIV and AIDS be of concern in teacher formation and development?

What are the major challenges that teachers face in providing education in the areas of HIV and sexuality?

Are schools and teachers able to cope with the demands that the introduction of HIV and AIDS, life-skills and sexuality education has imposed on them, or are they being expected to do too much in this area? Explain.

Should HIV and AIDS and related issues be a required examinable subject area in school or in teacher preparation programmes? Explain.

How successful have in-service training programmes been in equipping teachers to incorporate HIV and AIDS and related issues into their teaching?

Identify some areas where the management must take account of HIV and AIDS in the daily running of a school or teacher education institution.

Describe any practices in teacher preparation programmes that should be re-examined because of the way they increase the participants' risk of HIV infection.

Describe any areas in teacher preparation programmes that should be strengthened because of the way they reduce participants' risk of HIV infection.

Module 4.2

.... .TEACHER FORMATION AND DEVELOPMENT
IN THE CONTEXT OF HIV/AIDS

Introductory remarks

As the HIV and AIDS pandemic spread during the 1980s, education systems in high-income countries quickly took steps to incorporate HIV prevention education into their curricula. The response in middle- and low-income countries was slower, but by the late 1990s several education ministries had initiated HIV prevention programmes. Investigations in 2001 showed that most interventions focussed on learners only, with few programmes to equip teachers to deliver the new curricula that embodied HIV and AIDS education (Akoulouze, Rugalema and Khanye, 2001). The investigations also showed lack of analysis of the systemic implications of the pandemic and its relevance for educational planning.

The challenges that were identified in 2001 still persist. HIV and AIDS, sexuality and life-skills education is being introduced quite rapidly into school programmes, but teacher preparation and development programmes are not keeping pace with these advances. As a result, schools are endeavouring to infuse the subjects of HIV and AIDS, sexuality and life-skills into their curricula before anything similar is undertaken in teacher preparation institutions or, in many cases, in university faculties of education. In several countries, attempts are made through in-service training (INSET) to redress this situation, but for the greater part INSET programmes have not offered the fullness of knowledge or depth of comprehension needed to bring serving teachers to the level of competence required for teaching in this area. Programmes that are offered tend to be unsystematic, ad hoc, and poorly followed through.

These shortcomings point to the need for the thorough integration of issues of HIV and AIDS, sexuality and life-skills into all teacher preparation programmes. Ideally, in countries where HIV prevalence is high, these areas would constitute an independent academic discipline; while in countries where HIV prevalence is low (below 1 per cent of the general population) it might be sufficient to incorporate HIV and AIDS issues consistently into various parts of the teacher preparation programmes. There is also a need for in-service programmes that are sufficiently comprehensive and systematic to deliver essential content, skills and materials to serving teachers and to motivate them to take action.

To show why this is necessary, the module will first examine the meaning of teacher formation and development in the context of the AIDS pandemic, and why HIV and AIDS and teaching about them should be matters of concern within these processes. The module will then examine the challenges that one confronts when incorporating this area into the curriculum. This will lead to the consideration of three interrelated areas: an outline of a suitable curriculum; the development of educators competent in its delivery; and the importance of on-going professional

support from education ministries and university departments, and of systematic monitoring and evaluation programmes. The module will also consider critical HIV- and AIDS-related management and institutional issues that affect the learning process, in teacher education institutions and in schools. Finally, the module will briefly consider the importance of developing the reflective and critical abilities of teachers so that, in the context of HIV and AIDS, they can become more effective agents of social change and better role models for their students.

Throughout the course of the module, short exercises will invite users to return to some of the questions for reflection given above and to relate what is being proposed to their understanding and experience.

1. The context of HIV and AIDS

An understanding of the context of HIV and AIDS will help you appreciate why the module refers to 'teacher formation and development' rather than to 'teacher training'. The gravity of the current AIDS situation cannot be over-emphasized. The United Nations Secretary-General has identified the pandemic as the greatest challenge of our age and has pointed to the fact that HIV and AIDS are affecting people at an accelerating rate on every continent. In June 2001, the world set for itself the target of containing the disease by 2015, but world leaders have acknowledged that this goal will not be attained. Indeed, instead of being contained, the pandemic seems to be spreading. Almost 5 million people became infected with HIV in 2005, raising the numbers who are believed to be carrying the virus globally to more than 40 million, half of them women. In the same year, 3.1 million individuals died from AIDS-related diseases.

Currently, Africa is the most seriously affected region in the world. This situation could change, but because of the way the disease progresses and makes its impacts, it is inevitable that AIDS will still be affecting Africa 20 years from now. But if, by 2025, millions of Africans (as well as millions in other continents) are still becoming infected with HIV, it will not be because nothing could be done to prevent this. Rather it will be because not enough will have been done to apply the lessons learned in the first 25 years of the pandemic's history. Action taken today on the basis of these lessons has the potential to stop the spread of the pandemic.

One crucial lesson is that "a good basic education itself ranks among the most effective – and cost-effective – means of HIV prevention" (World Bank, 2002: 1). Moreover, the provision of HIV and AIDS education greatly enhances that effectiveness.

The most critical element would appear to be education itself, i.e. enlarging young people's opportunities to participate in educational programmes, particularly in schools. The available evidence suggests that improved knowledge, desirable behaviours, and declining infection rates have occurred among those who attended school, even though this was at a time when the curriculum did not contain much, if any, education on HIV, sexuality or reproductive health, and the education provided was not always of high quality. What appears to have contributed to the improved knowledge, desirable behaviours and declining HIV infection rates was not what students learned in school, but the fact that they attended and learned in a school setting (please refer to Module 1.3, *Education for All in the context of HIV/AIDS*, where a number of these ideas are further developed).

Furthermore, beneficial outcomes have been reported from educational programmes that incorporated HIV and AIDS, reproductive health, sexuality and life-skills into the curriculum. These positive outcomes, which have been found in several different communities and cultures, in high-, middle- and low-income countries, include the following:

- improved and successful negotiating skills;
- first intercourse taking place at a later age;
- reduced sexual activity;

- greater fidelity to one partner; and
- increased condom use.

Moreover, there is no evidence that the inclusion of reproductive health and sexuality topics in the school curriculum increases sexual activity, leads to promiscuous behaviour, or increases the risk of HIV infection.

With all that has been said above still in mind, turn now to Activity 1 which asks about reactions to sexuality education.

Activity 1

Reactions to providing sexuality education

Identify some places where you have heard or read that providing sexuality education in schools promotes promiscuity. What is your reaction, as an educator and as a member of a community, to the provision of such education?

The beneficial outcomes identified above are among the principal reasons why teacher formation and development programmes should be concerned with HIV and AIDS. Such programmes have the potential to:

1. help prevent the spread of HIV infection among learners and educators in the teacher preparation institution itself;
2. help prevent the spread of HIV infection among learners in the institutions where the newly qualified teachers will teach; and
3. protect the education sector's capacity to provide adequate levels of quality education.

Basically, what is being said here is that providing HIV and AIDS, sexuality and life-skills education can help curtail the rate of HIV infection, not only among those attending schools but also among the educators, whether these are tutors, qualified teachers, or student-teachers who are still going through their formation programmes. This reduction is a powerful reason why every programme concerned with the formation of teachers should make provision for training in this area.

It is also important to bear in mind that the great majority of those undergoing initial teacher formation are young, in their late teens or early twenties, and these are the ages where the prevalence of HIV infection is particularly high. The susceptibility of these young people to infection may be further increased by campus cultures and lifestyles that may be open to activities, behaviours and

practices that increase the possibility of HIV transmission. Although their levels of AIDS awareness may be high, student-teachers still need to extend their knowledge and understanding, and on the basis of this understanding to develop values, attitudes and skills that will enable them to pass safely through situations that expose them to the risk of HIV infection. Their success in doing so will further equip them to be effective and credible teachers in the broad field of HIV prevention.

2. Teacher formation and development

Traditionally, the initial preparation of teachers has been referred to as 'teacher training'. The model underlying this designation emphasizes the knowledge and skills teachers need to acquire in order to become effective in transmitting a recognized body of knowledge and skills to their students. The training period ensures the expertise of the trainees in the subjects they are to teach and equips them with a variety of techniques that will make them skilled in dissecting their teaching areas into easily assimilated chunks of information, transmitting these chunks to their students, and evaluating (through oral, written and practical assignments) whether or not students have in fact assimilated them.

This training perspective is necessary and must be continued. But in the context of HIV and AIDS it is not sufficient. Something further is required, not merely in relation to HIV and AIDS themselves, but in relation to other school disciplines, particularly in countries where HIV prevalence is high (1 per cent or above in the general population). The AIDS pandemic is so catastrophic, complex and all-encompassing that a teacher needs to be engaged not just as an academician or communicator of knowledge, but as a person and human agent.

For centuries many of the world's best teachers have endeavoured to mobilize their students around values, those concepts of the desirable that have a motivating force for an individual. In the context of HIV and AIDS, this should be the pattern for all teachers. Their aim should be to prepare their students for life in a society that is endeavouring to rid itself of the infection and to influence them in ways that will enable and motivate them to live in a fashion that will reduce their risk of HIV infection, contribute to the care, support and treatment of infected or affected persons, and play some part in mitigating the damaging consequences of so much sickness and death.

If student-teachers are to achieve this aim in their teaching years, their preparation programme needs to pay adequate attention to their personal development. As indicated in a proposed compulsory core module for all professional teacher education programmes in South Africa, the programme should provide opportunities that will enable prospective teachers to explore, understand and clarify their values, attitudes, inhibitions, prejudices, anxieties and fears. In addition to technical training on what to teach and how to teach it, student-teachers should be enabled to develop a self-understanding that would increase their potency to act as responsible persons and to form mature interpersonal relationships with others.

Teacher formation in the context of HIV and AIDS refers, therefore, to an initial academic and technical training of prospective teachers (what to teach and how to teach it) that is infused by such an engagement with the pandemic that it initiates the transformation of student-teachers into committed, responsible and effective agents of positive social change.

This formation process cannot be accomplished in the short period of initial teacher preparation. Rather it is a lifelong process which must be provided as part of teachers' continuous growth process. Teacher development, then, consists in on-going formation that is nurtured by the never-ending acquisition of new knowledge and skills, new understandings of oneself, and new ways of relating to

others. This development provides serving teachers with the space, information and encouragement they need in order to develop their capacity to respond positively to HIV and AIDS in their own lives, and to help their students do the same.

3. Challenges involved in incorporating HIV and AIDS education into the curriculum

The challenges encountered when striving to incorporate HIV and AIDS issues into a school curriculum are partly professional and partly personal. In their professional capacity, educators draw attention to the following:

- Their lack of preparation and professional competence. Many educators allege that they are not equipped to teach about HIV and AIDS. Some may show, through their teaching and responses to questionnaires, that their knowledge and understanding are deficient. Very few have been exposed to this area in their initial training programmes. In-service programmes are often found to be superficial, piecemeal and ad hoc, and do not always form part of a comprehensive programme. Tutors in teacher preparation programmes, and even lecturers in universities, are not always conversant with the issues, and few have received any special training to enable them to serve as qualified and effective instructors.
- The absence of a universally agreed curriculum framework for use in schools and for which college and university programmes should serve as a preparation.
- The already overcrowded curriculum and the lack of adequate time to give HIV and AIDS the necessary attention.
- The inadequacies of teaching and learning materials within the system and their very restricted availability within individual institutions.
- Teacher uneasiness with the assumption that countering HIV and AIDS among young people is a special responsibility that the education sector must assume virtually on its own.
- The lack of support from head teachers, school supervisors and inspectors, and the lack of policy on making HIV and AIDS and life-skills education an examinable area of study.
- The attitudes of parents, school management committees and parent-teacher associations, who may agree to the inclusion of HIV and AIDS in the curriculum but oppose the discussion of sexuality and other necessary sexual matters.

Responding to these challenges implies a series of determined steps. If it is conceded that in a world with HIV and AIDS schools should provide HIV preventive education for all learners, then education policy-makers and planners must adopt measures that will:

- build the requisite capacity of lecturers and tutors in university faculties of education and teacher preparation institutions;
- incorporate an HIV and AIDS education curriculum into the programme for teachers undergoing initial formation as an integral, required and examinable part of their programme;
- devise a suitable curriculum for the various levels of schooling, making this an integral, required and examinable component of the school programme;

- ensure the development, production and dissemination of sufficient quantities of support teaching and learning materials;
- make available the monitoring and evaluation back-up that is provided for other subject areas so that HIV and AIDS education is accorded professional standing on a par with other subject areas;
- promote partnerships that will facilitate collaboration across sectors, with private agencies, and with community and family representatives;
- implement HIV and AIDS policies for staff and students in all teacher preparation institutions.

At the personal level, educator reluctance to treat HIV and AIDS and sexuality in depth is a major constraint. Cultural factors, fears and personal sensitivities contribute in complex ways to the disinclination of many educators to do so.

- Culturally, many are unwilling to deal with sexuality, especially in mixed classes or with children of the opposite sex, because of taboos that prohibit open discussion on sex and sexuality, particularly with young people.
- Family, community and (sometimes) faith-based silence on sexual development gives rise to many fears among educators: fear of causing offence to parents or community leaders; fear that they might be accused of encouraging promiscuity among children; fear that their teaching might be interpreted as the sexual solicitation of children; fear that if children subsequently engage in sexual activity, they will be held responsible.
- Personal sensitivities also contribute to educator reluctance to deal with HIV and sexuality. Many, aware that as parents or community members they do not talk about these things within their families, feel equally inhibited in trying to do so with groups of learners. Some are conscious of the discrepancy between their personal way of living and what they are expected to propose to the learners. Others who know or suspect that they themselves are, or that somebody in their families is, infected with HIV are reluctant to deal with an issue that is so close to home.

In response to these misgivings, the following actions should be taken at various levels.

- Establishing a strongly supportive institutional environment that, in turn, is rooted in clear, widely disseminated and well-accepted education sector policies.
- Mobilizing the support of parents, community leaders, governing boards and similar gatekeepers for teaching about HIV and AIDS, sexuality and life-skills.
- Encouraging the participation of partner organizations and significant members of the community in certain aspects of teaching.
- Creating an institutional culture that places a high premium on the non-abuse of learners, the safety in every respect of girls and young children, and zero tolerance for violence, stigma and discrimination.
- Promoting the professionalization of education on HIV and AIDS, sexuality and life-skills, so that educators can engage with this area more dispassionately.

- Ensuring full understanding and acceptance by all parties of the research evidence that teaching about sexuality brings beneficial and not harmful results.

The activity that follows asks you to discuss certain issues with fellow teachers. This can be done with individual teachers or with a group of teachers. If you do not have easy access to teachers, you might be able to hold the discussions with some other educators, with traditional or religious leaders, with parents, or with some others in society who are concerned about the education of young people in the areas of HIV, sexuality and reproductive health.

Activity 2

Discuss with fellow teachers the professional and personal misgivings they experience when teaching HIV and AIDS, sexuality and life-skills, and take special note of any points additional to those proposed above. In particular, explore with them the extent to which they were prepared for such teaching in the course of either their pre-service or in-service training.

4. The curriculum response to HIV and AIDS

The curriculum response to HIV and AIDS should promote a holistic and comprehensive understanding of the pandemic, appropriate to the level of development of the learner. The response should then ensure the integration into classroom activities of good quality skills-based education on sexual health and HIV and AIDS, including life-skills. This section gives some indication of the areas that such a curriculum should address. It is not intended to serve as either a prescriptive or comprehensive curriculum guide. Rather, its principal purpose is to draw attention to the complex range of knowledge and competencies required for teaching in this area, and thereby to highlight the challenge arising in teacher preparation and development.

It should also be noted that integrating good quality skills-based education on sexual health and HIV and AIDS (including life-skills) into classroom activities in schools necessitates corresponding attention to these areas in teacher preparation and development programmes. However, the reason for adapting a school curriculum in this way is not the same as for adapting the curriculum in a teacher preparation institution. In schools, the primary purpose is to promote the development of the knowledge, skills, attitudes and values that will enable learners to protect themselves against HIV infection (and understand a variety of issues relating to care, support, treatment and impact mitigation). In teacher institutions, the primary purpose is to equip learners with the knowledge, skills and commitment needed for teaching in these areas, though a very important secondary purpose is also to further develop the knowledge, skills, attitudes and values needed for self-protection and a broad AIDS response.

Broad curriculum content

In a world with HIV and AIDS, schools owe it to their pupils, and teacher preparation institutions owe it to their students, to:

1. make them well informed. Surveys repeatedly bear out the need to pass on correct information on HIV and AIDS and their transmission, and to dispel the myths, false beliefs, wrong attitudes, ‘macho’ images and false sense of security that can lead young people to adopt risky behaviour;
2. position learner understanding of HIV and AIDS within a framework which takes account of the personal and society-wide factors and pressures that constrain personal freedom and make an individual more vulnerable to HIV infection;
3. facilitate the development of self-awareness and self-esteem, and the clarification of values;
4. deepen understanding of the meaning and implications of sexuality and relationships, of what it means to be male or female, and of the role of physical sexual activity;

5. promote understanding of the meaning of gender and gender roles, and foster deeper appreciation of equality between the sexes, the extent to which this is negated by extensive gender power imbalances throughout society, and what could be done to correct this situation;
6. promote the negotiation, decision-making, stress-management and other life skills needed to put understanding and knowledge into practice in the sexual sphere and other areas of interpersonal encounters;
7. help learners understand that responding to HIV and AIDS extends beyond prevention – narrowly conceived – to care, support and treatment for those who are infected or affected, as well as to alleviating the negative impacts that the pandemic has on individuals, households, communities and society;
8. deal with the ABC approach ('abstain, be faithful, use condoms') within the framework of responsible living and overall risk reduction. This involves highlighting the role and value of abstinence in its broadest sense (delaying the age of first sexual encounters, not having sex before marriage, remaining abstinent for a specified period, resuming abstinent behaviour, etc.) and the skills needed for this. It also includes transmitting risk-reduction skills that facilitate the avoidance of casual and commercial sex, encouraging a reduction in the number of concurrent partners, and discouraging sexual relations with older individuals and also the practice of unprotected sex;
9. create an institutional culture that encourages the development of life-affirming attitudes and values, enshrines gender equity in principle and practice, proscribes substance abuse (drunkenness, drug taking), stresses the importance of a healthy life-style (exercise, nutrition and a positive approach), and shows zero tolerance towards violence, stigma and discrimination;
10. foster a responsibility-promoting climate, in which individuals are empowered to take charge of their own lives in an ethical human response that embodies the professional ethics that should guide teachers, and the responsible choices that should guide teachers and students alike.

It can be seen that this schema extends well beyond an approach that is narrowly confined to 'behaviour change'. Consensus is growing worldwide that it is ineffective to limit HIV prevention messages to messages about sex, abstinence, fidelity and condom use (and, in certain societies, needle exchange and change from intravenous to oral drug use). This is because such a narrow approach does not take account of the personal and societal factors that restrict the freedom of an individual to make alternative, risk-free choices. Analysts are becoming increasingly aware that the narrow focus of HIV and AIDS programmes on personal behaviour change is one of the reasons for the current limited success in halting the spread of HIV infection.

Condom advocacy is the classic example. Countless women who have remained faithful within marriage have contracted HIV from their husbands because gender imbalances (in this case, women's inferior power status in relation to men) do not allow them to negotiate the circumstances of sex or the use of condoms. To be effective in HIV prevention and in their overall response to the pandemic,

education programmes must take account of this and similar factors, such as poverty, that constrain the freedom and choices of individuals. Hence they must extend beyond biological and narrowly conceived behavioural factors to include consideration, appropriate to the level of the learners' development, of such issues as poverty, gender power roles, urbanization, migration, and north-south relationships.

The activity that you are now asked to undertake is intended as a 'reality check' that brings to light what schools actually try to cover in these areas.

Activity 3

Examine the syllabus or materials used in school teaching of HIV and AIDS and related areas in order to find out the extent to which they deal with such matters as constraints on the ability of individuals to make fully autonomous choices, factors that increase personal vulnerability, or a very rationally conceived ABC prevention model.

Find out from teacher educators in your locality, or from the curriculum materials being used, the extent to which HIV and AIDS issues are present in pre-service teacher education programmes. What topics feature most prominently in these programmes?

5. Models of programme delivery

Clearly, the AIDS pandemic gives rise to so many areas of concern that it would be necessary to structure the various topics within a more limited number of themes such as HIV and AIDS, sexuality, human rights and vulnerability. What would seem to be important is, firstly, that the education system recognize the need to embody these themes in the curriculum, and, secondly, that it should do so in an appropriate and effective way.

In the relatively short period since HIV and AIDS became an education concern, education ministries have developed various models for including them in the curriculum. In a given institution, some of these models may run concurrently. The following are commonly used models.

1. **Integration across the curriculum:** HIV and AIDS, sexual and reproductive health, and life-skills are seen as cross-cutting issues that should be addressed in all subject areas and become examinable as parts of those subjects.
2. **The separate subject model:** HIV and AIDS and the related areas are designed as a freestanding separate examinable subject. The health and family life education (HFLE) initiative in Caribbean schools approximates to this model.
3. **The carrier subject model:** HIV and AIDS and the related areas become an integral part of an existing carrier subject (such as health education).
4. **The co-curricular model:** HIV and AIDS are not formally dealt with in the teaching curriculum, but are treated in assemblies, clubs (anti-AIDS clubs, etc.) and associations, drama and entertainment programmes, special events, and other areas of the non-formal curriculum.

Integration across the curriculum seems to be the most commonly adopted formal approach, while elements of the co-curricular model can be found in many schools. Integration is preferred because:

- it is a way of ensuring that every learner repeatedly encounters HIV and AIDS issues;
- integrating HIV and AIDS across the curriculum reflects the reality of life, where the pandemic and its consequences are integrated into every facet;
- it can be difficult to make room in an already overcrowded timetable for a new subject;
- there are not enough teachers with the competencies needed for teaching a purpose-designed HIV and AIDS subject.

Because of the way this model would allow issues such as poverty, gender imbalances, social and personal vulnerabilities, and the socio-economic context of HIV and AIDS to be rooted in disciplines such as social science, history, religious education or literature, it would seem to be appropriate for delivering much of the broader curriculum framework outlined in the preceding section.

Each of the models, however, has its advantages and its disadvantages. To clarify what these are, you are now invited to undertake Activity 4.

Activity 4

Outline the advantages and disadvantages of each of the models for the inclusion of HIV and AIDS in a school curriculum.

Find out which of these models schools in your area are following, and discuss with teachers and learners how effective they find them.

6. Programme delivery at the pre-service level

Clearly it is the responsibility of the curriculum authorities in each school system to determine what is best for their circumstances, having regard to their human and other resources and also to the level of HIV infection in their environment. But teachers who are to treat the range of areas outlined in Section 4 – whether these be integrated across the school curriculum, presented as a separate subject, or piggyback on a carrier subject – will need purposeful, intensive and comprehensive preparation. However, the method of delivery of a programme for those undergoing their initial teacher training are very likely to differ among countries according to HIV prevalence levels or the way in which the pandemic is developing.

- Where the prevalence of HIV is high (1 per cent or more of the general population) or is growing (as in Eastern Europe and parts of Asia), the need is for every teacher to be well versed in all that relates to HIV and AIDS. This need could best be responded to by giving HIV and AIDS and related issues the status of a separate, required, examinable module or subject in the curriculum for the preparation of teachers at all levels. This course should cover the basics that curriculum developers and HIV and AIDS analysts consider as the necessary minimum. It could be supplemented, at least in certain institutions (especially university education faculties) by an optional course that deals with many of the areas in greater depth.
- Where HIV prevalence is low (less than 1 per cent) and stable, the need remains for every teacher to acquire a minimum level of AIDS competence. This could be achieved by developing suitable required and examinable modules to form part of other subject areas. In effect, this is to use the carrier subject model at the teacher education level. Additionally, where HIV prevalence is low, institutions could offer supplementary optional modules or fully developed courses that would allow more extensive treatment of selected areas.

Whichever option is adopted, the first requirement will be to build the capacity of lecturers in the teacher preparation institutions to deliver AIDS-related programmes. Numerous pre-service and in-service training programmes relating to HIV and AIDS have encountered problems because the lecturing staff were not themselves AIDS-competent. AIDS-competence requires that lecturers have a theoretical and practical understanding of the pandemic and its implications, appropriate to the level of their other professional qualifications. The first priority is to develop such AIDS-competence in education staff at universities and in teacher education institutions.

7. Programme delivery at the in-service level

The number of people to be reached makes the challenge of developing AIDS-competence in serving teachers a formidable task. In-service training programmes have met with no more than limited success in reaching significant numbers and in developing the requisite understanding and teaching skills. The problems experienced by participants are common to those frequently experienced in in-service training and workshop programmes:

- Insufficiently focused content.
- Too much being covered.
- A one-off set of training sessions with no follow-up.
- No training programme as such, but merely a poorly co-ordinated series of training opportunities (often associated with the availability of funding for this purpose).
- Little support for participants when they return to the workplace.
- Issues of local relevance not dealt with.
- Interests and concerns of participants not taken into account at the planning level.
- Communication methods not directed to the aspirations and potential of adults of some experience and prior training.

Promoting the AIDS competence of serving teachers would be facilitated in the following ways:

- Formulating, in collaboration with representatives of serving teachers and teacher unions, a well-defined in-service HIV and AIDS programme or curriculum that clearly specifies the understandings, skills and attitudes that are to be developed over time and that will lead to an acknowledged qualification that merits salary increment.
- Providing intensive and extensive training to a core group of trainers who, in co-operation with ministry of education inspectors or standards officers (or AIDS units), would subsequently have responsibility for HIV and AIDS in-service programmes in sub-regions of a country or state.
- Developing a sufficient quantity of materials, many of which would be suitable for self-study, others providing support for classroom work, and making these freely available to participating teachers.
- Organizing teachers at school cluster or zone level for the sake of peer-group study and support in areas of the in-service HIV and AIDS curriculum.
- Ensuring that the core trainers and other qualified personnel follow up on training activities by support visits to participants in their schools and colleges.
- Providing incentives and acknowledgement for teachers who exercise in their classrooms the AIDS competencies developed during training programmes.

- Establishing from the outset monitoring and evaluation procedures that will help in keeping the in-service training programme on track and in adjusting it to changing needs.

