Education in the context of HIV/AIDS

The HIV challenge to education: a collection of essays

Edited by Carol Coombe
The HIV challenge to education: a collection of essays
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<td>ADEA</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral (treatment)</td>
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<tr>
<td>CBO</td>
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<td>Canadian International Development Agency</td>
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<td>CIET</td>
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<td>EDC</td>
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<td>EFA</td>
<td>Education for All</td>
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<td>ESAR</td>
<td>Eastern and Southern Africa region</td>
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<td>HRD</td>
<td>Human resources development</td>
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<td>ICT</td>
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<td>MOE</td>
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<td>NGO</td>
<td>Non-governmental organization</td>
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<td>OVC</td>
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<td>PLA</td>
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<td>PLWHA</td>
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<td>PSI</td>
<td>Population Services International</td>
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<td>PTA</td>
<td>Parent Teacher Association</td>
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<td>SADC</td>
<td>Southern African Development Community</td>
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<td>SADTU</td>
<td>South African Democratic Teachers’ Union</td>
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<td>SAMRC</td>
<td>South Africa Medical Research Council</td>
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<td>Sida</td>
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<td>SSA</td>
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<td>STD</td>
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<td>TFD</td>
<td>Theatre for Development</td>
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<tr>
<td>TTC</td>
<td>Teacher training college</td>
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<td>UNAIDS</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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CHAPTER 1. HIV/AIDS, POVERTY AND EDUCATION:
THE CIRCLE OF HOPE AND DESPAIR

Carol Morgan Coombe
March 2003

Carol Coombe has worked in Africa since arriving in Zambia as a
Canadian volunteer in 1968. From 1985-1994 she was based at the
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Abstract

This paper considers the consequences the HIV/AIDS pandemic is having on education, within the context of the global poverty discourse. It considers the scale and scope of the pandemic and its anticipated impact on learners, educators and education systems particularly in heavily-infected sub-Saharan Africa countries. It looks for lessons derived from 20 years of coping with HIV/AIDS in the SADC region. It includes proposals for improving the education sector’s response to the pandemic in order to protect education provision and quality, and to mitigate the distress of increasing numbers of orphans and other vulnerable children.

Introduction

Amartya Sen has argued that systematic public action can effectively counter intractable development problems (Sen, 1990). He maintains that success in coping with a public crisis relies on the extent to which the protective role of government can be integrated with the efficient functioning of other economic and social institutions, supplemented by sensible public activism.

Sen suggests that so long as a crisis is “relatively cost-free for government, with no threat to its survival or credibility, effective actions... do not have the urgency to make them inescapable imperatives for the government” (Sen, 1990; emphasis added). As a corollary, where there is independent democracy, an unfettered press, and energetic and sustained public pressure to take quick and effective action, governments will be held accountable to act.

Sen addresses both the what and the how of confronting a crisis. His advice is clear. It is necessary to:

- diagnose and analyze the causes of a crisis;
make determined integrated efforts to counteract those causes;
• integrate government efforts with those of civil society; and
• sustain public pressure for action.

This volume echoes Sen’s principles in a variety of ways, applying them to the battle to eradicate HIV/AIDS, mitigate the ramifications of its pandemic form, and save lives. It analyzes the complexities of the HIV/AIDS pandemic, and considers whether and how education sectors – governments working with civil society – are adequately addressing the hardships the pandemic is imposing on learners, educators, and education systems.

1. The nature of the problem

For 20 years, the counter-attack against HIV/AIDS has focused on preventing the spread of the disease. But in 2003 the reality is that it has spread worldwide. It is a true pandemic, creating a complex set of social, behavioural, governance, economic, and psychological problems that together constitute a completely distinct phenomenon.

Unfortunately there is little evidence, for example in programmes directed at poverty reduction in Africa or high-risk communities in Asia, that the consequences of HIV/AIDS for general populations are being factored into governments’ planning for development (Collins and Rau, 2000).

The HIV/AIDS pandemic is fuelled by disadvantage. In turn it creates and sustains misery and poverty. Thus more people become susceptible to infection and vulnerable to the impact of the pandemic. In these circumstances the puzzle is “how to achieve sustainable development essential for an effective response to the pandemic under conditions where the pandemic is destructive of the capacities essential for the response” (Cohen, 2001).
Poverty and HIV/AIDS thrive on each other. Education intrinsically offers hope, as it always has, that individuals and communities may rise above their circumstances. Unfortunately education, like health and social support, is inequitably accessible to the poor. Moreover, education systems in high-prevalence countries are themselves under attack by the pandemic and may therefore be unable to respond appropriately to the needs of learners and educators affected by the disease, especially the most vulnerable. Regrettably, education on its own provides no protection against HIV infection, as data reported in a recent South African study have shown (Shisana and Simbayi, 2002).