Many of these measures could be implemented by a more planned and rational use of existing resource centres. Adopting them will require an increase in the resources at the disposal of teacher training or HIV and AIDS units. An education ministry's preparedness to make these resources available (or to seek them from co-operating partners) would give a clear indication of its commitment to a dynamic response by the education sector to HIV and AIDS.

The ideas that have been presented here will lead you to reflect on training programmes that you have participated in and the value they added to your personal development. The activity that follows is designed to help you extend that reflection to the many other programmes and workshops offered by education ministries.

Activity 5

Obtain from your education ministry information on the HIV and AIDS in-service training courses offered during the past two years.

Who were the trainers at these courses?

How many teachers did they reach?

What was the content of the training?

To what extent were these courses adequate in terms of building the capacity of serving teachers to teach HIV and AIDS and related areas?

8. Teaching methodology

A positive aspect of the impact of HIV and AIDS on school systems has been the way it has stimulated developments along directions that for other reasons are considered desirable. A notable example is the greater sense of urgency that the pandemic has created in efforts to attain the Education for All (EFA) goals.

In the area of the curriculum, responding to HIV and AIDS has led to another beneficial outcome: greater focus on interactive and participatory teaching methodologies. These methodologies avoid excessive use of teacher lectures ('chalk and talk') and place greater reliance on learners playing an active role in the learning process. The methodologies involve a variety of approaches and activities such as talks, role plays, case studies, stories, games, discussions, quizzes, field visits, participatory process drama, making visual presentations for self-expression or to stimulate discussion, and question and answer sessions.

A characteristic of this interactive approach is that the teacher is no longer the sole purveyor of information or understanding, but shares with others the role of facilitating learning sessions. At times the co-facilitators may come from among the learners themselves (peer educators) and at other times they may come from elsewhere (parents, community leaders, health experts, persons living with HIV, etc.). Information coming from various surveys shows that, in fact, a large proportion of young people learn about sexuality and reproductive health matters, as well as HIV and AIDS, from their peers, the media and para-professionals who are not teachers. In some situations, learners feel more comfortable and confident when they learn about these matters from health or social workers. Further, the most significant learning experiences for many young people occur when they hear a person living with HIV giving a personal testimony and speaking about aspects of the pandemic.

All teacher preparation institutions should prepare student-teachers for such interactive methodologies and provide occasions for outsiders to participate in the training and formation activities. It is also desirable that the programme of in-service training, referred to in Section 7 above, provide for such exposure. In both instances, the experience is likely to result in more effective classroom interaction, not only in the field of HIV and AIDS and their related areas, but also in other subject areas.

But adopting interactive methodologies does not mean that all forms of teacher-directed and teacher-led learning must be abandoned. There will always be room for these. In particular, a curriculum that makes provision for the broad areas outlined in Section 4 above will provide much scope for the more traditional forms of teaching and learning. Hence curriculum delivery in the area of HIV and AIDS, in schools and teacher preparation institutions alike, will require a judicious combination of teacher-led and learner-centred methodologies.

9. Counselling and care

The HIV and AIDS pandemic has given rise to two special challenges for schools in countries with high levels of HIV: providing counselling services; and responding to the special needs of orphans and vulnerable children.

The experience of HIV and AIDS in one's immediate family is almost invariably extremely traumatic. This is partly because of the distress of seeing a loved one die a slow AIDS death, partly because of the stigma and silence that are attached to the disease, and partly because of the way HIV and AIDS affect every aspect of the life of an affected individual. Learners and educators both experience the traumatic effects, to the detriment of their personal well-being and ability to learn or teach as the case may be.

Especially affected are children who lose one or both parents to the disease. Sensitively conducted investigations have revealed the extent of the psychological scarring from which such children suffer (FHI, 2002). In addition, many children find themselves in grave economic difficulty following the loss of a parent or guardian, given the long period of illness, the costly medical attention and the reduction in income that precede an AIDS death. As the nature of the challenge continues to unfold, preliminary studies have revealed how psychologically fragile many orphaned children tend to be, how they associate with one another for security and understanding, and how they may not profit from the socialization processes that go on in families, schools and communities.

Clearly these are two areas to which every teacher should be sensitive. It would be unrealistic to expect regular teachers to be equipped with the counselling skills needed for dealing with traumatized children, orphans or teacher colleagues. Nevertheless, the teacher preparation programme should give some attention to these issues, so as to sensitize participants to their occurrence and to prepare them for some of the distressing realities that they are likely to encounter in their professional lives.

10. Management and institutional issues

In a world with HIV and AIDS, institutional managers need to ask themselves some searching questions:

1. What aspects of this institution or of our practices facilitate the spread of HIV? And therefore what measures should we put in place to change these aspects?
2. What aspects of the institution or of our practices inhibit the spread of HIV? And therefore what measures should we put in place to promote these?

These questions are relevant to teacher formation and development in the context of HIV and AIDS. Aspects that facilitate the spread of HIV could include the social and living arrangements in the college or training institution, and practices that are condoned (such as ease of access by 'sugar daddies' to young female students). They could also include the way students are placed for the periods of teaching practice, which are integral to good teacher preparation. Within the education sector as a whole, posting individuals away from their spouses or from the support of their families for significant periods, or requiring teachers to be away from home overnight to collect their salary payments in cash, or paying generous allowances to workshop participants in fashionable venues, could also be seen as factors that heighten the HIV vulnerability of individuals.

It is the responsibility of the management to subject these and similar practices to scrutiny under an HIV and AIDS lens to make sure they are not unwittingly increasing the HIV vulnerability of trainees and employees. One tragic outcome could be that HIV is contracted during the years of training, but does not manifest itself as AIDS until several years later. Such an outcome runs counter to the very purpose of the teacher preparation institution.

On the other hand, there are aspects and practices that inhibit the spread of HIV. One is an institutional culture that is very alert to the disease and its potential to spread, and that mobilizes the entire institution in efforts to contain it. What was said in Section 4 above about the institutional culture that schools should seek to promote bears repeating in the context of teacher education establishments. These establishments will encourage aspects that inhibit the spread of HIV and AIDS if they take steps to create an institutional culture that encourages the development of life-affirming attitudes and values, enshrines gender equity in principle and practice, proscribes substance abuse (drunkenness, drug taking), stresses the importance of a healthy life-style (exercise, nutrition, positive approach), and shows zero tolerance for violence, stigma and discrimination.

It could be hoped that teachers who experience such an environment during their period of formation would themselves endeavour to create a similar atmosphere in the schools where they will eventually teach.

Other issues that should be explored during the period of pre-service formation, and subsequently as part of on-going teacher development, include the following:

Education sector policy: It is essential that every teacher be familiar with the HIV and AIDS policy that several ministries of education (and other education

employers) have established. These policies have been developed in response to the gravity of the AIDS situation and show a commitment to responding in a humane and effective way to the pandemic within the education sector and its institutions. In certain instances, a ministry's policy may be spelled out at greater length in HIV and AIDS guidelines for educators. Teachers should be made aware of these, where they exist.

Workplace policy: In addition to a general sector policy, many education ministries have developed workplace policies dealing with HIV prevention; care, support and treatment of affected personnel; and occupational health and safety. Again, it should be an integral part of the preparation and on-going development of teachers to ensure that they become familiar with the contents of such a policy and know how to apply it in the situation of their own institutions.

Professional ethics: HIV and AIDS workplace policies usually imply attention to a code of conduct and the maintenance of a high standard of professional ethics in personal behaviour, especially in dealings with children. The AIDS context suggests that prospective teachers should be enabled to explore the expected standards through a variety of interactive techniques (case studies, role playing, etc.) that will deepen their commitment to understanding and maintaining behaviour appropriate for a trusted professional. Among other things, this will contribute to the credibility of the teacher as a role model in the classroom when dealing with matters of behaviour.

Partnerships: No matter how well disposed or informed, teachers cannot respond to all the demands that HIV and AIDS create. Instead, they must work closely with a wide range of partners, and their preparation programmes should help them explore how such partnerships could be made to work. Some partnerships will be within the education sector itself, for example with parent-teacher associations or school governing bodies. Others will involve public service areas such as health and social welfare, the community, non-governmental organizations, or traditional or religious leaders. Partnerships involving community members and organizations can be of crucial importance in helping overcome the gap that often exists between the school and the community and in facilitating the transformation of both school and community into safe, HIV-free areas, free from stigma and discrimination, and where the infected and affected are assured of care and support.

The final activity in this module asks you to reflect on unintended hazards or benefits arising from teacher training and management programmes. Because the issues are country- or even locality-specific, no set answers can be given. But that may be all the more reason why you need to think hard on the situations with which you are familiar. Good things and bad things can be happening without our being aware of them, but in the circumstances of HIV and AIDS it is better to bring such matters to the surface.

Activity 6

Can you identify any aspects (other than those mentioned above) in the training, posting or management of teachers that:

(a) facilitate the spread of HIV and AIDS; and

(b) inhibit its spread?

11. Education as a moral enterprise

The previous section referred to the presumption that teachers serve as suitable behavioural role models for their students. Society's expectations for schools and for teachers are very high in this regard. While acknowledging the importance of academic achievement, most parents believe that, in addition to promoting academic excellence, schools and teachers should positively influence the way in which their students live and relate to each other and the wider world. This leads parents to favour schools that show care and concern for individual students, are orderly and well-run, emphasize moral values and standards, and equip students for life in a changing and complex world. Moreover, parents wish to see these expectations for schools reflected in the personal lives of teachers.

HIV and AIDS have heightened these expectations. The apparently uncontrollable pandemic, with its many negative consequences, has accentuated the importance of the teacher as one who can provide pastoral care to young people in need, serve as a role model in many areas of personal behaviour, and be a catalyst for change in promoting understanding and tolerance in a climate beset by stigma and discrimination. This does not come naturally to teachers or anybody else. Neither is it something that can be achieved by simple prescription. As Fullan, the renowned expert on educational change, said: "What is important cannot be mandated" (Fullan in Tuohy, 1999: 1). Instead it is something whose growth within the prospective and serving teacher must be nourished during the periods of initial formation and on-going development.

Ensuring that the climate of schools and teacher institutions reflects the institutional culture referred to in Sections 4 and 10 will help in establishing a suitable environment for this transforming formation and development. But it will be necessary also to provide opportunities that allow teachers, whether they are students or qualified teachers, to get in touch with what HIV and AIDS mean in their lives. This implies that, in addition to academic content, programmes must seek to develop teacher capacity to reflect critically on HIV and AIDS in ways which engage the person and promote motivation. The desirable outcome would be teachers who are empowered to take charge of their own lives and to guide the lives of the young people entrusted to them in an ethical human response to the crisis.

Promoting this reflective capacity is a challenging task for which pre-service and in-service programmes on their own would hardly be adequate. These programmes need to be supported by inputs from a wide variety of stakeholders, especially people living with HIV, those with counselling skills, religious personnel, and representatives from affected communities. They need to be structured and delivered outside the normal programme bounds so that they can be more effective in enabling teachers to confront HIV and AIDS intellectually and emotionally. If the programmes succeed in having teachers internalize HIV/AIDS in this way, there is a greater likelihood that teachers will cease to view it as a distant problem which is the concern of others. Instead, seeing it as something real and belonging to themselves, they will be more likely to serve as positive models for their students and credible guides for the way they should behave.

Summary remarks

The literature gives much attention to what schools must do in an era of HIV and AIDS, and cites numerous school-based HIV prevention programmes. It gives much less attention, however, to what teacher formation institutions should do. Educators found it intuitively right to respond to the emergency of HIV and AIDS by establishing as a matter of urgency school programmes for the protection of the 'window of hope' that learners in primary and secondary schools are seen to constitute. But this sense of urgency did not extend to programmes that would prepare teachers for these new and demanding responsibilities.

Even after almost a quarter of a century of global experience of HIV and AIDS, school programmes remain somewhat haphazard. Some systems give evidence of little more than an uncoordinated range of pilot projects. Others have developed curriculum modules, but for the greater part these are very narrowly conceived within the framework of rational behaviour change models, individuals who control every aspect of the choices they make, and a simplistic straight-line ABC perspective. Very few school programmes have gone back to the roots to examine comprehensively how the subject of HIV and AIDS should be mainstreamed into a school setting, what this implies for curriculum content and delivery, and how teachers are to be prepared for their role in schools which are part of a world with HIV and AIDS.

A number of significant steps need to be taken to improve this situation.

- It needs to be determined how the subject of HIV and AIDS can be mainstreamed in the organizational and teaching aspects of schools, at least in countries with a generalized HIV pandemic.
- The curriculum needs to be transformed so that, going beyond the mere adding on of HIV-related topics, it reflects both broad HIV and AIDS concerns and more sharply focussed behaviour-related issues.
- There is a need to build the capacity of university and teacher-education staff to prepare new teachers for the delivery of this curriculum.
- A comprehensive programme of in-service training should be designed, and a cadre of trainers developed who will build the capacity of serving teachers to deliver the new curriculum.
- Support learning and teaching materials that are appropriate to the various levels ought to be developed and disseminated.
- HIV education must be established as a professional subject in its own right on a par with other school disciplines.

Mainstreaming HIV and AIDS in the organizational life of a school needs to be matched by its mainstreaming within teacher formation institutions, whether university or other. This requires that HIV and AIDS concerns take centre stage, so that all that goes on within the institution is informed by and takes full account of relevant HIV issues. The purpose is twofold: to ensure that staff and students routinely understand the relevance for HIV and AIDS of what they do as members of an institution; and to establish policies, programmes and activities which effectively address the concerns arising from the pandemic.

As with other developments in education, this agenda is not likely to move from paper to reality in the absence of understanding and commitment on the part of senior management in education ministries and partner organizations. Such commitment should lead, in turn, to a prioritized, costed, and time-bound plan of action. Until this is done, teacher formation and development in the context of HIV and AIDS will remain marginalized, with the outcome being failure to capitalize on the potential of education systems to respond as meaningfully as they should to the pandemic.

Lessons learned

Lesson One: In a world with HIV and AIDS, the curriculum and the methods of curriculum delivery cannot be the same – either in schools or in teacher preparation and formation institutions – as they would be in a world without the pandemic.

The saying "with HIV and AIDS it can no longer be business as usual" applies as much to the curriculum used in schools and teacher preparation institutions as it does in other domains of society. In countries where HIV and AIDS are a major problem, there is need for these subjects to be mainstreamed into the entire curriculum at both school and teacher preparation levels; for the curriculum to be re-worked to take account of the impacts of the pandemic; and for it to be re-developed around the pandemic as a central issue.

Lesson Two: The curriculum response to HIV and AIDS in schools, and therefore in teacher preparation programmes, needs to extend further than sexuality, sexual reproductive health (SRH) and life-skills, and should include attention to the factors, such as gender inequality, that render individuals vulnerable to HIV infection by constraining their ability to make free choices.

The sexuality, SRH and life-skills approach is valid and necessary, but it is not sufficient. As long ago as 1999, UNAIDS noted that the global response to the pandemic suffered from the major weakness of failing to "address the importance and centrality of social contexts, including government policy, socio-economic status, culture, gender relations, and spirituality" (UNAIDS/PennState Project, 1999: 24). The global response still fails to accommodate this insight, and in consequence there is inadequate productive guidance for school systems and teacher preparation programmes. Incorporation in the curriculum of the broader view advocated by UNAIDS could bring two highly significant benefits: it could make education programmes more effective, and it could address some of the factors that make teachers reluctant to teach in this area.

Lesson Three: The successful introduction of the subject of HIV and AIDS in school systems demands that a suitable planning cycle be identified and followed.

The steps to be taken follow one another logically:

1. Determine what is to be taught (the curriculum content) and how it is to be taught (the curriculum model and mode of delivery).
2. Build the capacity of third-level lecturers and tutors to provide training, and simultaneously develop learning and teaching materials.
3. Make use of this cadre of highly specialized personnel, incorporate the new areas as an integral part of pre-service programmes, and provide comprehensive and systematic in-service training for serving teachers.
4. Introduce the new curriculum areas into all schools.

The process is like building a house: one begins by laying down the foundations of a well-defined curriculum. On these, the walls of expert teacher educators, a competent teaching force, and a good supply of teaching-learning resources can be

built. Only then can the roof of teaching that can promise positive learning benefits in schools across a country or state be placed.

Lesson Four: There is equal need to adopt a suitable planning cycle and comprehensive programme that will build the capacity of serving teachers for the effective delivery of an all-embracing HIV and AIDS curriculum.

Existing in-service programmes are rarely comprehensive or systematic enough to make serving teachers competent in the delivery of an HIV and AIDS curriculum. Although the planning cycle is basically the same as that for pre-service training, greater determination is needed in the case of in-service activities, because of the strong tendency to deliver these on an ad hoc, unplanned basis, and frequently in response to the availability of funds as almost the sole rationale for mounting them.

Lesson Five: Teacher formation and development would be better adapted to respond comprehensively to HIV and AIDS if training establishments and schools developed institutional cultures that were single-minded in mobilizing institutional resources to respond to every dimension of the pandemic and to contain its spread.

HIV and AIDS is an area where there can be no divorce between the issues discussed or messages communicated in the classroom and what goes on in the other dimensions of institutional life. An understanding of the coherence between these will make better educators of those undergoing pre-service or in-service training. It will also help learners to develop a deeper sense of personal responsibility for halting the spread of the disease, providing care and support for those infected or affected, and working towards the alleviation of the negative impacts of the pandemic.

Lesson Six: HIV and AIDS constitute an extraordinary situation that demands an extraordinary response on the part of every person, including teachers.

The struggle against HIV and AIDS is the greatest challenge of our age. Success in overcoming the AIDS pandemic demands exceptional personal, moral and social commitment on everybody's part; teachers are no exception. Their professional life centres around young people who constitute the generation that provides hope for tomorrow but are also the generation most at risk of HIV infection today. Because of this, a great deal is expected of teachers. The future of millions of people depends in a real way on their dedicated response to all that the AIDS pandemic represents. To generate this commitment, teacher preparation and development programmes need to form prospective teachers so that they will become technically expert HIV and AIDS pedagogues who are personally dedicated to rolling back the pandemic and ushering in a world free of HIV and AIDS.

Answers to activities

Activity 1

Answers to this activity will depend on your personal perspective. However, you may like to refer to *Fact Sheet 05, Why young people need to learn about HIV/AIDS and sex*, contained in the HIV/AIDS and Education Toolkit for ministries of education produced by UNESCO Bangkok and UNAIDS (the full reference appears under UNESCO (2003) in the bibliographical references given at the end of this module).

Activity 2

You may want to refer to the paper by Tijuana et. al., referred to in the bibliographic references at the end of this module, which points out that teachers are a crucial link in providing valuable information about reproductive health and HIV/AIDS to youths, but that to do so effectively they need to understand the subject, acquire good teaching techniques, and understand what is developmentally and culturally appropriate. Teacher attitudes and experiences affect their comfort with, and capacity to teach about, reproductive health and HIV/AIDS. The pre-service setting offers an opportunity for future teachers to explore their own beliefs and concerns about these topics, while in-service training allows those already teaching to assess their views and increase their competence and confidence.

Activity 3

If you do not have access to the syllabus or materials from your own country, you can visit the International Bureau of Education's (IBE's) Global Curriculum Bank for HIV/AIDS Preventive Education database at the following address: http://databases.unesco.org/IBE/AIDBIB/. This is an international databank of curriculum material and related documentation for HIV/AIDS education at primary and secondary levels of schooling. The website gives information on sexuality and/or HIV education for Malawi, Nigeria, Zimbabwe, and some developed countries. To access the documentation, type CURRICULUM SCHOOL SYLLABUS in the box marked Documentation Type that appears when you open the website page.

Activity 4

A number of curriculum appraisal tools have been (or are being) developed by IBE. They can be accessed on:

www.ibe.unesco.org/AIDS/Manual/Manual_home.htm.

Activity 5

The answers to this question will be specific to your country.

Activity 6

The answers to this activity will be specific to your country.

Bibliographical references

Documents

Akoulouze, R.; Rugalema, G.; Khanye, V. 2001. *Taking stock of promising approaches in HIV and AIDS and Education in Sub-Saharan Africa: What works, why and how. A synthesis of country case studies*. ADEA Biennial Meeting, Arusha, Tanzania, October 7-11, 2001.

FHI. 2002*. Voices from the communities. The impact of HIV/AIDS on the lives of orphaned children and their guardians*. Lusaka: Family Health International. www.fhi.org/NR/rdonlyres/ei54mv6aqotbinqbndhkwigey54kjthile5u6rzsif35pra7bbpcmbbwqfws54cj4lckd6r2bxm44j/ZambiaVoicesCommunity.pdf

Gachuhi, D. 1999. *The impact of HIV/AIDS on education systems in the Eastern and Southern Africa region and the response of education systems to HIV/AIDS: Life Skills Programmes*. Paper presented at the Sub-Saharan Africa EFA Conference, Johannesburg, December 1999.

Kelly, M.J. 2000. *Planning for education in the context of HIV/AIDS*. (Fundamentals of Educational Planning, No. 66.) Paris: IIEP-UNESCO.

Kelly, M.J. with Bain, B. 2003. *Education and HIV/AIDS in the Caribbean*. Paris: IIEP-UNESCO.

Ministry of Education, Swaziland. 2001. *Study on the impact of the schools HIV/AIDS intervention programme in Swaziland*. Swaziland: Ministry of Education.

Ministry of Education. Zambia. 2003*a*. *HIV/AIDS guidelines for educators*. Lusaka: Ministry of Education.

Ministry of Education, Zambia. 2003*b*. Interactive methodologies manual for HIV/AIDS prevention in Zambian Schools. Lusaka: Ministry of Education.

Tijuana, A.; Traore, J.; Finger, W.; Daileader Ruland, C.; Savariaud, S. 2004. *Teacher training: Essential for school-based reproductive health and HIV/AIDS education. Focus on Sub-Saharan Africa*, Youth Issues Paper 3. Arlington, USA: FHI YouthNet Program. www.fhi.org/NR/rdonlyres/edmorint32vc5lxl5c6y53r2g7iutkutepccbk3gwnajd66qrpzmksekk6oqex4grokei6hgj23usg/YI3.pdf

Tuohy, D. 1999. *The inner world of teaching: Exploring assumptions which promote change and development*. London: Falmer Press.

UNAIDS Inter Agency Task Team on Education (IATT). 2002. *HIV/AIDS and education: a strategic approach*. Paris: IIEP-UNESCO.

UNAIDS; PennState Project. 1999. *Communications framework for HIV/AIDS: a new direction*. Geneva: UNAIDS. http://data.unaids.org/Publications/IRC-pub01/JC335-CommFramew_en.pdf

UNESCO. 2003. *HIV/AIDS and education: A toolkit for ministries of education*. Bangkok: UNESCO/UNAIDS. www2.unescobkk.org/elib/publications/aids_toolkits/index.htm

World Bank. 2002. *Education and HIV/AIDS: a window of hope*. Washington, DC: World Bank.

Module 4.3

R. Smart
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An education policy framework for orphans and vulnerable children

About the authors

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Module 4.3

AN EDUCATION POLICY FRAMEWORK FOR ORPHANS AND VULNERABLE CHILDREN

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Aims

The aim of this module is to enable ministry planners to increase awareness of the jeopardy facing all children with regard to their right to education, but in particular those who have been orphaned or made vulnerable as a result of HIV and AIDS. Once planners can understand the challenges facing orphans and vulnerable children (OVC) affected by AIDS, they can then implement important policy and programme interventions to increase and sustain education for OVC. By following a framework, this module guides users in the development of their own education and HIV and AIDS policies that successfully address the OVC issue.

Objectives

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

- describe and define the concepts of orphans and vulnerability in the context of HIV and AIDS;
- identify the policy-level challenges that education sectors must face, particularly in African countries, that have implications for orphans and other vulnerable children;
- propose recommendations for action to address the challenges, improve the situation for OVC, and to realize their right to education;
- recognize that education sector responses to OVC needs should not be confined to classrooms but should include psychosocial interventions and socio-economic contexts in order to fully address their educational needs;
- identify and list those interventions that contribute to the care and support of OVC.

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.

When are children vulnerable? What is the definition of an orphan?

What actions will ensure that the needs and rights of OVC are represented in education policies, plans and programmes?

What strategies and/or advocacy initiatives can be put in place in education sector structures to ensure that OVC realize their education rights?

How can EMIS (education management information systems) be modified to capture data on OVC?

What mechanisms can be put in place for schools, teachers and communities to formalize opportunities to recognize and respond to signs of vulnerability in school children?

What action should be taken to monitor and evaluate the roles and responsibilities of the sector in respect of OVC?

What actions can be initiated to strengthen the education-related aspects for OVC in development instruments, like poverty reduction strategy papers (PRSPs)?

Module 4.3

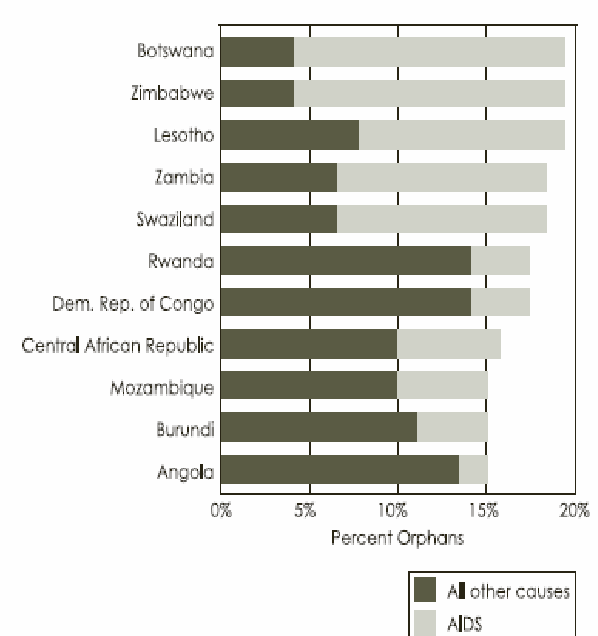
AN EDUCATION POLICY FRAMEWORK FOR ORPHANS AND VULNERABLE CHILDREN

Introductory remarks

In their 2003 publication, entitled *Accelerating action against AIDS in Africa*, UNAIDS summarized the impact of the AIDS epidemic on the education sector as follows:

"Good quality education is a powerful weapon against HIV/AIDS. Yet, across sub-Saharan Africa, only 57 per cent of children are enrolled in primary school. The added impact of the HIV/AIDS epidemic on the education system is undermining the fundamental right of every child to education, increasing the number of HIV/AIDS-related school drop-outs and raising young people's vulnerability to HIV infection. In high prevalence countries, substantial numbers of teachers are ill, dying, or caring for sick family members. Management of the education system is also threatened by illness and death of qualified persons."