2. Principles of crisis management

Since the HIV/AIDS crisis is unprecedented in modern times there is no model for what to do and how to do it. Sen argues for clear-minded diagnosis and collective dedication to deal with a crisis successfully. What this means as far as HIV/AIDS is concerned is that the response to the pandemic needs to be managed, and managed properly. Experience all over sub-Saharan Africa suggests that effective HIV/AIDS management must include:

- informed leadership;
- collective dedication by partners in the sector;
- research and information collection and analysis;
- management resources appropriate to the demands of the catastrophe;
- a policy and planning framework to co-ordinate action in the sector;
- funds mobilized and allocated to those who can use them best;
- priorities for short-term and long-term action; and
- monitoring and evaluation mechanisms in operation.
Ministries of education cannot do this job alone, but must work collaboratively with partners in and out of government.

Two pillars of strength have emerged that have a central role to play in counter-attacking HIV/AIDS. The first is communities where people are ill and dying, and where families, friends and colleagues are working together for survival. Sen’s ideal of public activism, as well as his notion of accountability, is well and strong in many communities that are hard-hit by HIV/AIDS, as governments ponder their next moves. The second pillar of strength is young people who have shown they have the energy and confidence, the ability to learn from their experience, and the sheer dramatic chutzpah to fight this disease among their peers and take the campaign even among adults. Educators should lend encouragement and support to such efforts, open their schools and colleges to them, but not try to organize or control them.

3. Reducing the impact of HIV/AIDS on education

HIV/AIDS lurks in communities and families, in the most intimate, private moments of human relationships. It is a creature of culture and circumstance, local perceptions and behaviours, custom and religious belief. That means it is virtually impossible to generalize about good practice: what works to break the power of HIV/AIDS in one place may not work in another. The passage of the pandemic has nevertheless highlighted important possibilities.

3.1 Setting generic strategic principles

UNAIDS has analyzed successes in Senegal, Thailand and Uganda in reducing the spread of HIV/AIDS (UNAIDS, 2001). It concludes HIV was contained largely because those three governments acted rapidly, intensively and extensively. Beyond that, however, the pandemic is
so complex, so variable, and so culture- and community-bound it is almost impossible to identify what particular actions make a difference (Parkhurst, 2000; Coombe, 2002).

Field experience and observation suggest nevertheless that there are a number of practical generic strategic principles for saving lives, and protecting education. Some of them are very basic.

_Honesty_. Everyone in the education sector needs to be more honest, to stop pretending that the sector is doing its best or that teachers are the ones best disposed to teach safe sex and reproductive health.

_Direct intervention v. behaviour change_. HIV/AIDS must be factored into poverty-reduction planning, and the pandemic confronted within the context of poverty that drives it. Relatively straightforward, radical, humanitarian interventions can be made: treating sexually transmitted infections, providing sufficient condoms to secondary and tertiary institutions, establishing home-based care and school feeding schemes, training peer health educator teams for all institutions, and ensuring each institution has access to adequate latrines and potable water, for example. These measures are only the beginning, but they can save lives in the short term while longer-term development programmes are being assessed, governments mobilized and resources allocated, while the capacity of NGOs is strengthened and behaviour-change programmes commenced in earnest.

_Management appropriate to crisis_. Crisis management capacity in and out of government must be enhanced. Where they exist, HIV-focal points in ministries of education – often curriculum specialists with a part-time brief to keep an eye on HIV matters – must be replaced with senior executives, generals who can fight this war with
appropriate senior management staff, *materiel*, mandates and resources.

*Simplicity.* Significant progress can be made rapidly by choosing relatively simple-to-manage interventions that are appropriate to the current management capacity of the sector. Changing adolescent behaviour via the curriculum is a complex and long-term initiative while tracking down and treating sexually transmitted infections among learner populations is easier to manage, and may be an attractive target for international agency support. The same is true of school feeding programmes that keep children in school and ensure they are properly nourished and socialized.

### 3.2 Providing support for children in trauma

Educators will need to develop techniques for targeting orphans and other vulnerable children (OVCs) within the context of poverty. Orphans are learners or potential learners, and as many as 10 to 15 per cent of all learners in high-prevalence countries will be orphans within the decade. In some schools as many as 60-70 per cent of learners may be profoundly affected by loss of parents. Hunter and Williamson (2001) suggest that effective strategies for OVCs must include strengthening families’ and children’s capacity to cope, mobilizing community and government support, and creating learning and social environments that protect and promote the rights of children and their families.

UNICEF, UNAIDS and other partners elaborated OVC programming principles in 2001 (UNICEF, UNAIDS *et al.*, 2001). Botswana (close to 40 per cent prevalence), where the Office of the President is responsible for the nation’s HIV/AIDS response, has taken practical action to promote the concept of a ‘circle of care’ for OVCs which includes largely voluntary home-based care (social welfare), a school
feeding scheme for all children (education), orphan subsidies (social welfare and health), and close co-operation among teachers, social workers and health practitioners (Abt Associates, 2001).

3.3 Working collaboratively

Governments regularly indicate they are committed to co-operating with NGOs. In practice, it is often not clear how partners at national and local level are being strengthened and resourced (MTT, 2000-2003). Governments clearly have a responsibility to coordinate and strengthen local responses, create policy and establish a regulatory framework. It is their duty to deliver health and social welfare services appropriate to community requirements, as well as to improve school and clinic programmes to cope with changing demands. They must ensure that sufficient funds are mobilized and channelled to those who can make best use of them. Ultimately, governments must work in support of communities, and national strategies must reflect this balance (International HIV/AIDS Alliance, 2000).

No one underestimates the difficulties of creating collaborative mechanisms, structures and processes to drive local programmes. There are few models from which to learn. Ministries of education have struggled for years to decentralize decision-making and executive responsibility, and now that lives depend on it, perhaps they will make faster headway. There is as yet little sense that in heavily infected countries the potential of HIV/AIDS to create havoc for education requires the appointment of senior, full-time and experienced executives to fight this war. The challenge of five million HIV/AIDS orphans in the SADC region by 2010 may help to focus governments’ attention more purposefully. This is a crisis that demands crisis management (see Appendix 1).
Meanwhile, at local level, NGOs, community- and faith-based organizations are making a difference in the lives of women and children. They provide support to teachers and heads as counsellors. They train children and teachers in peer counselling. They teach lessons of safe sex, work in communities to defuse violence, and care for the abused and violated. They are at the coalface. They are doing the job. Their contribution is not just considerable: it is fundamental, however fragmented it may be. Strengthening education’s response now depends on how the programmes of non-government partners are integrated in the sector’s strategic planning and resource allocations, and whether or not they can be scaled up effectively.

4. **Breaking the circle of despair**

The pandemic called HIV/AIDS is undoing the development gains of the past three decades, at least in Africa. It is folly to believe that similar challenges to development will not emerge in Latin America and the Caribbean, Eastern Europe, Asia and the Pacific. This is not an ‘African’ disease, it is not an ‘African’ pandemic.

Real progress will only be made when senior educationists and governments make a true commitment to fight this battle: the money, resources, and enough senior managers to make things happen. So far, the management foundation for creating an enabling environment is notably absent in infected areas of Africa as ever more children are dispossessed by the burden of HIV/AIDS.

Amartya Sen is principally concerned about making things happen, about finding ways to make a difference in the face of catastrophe: diagnosis, counteraction, collaborative dedication, and sustained accountability. The profile of the HIV/AIDS pandemic is being slowly defined so that it is now possible to identify where action must be taken. Government inertia has in effect empowered communities to
work co-operatively to take control of their own security and survival. But planning how to reduce the impact of the pandemic on the education service must still lie with national authorities. Who will hold them accountable?

HIV/AIDS is the most significant issue in developing-country education today, and perhaps the biggest challenge to development. The imperative to respond effectively to this pandemic requires a fundamental rethink of development principles and procedures, and of relationships between governments, local communities, and funding partners. Education is the potentially positive component of the HIV-poverty-education circle of hope and despair. Whether it brings hope – and more important, practical benefit – to the afflicted remains to be seen after two decades of widespread suffering and dispossession.

5. This volume

In this new context, education can no longer be ‘business as usual’. Learning institutions in an AIDS-infected world cannot be the same as those in an AIDS-free world. Challenged by this pandemic, the paradigm of education is shifting. It is necessary to change educational planning and management principles, curriculum-development goals, and the way we do education if the quality and level of education provision are to be sustained at reasonable levels, and the hard-won gains of the Education for All era retained.

Educators must of necessity move from a narrow ‘HIV education’ curriculum campaign towards a broader ‘HIV and education’ paradigm. What does ‘HIV and education’ mean? The pandemic-as-phenomenon is vastly complex, and individual educators, researchers, policy-makers and analysts, planners and funders each confront this plague from a different perspective, based on experience and training:

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Some are guidance and counselling specialists who are concerned about orphans and other vulnerable children in our classrooms; some are gender specialists concerned about violence against women and girls which spills into learning institutions and on which the disease thrives; some are teaching service managers concerned about controlling and managing the impact of high levels of morbidity and mortality on educators and children, and keeping education quality at acceptably high levels; others are educational planners and practitioners who concentrate on the potential consequences of the pandemic for education sub-sectors like higher education, schools, or early childhood development; others are curriculum and materials specialists; most are simply teachers who are trying to cope with children in trauma, children who are abused or suffering emotionally from untold loss to HIV.