Pupils who are orphaned or in vulnerable situations for whatever reason, but particularly because of HIV and AIDS, constitute a problem that is receiving specific attention in the education sector. Increasing numbers of local, national and international organizations are involved in researching the OVC issue, advocating for and supporting such children. While this research has led to the identification of problems and issues relating to the needs of OVC and the formulation of policies designed to address the issues, there is now a critical need to move these policies into practice within the education sector.



The EduSector AIDS Response Trust (ESART) is developing a body of knowledge to support education sectors that are faced with the multiple challenges posed by the AIDS epidemic. Policy is a central component of this body of knowledge. Generally, there is an

inadequate focus on OVC in the existing and planned policy development processes of education sectors. This module has been developed to address this important gap.

We begin by presenting the accepted norms and definitions concerning children, orphans, vulnerability and children's rights. We then explore the impact of HIV and AIDS on OVC and the role education can play to protect and support these children and to minimize the negative impact of the epidemic on their lives. In the final section, we examine the adapted framework.

1. Concepts and definitions

Definition of a child

Although children are defined differently in different countries, in most international and national conventions and laws, a child is a boy or girl up to the age of 18. In terms of the Convention on the Rights of the Child, a child under 18 may be considered an orphan if he or she has lost a mother, father or both parents, usually regardless of the cause of death of the parent or parents.

Eighteen years of age is generally accepted as the age when adulthood begins. However, in all countries there are legal exceptions, for example the age at which a child may be married, make a will or consent to medical treatment.

- In South Africa, a child may consent to a medical intervention such as an HIV test without parental consent at age 14.
- In Sri Lanka, Sri Lankan Kandyan and Muslim laws regulate the minimum age for marriage, and girls as young as 12 years old may be married with parental consent.
- In Ethiopia, a child may make a will when she/he reaches the age of 15.

In the context of HIV and AIDS, the definition of a child has particular relevance in the light of the following:

- The age at which compulsory education ends.
- Any differences between girls and boys, for example in relation to marriage and the age of sexual consent.
- Legal capacity to inherit and to conduct property transactions.
- The ability to lodge complaints or seek redress before a court or any other authority.

Definition of an orphan

The definition of an orphan varies from country to country (see Table 1). The main variables are:

- age – children up to 15 or up to 18 years;
- parent lost – mother, father, or both parents.

Table 1 Definitions of orphans from selected African countries

Botswana	A child under 18 years of age who has lost one (single parents) or two (married couple) biological or adoptive parents.
Ethiopia	A child under 18 years of age who has lost both parents, regardless of how they died.
Namibia	A child under the age of 18 who has lost either a mother, a father, or both parents – or a primary caregiver – due to death, or a child who is in need of care.
Rwanda	A child who has lost one or both parents.
Uganda	A child under the age of 18 years who has lost one or both parents.

Definition of a child orphaned by AIDS

The biennial report *Children on the brink* (COB) – a joint publication of UNAIDS, UNICEF, and USAID – has become the standard reference for definitions and estimates related to OVC. This report defines a child orphaned by AIDS as a child under 18 years of age who has lost at least one parent to AIDS.

Other variables presented in the estimates of OVC include:

- orphans as a percentage of all children;
- number and percentage of children orphaned as result of AIDS compared with total orphans;
- a breakdown of children who are maternal, paternal or double orphans.

The recent trend is to define orphans due to HIV and AIDS in terms of the death of one or both parents. It was also found that it is more detrimental, in terms of educational attainment, for an orphan to lose a mother rather than a father (Boler, Carroll, 2003; Bennell, Hyde, and Swainson, 2002; Subbarao, Mattimore, Plangemann, 2001).

Vulnerability

Vulnerability is a complex concept to define, as is illustrated in local/community definitions of vulnerability, which often include disabled or destitute children; in policy and support provision definitions, which list categories of children; and in working definitions, which are used in various documents (see Table 2 below). There rarely is consensus about and certainly no universal definition of vulnerability.

A major concern is that the orphan estimates do not reflect children who are vulnerable but still living with parents, or children vulnerable due to other causes or in addition to AIDS. Countries seeking to quantify the current and future burden of OVC may need to supplement their data on orphans with information from a situation analysis that covers all vulnerable children.

There is a body of evidence that challenges the assumption that orphans are the most vulnerable children. Using non-enrolment and non-attendance rates in

schools as proxies for vulnerability, studies by Ainsworth and Filmer (2002) and Huber and Gould (2003) found that in many countries poor children (rather than orphans) were most likely not to be enrolled in or to be out of school. Though generalizations across countries (28 countries in four regions in the Ainsworth and Filmer study) can be challenged, the link between poverty and vulnerability seems well established, suggesting that policies to raise enrolment among the poor will also have a positive impact on disadvantaged OVC. These findings seem to suggest that poverty at the community level is a main factor driving the conditions in which vulnerable children find themselves, and that if poverty is addressed, the quality of many children's lives would be improved.

Table 2 How children are defined as vulnerable in selected countries

Botswana	Street children Child labourers Children who are sexually exploited. Children with handicaps Children in remote areas from indigenous minorities
Rwanda	Children under 18 years exposed to conditions that do not permit fulfilment of fundamental rights for their harmonious development, including: Children living in households headed by children; Children in foster care; Street children; Children living in centres; Children in conflict with the law; Children with disabilities; Children affected by armed conflict; Children who are sexually exploited and/or abused; Working children; Children affected/infected by HIV/AIDS; Infants whose mothers are in prison; Children in very poor households; Refugee and displaced children; Children of single mothers; Children who are married before the age of adulthood.
South Africa - local community definition	Child who is orphaned, neglected, destitute or abandoned. Child who has a terminally ill parent or guardian. Child who is born of a teenage or single mother. Child who is living with a parent or an adult who lacks income-generating opportunities. Child who is abused or ill-treated by a step-parent or relatives. Child who is disabled.
South Africa - working definition for rapid appraisal	A child who is orphaned, abandoned, or displaced. A child, under the age of 15 who has lost his/her mother (or primary caregiver) or who will lose his/her mother within a relatively short period.
Zambia -Community committees identify OVC to qualify for the public welfare assistance scheme in terms of the following criteria:	Double/single orphans Does not go to school From female/aged/disabled-headed households Parent(s) is(are) sick. Family has insufficient food. Household below average standard

When it comes to understanding and defining vulnerability and the vulnerable child, what is recognized and agreed upon is that AIDS creates increasing poverty, is frequently accompanied by stigma and discrimination, and presents children with

unique psychosocial threats. All of these factors generate levels of vulnerability that are more profound than would occur in the absence of AIDS.

Box 1 Testimonies of orphans from Ingwavuma & East Rand, South Africa

"Every day is a struggle to go through. You wake up, go to school, get chased away and you are never sure of whether you'll eat before you sleep."

"Others when their mother is sick they are afraid to go to school in case their mothers die."

2. OVC and the education sector

AIDS impacts on the education of OVC

In households affected by HIV and AIDS, attendance of children at school often decreases as their labour is needed for subsistence activities and, in the face of reduced income and increased expenditure, money allocated for school expenses is used for basic necessities and health requirements. In those cases where children are not withdrawn from school, their education often competes with the many other duties that children in an affected household have to assume; this is particularly true for female children. Also, stigmatization may cause affected children to withdraw from school rather than tolerate exclusion or being ridiculed by teachers and peers.

Affected and orphaned children are often traumatized and suffer a variety of psychological reactions to parental illness and death. They endure exhaustion and stress from both work and worry, as well as insecurity and stigmatization as it is either assumed that they too are infected with HIV or that their family has been disgraced by the illness. Loss of a home, dropping out of school, separation from siblings and friends, increased workload and social isolation may all impact negatively on current and future mental health.

Activity 1

There are many OVC in your community in need of care and support. Please list some ways to assist them to remain in school.

The role of education in supporting OVC

As rights-based institutions, schools should play a major role in protecting pupils and teachers against discrimination. In addition, schools have undeniable advantages in the following areas:

- The identification of vulnerable children and orphans.
- The provision of psychosocial support to all children, but especially to those who are orphaned, who are facing orphanhood, or who are living in households affected by HIV/AIDS.
- Monitoring of the wellbeing of OVC.

Schools also have the potential to provide a range of education-related services to OVC, such as:

- delivering a daily meal to their pupils;
- providing after-school supervision for those who have no other adult supervision;
- linking children in particularly difficult circumstances to other relevant services to meet specific needs.

Box 2 Extract from *Kenya's National programme guidelines on orphans and other children made vulnerable* by HIV/AIDS

Strengthen response to reduce OVC vulnerability through:

Enrolling and retaining OVC in educational institutions like schools, non-formal schools and village polytechnics through mobilising sufficient resources for tuition fee waivers, accessible bursary facilities, educational supplies and feeding programmes.

These functions do not represent a departure from the traditional functions of the education sector; rather they demand an innovative way of looking at, and then fulfilling, existing functions. Schools can be adapted to provide a range of support for these pupils, but for this to occur schooling must be available to all children and every effort must be made to ensure that all children remain in school.

Teachers and older children can be sensitized and trained to support vulnerable children; food and clothing, especially uniforms, can be provided for children in especially difficult circumstances. Maintaining children's schooling is an important intervention in that it retains children's connection to their peers, to familiar adults and to an institutional identity. Furthermore, children associate going to school with leading a 'normal' life and being integrated into a community. Being able to attend school provides children and society with future knowledge and skills. Keeping older children in school could also help to prevent vulnerability to HIV infection by protecting children and reducing the child's need to seek shelter, food and clothing through, for example, risky encounters with unscrupulous adults.

In summary, apart from the accrued personal and social benefits of education for work and national development, attending school provides stability, institutional

affiliation and normalization of experience for children. Additionally, it places OVC in an environment where adults and older children are potentially available to provide material, social and emotional support.

Activity 2

Identifying and monitoring OVC

With your knowledge of the education system in your country, consider the present role of the school in the identification and monitoring of OVC. Make a note of your responses under the headings below.

Identification:

Monitoring:

3. Developing policy-level response to OVC in the education sector

In most African countries, government responsibilities for orphans and other vulnerable children have traditionally been placed within the purview of ministries such as that of gender, youth or social welfare – often the 'Cinderella' ministries in government. Any responsibility for OVC within the education sector, if it has existed at all, has been linked to responsibilities for youth who are out-of-school.

It is important to begin thinking about how the education sector can assume certain responsibilities for OVC within its mandates in order to begin mainstreaming the issue into policies and programmes, like some other issues related to HIV and AIDS. An education sector HIV and AIDS policy framework can either be narrowly or more broadly defined. Let us now explore a framework (adapted from the POLICY Project OVC framework[3]) that consists of ten elements that collectively constitute a comprehensive policy-level response to OVC by an education sector.

Laws governing the sector and provisions (international and national) for protecting the rights of children

In all countries, constitutions define the rights of citizens, including children. In addition most countries have child-specific legislation, such as children's acts, that give substance to these rights. Further, almost all countries are signatories to international conventions and agreements, such as the Convention on the Rights of the Child and the Universal Declaration of Human Rights, which elaborate the nation's obligations to its children.

The Convention on the Rights of the Child (CRC) is the framework that guides programmes for all children, including OVC. The CRC brings together children's human rights outlined in other international instruments by articulating the rights more completely and providing a set of guiding principles that fundamentally shape the way in which we view children. All the rights are interconnected and are of equal importance. Some important pillars of the CRC are:

1. the right to survival, development and protection from abuse and neglect;
2. the right to have a voice and be listened to; and

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[3] In 2002, the POLICY Project commissioned a policy-level analysis of country responses to orphans and other vulnerable children (OVC). No distinction was made as to the causes of vulnerability or orphaning, however the role of the AIDS epidemic in creating ever increasing generations of OVC was acknowledged. The analysis identified 12 policy elements that collectively constitute a framework that can be used to benchmark existing OVC policy-level responses or to guide the development of emerging responses to the OVC crisis. The policy framework has since been widely accepted and used to advance the OVC policy dialogue, particularly in African countries. This module has been developed by adapting the 12 policy elements from the original analysis to apply to the education sector.

3. that the best interests of the child should be a primary consideration.

In relation to education, the 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;
- take measures to encourage regular attendance at school.

Box 3 Extract from the Dakar EFA Goals (2000)

… 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 education of good quality.

Nations have also ratified international instruments that include a number of education-related targets, such as the Millennium Development Goals and the Education for All goals. In addition, in June 2001, all nations adopted the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Declaration, binding themselves to the development (by 2003) and the implementation (by 2005) of national policies and strategies that would, amongst other commitments, ensure the enrolment in school of *orphans and girls and boys infected and affected by HIV/AIDS on an equal basis with other children.*

Finally, in all countries there are laws that regulate the education sector decisions in stipulating, for example, the ages at which children must attend school, admission procedures, provision of universal primary education (UPE), specifications for children with special education needs, and so on.

These international and national instruments entrench principles such as a child’s right to education and non-discrimination in access to education, and yet in every African country there are thousands of school-age children who are not in school, even in those countries that have introduced free primary education. This is therefore the first policy element where recommendations can be made for action to improve the access for orphans and vulnerable children.

Table 3 Selected universal primary school enrolment figures

COUNTRY	Enrolment (pre fee abolition)	Enrolment (post fee abolition)
Kenya	5.9 million	7.2 million (increase of 22% or 1.3 million in first week of 2003)
Malawi	1.9 million	3 million
Tanzania	1.4 million	3 million
Uganda	2.5 million	6.5 million (2000)

Source: UNICEF, 2003.

Activity 3

What steps can be taken to ensure that OVC are included in laws relating to children and children's rights?

National education policy, strategic plans and guidelines that include an explicit focus on OVC

Most countries have education policies that dictate how the sector should operate. Linked to these policies are strategic plans and guidelines that typically provide the detail of 'how' the policy should be implemented.

Some countries also have HIV and AIDS policies for their education sector. These policies typically cover life skills education for pupils, workplace HIV and AIDS programmes for staff, and management and mitigation strategies. The policies and related strategies and guidelines may, but often do not, include recognition of the growing numbers of OVC, and of how the education sector could respond within its areas of comparative advantage.

As long as OVC are missing as a priority or are subsumed within broadly framed care and support targets in general education sector policies and in sectoral AIDS policies, strategies and guidelines, there is a risk that the education rights of this ever-growing group of children will be compromised.

Box 4 United Nations Report on AIDS-related policies for OVC (from the Secretary-General's Report of 24th March 2006)

Data from high-prevalence countries indicate some progress in the development of child-focused policy frameworks on AIDS but substantially less success in delivering essential services to children orphaned or made vulnerable by AIDS. Among 26 countries in sub-Saharan Africa, 22 report that they have national policies in place to address the additional HIV and AIDS-related needs of orphans and other vulnerable children, although country reports, on average, rate the level of national commitment to these vulnerable children as 5 or below on a scale of 1 to 10. Among the 18 countries with national policies, 14 report having reduced or eliminated school fees for AIDS-affected children and having implemented community-based programmes to support orphans and other vulnerable children.

Countries are increasingly opting for strategies that aim to address the needs of all vulnerable children, as targeting children living with HIV for special services may be stigmatizing and therefore counterproductive.

Education sector structures that include an OVC mandate

Typical structures that exist to co-ordinate and facilitate the work of an education sector include political or parliamentary bodies and committees; national structures on topics such as curriculum development, guidance and counselling, and teacher training; forums that bring together representatives from regional or district levels, as well as development partners and other stakeholders; teacher service commissions, teacher unions and student/pupil representative bodies; and school governing boards or parent-teacher associations at school level. Also within the sector, there may be one or more structures with a specific AIDS mandate, such as an AIDS committee or task team.

Box 5 Extract from the South African School's Act, No 94 of 1966

The governing body of a public school must:

a. Promote the best interests of the school and strive to ensure its development through the provision of quality education for all learners at the school.

h. Encourage parents, learners, educators and other staff at the school to render voluntary services to the school.

k. At the request of the Head of Department, allow the reasonable use under fair conditions of the facilities of the school for educational programmes not conducted by the school.

A case can be made to include a focus on OVC in the terms of reference of all of these structures, and yet in most countries this is the exception rather than the rule, and it requires real creativity to recognize any OVC focus in the functions of these structures.

In addition to the structures that exist to support the functions of the education sector, there will be multi-sectoral AIDS structures outside of the sector, such as the National AIDS Co-ordinating Agency (NACA) in Botswana, or even a structure brought into being specifically to address the problem of OVC, such as the National Task Force on Orphans (NTFO) in Malawi. There is always a critical need for strong education sector representation in these structures, yet there are more examples where the presence of the education sector is minimal or totally absent than there are of the opposite scenario.

Box 6 Key conference questions and/or themes at the South African conference on AIDS and the education sector (2002)

- What is the role of the education sector in preventing the spread of HIV among learners and students?
- How can the sector ensure that all learners and students, especially orphans and vulnerable children affected by HIV/AIDS, receive education and achieve their full potential?
- How can the sector, which is the biggest employer in our country, protect its educators and therefore the viability and quality of the education service in the face of HIV/AIDS?
- How can the education sector continue to improve access to and the quality of education services in the face of HIV/AIDS?
- What needs to be done? Who is responsible? Who is accountable?

National education sector consultations that include an OVC focus

All countries hold consultations or conferences for their education sector. These may have a specific theme, such as the implementation of a new policy, or the introduction of life skills education into school curricula; or they may be more general, such as planning to meet national education targets.

There are also regional and international education conferences, such as those convened by UNESCO, which are attended by national education sectors.

Whilst there has been a trend in recent years for these consultations to have AIDS as a theme, the programmes may, and often do, neglect OVC as an important focus.

Finally, there are – although outside of the education sector – international, regional and national AIDS conferences. The International Conference on HIV/AIDS and Sexually Transmitted Infections in Africa (ICASA) in Nairobi in 2003 was the

first to have a satellite session on AIDS and education, but the presentations did not deal in any depth with OVC. The conference programme itself was very lean on OVC and education.

Management information systems and impact assessments that cover OVC

Educational planning and budgeting is, or certainly should be, based on supply and demand data. In most countries, education sectors arguably have good data systems when compared to other sectors. In the system, known as the Education Management Information System (EMIS), information is gathered and analyzed annually on pupil enrolment, pupil drop-out, the number of pupils repeating, teacher/pupil ratios, teacher attrition, facilities at schools, provision of infrastructure, and so on.

As far as AIDS-related impact indicators and OVC are concerned, apart from a few pilot studies, these regular assessments do not capture any information about OVC. In a few countries, as a result of catastrophes, like the war in Uganda, questions have been added to their EMIS questionnaires in an attempt to track children such as war orphans.

In addition to regular education sector information collection and analysis, and in order to better understand and plan for the impact of AIDS, ministries of education often commission AIDS-impact assessments. Whilst these go into great detail to describe and model teacher mortality and morbidity and may make the link between the changing enrolment rates and the increasing numbers of children unable to attend school for a range of reasons (including orphanhood), most impact assessments are silent with regard to OVC. Specifically, they do not model or cost scenarios such as programmes to keep these children in school, programmes that would ensure them not only a primary or basic education, but also transition to secondary school, and interventions that would meet other needs they may have, such as nutritional support. This is therefore an area with great potential to include a much stronger emphasis on OVC. For more information on EMIS, see Module 3.2 – *HIV/AIDS challenges for education information systems*.

Mechanisms for defining and identifying the most vulnerable children

In most countries, very few schools have instituted mechanisms, such as registers, that identify orphans and other vulnerable children. When information is collected about the home circumstances of children, it is usually linked to identifying who will be responsible for paying school fees. Rarely can teachers provide the names of children who have been orphaned, who are living with sick caregivers, or who are vulnerable for any other reason. This gap is in part due to the lack of available services to which to refer these children for support, and is compounded further by a lack of support for the teachers themselves. Yet, despite the lack of formal mechanisms to identify OVC, teachers readily identify indicators of vulnerability, such as the appearance of children’s clothing, hunger, repeated and prolonged absenteeism, and poor or declining performance at school.

Box 7 Information gathered to identify OVC in Zimbabwe

In Zimbabwe, information by grade and gender is collected to identify OVC as follows:

- Single orphan
- Double orphan
- Neglected/abandoned
- Sick parents
- Sick pupil
- Very poor parents
- Child-headed household
- Other reasons

There are a number of creative ways in which vulnerable children can be identified, such as setting essay topics that provide children with opportunities to record their personal experiences, using drawings to explore children's coping strategies, introducing a suggestion box where children can 'post' letters to teachers anonymously, and communication books to allow caregivers and teachers to communicate with one another about a particular child. Community-based surveys, in addition to raising awareness and strengthening community involvement, are also useful to capture/quantify out-of-school OVC.

Monitoring and evaluating the OVC-related aspects in all M&E processes related to education policy implementation

Monitoring and evaluation (M&E) are critical elements of successful programmes, because they:

- determine programme effectiveness;
- identify and address problems;
- show impact;
- gather evidence of activities and results;
- strengthen fiduciary responsibility and accountability;
- show transparency.

In 2003, UNAIDS produced a report on progress on the global response to the AIDS epidemic. Using the UNGASS targets, a set of global/regional and national indicators was developed. In the set of nine national programme and behaviour indicators, there is one that deals with OVC and the education sector, namely the *ratio of current school attendance among orphans to that among non-orphans aged 10-14*.

Box 8 United Nations monitoring of orphan participation in education (from the Secretary-General's Report of 24th March 2006)

Although there has been some improvement in rates of school attendance, orphans (aged 10-14) continue to lag behind non-orphans. In sub-Saharan Africa, 70 per cent of non-orphaned children who live with at least one parent currently attend school, in comparison with 62 per cent of children who have lost both parents. Only 19.5 per cent of street children are being reached by outreach services.

Overall, the limited data available indicate that fewer than 10 per cent of households supporting children orphaned or made vulnerable by AIDS are reached by community-based or public sector support programmes.

This is but one way in which progress towards national and international education targets can be tracked. Other indicators might reflect education sector programmes that will benefit OVC, such as school feeding schemes, fee exemptions and psychosocial support programmes. For more information on monitoring and evaluation see Module 5.3 on *Project design and monitoring*.

Targeted issues-based advocacy

Advocacy is a set of targeted actions directed at decision-makers in support of a policy issue.

Few people, particularly those working in government, recognize the power of advocacy; and yet all of the policy-level recommendations made in this module will be enhanced if supported by advocacy. This is particularly true where the advocacy is part of a systematic, strategic approach rather than simply ad hoc or event-based.

Box 9 Possible advocacy themes

- Taking a rights-based and child-centred approach.
- Good quality free and compulsory basic education for all orphaned children.
- Keeping children in school protects them from HIV infection.
- Elimination of stigma and discrimination against OVC.
- Scaling up early childhood development programmes to accommodate very young OVC.

Valuable lessons about advocacy for the education rights of OVC can be learned from successful advocacy initiatives that have resulted in the implementation of

programmes to prevent mother-to-child transmission, and in improving access to life-saving antiretroviral treatments for persons living with HIV.

State support for OVC, specifically in terms of education

Universal primary education (UPE) has been introduced in a number of countries in the past decade or so, and has resulted in impressive increases in enrolments. UPE has clearly benefited many OVC who would otherwise never go to school or would drop out of school at some point. While these policies may have removed, in theory, the requirement to pay school fees, they have not, in reality, removed the obligation to pay for at least some aspects of schooling, such as contributions to school development funds, uniforms and books. These costs often represent significant barriers to education for OVC.

Box 10 The South African Schools Act, No 84 of 1996

The *South African Schools Act, No 84 of 1996* entrenches children's right to education by stipulating that public schools are not allowed to suspend pupils from classes, deny them access to cultural, sporting or social activities, or refuse to issue school reports if parents have not paid school fees.

OVC may also remain outside of the formal education sector as a result of demands to care for ailing caregivers or their siblings, work on the family farm, or enter the labour market to support their families. For these children, state support needs to take the form of skills-building and vocational training, which should ideally be accompanied by basic education and literacy training. This is an area where there is potential for partnerships with non-governmental organizations (NGOs) that have the necessary expertise to provide this sort of training.

Activity 4

What actions can be initiated to facilitate state support for OVC?

An OVC focus in the education components of PRSPs and HIPC initiatives in EFA plans and in funding applications

Mainstreaming AIDS into sectoral policies, plans and programmes is increasingly recognized as the only effective way to address both the causes and consequences of the epidemic. This requires a change of the current mindset to one that sees the epidemic as a long-term development issue with roots that are common to many other development challenges. It therefore makes abundant sense to include AIDS as a priority in PRSP and HIPC (highly indebted poor countries) initiatives. Examples where this has been done include Uganda's Poverty Eradication Action Plan (PEAP) and Namibia's National Development Plan (NDP) 2001-2006.

Box 11 The case of Malawi

> In Malawi, where free primary education was introduced in 1994, HIPC funds have been allocated to cover education-related expenses for some OVC. In 2003, 450 pupils in public secondary schools benefited from these funds.

Also, wherever there is an opportunity to mainstream AIDS, there is likely to be a similar opportunity to prioritize OVC in general, and OVC and education in particular. The following policy directive from the Uganda AIDS Commission is a good example:

"Sector ministries to revise and develop strategic action plans. These plans should describe the comparative advantages and planned interventions of each ministry in the fight against HIV/AIDS, including the problem of orphans in Uganda."

Within the Education for All – Fast Track Initiative, which is assisting countries in their efforts to give every girl and boy a complete primary education by 2015, there are resources to improve the quality and efficiency of primary education systems, which, in turn, can benefit OVC.

Finally, there are opportunities to include education-related activities for OVC in funding proposals, such as the Namibian proposal to the Global Fund, which includes:

- the provision of material support (such as school uniforms and shoes) to ensure OVC's access to education;
- expanding the existing school feeding programme for vulnerable children to cover OVC who are enrolled in the school-based counselling services; and
- the development, production and dissemination of curricula, necessary training materials and teaching aids for psychosocial support for OVC.

Summary remarks

This section of the module briefly highlights the key areas where intervention has implications for advancing the rights of orphans and other vulnerable children to education. These include:

- strengthening education systems to respond to the AIDS epidemic in general and to the issue of OVC in particular;
- building capacity in education sector personnel, like teachers, to deal with the multiplicity of factors facing AIDS-affected children and their families and communities;
- improving co-ordination, communication and consultation to, in turn, improve OVC responses;
- developing new, perhaps non-traditional, partnerships to deliver quality education that includes support for OVC;
- creating awareness of and promoting children's rights to education;
- removing or reducing stigma so that OVC are readily identified and can be targeted for support;
- scaling up small, localized successes;
- sustaining responses in the face of ever-escalating numbers of OVC.

Meeting the challenges at the policy level will create an enabling framework for action, which, when coupled with successful implementation, will constitute a giant step forward in securing the rights of every African child to education and to the development of his or her "personality, talents, and mental and physical abilities to their fullest potential" (Convention on the Rights of the Child: Article 29).

Lessons learned

Lesson One: Education needs are the same for all children, including OVC.

While AIDS has a negative impact on education systems, an additional impact of the epidemic is the number of OVC created. Within the classroom, education needs of OVC do not differ from those of other pupils. There is no evidence suggesting that pupils are treated differently by teachers on the basis of their orphaned status. The greater need of OVC is for psychosocial support.

Lesson Two: Policies to raise school enrolment among the poor will have a positive impact on disadvantaged OVC.

The Ainsworth and Filmer (2002) study has shown that there is a well-established link between poverty and vulnerability. In countries instituting universal free primary education, enrolments have increased permitting access to schooling for OVC and poverty-affected pupils who were previously unable to attend school.

Lesson Three: Potentially schools have an important role to play in minimizing the impact of the epidemic on children.

Academic institutions, especially schools, can play a vital role in the following areas:

- They provide a sense of community and contribute to the socialization of children as they interact with their peers, both in the school and the community.
- In those schools where school feeding programmes operate, at least one meal per day is provided to the child.
- They can provide psychosocial support and counselling.
- They can monitor the status of children.
- They can identify possible organizations and individuals to support children and their families.

Answers to activities

Question 1: When are children vulnerable? How would you define an orphan?

Refer to subheading 1, *Concepts and definitions*, in the text. Also, check your national policies.

Question 2. What actions will ensure that the needs of OVC are represented in education policies, plans and programmes?

- Ensure that the children's sector is strongly represented at all policy, planning and strategy sessions.
- Reflect OVC as a priority special-needs group in all sectoral policy, planning and strategy processes, in the same way that children with disabilities are catered for in such processes

Question 3. What strategies can be put in place in education sector structures to ensure that OVC realize their educational rights?

- Insert or elevate the issue of OVC in the terms of reference of all education sector structures.
- Hold these structures accountable, particularly the legally mandated structures, for implementing strategies to ensure that OVC realize their educational rights.
- Ensure appropriate representation from the education sector on all multi-sectoral HIV/AIDS bodies, and an appropriate reflection of the OVC-related roles and mandate of the education sector in national HIV and AIDS policies, strategies and plans.
- Ensure that the education rights of OVC are part of broader children's rights advocacy initiatives.
- Where necessary, build the capacity of organizations and individuals to conduct advocacy.
- Increase children's participation in advocacy activities; in particular ensure that the voices of orphans and other vulnerable children are heard.

Question 4. How can EMIS be modified to capture data on OVC?

- Improve school record keeping to record and track OVC enrolled in school. Schools are required to keep detailed personal records of pupils/students/learners.
- Review EMIS data to include OVC-related information and ensure feedback to those who can use this information for planning and programming.
- Include OVC assessments and modelling in education sector AIDS impact assessments, and, again, use this information for planning and programming.

Question 5. What mechanisms can be put in place to formalize opportunities to recognize and respond to signs of vulnerability in school children?

- In teacher training programmes, both pre-service and in-service, include skills on how to identify vulnerability in children and how to offer the support these children require.
- Provide support for teachers to act when they identify OVC, and information about services to which they can refer children with specific needs.
- Strengthen programmes that address factors causing vulnerability, such as school-based nutrition programmes.
- Enhance collaboration between schools and other sectors that can provide services and support, such as social welfare, health, labour, agriculture and NGOs.
- Initiate processes to recognize and deal with discrimination against OVC, and ensure that identification does not inadvertently cause discrimination and increase vulnerability.
- Implement procedures to improve the tracking of OVC, linked for example to detailed profiles of pupils that should be initiated upon the child's registration at school.

Question 6. What action should be taken to monitor and evaluate the roles and responsibilities of the sector in respect of OVC?

- Review education sector targets and monitoring and evaluation programmes to adequately reflect the roles and responsibilities of the sector in respect of OVC.
- Report on progress related to OVC and education at national, regional and international level.

Question 7. What actions can be initiated to include OVC and education in development instruments, like PRSPs?

- Conduct an analysis of PRSP activities, and use the results to lobby for a focus on OVC and education.
- Ensure that appropriate targets are set to track OVC and education within processes such as PRSPs and that sustainability plans are in place.
- Ensure that education-related activities are included in funding proposals.

Activity 1

Establish systems of support related to direct responsibilities, such as education, including alternative/flexible education, counselling and psychosocial support (PSS), after-school supervision, protection from discrimination and recreation as well as support related to more indirect responsibilities, such as facilitating referrals for shelter, food, clothing, healthcare, access to social security, protection from exploitation, and skills-building and income-generation.

Provide material support with:

- school fees and bursaries – such as providing information to children and caregivers on how to access bursaries or fee exemptions;
- school uniforms – such as donations of old uniforms, collecting uniforms from pupils who are leaving school, etc.

Create safe spaces for children to:

- talk to teachers;
- do homework;
- access peer support.

Provide psychosocial support to:

- help children who are caring for ill parents and/or siblings;
- help bereaved children deal with grief and loss.

Provide education support to:

- help children catch up with school work following any long absences;
- create alternative learning situations for infected and affected children who cannot participate in normal schooling (for whatever reason).

Collaborate with agencies offering services and support to children by:

- finding out about other organizations in the area that help vulnerable children and their families;
- keeping contact details of organizations easily accessible to children;
- inviting organizations to deliver talks at the school, explaining what services they offer and how they can be reached.

Create teacher support teams to support one another and to share lessons and experiences with colleagues.

Activity 2

Identification activities

Create and institutionalize a system of OVC identification that includes the following:

Agree on definitions and signs, for example:

- children who have lost a parent/primary caregiver;
- children with a sick parent/primary caregiver;
- children dropping out of school (or in and out of school);
- school work deteriorating;
- appearance that is changing/worsening;
- no school lunch;
- teasing/targeting by peers;
- psychological or behavioural problems.

Use school activities to collect information in a non-threatening manner, such as:

- setting essay topics that provide children with opportunities to talk about personal experiences;
- establishing a suggestion box at school where children can post letters to teachers about anything they want the school to know.

Establish ways of communicating with caregivers, for example:

- introduce 'communication books' where caregivers and teachers can communicate with each other about concerns regarding the child.

Keep and analyze records:

- of absenteeism;
- of whether children are repeatedly late for school;
- of children who struggle to complete their homework.

Respond to the following warning signs:

- hunger;
- dirty, unkempt appearance;
- falling asleep;
- withdrawal.

Monitoring activities

Monitor OVC in the following ways:

Follow up on referrals and find ways to work with other agencies and community child support structures.

Keep a register of OVC and school records of children's home circumstances, such as:

- who is caring for the child;
- where is the child living;
- current parental status of the child, or knowledge of the parents;
- whether the child getting a meal every day;
- whether the child feels safe with the current caregiver;
- whether they have a choice of who they live with; who would they like to live with?

Identify specific needs (e.g. food) and have an action plan to address the needs.

- Report on each child on a regular basis.

Activity 3

- Review the national education sector laws to ensure that they comply with the Constitution, any child-specific legislation, and the international conventions and agreements that have been ratified.
- Investigate and address all barriers to the full enjoyment of children's rights to education.
- Prioritize implementation of the legal provisions related to education, specifically those related to OVC.

Activity 4

- Ensure that provisions for free primary education, where these exist, are enforced, supervised and monitored.
- Incorporate basic education into skills-building and vocational and other training for children and youths who are not in school.
- Ensure that girls benefit as much as boys from formal and non-formal education opportunities.
- Ensure that all artificial barriers, such as the need for uniforms and payment of levies that deny entry into schools, are removed.

Appendix: Orphan statistics for sub-Saharan Africa

Table 1: Sub-Saharan Africa: Orphan estimates by type and cause, 2003

Country	All children 0-17 (thousands)	Total orphans as a percent of all children	Total number of orphans	Total number of orphans due to AIDS	Orphans due to AIDS as a percent of all orphans	Maternal orphans			Paternal orphans			Double orphans			Children orphaned in 2003
						AIDS	Non-AIDS	Total	AIDS	Non-AIDS	Total	AIDS	Non-AIDS	Total	
Angola	7,000	15%	1,000,000	110,000	11%	86,000	420,000	510,000	79,000	620,000	700,000	67,000	130,000	200,000	110,000
Benin	4,000	9%	340,000	34,000	10%	22,000	130,000	150,000	21,000	210,000	230,000	11,000	32,000	43,000	39,000
Botswana	800	20%	160,000	120,000	77%	110,000	20,000	130,000	75,000	23,000	99,000	62,000	2,000	64,000	25,000
Burkina Faso	8,000	11%	830,000	260,000	32%	190,000	270,000	450,000	160,000	370,000	530,000	100,000	58,000	160,000	89,000
Burundi	4,000	15%	660,000	200,000	30%	140,000	230,000	370,000	130,000	310,000	430,000	90,000	54,000	140,000	71,000
Cameroon	8,000	12%	930,000	240,000	25%	160,000	310,000	470,000	140,000	470,000	600,000	83,000	66,000	150,000	120,000
Central African Republic	2,000	16%	290,000	110,000	39%	83,000	81,000	160,000	71,000	120,000	190,000	48,000	17,000	65,000	36,000
Chad	4,000	12%	500,000	96,000	19%	65,000	170,000	240,000	59,000	280,000	340,000	35,000	40,000	76,000	61,000
Congo	2,000	13%	260,000	97,000	37%	68,000	70,000	140,000	56,000	110,000	170,000	33,000	14,000	47,000	29,000
Congo, Democratic Rep. of	24,000	17%	4,200,00	770,000	18%	570,000	1,600,000	2,200,000	490,000	2,300,000	2,800,000	370,000	430,000	790,000	480,000
Côte d'Ivoire	7,000	13%	940,000	310,000	32%	230,000	260,000	490,000	180,000	460,000	640,000	120,000	62,000	180,000	110,000
Djibouti	300	11%	33,000	5,000	15%	3,000	12,000	15,000	3,000	19,000	22,000	1,000	2,000	4,000	4,000
Equatorial Guinea*	200	13%	24,000					13,000			16,000			5,000	3,000
Eritrea	2,000	10%	230,000	39,000	17%	24,000	79,000	100,000	21,000	130,000	150,000	9,000	14,000	23,000	26,000
Ethiopia	35,000	11%	3,900,000	720,000	18%	460,000	1,400,000	1,800,000	410,000	2,100,000	2,600,000	190,000	270,000	460,000	470,000
Gabon	500	11%	57,000	14,000	24%	9,000	18,000	27,000	8,000	30,000	38,000	4,000	3,000	7,000	7,000
Gambia	500	9%	45,000	2,000	5%	1,000	17,000	18,000	1,000	30,000	31,000	500	4,000	4,000	5,000
Ghana	10,000	10%	1,000,000	170,000	17%	120,000	370,000	490,000	96,000	540,000	640,000	49,000	75,000	120,000	110,000
Guinea	4,000	10%	420,000	35,000	8%	24,000	180,000	200,000	22,000	250,000	280,000	14,000	45,000	59,000	46,000
Guinea-Bissau*	800	11%	81,000					36,000			56,000			11,000	10,000
Kenya	15,000	11%	1,700,000	650,000	37%	560,000	500,000	1,100,000	380,000	750,000	1,100,000	330,000	110,000	450,000	230,000
Lesotho	1,000	19%	180,000	100,000	56%	79,000	45,000	120,000	64,000	49,000	110,000	49,000	7,000	56,000	28,000
Liberia	2,000	13%	230,000	36,000	15%	27,000	92,000	120,000	24,000	130,000	160,000	17,000	25,000	42,000	28,000
Madagascar	9,000	11%	1,000,000	30,000	3%	17,000	460,000	480,000	17,000	640,000	660,000	7,000	120,000	130,000	110,000
Malawi	7,000	14%	1,000,000	500,000	48%	360,000	260,000	610,000	310,000	350,000	660,000	190,000	47,000	240,000	130,000
Mali	8,000	10%	730,000	75,000	10%	49,000	290,000	330,000	43,000	430,000	470,000	21,000	59,000	80,000	86,000
Mauritania	1,000	9%	140,000	2,000	1%	900	57,000	58,000	900	95,000	96,000	300	14,000	14,000	16,000
Mozambique	10,000	15%	1,500,000	470,000	31%	330,000	480,000	810,000	280,000	690,000	980,000	190,000	110,000	290,000	200,000
Namibia	1,000	12%	120,000	57,000	48%	41,000	30,000	71,000	33,000	40,000	73,000	19,000	5,000	24,000	21,000
Niger	6,000	11%	680,000	24,000	4%	14,000	310,000	320,000	13,000	420,000	430,000	5,000	66,000	71,000	80,000
Nigeria	69,000	10%	7,000,000	1,800,000	26%	1,200,000	2,400,000	3,600,000	1,000,000	3,300,000	4,400,000	490,000	420,000	920,000	870,000
Rwanda	5,000	17%	810,000	160,000	20%	140,000	370,000	510,000	130,000	420,000	550,000	120,000	120,000	240,000	65,000
Senegal	5,000	9%	460,000	17,000	4%	11,000	180,000	190,000	10,000	310,000	320,000	4,000	50,000	54,000	51,000
Sierra Leone*	2,000	14%	350,000					160,000			260,000			68,000	40,000
Somalia*	7,000	11%	770,000					360,000			510,000			96,000	83,000
South Africa	17,000	13%	2,200,000	1,100,000	48%	740,000	440,000	1,200,000	570,000	830,000	1,400,000	290,000	74,000	360,000	370,000
Sudan	16,000	9%	1,300,000	91,000	7%	55,000	520,000	570,000	49,000	840,000	890,000	18,000	99,000	120,000	150,000
Swaziland	600	18%	100,000	65,000	63%	48,000	21,000	69,000	42,000	24,000	66,000	29,000	3,000	32,000	17,000
Tanzania, United Republic of	14,000	14%	2,500,000	980,000	40%	710,000	650,000	1,400,000	580,000	1,000,000	1,600,000	370,000	130,000	500,000	310,000
Togo	2,000	9%	240,000	54,000	23%	37,000	74,000	110,000	32,000	130,000	160,000	18,000	17,000	34,000	31,000
Uganda	18,000	14%	2,000,000	940,000	48%	700,000	450,000	1,100,000	570,000	700,000	1,300,000	380,000	87,000	470,000	190,000
Zambia	6,000	19%	1,100,000	630,000	60%	510,000	200,000	710,000	370,000	290,000	670,000	290,000	33,000	320,000	120,000
Zimbabwe	7,000	19%	1,300,000	980,000	78%	800,000	130,000	940,000	560,000	190,000	760,000	420,000	14,000	440,000	160,000
Total	**350,000**	**12.3%**	**43,400,000**	**12,300,000**	**28%**	**8,900,000**	**14,100,000**	**23,000,000**	**7,300,000**	**20,900,000**	**28,200,000**	**4,600,000**	**3,100,000**	**7,700,000**	**5,200,000**

Note: Due to rounding, totals may not equal sum of column or row figures.
** These countries have insufficient HIV prevalence information to make an estimate of orphans due to AIDS.*

Source: UNAIDS/UNICEF/USAID, 2004.

Bibliographical references

Documents

Ainsworth, M.; Filmer, D. 2002. *Poverty, AIDS and children's schooling: A targeting dilemma*. Policy Research Working Paper 2885. Washington, DC: World Bank, Africa Region. http://www-wds.worldbank.org/external/default/WDSContentServer/IW3P/IB/2002/10/12/000094946_02100204022275/additional/124524322_20041117182553.pdf

Barnett, T; Whiteside, A. 2002. *AIDS in the twenty-first Century: Disease and globalization*. New York: Palgrave Macmillan.

Bennell, P.; Hyde, K.; Swainson, N. 2002. *The impact of the HIV/AIDS epidemic on the education sector in sub-Saharan Africa: A synthesis of the findings and recommendations of three country studies*. Brighton: Centre for International Education, University of Sussex.

Boler, T.; Carroll, K. 2003. *HIV/AIDS and education: Addressing the educational needs of orphans and vulnerable children*. UK: ActionAid International and Save the Children Fund. www.aidsconsortium.org.uk/Education/Education%20downloads/EfucationOVC%20paper%20(small).pdf

Convention on the Rights of the Child, Article 29. www.ohchr.org/english/law/crc.htm

Coombe, C. 2003. *Mitigating the impact of HIV/AIDS on education systems in Southern Africa*. Pretoria, South Africa.

Giese, S.; Meintjes, H.; Croke, R.; Chamberlain, R. 2003. *Health and social services to address the needs of OVC in the context of HIV/AIDS: research report and recommendations*. Pretoria : Children's Institute and national Department of Health.

Huber, U.S.; Gould, W.T.S. 2003. *The effect of orphanhood on primary school attendance reconsidered: The power of female-headed households in Tanzania*. Liverpool, UK. University of Liverpool.

Pharoah, R. (Ed.). 2004. *A generation at risk? HIV/AIDS, vulnerable children and security in Southern Africa*. Monograph N° 109. Pretoria: Institute for Security Studies. www.iss.org.za/Monographs/No109/Contents.htm

Smart, R. 2003. *Policies for orphans and vulnerable children: A framework for moving ahead*. Washington DC: Futures Group. www.policyproject.com/pubs/generalreport/OVC_Policies.pdf

Subbarao, K.; Mattimore, A.; Plangemann, K. 2001. *Social protection of Africa's orphans and other vulnerable children*. Washington, DC: World Bank, Africa Region. http://siteresources.worldbank.org/AFRICAEXT/Resources/African_Orphans.pdf

UNAIDS/UNICEF/USAID. 2004. *Children on the brink 2004. A joint report on orphan estimates and a framework for action*. UNAIDS/UNICEF/USAID www.unicef.org/publications/index_22212.html

UNICEF. 2003. *The state of the world's children 2004*. Geneva, Switzerland: UNICEF. www.unicef.org/sowc04/

Module

R. Smart

HIV/AIDS care, support and treatment for education staff

About the author

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Module 4.4

HIV/AIDS CARE, SUPPORT AND TREATMENT FOR EDUCATION STAFF

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Aims

The aim of this module is to enable participants to plan and implement a comprehensive care, support and treatment programme for educators and other education sector employees who are infected or affected by HIV and AIDS.

Objectives

At the end of the module, participants will be able to:

- explain the care, support and treatment needs of education sector employees who are infected or affected by HIV and AIDS;
- describe the components of an optimal programme for care, support and treatment in the workplace;
- design a context appropriate AIDS care, support and treatment workplace programme for an education sector institution;
- apply this learning to their own contexts to identify specific recommendations to strengthen their ministry's AIDS care, support and treatment workplace programme.

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.

Why is it important to have a workplace HIV and AIDS programme?

Why is it necessary to include care, support and treatment as part of a workplace HIV and AIDS programme?

What are the links between HIV prevention, and care, support and treatment?

What are the care, support and treatment needs of education sector employees who are either infected or affected by HIV and AIDS?

What, if any, are the special needs for care, support and treatment of female employees who are infected or affected?

What is the minimum package of care, support and treatment that should be provided by any workplace?

What care, support and treatment programmes can ministries of education and educational institutions (e.g. schools) realistically provide for their employees?

What are the likely implications (positive and negative) for ministries of education and educational institutions of providing care, support and treatment to infected and affected employees?

What are the options for delivering a workplace care, support and treatment programme?

What are the implications for education sectors in developing countries, and for their AIDS responses, of rapidly increasing access to antiretroviral therapy for persons infected with HIV?

Module 4.4

HIV/AIDS CARE, SUPPORT AND TREATMENT FOR EDUCATION STAFF

Introductory remarks

This module covers the care, support and treatment needs of infected and affected teachers and other education sector employees; the components of a comprehensive treatment, care and support programme; policy provisions for treatment, care and support programmes; and tools for designing a context-specific treatment, care and support programme.

A care, support and treatment programme is one part of a comprehensive sectoral or institutional response to HIV and AIDS. Other components that need to be in place and that need to complement the care, support and treatment programme are the following:

- A range of strategies that aim to manage and mitigate the impact of the epidemic on the sector or institution.
- A range of prevention interventions that aim to prevent new HIV infections among staff.
- A range of interventions for clients and beneficiaries, such as pupils.

Care refers to the steps taken to promote a person's well-being through medical, psychosocial, spiritual and other means.

Support refers to services and assistance that could be provided to help a person deal with difficult situations and challenges.

Treatment is a medical term describing the steps taken to manage an illness or injury.

The care, support and treatment component of a workplace HIV and AIDS programme is commonly referred to as a 'wellness programme'. A wellness programme can be defined as a multifaceted, multidisciplinary workplace care, support and treatment programme into which AIDS has been integrated and that aims to benefit:

- the institution by keeping HIV-infected employees healthy and fit to work for as long as possible;
- HIV-infected employees by delaying the onset of illness and AIDS, preventing opportunistic infections and providing a range of treatment, care and support services and options;
- AIDS-affected employees by providing support services and options;
- all employees by creating an enabling, caring and supportive working environment.

There are many reasons why an institution should establish and implement a wellness programme. These include the following:

- Until there is widespread availability of antiretroviral therapy (ART) and highly active antiretroviral therapy (HAART), employees living with HIV will experience evermore frequent illnesses and will become progressively incapacitated.
- AIDS is a disease with profound psychosocial implications, which, if not managed appropriately, can be as debilitating as the physical effects of the disease.
- Wellness programmes delay the need for ART. For example, with appropriate prophylaxis (measures designed to preserve health and prevent the spread of disease), episodes of illness can to a large extent be prevented, and if they do occur they can often be managed at primary healthcare level.
- Where HAART *is* available, wellness programmes can promote adherence, prevent side effects and the onset of resistance to antiretroviral drugs.
- Wellness programmes can mitigate the impact of the epidemic on the staff and on the institution as a whole.

Box 1 Supporting sick colleagues

- Educators and other staff who develop AIDS-related illnesses need understanding from their colleagues.
- Increasingly they will need days off work or become exhausted during the day and need to lie down for some time.
- During these times, other members of staff will have to cover for them, and this will have an impact on their own work and wellbeing.
- The scale of the HIV epidemic is so great in the country that, until we all practice safer sex, these things will form part of a new reality with which we have to live.
- Educators often feel overburdened already and find it hard to see how they could do more work. Such feelings are very understandable. This emergency makes exceptional demands on all South Africans. Perhaps we should remember that one day our healthy colleagues might have to cover for us, unless we protect ourselves from infection.

"The most important part of our work is to educate people to accept, love and support those with HIV, so that we do not have to hide away or be silent. The more we hide away, the more pressure we feel, the sicker we get and the faster we die." (Valencia Mofokeng, HIV-positive widowed mother and leader of the Orange Farm Anti-Aids Club's support group for people living with HIV/AIDS, in *Reconstruct*, *7 November 1999*.)

Source: Department of Education - South Africa, 2000: 15

This module on care, support and treatment for educators and other education sector employees should be studied in conjunction with Module 1.4 on *HIV/AIDS-related stigma and discrimination* and Module 5.1, *Costing the implications of HIV/AIDS in education.*

1. Positioning HIV and AIDS within a workplace wellness programme

Ideally, a workplace wellness programme should not be AIDS-specific; rather it should be broad-based, covering a range of wellness initiatives such as drug and alcohol avoidance, stress reduction, smoking cessation, counselling, and the management of chronic diseases (e.g. hypertension and diabetes). Situating AIDS-related services within such a programme can enhance acceptability by employees and reduce possible stigma that may be associated with a dedicated AIDS wellness programme.

Education sector institutions may have existing programmes that can integrate HIV and AIDS components. Examples of these are employee assistance programmes (EAP) run by qualified practitioners in education ministries in many countries. Accepting that the above scenario is the ideal, the balance of the module will concentrate on the **AIDS-specific components** that could be included in a workplace wellness programme.

Box 2 Example of an employee assistance programme

The Employee Assistance Programme in the Eastern Cape Department of Education (South Africa) fulfils the following AIDS-related functions.

- Assistance to employees, from Head Office (HO) level down to the districts, including providing counselling for those infected and affected by HIV.
- Support to establish *support groups.*
- Workshops for school managers to create awareness of the EAP services.
- Referrals to external psychologists (as there are no psychologists in the department).
- Liaison with other units to assist staff who are infected or affected.
- Visits to employees' families.
- Lunch-hour talks for HO staff held jointly with other units.

2. AIDS-related needs for care, support and treatment

A wellness programme should ideally reflect a continuum of care that covers:

- those employees who are uninfected but at risk;
- asymptomatic HIV-infected employees;
- employees with early HIV disease;
- employees with late-stage disease or AIDS;
- employees with terminal illness;
- affected employees;
- possibly dependants and family members.

Obviously the needs and demands are different at each point along the continuum. The framework below lists some of the key needs, demonstrating the links between prevention on the one hand, and care, support and treatment on the other.

Table 1 Key needs of infected and affected employees

Target group	Needs
All employees	General life skills and HIV prevention Sexually transmitted infection (STI) prevention and care Promotion of voluntary counselling and testing (VCT) Access to VCT
Infected employees	Access to HIV testing Counselling and psychosocial support Support groups and networks of people living with HIV
Infected employees – early HIV disease	Wellness management (including protecting the immune system, safer sex and harm reduction, and improved lifestyles) Prophylaxis for opportunistic infections
Infected employees – late stage HIV disease or AIDS	Treatment of opportunistic infections Effective pain relief Management of symptoms HAART Support with succession planning
Affected employees and affected families	Assistance with material needs and household tasks Spiritual and emotional support, and bereavement support Advice about wills and inheritance Preparation for death and the funeral Support for children orphaned by AIDS

3. Components of a comprehensive workplace wellness programme

A workplace wellness programme should contain the following AIDS-related components.

Nutritional advice and support

For those living with HIV, nutritional difficulties such as malnutrition, malabsorption (faulty absorption of nutrient materials from the alimentary canal), and oral, oesophageal and gastrointestinal infections are frequent, and therefore good nutritional status is critical for continued health. A wellness programme could provide:

- advice on what foods to eat and not to eat, how to use food to boost the immune system, how to fight opportunistic infections, how to prepare and store food safely, and how to maintain one's appetite;
- support for good nutritional status in the form of nutritional supplements, vitamins and trace elements.

Box 3 Extract from Kenya Education sector policy on HIV/AIDS (October 2003)

> 2.0 Access to health services
>
> 2.2 All learning institutions and workplaces shall facilitate access to information on health and when and where staff and learners should seek treatment promptly for STIs, tuberculosis and other opportunistic infections.
>
> 2.3 All learning and training institutions and workplaces shall promote the role of nutrition and food security for positive living.

Lifestyle education and harm reduction

Often referred to as positive living, this is a way of living in which people living with HIV take control of their physical, mental and spiritual health. It involves:

- diet and healthy nutrition;
- limiting unhealthy practices such as alcohol consumption and smoking;
- regular exercise, relaxation and meditation;
- avoiding stress;
- safer sex practices to prevent HIV transmission and re-infection;

- making plans for the future;
- sharing problems.

A wellness programme could provide positive living advice and support for people living with HIV.

Treatment of minor ailments

HIV disease is typically asymptomatic for many years following infection. However, at some point infected employees will develop symptoms such as diarrhoea and skin rashes. These minor ailments associated with HIV disease can usually be managed at primary healthcare level. Traditional medicines are also very effective in treating many HIV-related symptoms and conditions. A wellness programme could raise awareness of and promote early treatment for minor ailments, and then facilitate access to the relevant health services.

Treatment of sexually transmitted infections (STIs)

The existence of an untreated STI can not only facilitate transmission from an HIV-infected person to his or her partner during unprotected sex, but can also increase the risk of re-infection for an infected person who is re-exposed to HIV. This intervention should involve STI screening, treatment and education, including HIV prevention education, and contact tracing and treatment of sexual partner/s. A wellness programme could raise awareness of and promote early health-seeking behaviour for STIs.

Reproductive health services for women

This includes family planning, counselling about dual protection (against pregnancy and HIV/STIs), prevention of mother-to-child transmission (PMTCT) services, information about and referrals for pregnancy termination (in countries where this is available), and information and support for women employees returning to work after maternity leave. A wellness programme could provide information for female staff and facilitate access to these services for women.

Prevention of opportunistic infections

Taking tuberculosis (TB) preventive therapy can reduce the risk of HIV-infected persons becoming sick with TB. Prophylaxis is also possible for other opportunistic infections, such as pneumocystis carinii pneumonia. A wellness programme could raise awareness of the opportunities for prophylaxis of opportunistic infections and facilitate access to services that provide prophylaxis, and manage clients receiving prophylaxis.

Surveillance for and prevention and treatment of opportunistic infections

For people living with HIV, knowledge of the signs and symptoms of opportunistic infections is important, as is understanding the importance of seeking early treatment. TB is the most common opportunistic infection and the most frequent cause of death in people living with HIV in Africa. TB can be cured as effectively in those who are HIV-positive as in those who are HIV-negative (using the same drugs for the same amount of time).

The directly observed treatment short-course strategy (DOTS) is the ideal way to ensure that employees with TB complete their treatment. A treatment supporter can be a health worker, employer, co-worker, shopkeeper, traditional healer, teacher, or community or family member. Because of the association of TB and HIV, every TB patient should be offered HIV counselling and testing by a trained counsellor. A wellness programme could educate staff on the signs and symptoms of opportunistic infections, provide DOTS for staff with TB, and promote and facilitate access to voluntary counselling and testing (VCT) for staff with TB.

Highly active antiretroviral therapy (HAART)

HAART involves treatment with two or more antiretroviral drugs (ideally with three drugs to delay and prevent the onset of drug resistance) for people with advanced HIV disease and evidence of a compromised immune system. In addition to the other components of a wellness programme, it is important to include HAART because it:

- promotes wellness;
- delays the onset of late-stage AIDS disease;
- prevents disease progression and opportunistic infections;
- decreases infectiousness;
- greatly improves the quality of life and life expectancy;
- decreases absenteeism, hospital admissions and the cost of treatment of opportunistic infections;
- strengthens prevention through increased uptake of VCT, PMTCT and behaviour change.

There is an optimal time to start HAART – often between five and eight years after the initial infection, and then for the rest of the employee's life. Therapy is likely to extend the employee's working life by five to eight years on average. Some employees will do very well on HAART, but some may not be able to tolerate the medication as a result of side effects or drug toxicity, or may not adhere to the medication, resulting in treatment failure. A wellness programme could provide information about HAART, facilitate access for eligible staff to services providing HAART, and provide support for compliance for staff taking HAART.

Psychosocial support and support group activities

Psychosocial support is arguably as important as medical care for people living with HIV. It can take the form of one-on-one counselling or support-group activities.

Traditional healers can also play an important part in providing psychosocial support.

Support groups are groups of people who are facing similar challenges and who have decided to meet regularly to share experiences and to help each other. Support groups require:

- privacy, so that members feel confident to share and disclose often intensely personal matters;
- a time to meet that suits the schedules of the members;
- a skilled facilitator;
- carefully considered membership criteria and methods of operating.

Post-test clubs are sometimes established by groups of people who have undergone an HIV test. They function to provide support for their members, as well as to provide HIV- and AIDS-related information. A wellness programme could provide on-going counselling for infected and affected staff and could facilitate the establishment of support groups.

Family support

The objective of family support is to render holistic support to affected families, in particular for future and succession planning. Some of the issues that need to be provided for are the following:

- How property or money will be managed in the event that the employee becomes disabled, who will inherit, and whether a power of attorney should be prepared.
- Decisions about employee benefits and personal insurance.
- Planning for future medical care.
- The drafting of a will.
- Deciding about a living will.
- Deciding about who will have custody of the children and who will be their legal guardian.

Box 4 Extract from Uganda Ministry of Education and Sports; HIV/AIDS strategic plan (April 2001)

Objective 7: To promote/build partnerships with NGOs/CBOs and other stakeholders for effective implementation of AIDS education, counselling/testing and health services in education institutions.

1. Initiate and foster partnerships with other stakeholders for effective implementation of AIDS education, counselling and care in educational institutions.
2. Establish a consortium composed of representatives from key organisations involved in AIDS education, counselling and care in the

education sector.

3. Convene meetings and identify areas of collaboration and organisations with the capacity to implement such activities.
4. Develop an agreement for collaboration and partnerships with these organisations.

A wellness programme could provide advice and support to infected and affected staff in their future planning.

Box 5 Succession planning in Uganda: early outreach for AIDS-affected children and their families

The components of a succession planning programme should include:

- counselling for HIV-positive parents on sero-status disclosure to their children;
- creation of 'memory books';
- support in appointing standby guardians;
- training for standby guardians.
- legal literacy and will-writing;
- assistance with school fees and supplies;
- income-generation training and seed money;
- community sensitization on the needs and rights of AIDS-affected children.

A wellness programme requires partnerships with services and agencies, such as clinics, social welfare agencies and other government departments, for any services and support that can not be provided at the workplace. It also requires the establishment of referral networks to these services and agencies.

Home-based care is one of the options for caring for employees with late-stage HIV disease, and many institutions are entering into partnerships with NGOs providing home-based care services.

A wellness programme could investigate the services provided by other institutions that staff may require; it could then enter into partnership with those organizations able to provide the necessary services, and could establish effective referral mechanisms to facilitate access by staff to these services.

The World Health Organization (WHO) depicts a generic HIV and AIDS continuum of care in the diagram below, indicating the multiple referrals and partnerships that need to be established for effective care, support and treatment.

Figure 1 The HIV and AIDS continuum of care

The HIV/AIDS Continuum of Care

Primary Health Care
-Health posts
-Dispensaries
-Traditional
-Orphan care

Secondary Health Care
District Hospitals
HIV Clinics
Social/legal Support
Hospice

Community Care
NGOs
Churches
Youth Groups
Volunteers

Voluntary Counselling Testing

The entry point

PLWHA

Specialists and Specialised Care facilities

Tertiary Health Care

Peer support

Palliative emotional and spiritual support self care

Home care

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HIV/AIDS and Sexually Transmitted Diseases/WHO

Source: UNAIDS; WHO, 2002.

Activity 1

Wellness programme audit and planning tool

Look at the elements in the wellness programme checklist below and decide one by one whether they are present in your work environment. Mark with a tick (✓) those that are present and with a cross (x) those that are absent. Then decide which components are priorities for improving your education sector's or institution's wellness programme. These may be components that are currently absent as well as those that are present but that should be improved or strengthened. Ensure that the checklist is used when developing your education sector's or institution's HIV and AIDS plan or when making recommendations to management regarding your sector's or institution's HIV and AIDS programme.

Wellness programme checklist

PRESENT OR ABSENT	PROVISION FOR A COMPREHENSIVE WELLNESS PROGRAMME WITHIN THE HIV/AIDS POLICY	PRIORITY AREAS FOR IMPROVEMENT
	Provision for a comprehensive wellness programme within the HIV and AIDS policy	
	Wellness programme popularised and promoted to staff	
	People living with HIV involved in planning and promoting the wellness programme	
	Regular education, for all staff, on healthy living and harm reduction	
	Vitamin, mineral and other nutrient supplements provided or access facilitated for infected staff	
	Access facilitated to comprehensive STI treatment	
	Prophylaxis provided or access facilitated to prevent common opportunistic infections	
	Treatment provided or access facilitated for minor ailments	
	Pregnant staff have access to HIV testing and to PMTCT programmes	
	Surveillance for TB encouraged and treatment for staff with TB provided or access facilitated	
	Regular VCT promotion campaigns, with management taking HIV tests publicly	
	TB and STI clients encouraged to have HIV tests, with pre- and post-test counselling	
	Access to VCT easy (times and location) and services acceptable to staff	
	HAART available on a cost-sharing basis for infected staff meeting treatment criteria	
	EAP at all institutions, providing on-going counselling services	
	EAP practitioners trained in HIV and AIDS or programme has access to services of AIDS counsellors	
	Mechanisms in place to ensure confidentiality for staff using EAP services	
	Structured support programme in place for counsellors	
	Support group/s established and meeting regularly	
	Counselling extended to families and dependants of infected staff members	
	Counselling extended to families and dependants of infected staff members	
	Legal assistance available for succession planning and family support	
	Support and counselling provided/facilitated for dependants, including orphaned children	
	Partnerships and referral processes established with relevant NGOs and service providers	
	Staff with terminal HIV disease access home-based or hospice care	
	Reasonable accommodation available for staff unable to fulfil normal duties	
	Budget for wellness programme available, as part of workplace HIV and AIDS programme budget	
	M&E of workplace HIV and AIDS programme includes wellness programme indicators	
	Monitoring of wellness programme includes feedback from beneficiaries (e.g. people living with HIV)	

Activity 2

Checklists for wellness programmes

Choose one of the checklists below, each of which relates to a different aspect of a wellness programme, and add/amend it so that it can apply to your context.

Checklist One: Establishing an effective counselling service

- Convince decision-makers of the need for and value of a counselling service.
- Consider the pros and cons of establishing an on-site service versus outsourcing the service or referrals to community services (which are often perceived as more accessible and acceptable options).
- Integrate HIV counselling into broader counselling services.
- Select counsellor trainees who have warm and caring personalities, are good listeners, are respected by others, and are motivated and resilient.
- Train them and follow up the training with supervised practice and ongoing in-service training.
- Provide regular and structured psychological support to the counsellors to maintain quality of counselling and prevent burn-out.
- Be sensitive to the location and time of the service provision, in terms of accessibility and ensuring that they do not become stigmatized.
- Have adequate supplies of information materials and condoms.
- Run campaigns to promote the services.
- Provide counsellors with adequate referral services – to other counsellors, and for HIV testing, for treatment, antenatal care, family planning, social support and orphan care.
- Set up clear counselling standards and protocols, including mechanisms to ensure confidentiality.

Checklist Two: Basic requirements for a PMTCT programme

- Family planning/reproductive health and contraceptive service.
- Antenatal, delivery and postpartum care services that are adequate and accessible, and a functioning referral system in case of complications.
- Information campaigns and community-based efforts to increase acceptance of PMTCT programmes.
- Adequate VCT services, including reliable tests and trained AIDS counsellors, for all female employees who are pregnant or thinking of becoming pregnant and their male partners.
- Adequate supplies of male and female condoms.
- An affordable, feasible antiretroviral treatment regimen to prevent mother-to-child transmission of HIV.
- Counselling about breast-feeding, including information on alternative infant options.
- Follow-up of all women, children and their families to help them deal with issues such as nutrition.
- Referral to other HIV prevention, treatment and care programmes.

Checklist Three: Involvement of people living with HIV in a wellness programme

- Senior management collaborates regularly and publicly with people living with HIV in creating AIDS-related wellness programmes.
- Support groups are established and run by appropriately skilled and supported people living with HIV.
- People living with HIV and who are successfully on HAART educate others considering treatment.
- Newly-diagnosed HIV-infected employees are given counselling by other people living with HIV (who have had similar experiences).
- People living with HIV provide first-hand experience of what makes (or doesn't make) a service client-friendly.
- Experienced people living with HIV are involved in selecting clients for treatment, alongside physicians and other community members, ensuring equity in selection when resources are limited.
- Selected people living with HIV are trained to assist in the education of clinical and support staff, to ensure that training is grounded in real-life experiences, and to equip staff to offer appropriate treatment and support.
- The visibility of people living with HIV and using treatment successfully acts as a powerful tool for combating stigma, encouraging people to come forward for HIV testing, counselling and treatment.
- Training is conducted for people living with HIV on personal empowerment, communication and presentation skills, HIV and AIDS facts, the legal aspects of HIV and AIDS, and skills for organizing and conducting policy dialogue to enable them to more effectively contribute to the wellness programme.

4. The role of education sectors and institutions in providing care, support and treatment for infected staff

Education sectors and institutions are not in the business of providing health services, however the AIDS epidemic challenges us to redefine traditional functions and develop creative approaches to ensure that comprehensive programmes are implemented – both inside and outside of the workplace. For example, ministries of education have the potential to modify the work circumstances of infected staff to enable them to continue working, to access health and social services, to deal with health challenges such as starting on HAART, and so on.

In the workplace, wellness programmes can be delivered in one or a combination of the following ways:

- In-house programmes and on-site services
- Third-party health insurance plans (e.g. medical aid)
- Contracts with a stand-alone AIDS management programme
- Referrals to public, private and NGO health facilities and social services

Box 6 Supporting sick learners

- Learners and students are expected to attend classes in accordance with legal requirements for as long as they are able to function effectively and pose no medically significant risk to others in the school or institution.
- Every school with sufficient facilities should have an area where learners and educators who are feeling unwell can lie down during the day for short periods. This will enable learners who are sick to stay in school for longer.
- If and when they become ill or pose a medically significant risk to others, they should be allowed to study at home and academic work should be made available for this. Where possible, parents should be allowed to educate them at home.
- Some learners with HIV/AIDS may develop behavioural problems or suffer neurological damage. Such learners should be assessed and, where possible and appropriate, placed in specialized residential institutions for learners with special education needs.
- Some extra-curricular activities can be very stressful for learners with HIV. Educators need to be sensitive to this and excuse such learners from participation when necessary.
- Medicines often have to be taken at set times in order to be properly effective. Educators need to be aware of this and allow learners with HIV to slip out of class to take medication when necessary.
- Schools should help learners with HIV to form a support group or to link with one in the community.

Source: Department for Education - South Africa, 2000: 14-15.

Activity 3

Testing the feasibility of workplace wellness programme components for the education sector

1. Discuss each of the ten components of a wellness programme (see below), listing what your sector or institution (i) is already doing; (ii) can do immediately with little or no resources (financial, human or material); (iii) can do, but only with the injection of resources and/or training; (iv) cannot do because this is beyond the scope of the sector's or institution's competency or mandate.

- Nutritional advice and support
- Lifestyle education and harm reduction
- Treatment of minor ailments
- Treatment of STIs
- Reproductive health services for women
- Surveillance for and prevention and treatment of opportunistic infections
- HAART
- Psychosocial support and support group activities
- Family support
- Referral networks and partnerships

2. Review the final list of activities that are beyond the sector's or institution's scope and mark those that would be possible in partnership with one or more partners (such as an NGO, a health service provider or other ministries or institutions). Make a list of these potential partners and identify what they can bring – in terms of the wellness programme – to the partnership.

3. Now, looking at the lists that have been generated, agree on what should constitute a 'minimum package' for a workplace wellness programme that can realistically and feasibly be provided in your particular context.

4. Create a set of recommendations to management to approve not only a 'minimum package' but also those additional activities that are deemed to be priorities, specifying what the necessary resource inputs may be to achieve them and where partnerships are required to support these activities.

Summary remarks

The care, support and treatment needs of staff who are infected or affected by HIV and AIDS are numerous and variable. A workplace care, support and treatment programme has significant benefits, not only for infected and affected employees, but also for the sector or institution. A workplace care, support and treatment programme, often referred to as a 'wellness programme', should be an integral part of a comprehensive sector or institutional response to AIDS, and the AIDS-related components should, as far as possible, be integrated into broader wellness initiatives.

A wellness programme is thus a multifaceted and multidisciplinary intervention that includes AIDS-related components such as:

- nutritional advice and support;
- lifestyle education and harm reduction;
- treatment of minor ailments;
- treatment of STIs;
- reproductive health services for women;
- surveillance for and prevention and treatment of opportunistic infections;
- HAART;
- psychosocial support and support group activities;
- family support;
- referral networks and partnerships.

Education ministries and institutions, though they may not be able to provide some of the health-related services, can still plan, implement and monitor a number of important aspects of a wellness programme.

Lessons learned

Lesson One

It is not enough to have a strong workplace HIV prevention programme for employees. Instead, such a programme should be at one end of a continuum of prevention and care, support and treatment.

Lesson Two

Education ministries and institutions must be prepared to 'think out of the box' when designing their wellness programmes – there are many activities and interventions that can be implemented effectively either at sector or institutional level.

Lesson Three

Having a non-stigmatized, acceptable and accessible wellness programme for infected staff can be a powerful incentive for staff to learn their HIV status, and, if positive, to be able to benefit from the programme.

Lesson Four

Promoting and providing holistic wellness programmes for infected employees can enhance their quality of life and extend their productive working lives. The benefits for affected employees will be significant too in terms of productivity and morale.

Lesson Five

Institutions should start with a 'minimum wellness package' and build on this over time. They should also work in partnership with other organizations to facilitate access to services that infected and affected employees may need.

Answers to activities

Activities 1 and 2

There are no right or wrong answers to Activities 1 and 2, and the responses will depend on individual country contexts. You may, however, want to share your answers with a senior colleague or your mentor.

Activity 3

A minimum package at ministry level may consist of:

- lifestyle education and harm reduction (targeted at all staff);
- established referral networks and partnerships for nutritional advice and support, treatment of minor ailments, treatment of STIs, reproductive health services for women, surveillance for and prevention and treatment of opportunistic infections and family support;
- benefits to cover HAART, or a cost-sharing arrangement;
- psychosocial support from a trained counsellor – possibly within a broad-based employee assistance programme;
- on-site or community-based support group activities.

Bibliographical references and additional resource materials

Documents

Department of Education. 2000. *The HIV/AIDS emergency*. South Africa's Department of Education Guidelines for Educators. Pretoria: Department of Education.

Evian, C. 2002. *Primary AIDS care for primary health care personnel providing clinical and supportive care of people with HIV/AIDS*. Houghton: Jacana Education.

Smart, R. 2004. *HIV/AIDS guide for the mining sector: A resource for developing stakeholder competency and compliance in mining communities in Southern Africa*. Ontario: Golder Associates. www.ifc.org/ifcext/enviro.nsf/AttachmentsByTitle/ref_HIVAIDS_section1/$FILE/Section+1b.pdf

Horizons. 2003. *Research summary; succession planning in Uganda: Early outreach for AIDS-affected children and their families*. Washington, DC: Population Council. www.popcouncil.org/Horizons/ressum/orphans/orphanssum_methods.html

ILO. 2002. *Implementing the code of practice on HIV/AIDS and the world of work* (Module 7).

Network of African people living with HIV/AIDS. (undated). *A healthy diet for better nutrition for people living with HIV/AIDS*. Nairobi, Kenya: Network of African people living with HIV/AIDS.

Orr, N.M. (Undated). *Positive health*. Metropolitan.

Southern Life. (Undated). *Future positive – financial planning with HIV/AIDS*.

The Canadian AIDS Treatment Information Exchange. 1999. *Managing your health*. Available on: www.catie.org

UNAIDS; WHO. 2000. *Fact sheets on HIV/AIDS for nurses and midwives*. Geneva: UNAIDS: WHO. http://data.unaids.org/Publications/External-Documents/who_factsheets_nurses-midwives_en.pdf

UNAIDS; WHO. 2002. *Report on the Global AIDS Epidemic*. Geneva: UNAIDS: WHO. www.unaids.org/en/HIV_data/2006GlobalReport/default.asp

Module 4.5

S. Johnson

School level response to HIV/AIDS

About the author

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Module 4.5

SCHOOL LEVEL RESPONSE TO HIV/AIDS

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Aims

The aims of this module are to guide school heads and school management teams in primary and secondary schools. It is aimed at this target audience because the module deals with a school level response. Obviously each school requires assistance in various ways from districts and regions. However, the module takes as its starting point the school and those who work in it. It may also be a useful resource for planners and managers working at district or regional levels, but does not address their role in detail here.

Objectives

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

- understand the ways in which HIV and AIDS can affect the school community;
- know the areas where a response is needed at school level:
  - HIV prevention among learners and teachers;
  - protecting or maintaining the quality of education in the face of the epidemic;
  - care and support for vulnerable learners and learners infected with HIV;
  - care and support for teachers infected with HIV or affected by AIDS;
  - managing and leading the response at a school level;
- generate ideas about how to develop a holistic response to HIV and AIDS at a school level in different contexts.

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 bad is HIV in the community in which you work? How do you know this?

What are the three major challenges facing schools in your community? (You may want to make a longer list, and then prioritize).

Which of these problems do you think is made worse by HIV? Why?

Module 4.5

SCHOOL LEVEL RESPONSE TO HIV/AIDS

Introductory remarks

Since the late 1970s, the Human Immuno Deficiency virus that causes AIDS has spread quickly across the world. Despite efforts to contain it, HIV has become an epidemic. Throughout this time people have lived with HIV. Parents with HIV have sent their children to school. Teachers with HIV have been teaching, and learners with HIV have been trying to learn. Now it is time to step back and ask ourselves the following questions:

- How do HIV and AIDS affect the education sector in general?
- How do HIV and AIDS affect schools specifically?

It is important to be aware that the HIV epidemic is very different in different countries. Much of this module assumes a generalized HIV epidemic, similar to that found in most Southern African countries. In this setting the impact of HIV on the education sector is profound. However, in countries with more concentrated HIV epidemics, the impact of HIV on the education system may be less severe and not all the approaches taken in this module are relevant. It is important to carefully consider your own context, and apply those parts of this module that seem most appropriate to your setting.

The effect on the education sector

The HIV epidemic is a slow process. It slowly destroys families and school systems, and changes the way schools work. At first only a few learners in a school have no parents or struggle to pay their fees. Only a few teachers are often ill. Over time, however, more and more people become ill. Their problems add up to a considerable drain on the education system.

The effect on schools

Many schools already experience great problems. Schools can no longer depend on healthy learners, stable families and sufficient teachers to build a strong economy. Learners may be affected by the epidemic in the following ways: children may be orphaned, their families may not be able to pay school fees, they may not have

uniforms, they may be hungry and they may not be accepted by the school and the community.

Teachers themselves are also affected by the epidemic. They may die or they may be unable to work hard because of stress and chronic illness. They may also be overstretched because their colleagues may be sick or dying. The education system is already struggling to provide enough teachers, managers and other staff to replace those who are ill or deceased.

1. The role of schools as part of a national response to HIV and AIDS

In this section you will:

- learn how to do a risk assessment for a school;
- answer questions that help to check the capacity of a school to prevent the spread of HIV.

Schools have an important role to play as part of a national response to the HIV/AIDS epidemic. The first thing that schools need to do is to find out how HIV and AIDS are affecting their school. This can be done by doing an HIV and AIDS risk assessment of the school and the wider community.

A risk assessment is helpful for two reasons:

1. It can help you to understand clearly how the epidemic can affect your school and the wider community.
2. It can help you to think about the positive actions your school can take to address the effects of HIV and AIDS.

Activity 1

The following questions in the checklist below can help a school look at its own situation and decide how great the risk is. When answering the questions, try not to just give your opinion. Take time to think and talk to others before you decide on your answers.

Risk assessment

Check the risk to the school	YES	NO	NOT SURE
Has the number of orphans increased in the community?			
Does being an orphan affect their attendance at school?			
Does the number of orphans affect payment of fees and contribution to the parent teacher association?			
Is there a drop in the number of children enrolling for school?			
How many learners have dropped out?	Number of dropouts:		
Is the pressure to earn money keeping learners out of school?			
Are there more girls dropping out of school than boys?			
Do older learners in a class increase the threat of HIV infection?			
Are teachers regularly out of school attending funerals?			
Is teacher absenteeism increasing?			
Is the quality of education in classrooms suffering?			
Are teachers being trained to deal with HIV and AIDS-related issues in the classroom?			
Are teachers willing to take responsibility for identifying learners at risk?			
Are there unsafe places in your school?			
Check the risk to the community			
Is sexual violence and abuse a problem in the community?			
Do community members talk openly about HIV and AIDS?			
Are HIV and AIDS awareness programmes working well?			
Are family incomes decreasing because of unemployment, the high cost of medical care and funerals?			
Are children who lose their parents looked after by their families?			
Do they have to fend for themselves?			
Do foster families care for these children as they would care for their own children?			
Is the local community able to care for children at risk?			
What support grants or methods are available in your community for children at risk and their foster families?			

Once a school has done a risk assessment it should have a clearer picture of the difficulties that it faces. It may be helpful to think about difficulties in a different way and to turn these into key challenges.

Activity 2

Use the information from the risk assessment to define the key challenges that the school faces.

For example, a key challenge may be to provide training for teachers in HIV and AIDS so they that can respond to questions from learners.

The key challenges are:

Five critical priorities

An important way for a school to respond to HIV and AIDS is to work out an action plan. AIDS policy and action plan will be discussed in more detail in Section 4. However it is important to think of critical priorities as preparation for developing a policy and action plan.

There are five critical priorities that schools must take into account when they work out an action plan.

1. Prevent the spread of HIV.
2. Work together to continue to protect the quality of education.
3. Provide care and support for learners affected by HIV and AIDS.
4. Provide care and support for teachers affected by HIV and AIDS.
5. Manage and lead a response at school level.

2. Integrating education on HIV and AIDS in the regular curriculum

In this section you will:

- understand that schools can play an important role in preventing the spread of HIV;
- become aware of the factors that increase the risk of infection in schools ;
- read about practical ways to prevent HIV infection in schools;

All schools face the immediate challenge of preventing HIV from spreading, especially among young people. Most infections happen in young people, especially women, either in school or soon after they leave. There are many ways to try to make young people aware of HIV through TV, radio and billboards.

Many young people have heard messages of abstinence, staying faithful to a partner and using condoms from non-governmental and other organizations that try to make them aware of safe sex practices. However, schools need to make prevention of HIV a priority.

Risk factors for HIV infection

Activity 3

Here are some questions you can think about to find out what factors increase the risk of HIV infection in a school or in community.

Are there any other factors that put people at risk?

How can the following factors increase the risk of HIV infection in a school or community?

-silence about HIV or AIDS;

-judging people who are infected;

-alcohol and drug abuse;

-young people having sex with older men or women for money or gifts;

-learners having sex with each other; with teachers;

-sexual harassment and sexual bullying;

-beliefs that men have more rights than women.

Are there any other factors that put people at risk?

Activity 4

Zanele's story

Read the following case study.

Zanele had to leave school in Grade 9 because she was pregnant. Her mother died two years ago and she lives with her aunt who is unemployed. She looks after her four-year-old boy. She is HIV-positive and has started to get sick quite often. She gets very depressed and sometimes goes out drinking. She has often thought of killing herself but then she remembers her child.

Zanele used to be one of the top learners at the school she attended. Then she met an older man, a friend of her uncle's. He started offering to take her out in his car and bought her gifts. At first they were small gifts, but soon they got more expensive.

Zanele enjoyed the attention and soon got used to getting nice clothes and money from him. When he wanted to have sex with her, she agreed. Sex became a regular thing and often happened after they had been out shopping. A few months later she fell pregnant.

She was scared to tell him because she didn't know how he would react. Eventually she told him and he got angry and accused her of sleeping with the young men who stood outside the school gates after school. Zanele didn't know what to do. She kept her pregnancy a secret and only told her aunt when it was obvious that she was pregnant. Her aunt said that she and the baby could still stay with her.

During Zanele's pregnancy, she found out that she was HIV-positive. She has been living with HIV for the last four years and has recently started to get sick.

The father of her child has never spoken to Zanele again and has never helped her in any way to support the child. Sometimes she sees him with other young girls from the school she used to go to. She wonders whether they realize that they could end up like her. What factors increased the risk of HIV infection for Zanele?

Find ways to prevent HIV infection

There are a number of practical ways to prevent HIV infection among learners and teachers, for example:

Provide correct information

Teachers and other staff need to be given correct, basic knowledge. Teacher training institutions need to include information (in-service and pre-service programmes) about HIV and AIDS. Staff members need to understand how HIV and AIDS will affect their lives and their families. This information should encourage them to act responsibly and protect themselves from becoming infected or infecting others. Young people, especially adolescents, are especially at risk of being infected with HIV as they are often given wrong information about sex and HIV from their classmates. This is why it is important to provide people with accurate information.

Develop skills that will help learners and staff to act positively:

- Skills for decision-making, negotiation and condom use;
- Skills to access appropriate services for the treatment of sexually transmitted infections (STIs) and other infections, and for counseling;
- Skills for positive living;
- Skills to promote gender equality.

Encourage HIV testing and safer sex practices

One way to prevent the spread of HIV is to make it easy for people to get tested. It is important to encourage those who have been tested and who know their HIV status to act responsibly. Teachers and other staff need up-to-date information about how to access services for a variety of sexual health issues. Young people in particular need access to clinics that are youth-friendly so that they can get help quickly and non-judgemental advice about issues such as STIs and contraception. These clinics should also help them to get free condoms and make them feel more comfortable about using them.

Set up peer education

Many young people find it hard to resist sexual pressure. They look for approval from adults and their peers. Sometimes they will do almost anything to get approval, including having unprotected sex. The problem is that unsafe sexual behaviour usually happens outside the school premises. For this reason, trained peer educators are more suitable to talk to young people about issues like this.

There are a few ways to make sure that a peer educator programme is successful. These include the following:

- Be clear about the objectives of your programme. Include young people in the planning stage.
- Take time to appoint the right person to coordinate the programme. They should be trusted by young people in the school.
- Select young people who are highly motivated to be part of the programme. Let the learners at the school be involved in deciding who would make good peer educators.
- Provide sufficient training for the peer educators, as well as ongoing support.
- Link the peer educators with other services, for example local clinics and counselling services.
- Monitor the activities of the peer educators on an ingoing basis.

Speak out against sex between young girls and older men in your community

Many young girls are at risk because of their social or economic position. They may be tempted to have sex with older men, including teachers, in exchange for gifts. Unsafe sexual behaviour like this must be discouraged. In this way, schools can help to change behaviour and keep young people safe.

Ensure that life skills training is effective

Schools should make sure that a life skills programme is in place that helps learners to resist pressure, understand healthy and positive sexual relationships and build self-worth. A programme like this should include correct information about hygiene, good nutrition, how the body works and sexual health. It should teach young people about sex, encourage boys and girls to respect and protect their bodies and to build healthy relationships. Schools should involve parents and members of the community in their life-skills programmes so that everyone understands and supports the messages of these programmes.

Make schools safer places

Schools need to make sure that the physical space is safe for learners. They need to make sure that there are no unsupervised areas where drug abuse, bullying, sexual harassment or even rape can take place. It is also important that schools take some responsibility for the safety of the learners on their way to and from school, as well as in the school.

Work in partnership with others

Young people are at greatest risk outside school. Changing behaviour is not easy. Schools need the support of the community. This means that schools need to become

part of a network to help protect learners and teachers. This involves finding out which traditional authorities, parents, non-governmental organizations (NGOs), community-based organizations (CBOs), faith-based organizations (FBOs) and other government departments work in the area. It may be possible to form relationships and to work with them. Schools also need to work with youth organizations, community structures and religious organizations to prevent the spread of HIV.

Check school capacity to prevent HIV infection

Activity 5

A school can check its capacity to prevent the spread of HIV by answering YES or NO to the following questions.

	YES	NO
Does the school have a functioning life-skills programme?		
Does the school take action against bullying, harassment and inappropriate sexual relationships?		
Are boys and men encouraged to be caring and respectful?		
Does your school recognize the role that young people can play in preventing the spread of HIV?		
Has your school done anything to make young people partners in prevention?		
Does a school have a code of conduct and is it observed?		
Do students ever speak of 'sexually transmitted grades'?		
Have you encouraged members of the surrounding community to become partners in prevention?		

The following questions require more detailed responses:

- What has been done to improve the skills of teachers who teach life skills?

- What materials do they need for self-study, distance education, peer group learning and in-service education and training (INSET) in school?

- What is done in the school to prevent such practices as sexually transmitted grades?

3. How schools can protect the quality of education

In this section you will:

- find out what it means to protect the quality of education;
- use a checklist to find out whether the quality of education in a school is threatened;
- think of ways in which schools can protect the quality of education.

HIV and AIDS affect the personal lives of both learners and teachers. When learners and teachers experience hardship in their lives, this disrupts the learning process in every school. This is why it is important to protect the learning process and to plan for quality education.

The HIV epidemic affects the quality of education in the following ways:

- When teachers become ill, learning is affected.
- Learners are left without consistent teaching and colleagues often have to take double classes.
- Teachers who are carrying a double load experience higher stress levels and can feel demotivated.
- Learners and the school as a whole can feel demotivated.
- Learners do not get the attention that they deserve.

Normally the everyday routines and the education process help children to grow. When these are affected, schools can stop functioning effectively. Then educational quality can suffer.

The curriculum alone cannot provide quality education, but it can help to improve the quality of life of the learner. The school environment alone cannot provide quality education, but it helps to keep children healthy and safe. Regular attendance alone cannot ensure quality education, but it can help learners to succeed.

Schools need to think of ways to protect the quality of education. For example they need to ask the following questions:

- How do you replace human resources that are lost?
- How can schools fund assistance at short notice when teachers are sick or absent?
- What are the training needs of replacement teachers and staff who come in to help?
- How do these issues affect the development planning of your school?
- How do schools ensure education for orphans and children at risk?
- How do the lives of learners improve because they have attended classes?

- In what ways are children better off because they have spent a morning at school?

Asses the threat to quality education

It is not always easy to see a direct link between HIV and the problems at school. It may be more helpful to take a general look at how widespread illness and death affect the quality of education.

Activity 6

Check whether the quality of education is threatened in your context. Here is a list of the most common problems a school might face. Read through them and give each problem a score (tick the box): 5 for a big problem; 4 for a growing problem; 3 if you have this problem but are coping with it; 2 if this problem only affects a small part of the school; 1 if this is not a problem for you.

Teachers	1	2	3	4	5
Many teachers are off sick at the same time.					
There is no quick replacement for teachers who are off sick.					
Some teachers who are too sick to teach cannot be replaced until they have passed away.					
It is difficult to find educated members of the community who can replace absent teachers.					
Many teachers are unmotivated and tired, or are absent because of involvement in other activities.					
Many teachers are struggling with illness and death in their families.					
Some teachers cannot cope with the workload.					
Some teachers do not adhere to a code of conduct and ethics.					
Learners					
There is a problem with learner absenteeism.					
A growing number of learners are demotivated and tired.					
A growing number of learners have emotional problems.					
A growing number of learners experience illness and death in their families.					

A growing number of learners have learning difficulties.					
A growing number of learners cannot cope with the workload and fall behind.					
Finance and facilities					
Classes are overcrowded.					
Books and learning materials are lost because classrooms are not well organized.					
It is a struggle to collect school fees and contributions to the parent-teacher association.					
There are no resources for replacing absent teachers.					
The maintenance of the school grounds is poor.					
There is no clean water.					
Toilet facilities are poor.					
There are no special toilet facilities for girls.					

Look back at your list and answer these questions:

What are the biggest problems affecting the quality of education in your context?

What support do schools need from the district office to maintain the quality of education?

What support do schools need from the wider community?

In the end, whose responsibility is it to provide quality education in the face of HIV?

Find ways to protect quality

There are a number of ways in which schools can protect the quality of education despite the difficulties that they face.

Activity 7

Look at the following ways that schools around the world have tried to maintain quality education. Put a tick next to those that would be realistic in your context. Add any other ways you can think of to protect the quality of education.

1. Using volunteers from the community as teaching assistants to help teachers to manage large classes	
2. Providing at least one meal a day at school	
3. Keeping half-day school hours to allow older learners to go to work	
4. Arranging apprenticeships with local businesses to support learners who cannot afford school fees or uniforms	
5. Structuring the curriculum around flexible timetables. This allows teachers to do their work in shifts.	
6. Investing in self-study materials that allow older learners to study in study groups or with class assistants.	

Other ways:

Make sure the right structures are in place to protect quality

It is important to have the right structures in place in a school that can help to protect education quality. Two examples of such structures are a school management team and school governing body. Other structures will be discussed in Section 4.

1. The school management team (SMT) is made up of the school head and other senior teachers who deal with management issues on a day-to-day basis. For example a SMT can decide what to do if a child is hungry or distressed at school because of problems caused at home by HIV and AIDS.

2. The school governing body (SGB) or parent-teacher association (PTA) is an elected body of parents and teachers. The SGB/PTA can make decisions on issues such as expenditure, fundraising, hiring of teachers and creating additional teaching posts (outside of South Africa these last two may not be in the competence of such bodies). For example, SGBs can be involved in developing an HIV and AIDS policy and action plan.

These structures may be similar in schools in other contexts or they may be slightly different and called by different names such as 'support groups'.

Find ways to deal with absenteeism

Teachers try to help when their colleagues are frequently absent. They do not always cope with the extra work and the children miss out on teaching time. Schools need to find ways to deal with absenteeism in the short, medium and long terms.

Activity 8

Look at the following short-, medium- and long-term responses to absenteeism. Which of these responses are appropriate, sustainable and cost-effective in your context? Tick the correct box(es).

Short-term response	Appropriate	Sustainable	Cost-effective
Teachers combine classes to cover for those who are ill.			
SMTs and teachers discuss stresses related to absenteeism and look for immediate ways to support each other.			
SGB members arrange visits to those who are ill.			
Contact NGOs, CBOs, FBOs for more ideas for coping with absenteeism			
Contact the district and the ministry to find out what support they can offer.			

Medium-term response	Appropriate	Sustainable	Cost-effective
School head works with other schools in the area and creates a local list of retired teachers and volunteers who can help at short notice.			
Schools form a cluster group and together set a fixed rate to pay replacements for their help.			
SGBs budget for paying short-term replacements.			
District officials work together with school heads and unions to set up clear guidelines for managing short and long absences of teachers.			
School heads link up with learning support services to get ongoing support for teachers who are affected by HIV.			

Long-term response	Appropriate	Sustainable	Cost-effective
Districts create posts for class assistants.			
Look at how assistants can play a greater role in the classroom.			

4. How schools can provide care and support for learners

In this section you will:

- understand more about how the lives of children are affected by HIV and AIDS;
- learn about important steps to take to support vulnerable children and infected learners;
- know how to do a school survey to identify vulnerable children;
- plan to make a home visit to collect more information;
- decide how to prioritize which children need help most;
- prioritize actions to keep vulnerable children in school.

The lives of many children are disrupted by HIV and AIDS. Some learners may be infected with HIV. However, a much larger number will be affected by HIV and AIDS in many different ways. For instance, children more and more have to deal with family members who are ill or who die. These children are increasingly affected by the epidemic and face a number of difficulties. They may be dealing with the emotional trauma of watching their parents, relatives or caregivers get sick and die. They may get depressed or suffer from anxiety. They may also worry about whether they too are infected. They may fear death and worry about the future should a parent or guardian die. We refer to these children as vulnerable children.

Vulnerable children may also suffer materially. They may not get proper food, clothing and toiletries. Orphaned children often have to work to support their brothers and sisters. It is more likely that girls will be taken out of school or will drop out to care for sick parents or siblings and perform domestic chores.

These children find it difficult to attend school regularly if they have to look after the home and care for younger siblings. They often do not have the money to pay school fees or buy school uniforms. Not only do these children experience great hardship, they may also be blamed because someone close to them has been sick or has died of AIDS.

Steps to support vulnerable and infected learners

There are some important steps you can take to support vulnerable children and infected learners.

Step 1. Identify children in need by doing a school survey

There are many children that need care and support. To understand what problems they experience, you need to collect information about these children in a careful and confidential way. One way to do this is through a school survey.

A teacher is probably the best person to do this survey. For example, they could ask learners in their class who may be experiencing any problems to come and talk to them privately. Once these survey sheets are completed, teachers should pass them on to their school management team or another structure that is responsible for deciding what to do.

It is important to bear in mind that when vulnerable children are identified, they should not be singled out. This may result in stigmatization. Investigating a learner's background should be handled sensitively and in a way that will not cause them more problems than they already have. Teachers should be sensitized to this issue.

Activity 9

Look at the example of a school survey form below. Adapt or change this form to suit the context that you work in. You may want to take some things out or add other things instead.

Example of a survey form

Grade 1	Problems faced by learners								
Names	Has lost a parent	Lives with relatives	Poverty, unemployed	Suspected abuse/ emotional neglect	Chronically ill	Often absent	Other problems and comments	Possible action	Referral
Dudu D		X	x	x			Guardian has disclosed to staff.		
Elsie P	x	X			x	x	Struggles to accept death of father.		
Mark V	x	X					Seems a happy, well-balanced boy.		

Step 2. Draw up a combined list from all the class surveys

The school management team should combine all the class surveys and draw up one list of all the vulnerable children at that school. Then the team should decide how to prioritize the children that need help most. The SMT should repeat the survey every six months to keep information on learners up-to-date.

Step 3. Arrange a household visit to collect more information

Some of the vulnerable children may still attend school. Others may attend erratically, have dropped out altogether, or have never attended. For this reason it is important to visit the households of children who are attending school as well as those who are not. Some of the children who are not attending school may be homeless.

One or two members of the SMT or SGB from a specific school, preferably female, should conduct a home visit to collect information and assess how best to offer care and support to vulnerable children at that school. The member(s) should fill in a form for each household visited.

Activity 10

Look at the following example of a form to collect important information on a household visit. Think about things that you would add or take out if you used this form in your context.

Name and address of household:			
Household visited by:			
Date of first visit:			
Number of children:	How many children live here?	Number of children enrolled in school	Number of children attending school regularly this week.
0-6 years			
7-12 years			
13-18 years			
19 years and older			
Is this a child-headed household?			
General observations			
Main issues discussed during visit			

Step 4: Decide which children need help most

It is difficult to decide which children need help most. Prioritizing is not a decision that someone can do alone. A decision about priorities needs to be made by a SMT or another kind of support group. It is important for the school management team or support group to make sure that it takes on children and actions according to its capacity. If there are actions that the school cannot take on, then it must know where to refer a child or household for help.

Step 5: Prioritize actions to help children stay in school

There are a number of actions[4] that can help to keep children in school. The following list of actions is like a menu of possibilities. A SMT or support group would not have to do all these things. It is important to be realistic about what actions can be taken to help children in need. Sometimes it is the small, simple actions that can make the biggest difference.

At home	At school
Give clothes	Find extra school uniforms
Accept and care for people living with HIV	Find extra books and stationery
Cook meals and give food	Check that children have safe transport to and from school.
Go shopping	Help provide breakfast and lunch for children at school
Look after young children and listen Read or tell children stories Listen to a child's problems	Supervise homework
Help with food gardens or in the fields	Help organize a school-fee exemption
Take a child for immunization or treatment	Follow up on a child that has been absent.
Help to get financial support or food	Talk about HIV and AIDS in schools
Other actions:	Other actions:

[4] Taken from COS Project Poster: Join a Circles of Support Group Project.

Activity 11

Think about the following questions:

Which children do you think need help most in the context in which you work?

Which actions are most realistic for this context?

5. How schools can provide care and support for teachers and other staff

In this section you will:

- learn how to protect the rights of teachers living with HIV or AIDS;
- be made aware of the physical, medical, emotional and social needs of teachers;
- consider different ways in which schools can support infected and affected teachers;
- think about the kind of structures you will need to create a caring and supportive school environment.

No one is immune from the effects of the HIV epidemic. This includes teachers.

Teachers living with HIV or AIDS have the right to protection. The law in most countries protects the right of teachers living with AIDS. Universally agreed human rights principles protect teachers against:

- Unfair discrimination: Everyone affected by HIV and AIDS should be treated fairly and sympathetically. Teachers also need to be protected from unfair discrimination by colleagues at school. Some teachers may discriminate against a fellow teacher because he or she is HIV-positive. For example, they may refuse to work with a teacher because of his or her HIV status.
- Unfair dismissal: This means that teachers cannot be dismissed if they are HIV-positive. In addition, no one can be prevented from teaching or being promoted because of their HIV status.
- Coercion: No teacher can be forced to have an HIV test as a condition for appointment or continued work.
- Unfair labour practices: Every teacher should have the right to leave if they are sick. Schools need to make adequate provision to deal with increased absenteeism at school.

Teachers not necessarily HIV-infected are nevertheless affected by HIV and AIDS. The HIV epidemic puts more pressure on teachers to take on the role of caregivers, counsellors and community facilitators. They may not always play the role of social workers, but there is a great need for them to be caring and to know where to get professional support.

Teachers must also be realistic about the kind of support and care they can offer both to colleagues and their learners. This is important so that they can respond to social problems at school but also take care of their own well-being.

Teacher stress can cause many problems. It can:

- increase absenteeism
- bring on illnesses
- lead to alcohol and drug abuse
- make it more difficult to be good, caring role models.

Laws protecting teachers

Activity 12

Think about the following questions:

What laws in your country protect the rights of teachers living with AIDS? How can you find out more about these laws?

What can be done to resolve situations where teachers are discriminated against because of their HIV status?

Types of support that teachers may need

Teachers who are infected and affected by HIV and AIDS need support in the following ways:

Physical and medical support: A teacher who is HIV infected is constantly struggling to fight disease and illness. When a teacher develops AIDS, he or she may feel ill more often during the working day. Like other ill teachers they will need time off work or a rest room to lie down. These teachers will also need medical treatment.

Emotional and social support: Teachers who get sick may experience a number of different feelings:

- **Depression and hopelessness.** A teacher may lose interest in his or her work and feel that nothing matters.
- **Feelings of loneliness.** A teacher can feel this way if he or she has no support.
- **Worry about the future.** A teacher may worry about children or a partner that he or she will leave behind.
- **Anger or guilt.** A teacher may feel angry towards a partner for infecting him or her or guilty if they infected someone else.
- **Grief.** Teachers will have to deal with death in some way. It may be the death of a loved one, a colleague, a friend or even one of their learners. They will feel strong emotions such as shock or disbelief, anger, and eventually acceptance.

Activity 13

Think about the following question:

In what other ways do you think teachers in your context may need support

Schools can support teachers in the following ways:

Reinforce teachers positively

Teachers can make a very big difference in children's lives. When teachers are aware of this, it can reduce their own stress. Schools need to recognize and reward teachers that provide care and support for learners and colleagues.

Provide teachers with knowledge

An important way to fight discrimination is to make sure people have the correct knowledge about HIV and AIDS. Teachers need to develop their own knowledge and gain skills in counselling. This will give them more confidence in making a difference in the lives of others and can prevent them feeling hopeless and not knowing what to do.

Make sure teachers have someone to talk to

A powerful way to reduce stress is to talk about feelings and problems. Teachers should be able to get professional help from a doctor, psychologist, spiritual leader or counsellor. Support groups are a healthy way to build relationships between colleagues. These groups help people to share ideas and solve problems together.

Encourage teachers to manage their own stress levels

Here are some practical ways for teachers to manage their stress levels:

- Get enough sleep
- Eat healthy food that is high in fibre and low in fat and sugar
- Don not drink too much coffee or tea

- Get regular physical exercise, even if it is just a half-hour walk in the afternoon
- Practise relaxation exercises such as deep breathing
- Don not abuse alcohol because it weakens the body and reduces ability to deal with stress. Contact Alcoholics Anonymous for support.
- Reduce or stop smoking. Smoking does not relieve stress – it actually increases it because nicotine is a powerful stimulant. Smokers could form a support group to help them to stop.
- Take time out to enjoy activities with friends and family. Play and laughter are great stress-relievers.
- Make time for yourself to do the things you enjoy.
- Engage in spiritual activities such as praying, making music or going to church.

Build supportive and appreciative leadership

School managers can play a very important role by supporting staff and showing them they are appreciated. School managers need to ask themselves some questions: How do they see their staff? Do they focus more on negative behaviour than positive behaviour? Do they acknowledge staff members often enough? Are they too stressed themselves to notice?

Structures to create a caring environment

Schools should also consider setting up certain structures to create a caring, supportive environment for teachers. These structures can include:

Teacher support team

It is possible to make the whole environment of a school more caring by setting up a structure like a teacher support team. This team is made up of teachers and perhaps someone like a spiritual leader too. It can do the following practical things to help teachers:

- Find out where teachers can get help. Make a list and share information about all the service providers in their area.
- Invite speakers for monthly staff workshops. Topics could include managing personal finances, relaxation techniques, personal relationships, coping with depression, addiction and losing weight. Provide a box into which teachers can put suggestions for future speakers.
- Start a walking club, a teachers' choir, a book club or a drama group.

Management and leadership issues have to be dealt with by your SGB. Make sure the teacher support team does not become a staff grievances committee. Its function should be to plan activities that can help teachers in their role as caregivers.

School management team (SMT)

A school management team (SMT) can ensure that teachers feel supported and acknowledged. There are a number of ways to do this:

- Have an open-door policy. Listen to teachers.
- Acknowledge staff regularly and sincerely.
- Think of ways to reduce teacher stress.
- Set a good example by supporting staff members.
- Encourage staff members to support one another.
- Discuss a code of conduct and what it means for all teachers *vis-a-vis* other colleagues, as well as *vis-a-vis* learners.

School governing body (SGB) with a vision

The role of a SGB is to make the idea of a caring school environment a reality. There are a number of important questions that an SGB can ask:

- In what ways are we already a caring school?
- In what ways can we become more of a caring school?
- What opportunities do we have to be more supportive of our staff?
- What threatens our ability to be more supportive of our staff?
- How can we make a caring school part of our school development plan and mission?

Activity 14

Think about the following questions:

What structures already exist at school or district level in your context?

What structures are realistic at a school or district level?

Do teachers know about ARV roll-out programmes in your context?

How can teachers be supported to access counselling and treatment?

6. Lead and manage an effective response at school level

In this section you will:

- consider what is needed to lead and manage an effective response;
- learn why it is important to have a living HIV and AIDS policy;
- use a template for an HIV and AIDS policy if you do not have one already;
- think about the kind of structures needed to implement the policy;
- understand why an action plan is needed to implement policy successfully.

An effective response to the epidemic requires leadership and management. Every school needs to identify good leaders and managers to drive an effective response.

Two powerful tools that schools can use to manage a response are:

1. an HIV and AIDS policy; and
2. an action plan.

In countries where the HIV epidemic is a national emergency, every school should have an HIV and AIDS policy. This policy should be in line with the national guidelines issued by the ministry of education of that country. The policy must agree with the Constitution and the law.

An effective HIV and AIDS policy states very clearly what the school believes. It also clearly lays out the school's aims. It should deal with other critical properties discussed in Section 1.

Activity 15

Some schools may already have an HIV and AIDS policy but some may not. Those schools that do may want to check that they have covered the main priorities.

You can use the following template as a guide to develop an HIV and AIDS policy.

Template of an HIV and AIDS school policy

HIV and AIDS Policy of ______________________

Date: ______________________________

Written by: ____________________________

Signature: ____________________________

Priority 1: Prevention	What our school believes about preventing the spread of HIV and what it aims to do.
Type of structure	
Priority 2: Protecting the quality of education	What our school believes about protecting the quality of education and what it aims to do.
Type of structure	
Priority 3: Providing care and support for learners	What our school believes about providing care and support for learners
Type of structure	
Priority 4: Providing care and support for teachers	What our school believes about providing care and support for teachers and what it aims to do.
Type of structure	
Priority 5: Managing an effective response at school level	
Type of structure	

Priority 1: Prevention of HIV infections

What are the issues?

In the end your HIV prevention policy should be fairly detailed and should include issues such as:

providing correct information to teachers and learners about HIV transmission;

promoting safe sex practices for both teachers and learners;

setting up peer education programmes;

speaking out against sex between young girls and older men;

providing effective life skills training;

making schools safe places to prevent bullying, abuse or stigmatization;

promoting universal precautions.

Priority 2: Protecting the quality of education

What are the issues?

Managing absenteeism, illness and trauma among learners and staff.

Protecting the human resources (teachers) that are lost.

Providing for the training needs of teachers.

Finding the money to fund short-term help.

HIV and AIDS Policy of ____________________ Date: ______________________________ Written by: ___________________________ Signature: ____________________________	
Priority 1: Prevention	What our school believes about preventing the spread of HIV and what it aims to do.
Type of structure	
Priority 2: Protecting the quality of education	What our school believes about protecting the quality of education and what it aims to do.
Type of structure	
Priority 3: Providing care and support for learners	What our school believes about providing care and support for learners
Type of structure	
Priority 4: Providing care and support for teachers	What our school believes about providing care and support for teachers and what it aims to do.
Type of structure	
Priority 5: Managing an effective response at school level	
Type of structure	

Priority 3: Care and support for learners

What are the issues?

Try to be specific about the way you plan to respond to learners' needs. This makes your policy a useful and effective document. Some of the issues you would need to think about are:

creating a caring, supportive school environment and identifying vulnerable children;

creating a safe school where learners are protected against stigma and discrimination;

creating a healthy school where the physical and emotional health of all learners and staff is important;

creating a caring classroom which becomes a safe and nurturing place for learners;

encouraging peer support both inside and outside the classroom.

Priority 4: Care and support for teachers

What are the issues?

Creating an open school that promotes human rights, disclosure and confidentiality.

Creating a school that does not allow discrimination or unfair dismissal.

Being aware of the physical, medical, emotional and social needs of the sick teacher.

Dealing with death and sorrow in the school in an open and caring way.

Dealing with teacher stress by finding ways to manage stress better.

Promoting mutual support in the school amongst teachers and other staff.

Developing supportive leadership that recognizes and acknowledges the role of teachers.

Priority 5: Managing an effective response at school level

What are the issues?

Developing a vision for the school that withstands the HIV epidemic.

Developing an HIV and AIDS policy if the school doesn't have one already

Understanding what it takes to make a policy work in a school.

Finding out about other examples of successful policy implementation.

Ensuring that there is a clear action plan to implement the policy.

Monitoring and reviewing the policy regularly.

Structures to implement policy

A good policy will briefly outline what structures are needed. It will show how the policy should be implemented in an ongoing way. Schools should not feel that they have to set up a number of new structures. Sometimes too many teams and committees are a burden and can end up duplicating one another's work. What you put in place will depend on what structures already exist. Remember that you could expand the role of existing structures (e.g. the fundraising committee or school safety committee) to meet your needs.

Activity 16

Think about what structures you have and what you still need. Look at the examples of structures below.

How could you adapt existing structures to include the tasks that are outlined in these examples?

Think about the kind of structure(s) you would need if these structures do not exist.

School-based support team (SBST)

Who could be involved? Members of the SGB, SMT, life orientation staff, teachers, learners, someone from the department of social services.

What could it do? The SBST could be an umbrella body for the other committees. It could drive your HIV and AIDS policy, make sure that actions happen, respond to crises and make financial decisions.

Teacher support team

Who could be involved? Members of the SMT, union representatives, teachers, people living with HIV.

What could it do? Deal with Priority 3 - Care and support of teachers.

- Support teachers personally so that they cope emotionally with the difficulties of colleagues and learners living with HIV and AIDS.

- Refer teachers for counselling and support.

- Identify teacher needs regarding workplace policies, leave and professional development.

Life skills and HIV prevention team

(This may be part of the staff development committee in some schools.)

Who could be involved? Life-skills and other teachers, members of SGB, learners.

What could it do? Deal with Priority 1 – Prevention of HIV infection.

- Drive life-skills and HIV-prevention programmes, e.g. awareness campaigns.

- Network with HIV and AIDS organizations and service providers.

- Involve community and youth.

Health and safety team

Who could be involved? Teachers, a local health care worker, learners and PLWH.

What could it do? Deal with Priority 1 – Prevention of HIV infection.

- Create and maintain a healthy school.

- Deal with nutritional issues, hygiene and cleanliness of the school. Make sure that the sick bay and the first-aid kit are properly maintained and create awareness around universal precautions.

- Advise the SGB on all health matters.

Youth peer health team

Who could be involved? Youth, teachers, social workers, PLWH, nurses, doctors and other professionals.

What could it do? Deal with Priority 2 – Care and support of learners.

- Provide paraprofessional training for youth to support fellow learners.

Go back to the HIV and AIDS policy template in Activity 15. Fill in the kind of structure(s) that you already have. Write down any new structures that you think are necessary.

Developing a school policy on HIV and AIDS is an important first step. The policy gives guidelines on the way forward. Guidelines, however, are not enough. You still have to plan practical actions that will help to make the policy a living document. An action is not an action until it gets done! Many policies and action plans are useless because people talk about their intentions, but never actually do the work. A policy will only become a practical document when actions are carried out.

Before you draw up an action plan, you need to decide:

what action to take;

what activities will be involved;

who will be responsible;

what the timeframes will be;

what budget there is.

Activity 17

Use the following template to implement a policy and plan action.

<table>
<tr><td colspan="5">HIV and AIDS ACTION PLAN OF ____________________
for YEAR</td></tr>
<tr><td colspan="5">Priority:____________________________

Date:

Participants:</td></tr>
<tr><td>Action?</td><td>Activities?</td><td>Who is responsible?</td><td>By when?</td><td>Budget?</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
</table>

Summary remarks

All over the world control of HIV has been best when the local response has been strongest. The same can be expected from the Education Sector, where the response to HIV needs to be led by schools. It is at schools where young people spend many hours every day, it is the place where educators, the biggest number of all civil servants, need support.

At the very least schools need to ensure they maintain their basic function and purpose, which is to educate learners. Added to this they need to ensure that learners and educators are kept safe from HIV, and that nothing in the school environment contributes to the spread of the epidemic. Schools have another task in preparing young people for sexual activity, and having the time and staff in place to provide good Life Skills facilitation as part of the school curriculum.

But the responsibility of schools also extends to supporting vulnerable children. These children are present everywhere, but their numbers increase dramatically when the HIV epidemic is severe. Schools have an important role, not necessarily in the provision of care, which is not their main function, but in ensuring that children receive the care they deserve.

In many countries HIV is just one of many developmental issues that schools face. It is important to consider HIV issues in other initiatives, just as it is important to consider gender issues, poverty reduction and general development in HIV programmes.

Hopefully the materials that are contained in this module will be useful in supporting an HIV response at a school level. But this is only a start. Please send back comments and feedback, so that the next version can be stronger and build on your experience.

Lessons learned

This module has focused on a school level response to HIV and AIDS. Any response must be based on five critical priorities:

1. Prevention of the spread of HIV.
2. Working together to continue to protect the quality of education.
3. Providing care and support for learners affected by HIV and AIDS.
4. Providing care and support for teachers affected by HIV and AIDS.
5. Managing and leading a response at school level.

The module has covered each of these priorities in some detail.

Where HIV and AIDS is a national emergency, every school should have an HIV and AIDS policy as well as an action plan to implement the policy. The critical priorities must be included in the policy. The action plan should set out clearly how the priorities will be achieved, by whom and by when.

Hopefully this module will help schools to see that the response begins at school and shows ways in which schools can respond effectively to HIV and AIDS.

Answers to activities

Activity 1

There is no right or wrong answer for this activity. The answers will depend on the specific school situation.

Activity 2

Same as in activity 1. However, it is important to think as broadly as possible, and focus on all the possible ways that HIV is affecting or could affect your school. Remember that HIV will make existing problems worse in many situations.

Activity 3

There is considerable research showing how silence about HIV, stigma, unequal relationships between men and women and women, alcohol and drug abuse and sexual violence contribute to the spread of HIV. Alternatively, acting to remove some these factors is often critical the responding to the HIV epidemic.

Activity 4

Risk factors in this case could have been:

- The death of her mother
- Poverty
- Young girls having sex with older men in exchange for gifts
- Lack of knowledge about contraception and safe sex practices.

Activity 5

Depending on how many questions you answered "yes" to, you can work out whether you have assessed your school's capacity to respond. For example: good = 6-8; fair = 4-7; poor = 1-3. The adequacy of a response should be looked at considering the priorities that you established in activity 2. For example, if sexual harassment is a problem, then the school should definitely have a code of conduct that is monitored and enforced.

Activity 6

Many of these things are not HIV specific, but HIV can make these worse. Use this exercise the get an idea of where your school is stronger and weaker in maintaining quality education. Note where you don't have enough information to answer a question. Is this important to you? Then you need to find a way to get the answers you need

Activity 7

The answer will depend on the specific school situation. However, try and think creatively of ways to respond to situation in your school.

Activity 8

Again, the answers here will depend on the specific school situation.

Activity 9

One issue you may have to deal with here is confidentiality. The class teacher may not be the best person to identify children in need. Other methods, for example using an anonymous letters or notes in a box, may be better in your situation. However, the fact is that it is impossible to provide support to children if there is no way of telling which ones need help.

Activity 10

There may be different groups in the community that could conduct household visits. These could include social workers, NGOs etc. However, there is a particular power to teachers getting involved in supporting families affected by HIV and AIDS, and this does have an additional impact on fighting stigma.

Activity 11

The answer will depend on the specific school situation. Do you have this information? You may need to find ways to collect this information, and check with a wide range of stakeholders to accurately asses the needs of children.

Activity 12

UNAIDS and the UNDP have a lot of resource material looking at issues of HIV and human rights. Discrimination against a person on the basis is considered a violation of human rights, and is illegal in most countries.

See www.unaids.org and www.hrw.org.

Activity 13

The answer will depend on the specific school situation. However, see the ideas that are given below this activity.

Activity 14

Use this activity to consider what structures support teachers in the education sector, but also what is available in the community. After all, schools can't do everything. Has the school made contact with the local clinic or hospital? What about NGOs or CBOs that offer support or counselling services? Think carefully of groups or even individuals that can assist the school. Maybe there are parents who have some support skills.

Activities 15-17

These activities involve designing a school policy and plan, and putting in place structures to support this. This response is most appropriate in countries and communities with a high HIV burden, such as in most of Southern Africa. In areas with a lower HIV burden it may be more valuable to use this planning process to highlight other important development challenges for your school, or issues such as school safety, which is important both as an HIV response and as a broader development issue.

Bibliographical references and additional resource materials

Department of Education. 2003. Develop an HIV and AIDS plan for your school. A guide for school governing bodies and management teams. (www.doe.gov.za).

Additional resource material

Circles of Support. 2004. Training material. Produced by Health and Development Africa for the SADC Health Sector Coordinating Unit HIV/AIDS Project.

Module 4.6

M. Crewe
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The higher education response to HIV/AIDS

About the authors

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Module 4.6

THE HIGHER EDUCATION RESPONSE TO HIV/AIDS

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Aims

The aim of the module is to:

- enable you to understand the role that higher education can play in addressing HIV and AIDS;
- present the ways in which tertiary and higher institutions can act to address HIV and AIDS within the institutions, in the surrounding communities and in the wider society.

Objectives

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

- recognize the ways in which tertiary and higher institutions can operate to support staff and students dealing with HIV and AIDS both personally and professionally;
- understand the role of staff and students in programmes and curricula that address HIV and AIDS;
- develop an institutional HIV and AIDS policy for your tertiary or higher education institution, that takes into account the managerial and workplace issues that tertiary and higher institutions face under the increasing burdens of HIV and AIDS;
- design and develop appropriate responses to HIV and AIDS within the structures of higher education and its many complex social, economic and political issues;
- initiate monitoring and evaluation (M&E) systems to measure programme and project progress.

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 space provided. As you work through the module see how your ideas and observations compare with those of the author.

Should tertiary and higher education institutions provide leadership in response to HIV and AIDS? Why or why not?

Identify some possible impacts of HIV and AIDS on the functions and operations of tertiary and higher institutions.

Why is an HIV and AIDS policy necessary in a tertiary or higher education institution?

What leadership can tertiary and higher education institutions provide in addressing the challenges of HIV and AIDS in the education sector and the wider community?

What are some of the workplace issues that tertiary and higher education institutions will need to address when dealing with HIV and AIDS?

What opportunities for transformation do HIV and AIDS represent for institutions of higher education?

Module 4.6

THE HIGHER EDUCATION RESPONSE TO HIV/AIDS

Introductory remarks

Tertiary or higher education institutions are those that have theory-based programmes intended to provide sufficient qualifications for gaining entry to advanced research programmes and professions with high skill requirements. They also have programmes devoted to advanced study and original research, and thus lead to the award of advanced research qualifications (UNESCO, 2005: 397). Tertiary level or higher education institutions could include universities, polytechnics, teacher training colleges and/or other specialized colleges of further education and training. In the context of this module, the term tertiary institutions will be used interchangeably with the terms institutions of higher learning or higher education institutions. These institutions are for the greater part preoccupied with the following roles:

- Transmitting the accumulated body of global knowledge relevant to the development of society through teaching (UNESCO, 2006).
- Creating new knowledge and extending boundaries of knowledge through research (Crewe, 2000).
- Preserving knowledge on national and international values of culture, history, art and science through technology, publications and library acquisitions.
- Providing advisory, extension and consultancy services on issues that are relevant to the socio-economic advancement of society (Otaala, 2000)

Tertiary and higher institutions must be aware of how HIV and AIDS are affecting their functioning and operation, especially in countries where the virus is endemic. HIV and AIDS can reduce student enrolments through deaths, illness, financial constraints, and demand for home care of sick relatives and friends. HIV and AIDS also increase the cost of training academic and support staff due to attrition, premature deaths, and employee benefits given in case of illness or after death. Moreover, these impacts can adversely affect the quality of education within the institution because sick, depressed, unmotivated or demoralized staff cannot be expected to teach effectively, nor can infected and affected students be expected to fully comprehend educational instructions or assume all the course workloads.

Accurate data on HIV prevalence levels among staff and students may be lacking in some higher and tertiary education institutions, but there is anecdotal evidence that HIV- and AIDS-related illnesses and deaths among both staff and students in these institutions are on the increase. Student absences and deaths are, however, less conspicuous owing to rapid growth in student populations in these institutions and also due to the fact that many students with HIV- and AIDS-related illnesses withdraw from their studies and subsequently there is little way of tracking where they go and what

happens to them. It is possible that HIV-related absenteeism, the loss of skills, and the overall costs and impacts due to HIV and AIDS are seriously undermining the capacities of tertiary institutions to achieve their defined educational and research goals (Abebe, 2004; Anarfi, 2000; ACU, 2002; Crewe, 2000).

This module examines how tertiary and higher education institutions can develop effective policies and strategies for dealing with the impact of HIV and AIDS. It shows how members of these institutions can be equipped with the knowledge, information and skills to address HIV and AIDS as a workplace issue as well as its potential impact on the process of teaching, research, learning, staff recruitments and retention. The module will also show how higher education institutions can provide intellectual leadership in HIV and AIDS education, prevention, care and research to the wider society.

1. Why should tertiary and higher education institutions be concerned with HIV and AIDS?

Tertiary or higher education institutions have an ethical and intellectual responsibility to set an example by openly debating the issues surrounding HIV and AIDS and finding creative responses to this epidemic. These institutions constitute one of the essential components in developing a united and effective country response to the pandemic for the following reasons:

- These institutions cater for sexually-active young people, mostly in the 18-30 year old category. Global data shows that more than a third of all people living with HIV are under the age of 25 (UNAIDS, 2004).
- Certain aspects of social life place members of tertiary and higher education institutions at risk of contracting HIV. Enhanced personal freedom coupled with the attractions and pressures of life in tertiary and higher education institutions is a recipe for sexual activity and experimentation. Casual sex and multiple sexual partnerships are common. Instances of offering sex in return for favours like promotions or good grades – which are euphemistically termed as 'sexually transmitted degrees and diplomas' – exist in some of these institutions. Commercial sex may not be uncommon as poor students seek to earn money to pay for their fees or for personal upkeep.
- Campuses are places where the safety of all students and staff, especially women must be guaranteed. Nevertheless, some university residences have earned a reputation as being places where rape, sexual violence and harassment of women are commonplace and where unprotected sex is perhaps the norm.
- These institutions have a responsibility to ensure that all trained graduates have the capacity to deal with HIV and AIDS at their own individual and professional levels.
- These institutions have an obligation to cater for the welfare of their members by creating an environment that reduces the likelihood of HIV transmission.
- HIV and AIDS can seriously impair and undermine the operation and functioning of tertiary and higher education institutions. Often, it takes particular talents, resources and a lot of time to produce specializations in particular academic disciplines. Subject specialists in tertiary level institutions cannot be interchanged easily, as may be the case in other school levels. Even where skilled manpower exists, the process of staff recruitment to replace other staff lost to HIV and AIDS is expensive both in terms of time and resources.
- Higher education institutions have a responsibility to promote gender sensitization and awareness of the situation of women with respect to the epidemic and the larger society.

Tertiary and higher education institutions can contribute to more effective, expanded and sustained responses to HIV and AIDS. These institutions can assist

the wider society in developing knowledge-based solutions to the problem of HIV and AIDS, such as through vaccines and other forms of social and behavioural research. As centres of excellence in research and knowledge building, tertiary institutions have an institutional responsibility to society.

Activity 1

Identify some of the ways in which you think HIV and AIDS will have an impact on the institution in which you work – is this likely to be on staff, students, teachers, the management processes or the quality of teaching?

How would you act to reduce this impact, and what steps would you put in place to ensure that your institution is 'HIV and AIDS literate'?

2. What makes tertiary and higher education institutions or higher education institutions able to contribute effective responses to HIV and AIDS?

Tertiary and higher education institutions occupy an advantageous position that allows them to easily influence and shape debate, action and policy with regard to HIV and AIDS, both at institutional and societal level.

These institutions:

- are responsible for the preparation of a large segment of the professional and skilled personnel that society needs.
- are crucial agents of change and can influence how society responds to issues such as HIV and AIDS;
- can offer leadership in terms of critical debate, policy development and research;
- are capable, through medical and social research, of generating new knowledge that can have enormous benefits to both the public and private sectors in dealing effectively with HIV and AIDS;

Yet, in spite of this advantage:

- due to weak surveillance systems, many higher education institutions lack accurate data on the magnitude of the HIV epidemic and the health problems of staff and students within the institution (Nzioka, 2006).
- a culture of silence surrounds the disease at the institutional, academic and personal levels (Kelly, 2001);
- initiatives to address HIV and AIDS in most institutions are ad hoc, fragmented, not embedded within an institutional framework, and lacking a 'holistic approach', making it difficult to evaluate their effectiveness;
- many responses to HIV and AIDS are often driven by individuals and small groups with little impact;
- some tertiary and higher education institutions do not have an HIV and AIDS policy in place;
- most HIV and AIDS strategies and programmes in tertiary and higher education institutions focus on prevention and are not sufficiently comprehensive;
- in most instances, the context in which tertiary and higher education institutions must respond to the epidemic is constrained by the absence of a national policy or guidelines specific to tertiary and higher education institutions. There are no incentives for top institutional leadership, staff, or even students to make HIV prevention and management an institutional priority. Since most students in tertiary or higher education institutions are adults, there is always an assumption that these students are already equipped with adequate HIV and AIDS education from their secondary schooling.

3. Mainstreaming HIV prevention and management of AIDS

There is a need to mainstream HIV and AIDS into the core functions and operations of tertiary or higher education institutions and to increase the overall relevance of the epidemic into all such institutions. Mainstreaming can be defined as "the process of analyzing how HIV and AIDS impacts on all sectors now and in the future, both internally and externally, to determine how each sector should respond based on its comparative advantage" (Elsey and Kutengule, 2003).

In the context of a higher education institution, it may mean looking at how the epidemic is likely to affect the department's goals, objectives and programmes and whether the department has a comparative advantage to respond to and limit the spread of HIV, and also to mitigate the impact of the epidemic.

There is certainly no standard approach or universal recipe to mainstreaming HIV and AIDS into the life of any institution. In the case of tertiary institutions, mainstreaming can involve integrating HIV and AIDS into core operations, functions and curricula. For example, HIV and AIDS is now part of professional studies at Kaliro National Teacher Training College in Uganda and at Migori Teacher Training College in Kenya. HIV and AIDS could also be integrated into non-curricular activities such as sports and creative art or debates.

Mainstreaming entails:

- examining how the institution is influencing the spread of HIV within the university and the surrounding communities.
- putting in place policies and practices that protect institutional staff and students from HIV infection while also supporting the infected to live with HIV and AIDS and its impact;
- ensuring that training and recruitment takes into consideration possible future staff depletion rates and disruption that are likely to be caused by increased morbidity and mortality due to HIV and AIDS;
- refocusing the work of the organization so as to ensure that the infected and the affected are still able to be optimally productive;
- ensuring that the institution's activities do not increase the vulnerability of the communities working with or around the institution;

Box 1 Key features in mainstreaming HIV and AIDS

- Sustained, committed, creative and dynamic leadership.
- Identification of institutional constraints (such as lack of skills and finances) for effecting desirable changes.
- Re-ordering priorities so that essential resources are shifted to HIV and AIDS concerns and activities.
- Strengthening staff and student capacities to understand HIV and AIDS and build responses into programmes.
- Establishment of clear indicators of success in the mainstreaming itself, in prevention, in care and support, and in the mitigation of the impacts of HIV and AIDS.

4. Gender mainstreaming

Gender mainstreaming is the process of assessing the implications of any planned HIV and AIDS action, policy and programme on both women and men. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of institutional HIV and AIDS policies and programmes so that everyone benefits equally. The ultimate goal of gender mainstreaming is to achieve gender equality.

Since in the case of higher education institutions, it is well known that women are considered at higher risk of transmitting the virus, gender mainstreaming in the context of tertiary and higher education institutions requires the following:

1. Collection, analysis and use of sex-disaggregated data on HIV and AIDS in all faculties, and departments.
2. That the right of all women, including girls, to protection from exposure to the possible risk of HIV infection is explicitly recognized.
3. Protection of the legal, civil and human rights of women/girls affected and infected, and giving women access to treatment, counselling and support on an equal footing with men.
4. Monitoring the impact of HIV and AIDS on both men and women in these institutions.

Students in the tertiary and higher education institutions are increasingly under pressure to pay higher fees, and this pressure is perhaps much more acute on female students, who are now being pressured into commercial sex work or sexual liaisons with older men to secure these extra finances to bridge their fee gaps (Ochanda, Njima and Schneegans, 2006;). Recent studies in Uganda, Kenya, Ethiopia and Zambia appear to suggest that women in the age cohort attending tertiary and higher education institutions such as teacher colleges and universities are more vulnerable to HIV infection (Ashebir, 2007; Katahoire and Kirumira, 2007; Nzioka, 2006; Ramos, 2006). There are probably now many more female students in tertiary and higher education institutions that are infected with HIV than their male counterparts.

Gender mainstreaming may lead to reduced HIV transmission among women and girls through safer sexual practices, such as increased use of male and female condoms, faithfulness to one uninfected partner, and abstinence.

Activity 2

How would you go about mainstreaming HIV and AIDS into the core functions of your own institution? What about gender mainstreaming?

5. Developing institutional leadership on HIV and AIDS

Evidence shows that an effective response to HIV and AIDS requires a strong and visionary leadership. Strong and committed leadership can inspire action, mobilize resources, establish policies and set up responsive organizational structures (see also Kelly and Bain, 2005). In instances where institutional leaders have made HIV and AIDS a priority, the response has been immediate, effective and visible.

In higher education institutions leadership that comes from vice chancellors or a designated senior manager sends a strong message within the institution and to the wider community that HIV and AIDS management is a priority. A recent study on the response of teacher training colleges (TTCs) to HIV and AIDS demonstrated that when institutional heads provide leadership in HIV and AIDS, college communities are likely to take such activities more seriously (Nzioka, 2006).

One example is the University of Durban, now known as the University of KwaZulu-Natal, where strong response began in the late 1990s under the leadership of the Vice-Chancellor. One outcome was the establishment of what is now the internationally renowned Health Economics and AIDS Research Division (HEARD) under the leadership of Professor Alan Whiteside. In institutions like this, decision-making and programme management structures have been established, networks have been created, resources have been found and the climate of silence and denial about AIDS has been broken.

The creation of the position of Chair in HIV and AIDS Education at the University of the West Indies, Barbados, in October 2004 is yet another good example of how tertiary institutions can develop institutional leadership in response to HIV and AIDS. This Chair was created by the Commonwealth Secretariat, in partnership with the United Nations Educational Scientific and Cultural Organization (UNESCO) with the aim of providing institutional leadership on HIV and AIDS through education in the Caribbean. This was the first time an internationally supported Chair in the area of HIV/AIDS and Education was created in a higher education institution to highlight the critical role that higher education institutions can play in the response to HIV and AIDS (Morrissey, 2005).

Strong and focused leadership is necessary to break the highly observable culture of silence on HIV and AIDS and to help to acknowledge the threat to institutional functions and operations. Effective responses to HIV and AIDS by top institutional leadership in tertiary institutions should:

- acknowledge that HIV and AIDS may have an impact on the institutions' functions and operations;
- recognize that HIV and AIDS could undermine the quality and quantity of the training and educational services offered;
- prioritize a careful and well co-ordinated response to HIV and AIDS;
- integrate HIV and AIDS into the institutional mission, while ensuring that HIV- and AIDS- related stigma and discrimination is addressed;.
- target all members of the institutional community including students, teachers/lecturers and non-teaching staff;
- establish interventions that are both inward-looking (protecting the institution's own functioning) and outward-looking (serving the needs of the wider society).

Leadership in the response to HIV and AIDS should not, however, be limited to only the top levels of institutional management. In tertiary institutions, leadership could also come from deans, heads of departments and professors. Leadership could also come from student anti-AIDS clubs, professional student associations, peer-group networks and possibly from people living with HIV (UNESCO, 2006). The University of Nairobi has a very strong association known as Medical Students Against AIDS (MSAA), which serves not only university students but also offers peer counselling to secondary school students and other forms of assistance to many urban communities in Nairobi. Similar organizations can also be found in other public universities in Kenya, such as in Kenyatta University (Ochanda, Njima and Schneegans, 2006).

For more information on leadership and HIV and AIDS management, see Module 1.5, *Leadership against HIV/AIDS in education*.

6. Developing an institutional HIV and AIDS policy

A policy is a statement of intent. An institutional HIV and AIDS policy is necessary at the institutional level because it seeks to answer the following questions: What should be done? Why? By whom? How? The existence of a policy is not a guarantee of action, but the existence of a written policy implies a tacit admission that the institution perceives HIV and AIDS as an institutional priority that must be addressed.

Policies in themselves do not however provide solutions to the challenges posed by HIV and AIDS in tertiary institutions. Rather, the presence of an institutional HIV and AIDS policy will provide a broad framework upon which institutional action can be premised. Policies can then be translated into action by an institutional structure such as an action committee, which is mandated with such responsibility and is accorded resources for this purpose.

On the other hand, the absence of a written policy does not always mean the absence of a framework of action against HIV and AIDS. Some institutions have evolved and developed certain practices and programmes in response to HIV and AIDS that do not derive from any written policies. Some institutions also take the view that programmes can be launched and delivered successfully without a fully developed policy framework, and can then be formalized into policies if necessary. Where such practices, activities and programmes have evolved, they have become part of an institutional culture that continues to drive action against HIV and AIDS in the institutions.

Nevertheless, a written institutional HIV and AIDS policy is necessary because it can assist a tertiary institution in:

- defining the institution's position with regard to HIV and AIDS and in setting clear guidelines on how the epidemic can be managed within the institution;
- defining the rights, obligations and responsibilities of all the stakeholders in an institution, including affected and infected persons and their partners;
- setting the behavioural standards to be expected of each institutional member;
- setting institutional standards for communication about HIV and AIDS;
- identifying the human, material and financial resources to be used for HIV- and AIDS-related activities;
- legitimizing institutional actions on HIV and AIDS and aligning the institutional responses to the broader national policy framework;
- providing guidance to institutional managers and other players and providing an overall framework for action;
- indicating commitment to deal with and control HIV and AIDS;
- ensuring consistency with national and international practices.

Institutional HIV and AIDS Policy vs. Workplace HIV and AIDS Policy

The wider institutional HIV and AIDS policy needs to recognize the specific needs of both staff and students but should remain separate from an HIV and AIDS workplace policy. Students are not employees of institutions of higher learning, and may not be adequately covered under an HIV and AIDS workplace policy. Nevertheless, they are part and parcel of the work environment and there is evidence that students and staff

in these institutions interact in a variety of ways which permit the spread of HIV and AIDS within both groups. Therefore, an institutional HIV and AIDS policy should be broad enough to cover students and staff.

For example, an institutional HIV and AIDS policy may need to provide for adjustable academic programmes so as to accommodate the needs of students who need time out of their studies for reasons of ill health or dealing with the impact of HIV and AIDS in their families or communities. The institutions may also need to think of ways of developing expanded support services for infected and affected staff and students. One consideration may be to train staff and students as educators and counsellors to support and help their peers and colleagues.

Universities such as Nkumba University in Uganda, the University of Zambia, the University of Kwazulu-Natal in South Africa and a whole host of universities and tertiary institutions in sub-Saharan Africa have developed institutional HIV and AIDS policies. Reading through these policies shows that they are broad enough to take account of both staff and students' needs. Thus, it appears that these institutional HIV and AIDS policies are more comprehensive than a workplace HIV and AIDS policy. Normally, a workplace policy consists of a detailed document on HIV and AIDS within all aspects of the workplace and its staff, setting out prevention programmes, treatment and care for staff living with and affected by HIV and AIDS. It could also be part of or found within the institutional policy or agreement on safety, health and working conditions, or just a short statement of principle. (For more information on workplace policies, see Module 2.3, *HIV/AIDS workplace policies and programmes*).

Activity 3

1. Identify the major challenges and obstacles that are likely to come in the way of developing and subsequently implementing your HIV and AIDS policies and programmes in your institution.

2. How can your institution overcome these challenges and obstacles?

7. Integrating HIV and AIDS into academic and non-academic programmes

One main outcome of HIV and AIDS policies in a tertiary or higher education institution should be the mainstreaming of HIV and AIDS into the formal and non-formal curricula. HIV and AIDS education needs to be incorporated into the curriculum of all faculties. Students and staff need to be "HIV-aware, HIV-competent and HIV-safe" (Coombe, 2003). To do this, they need to fully grasp, understand and internalize pertinent facts and practices relating to HIV and AIDS. This might however, only come about if these institutions have competent and credible systems for delivering HIV and AIDS education.

In seeking to provide HIV and AIDS education, tertiary and higher education institutions may need to explore adopting the use of a variety of approaches.

Teaching HIV and AIDS as 'separate subject"

HIV and AIDS can be taught as a compulsory subject or topic across all degrees or diploma courses in the institution. This teaching could entail providing information on basic epidemiological facts about HIV and AIDS, the impact of HIV and AIDS on society, and desirable protective behaviour *vis-à-vis* HIV and AIDS, such as safer sex practices and life skills. To ensure students take the teaching seriously, compulsory questions should be included in their examinations to assess their competence in understanding the critical issues.

Integrating HIV and AIDS into existing subject

HIV and AIDS education can be integrated into an existing subject to which the epidemic may be relevant, such as civics, religious education, social ethics, social studies, or health education. The advantage of this approach is that the carrier subject teachers are likely to see the relation between HIV and the other aspects of the subject. These teachers are also likely to have a greater grasp of the subject and be able to find appropriate examples and issues owing to their experience in teaching the subject. The training of lecturers on how to integrate HIV and AIDS into their subject areas of competence is also likely to be easier, faster, and cheaper than through infusion or creating a separate course.

Infusing HIV and AIDS across the curriculum

Another option is infusing HIV and AIDS into the curriculum. For example, the Africa University in Zimbabwe and the University of Botswana have taken steps to mainstream HIV and AIDS education into many of their training programmes.

Infusion would give students a greater understanding of how to mitigate the impact of HIV and AIDS in their area of expertise such as in Chemistry, Engineering, or law. This will require that students be taught to understand the epidemic and its ramifications on the society including such issues as: what has caused the epidemic to unfold in the way that it has? How has the response of the state helped or hindered the response? What is the role of the private and public sector in addressing HIV and AIDS? How will an effective workplace programme be developed in the sectors in which the students are employed?

Infusing of the HIV and AIDS into the curriculum requires that there are sufficiently trained and motivated staff to offer the course, to teach well and to evaluate the students. This could potentially pose a huge burden on staff, particularly if they themselves are not trained in the teaching HIV and AIDS and might already be overburdened. This approach also assumes that the institution is ready to shoulder the additional financial cost of preparing the staff and providing the course materials, and that students are willing to participate in such a compulsory programme. Ideally, students and staff should somehow be involved in the decision to make it compulsory and in appreciating the relevance of learning about HIV and AIDS to their courses, lives and future careers.

Integrating HIV and AIDS into extra-curricular activities

Tertiary and higher education institutions might also wish to consider integrating HIV and AIDS into non-curricula activities such as sports, or creative arts like drama and music subjects, going to see plays and concerts, and debates.

Box 2 Integrating HIV and AIDS into extra-curricular activities

The Office of the Associate Vice-President for Research and Graduate Programs at the University of Addis Ababa has introduced a new interactive play entitled “Walkers of Life”. “Walkers of Life” focuses on the campus life of students and the risky sexual behaviors, examining the knowledge, attitudes and practices, in this case of the audience (i.e. students) and has intervals at which a moderator asks the audience for an opinion or challenges them on some controversial issues such as peer pressure, faithfulness to sexual partnerships, the desire to experiment new experiences, pressure to have unprotected sex in different contexts, and living away from immediate parental guidance.

The play is part of the Modeling and Reinforcement to Combat HIV/AIDS (MARCH) project at Addis Ababa University. The MARCH project seeks to promote behaviors that reduce the risk of HIV infection through providing role models. The project also includes reinforcement activities in which these positive behaviors are discussed and assimilated in a peer group setting and sustained via community support.

MARCH targets the Addis Ababa University students, academicians and administrative staff, promoting abstinence, mutual fidelity and other preventive behavior. The organizers hope that such an interactive play will create an environment conducive to free interaction among the audience on the issues raised in the play. The play, which was produced by the University’s School of Theatrical Arts, targets the 30,000 students plus 3,000 academic staff in the 12 campuses of the University of Addis Ababa, together with other students from all over Ethiopia.

Source: http://www.aau.edu.et/march/index.php

Combination of different approaches

Given the diverse nature of institutions of higher learning particularly universities, it is possible that many of the approaches outlined above might be appropriate for use across the different sections, and departments in the institution. Tertiary and higher education institutions might also wish to try using a combination of these techniques.

Any approach assumes that the institution is ready to shoulder the additional financial cost of preparing the staff and providing the course materials, and that students are willing to participate in such a compulsory programme. Ideally, students and staff should somehow be involved in the decision to make it compulsory and in appreciating the relevance of learning about HIV and AIDS to their courses, lives and future careers.

8. Research

Integrating HIV and AIDS into the professional and intellectual work of staff and students in tertiary institutions is a form of mainstreaming or institutionalizing HIV and AIDS.

Universities and other tertiary institutions exist in society to provide intellectual guidance and to cater to the need for knowledge and expertise in particular demarcated areas of specialization within the society. The dense concentration of intellectual expertise in tertiary and higher education institutions places them in the forefront of the global search for an improved biomedical, epidemiological, scientific, social and economic understanding of HIV and AIDS. With no known cure for the virus and its related illnesses, the potential role of universities and other tertiary and higher institutions in biomedical research that seeks to address this critical issue is even more urgent (UNGASS, 2001). Tertiary and higher education institutions can make their own unique contribution to the various areas of prevention, care, treatment and impact management, and can contribute to technical advancement, new products, improved diagnosis and treatment, new understandings, improved economic growth, accelerated industrial and agricultural growth, and an improvement in the quality of life.

A good research base ensures a good understanding of social and scientific issues as well as offering the institution the opportunity to develop a database and better knowledge of how to address the many issues related to this epidemic. All faculties and departments need to be encouraged to develop an HIV and AIDS research profile and encourage students to use HIV and AIDS as the basis of their research. There is a need to develop simulation models on the possible future impacts of HIV and AIDS, calculate the potential cost under different conditions, and use that data when planning interventions to counter the adverse effects of HIV and AIDS.

HIV and AIDS research in tertiary institutions could also be externally oriented focusing on the knowledge, understanding and information needs of society. However, there is also need for research that is directed towards the information needs of the university itself. Under the auspices of the International AIDS Vaccine Initiative (IAVI), the University of Nairobi in Kenya has been working in conjunction with Oxford University in the United Kingdom on the development of an AIDS vaccine, while a similar partnership has developed between the University of Cape Town, South Africa's Medical Research Council and the National Institute of Virology and a North Carolina-based biotechnology firm (Kelly, 2003). This is an example of externally oriented research.

Finally, tertiary and higher education institutions could be involved in theoretical and applied research, both of which could contribute to an intellectual understanding of the epidemic as well as giving policy and intervention direction. Research should also offer a critique of existing programmes and policies, as well as a critical examination of donor agendas and the ways in which these shape national responses.

Activity 4

When you consider the ways in which your institution is structured, how would you best integrate HIV and AIDS into student activities and the overall learning environment?

9. Financial resources

The ways in which HIV and AIDS will affect the finances of the institution are many and varied. Campus health services will face considerable financial strain if they have to provide HIV testing, counselling, treatment for opportunistic infections and sexually transmitted infections and anti-retroviral treatment (when this is not provided by the state). A further direct cost for the health services of an institution will be increased expenditures on disposable materials such as gloves and other equipment to protect health workers and researchers.

Funeral benefits need to be considered, as well as replacement costs of staff who leave or who die and skills training for new members of staff. Other costs would include temporary replacement of staff. The benefit packages for staff members can also be affected as the demand for payout of these packages can occur sooner than expected.

Some of the indirect costs include staff absenteeism due to illness or family responsibilities, caring for others and attending funerals.

The HIV epidemic is also threatening the funding sources of tertiary and higher education institutions. Money previously budgeted for other services may have to be channelled towards HIV- and AIDS-related expenditures implying the need to raise more money. HIV- and AIDS-related costs may also mean less money available for bursaries and scholarships and may affect the ability of students to pay for their tuition and books and other requirements.

10. Community outreach programmes

Institutions of higher learning can play an important role in the development of community outreach projects for HIV and AIDS prevention, care, and counselling of the infected and affected. These could include impact-mitigation projects for orphans and vulnerable children, and people living with HIV or suffering from AIDS. Students could be encouraged to participate in the development and implementation of awareness campaigns and peer-education activities within the university community as well as the surrounding ones. They could also assist local communities by offering skilled/professional services free of charge, which could also serve as opportunities for the students to gain professional experience. For example, in some countries, university students from different faculties would visit a slum settlement within the vicinity of the university and offer public education and free medical services to the inhabitants. Such outreach programmes were also observed in teacher colleges in Kenya, where teacher trainees visit schools on the weekends to do their teaching practice and educate the local communities on the risks of HIV and AIDS (Nzioka, 2006).

11. Monitoring and evaluation

Programmes must also be created for tertiary and higher education institutions to monitor and evaluate their policies and programmes. Monitoring involves tracking the inputs, processes, outputs and quality of a programme over time. It also involves assessing whether the ways in which a programme is being implemented is consistent with its initial design and implementation plan.

Institutions of higher learning can develop both quantitative and qualitative monitoring indicators. Quantitative indicators would include items that are easily measured or counted, for example:

- number of student programmes and activities;
- number of participants per activity;
- number of counsellors available;
- number of counselling sessions held;
- number of times a promotional radio spot was aired;
- number of posters distributed;
- condom uptake;
- other programme elements carried out their frequency.

Quantitative monitoring involves record-keeping and numerical counts. Activities in the project/programme timeline of activities should be closely examined to see what kinds of monitoring activities might be used to assess progress. The method for monitoring and its associated activities should be designed from the start of the programme and integrated into the project timeline.

Higher education institutions can also develop qualitative monitoring indicators. Such indicators can provide information on how well the elements are being carried out. Qualitative issues concern items that are harder to get at and more difficult to measure. This kind of information could be obtained through in-depth interviews and focus group discussions.

Qualitative questions for a project may include:

- how are staff and student attitudes on stigma and discrimination changing as a result of a training or course?
- how are programme activities influencing behaviour change?

Evaluation entails assessing programme outcomes, what such outcomes mean and whether such outcomes make a difference. Sustained monitoring and evaluation is an essential activity of any HIV and AIDS programme, and the findings need to be relayed to the staff and students who are involved in the programme.

Part of the monitoring and evaluation process is to ensure that all tertiary and higher education institutions have the capacity to:

- develop;
- implement;
- finance
- sustain; and
- evaluate programmes and projects

Strengthening the HIV and AIDS monitoring and evaluation process also allows staff to build their capacity for ensuring identification of programme and project weaknesses to enhance programme effectiveness.

Activity 5

What are the major obstacles to monitoring and evaluating a programme's activities in your institution? How can these obstacles be overcome?

In what ways can you ensure effective monitoring and evaluation of HIV and AIDS programmes in your institution?

Summary remarks

Tertiary and higher education institutions have a crucial role to play in developing responses that will ensure that all staff and students have access to education, prevention and care in an environment in which their rights are protected. Tertiary institutions are uniquely placed to develop innovative and effective responses to HIV and AIDS. This is because as institutions of higher education, they are concerned with the generation and development of new ideas and their key role is to push the boundaries of knowledge and to give intellectual leadership and vision. At the same time, tertiary or higher education institutions are more vulnerable to HIV and AIDS than other formal institutions of learning because they cater mainly for students who fall within the ages of 18-25 – an age group with a high HIV prevalence, which is largely as a result of unprotected sexual relations. Understanding this dichotomy can help higher education institutions to develop policies that address the issues of risk and prevention within universities.

Tertiary and higher education institutions remain committed to:

- developing new sources of knowledge and understanding;
- challenging the *status quo* and developing new explanatory frameworks;
- critical research that will lead to new social formations and new ways of coping with complex social, economic and political issues;
- influencing policy-makers in both the public and the private sector to develop programmes and implement policies that will ensure that issues such as HIV and AIDS are not merely pushed into the existing policies and programmes;
- ensuring that research findings are channelled to appropriate audiences;
- ensuring that HIV and AIDS become core concerns of the institution.

Tertiary and higher education institutions could develop and design policies and responses to HIV and AIDS that take into account all of these commitments as well as the different ramifications of the epidemic. Understanding how societies live through epidemics is a crucial aspect of tertiary based work.

Academics have a key role to play in fostering new social movements and a new social consciousness as well as developing a critical engagement with the wider social, political and development issues of the epidemic and understanding the role of the tertiary sector in globalization and development.

Tertiary and higher education institutions have at their disposal a wide and well trained skills base and they need to ensure that they are able to retain this. The time and resources devoted to training academics and support staff needs to be offset against the costs of antiretroviral treatment and other support services for staff and students living with HIV and AIDS.

Through active research and community participation, tertiary and higher education institutions can act as role models for other institutions. On the whole, tertiary and higher education institutions are able to support countries to develop comprehensive responses to HIV and AIDS that are based on research, intellectual activity, models of understanding and engagement *vis-à-vis* the epidemic as well as offering practical solutions and policy and programme implementation.

Lessons learned

Lesson One

HIV and AIDS have a crippling effect on the functioning and operation of tertiary and higher education institutions, particularly in highly-impacted countries. At the same time, tertiary institutions occupy an advantageous position in society and play a key role in developing strategies for the prevention and control of HIV and AIDS within and outside the institution.

Lesson Two

Strong and visionary leadership is essential in the development of institutional responses to HIV and AIDS in tertiary and higher education institutions.

Lesson Three

For tertiary and higher education institutions to respond effectively to HIV and AIDS, they need to develop institutional policies on HIV and AIDS that establish appropriate internal programmes for mainstreaming HIV and AIDS into institutional life.

Lesson Four

As part of the mainstreaming process, HIV and AIDS need to be integrated into the curriculum so that every student can become AIDS competent.

Lesson Five

Tertiary and higher education institutions should dedicate part of their research mandate to issues relating to HIV and AIDS.

Lesson Six

Tertiary and higher education institutions should encourage both staff and students to engage with the external community on issues of HIV and AIDS.

Lesson Seven

An effective monitoring and evaluation system is required in each tertiary institution in order to track institutional progress in response to HIV and AIDS.

Answers to activities

Activity 1

HIV and AIDS can impact on your institution by reducing demand, supply and quality of education directly or indirectly through increased staff, students', parents' and relatives' morbidity and mortality. This can therefore affect the operations and functions of your institution in a number of negative ways, including loss of skills, and absenteeism, leading to low quality teaching and reduced institutional revenue. You can also think of other indirect ways in which HIV and AIDS can affect your institutions, such as in loss of reputation.

Some of the ways of reducing this impact could include provision of preventive education to staff and students and enhancing access to treatment, care and support to the infected and affected.

Activity 2

Mainstreaming entails integrating HIV and AIDS into the key functions and operations of an institution. In the case of tertiary institutions, mainstreaming implies ensuring that HIV and AIDS is taken into account in the institutional planning and budgeting process, in research activities, and is also infused or integrated into formal curricula and other extra-curricular activities.

You could mainstream HIV and AIDS into your organization through:

- developing an institutional policy on HIV and AIDS;
- creating HIV and AIDS management structures;
- creating projects and programmes on HIV and AIDS;
- widening the levels of institutional participation in HIV and AIDS activities;
- identifying human and financial resources for HIV and AIDS activities;

For gender mainstreaming, you would need to evaluate the problems as to how they affect men and women differently, and then address these differences in the actions listed above. For example, when infusing HIV and AIDS information into courses, the gender aspects of the problem could also be explored and discussed as to how it contributes to the problems of HIV transmission.

Activity 3

Major challenges in the development of an effective response to HIV and AIDS include lack of strong and committed leadership, lack of financial resources and skilled human resources. These obstacles can be averted through accelerated HIV and AIDS awareness within institutional membership, planning for HIV and AIDS, identifying and allocating resources to HIV- and AIDS-activities, and building the capacities of the institutional membership to deal with HIV and AIDS through training.

Activity 4

Integrating HIV and AIDS into students' activities and overall learning environment requires:

- ensuring that students can seen the possible implications of HIV and AIDS and relate it to their day-to-day lives;
- developing a clear perception of the linkage between HIV and AIDS, the teaching and learning environment, exams, staff and students' wellbeing, the structure of degrees/diplomas;
- creating a climate of intellectual engagement with HIV and AIDS, supporting pertinent research and developing ways of understanding how students are able to cope with the impact of HIV and AIDS;
- demonstrating how HIV and AIDS will affect the financial resources of the institution as well as the financial position of students.

Activity 5

Some of the major obstacles to proper monitoring and evaluation (M&E)

- Lack of baseline information
- Lack of clear indicators
- Lack of well kept data

Your institution may need, among other things, to develop:

- a checklist of critical issues to be dealt with during M & E;
- develop clear and measurable indicators;
- develop appropriate evaluation methodologies;
- develop an understanding of how to gather different data sets using these methodologies and how to use the different data sets;
- develop appropriate questions.

Bibliographical references and additional resource materials

Documents

Abebe, G. 2004. *African universities' response to HIV/AIDS in the Global AIDS Initiative countries: A synthesis of country reports*. Accra: Association of African Universities.

Anarfi, J.K. 2000. *Universities and HIV and AIDS in Sub-Saharan Africa – A Case Study of the University of Ghana*. Study commissioned by the ADEA Working Group on Higher Education. Accra, Ghana.

Ashebir, D. 2007. *Mitigating the impact of HIV/AIDS in teacher training institutions: Analyzing the response in Ethiopia*. Paris: IIEP-UNESCO.

ACU. 2002. *Commonwealth Universities in the Age of HIV and AIDS: Guidelines towards a Strategic Response and Good Practice*. London: Association of Commonwealth Universities.

Coombe, C. 2003. *HIV and AIDS and teacher education: a synopsis of observations and principal conclusions.* Pretoria: InWEnt. www.harare.unesco.org/hivaids/webfiles/Electronic%20Versions/draft%20report%20inwent.doc

Crewe, M. 2000. *HIV and AIDS and tertiary education: New possibilities, new hope*. *SAfAIDS News*, *8*(2).

Chetty, D. 2000. *Institutionalizing the response to HIV and AIDS in the South African university sector: A SAUVCA analysis*. SAUVCA occasional paper N° 2. Pretoria: South African Universities Vice-Chancellors Association.

Elsey, H.; Kutengule, P. 2003. *HIV/AIDS mainstreaming: A definition, some experiences and strategies*. Durban: University of KwaZulu-Natal. www.sarpn.org.za/documents/d0000271/P263_HIV_Report.pdf

Katahoire, A.; Kirumira, E. 2007. *The impact of HIV/AIDS on higher education institutions in Uganda and their responses to the pandemic: a case study of a university and a teacher training college*. Paris: UNESCO-IIEP.

Kelly, M.J. 2001. *Challenging the challenger: understanding and expanding the response of universities in Africa to HIV and AIDS*. Washington, DC: World Bank.

Kelly, M.J. 2003. "The significance of HIV/AIDS for universities in Africa to HIV and AIDS". In: *Journal of Higher Education in Africa*, *1*(1), 1-23.

Kelly, M.J.; Bain, B. 2005. *Education and HIV/AIDS in the Caribbean*. Paris: IIEP-UNESCO.

Morrissey, M. 2005. *Response of the education sector in the Commonwealth Caribbean to the HIV/AIDS epidemic: A preliminary overview*. Geneva: ILO. www.ilo.org/public/english/dialogue/sector/papers/education/sn-educat1.pdf

Nzioka, C. 2001. *The impact of HIV/AIDS on the University of Nairobi*. Paris: ADEA.

Nzioka, C. 2006. *Kenya: strengthening teacher education in HIV and AIDS*. In: *IIEP Newsletter*, 24(4), 9-10.

Ochanda, A; Njima, R.; Schneegans, S. 2006. "Students choose life in Kenya". In: *A World of Science*, *4*(4), 19-23.

Otaala, B. 2000. *Impact of HIV and AIDS on the University of Namibia and the university's response*. Windhoek: Printech.

Ramos, L. 2006. *Analyzing the response of a teacher training institution to HIV and AIDS: A case study from Zambia*. Paris: UNESCO.

UNFPA. 2004. *At the crossroads: Accelerating youth access to HIV/AIDS interventions*. New York: UNFPA. www.unfpa.org/upload/lib_pub_file/316_filename_UNFPA_Crossroads.pdf

UNESCO. 2005. *EFA Global Monitoring Report 2005*. Paris: UNESCO.

UNESCO. 2006. *Expanding the field of inquiry: a cross-country study of higher education institutions' responses to HIV and AIDS*. Paris: UNESCO.

UNGASS. 2001. *Declaration of commitment on HIV/AIDS*. United Nations General Assembly, 26th Special Session. New York: United Nations. www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html

Additional reading materials

AIDS Policy Formulation Project. 2002. *Nkumba University HIV and AIDS Policy*. Entebbe, Uganda: Nkumba University.

Crewe, M.; Maritz, J. 2005. *UNESCO review of higher education institutions' responses to HIV and AIDS: the case of the University of the West Indies*. Kingston: UNESCO.

HIV and AIDS Committee. 2003. *Highridge Teachers College HIV and AIDS Policy*. Nairobi, Kenya: Highridge Teachers College.

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 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.

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.

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M. J. Kelly

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1.4 HIV/AIDS-related stigma and discrimination
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Volume 5: Costing, Monitoring and Managing

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M. Gorgens

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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.