All are educators trying to understand in one way or another the parameters of the HIV challenge. And all are affected by the pandemic. A broad multidisciplinary approach by educators to the pandemic is essential and the papers in this collection reflect some of their multifaceted concerns.

Michael Kelly’s paper, “Preventing HIV transmission through education”, was first presented at South Africa’s Ministerial Conference on HIV/AIDS and the Education Sector: An Education Coalition Against HIV/AIDS (30 May-1 June 2002). Kelly emphasizes the link between education and prevention programmes: at the present time, education is the only ‘social vaccine’ available against HIV infection.
Desmond Cohen, in “HIV and education in sub-Saharan Africa: responding to the impact”, takes an overview of the implications of the pandemic for education systems, for learning institutions, and for education quality. His concern lies with the managerial ability of education systems to meet their core responsibilities, as they are additionally hard-pressed by HIV/AIDS.

Gabriel Rugalema and Vivian Khanye, in “Mainstreaming HIV/AIDS in the education systems in sub-Saharan Africa: some preliminary insights”, explore attempts by African ministries of education to mainstream HIV/AIDS, to integrate HIV/AIDS issues in education policies, programmes and projects in order to have an impact on the epidemic, and then to implement. Their analysis is based on country action research being undertaken under the aegis of the Association for the Development of Education in Africa (ADEA), and it provides a critical initial evaluation of ministries’ successes and failures.

Relebohile Moletsane, Robert Morrell, Elaine Unterhalter and Debbie Epstein, in “Instituting gender equality in schools: working in an HIV/AIDS environment”, take the discussion to school level, and engage particularly with the language of gender equality. Their paper explores the role of school cultures in sustaining or undermining initiatives concerning HIV/AIDS education on the assumption that “focus on schools as organizations and their social location has not previously been a feature of any of the published research on HIV/AIDS and education”.

John Lawrence’s analysis of the UNDP-sponsored interactive virtual e-dialogue (“The Internet and social development: African voices on HIV/AIDS and education”) suggests that networking through a user-friendly medium provides unique opportunities for governments, individuals, professionals and technical personnel to ‘break the silence’ around HIV/AIDS. He sets out some of the thematic
interchanges promoted by the e-dialogue and the advantages of this form of information-sharing among constituencies in the sub-Saharan region and beyond.

Liesel Ebersohn and Irma Eloff, in “The black, white and grey of rainbow children coping with HIV/AIDS”, explore the complexities of how children cope with the traumas associated with HIV and AIDS. This seminal analysis builds on a recognition that it is no longer possible to assume that all children process trauma, loss and grief in the same way, and as such initiates what will be a continuing exploration of culture and grief. The paper assumes that cultural beliefs and values are fundamental guidelines in the cognitive process of determining what an event means, and that while it is possible to assume certain universal principles of coping, traditional indigenous coping mechanisms in South Africa are likely to differ from those elsewhere.

Amy Hepburn (“Increasing primary education access for children in AIDS-affected areas”) is also concerned about children distressed and disadvantaged by the pandemic. She considers the depth of the orphaning crisis in Africa and the barriers to learning encountered by orphans and other vulnerable children. Her paper concludes with proposals for ways in which communities can take charge of the needs of such learners for critical learning skills, while taking into account their need for security, stability, personal growth and development.

Fiona Leach (“School-based gender violence in Africa: a risk to adolescent sexual health”) questions whether African learning institutions are appropriate places for delivering risk-awareness campaigns. She considers the existence of a culture in learning institutions that promotes the development of stereotypical masculine and feminine behaviours and strong peer pressure to
conform, and continues to condone gender-based violence. She concludes with proposals for ‘breaking the silence’ around unsafe environments in learning institutions.

Gudmund Hernes (“UNESCO and HIV/AIDS”) provides a powerful assessment on 10 principal lessons that have been learned since HIV/AIDS began its devastation over 20 years ago. He aptly concludes this series of articles with the observation that “much is still not known about the HIV/AIDS pandemic. Much remains to be learned and our understanding in many respects remains deeply flawed. But enough is known to act. We know we must act immediately, decisively and massively”.

The articles in this collection have only touched the surface of profound concerns about HIV and AIDS. Perhaps it serves particularly to highlight gaps in understanding of prevention, social support and management issues at the core of successful responses to the pandemic. More is needed, much more, and it is clearly evident that education sub-sectors – particularly higher education, early childhood development and lifelong and alternative learning – and the plight of orphans and affected learners require their own critical explorations.

Perhaps the most urgent need of all is to understand the process of managing the response to HIV/AIDS, of moving beyond identifying the problems and then doing some strategic planning. Implementation of effective anti-AIDS initiatives has been, quite clearly, woefully inadequate worldwide. The urgent need to save lives creates an opportunity to improve education provision at all levels. In this way, and in this way alone, HIV/AIDS may have a positive impact on education.

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References


HIV/AIDS, poverty and education: the circle of hope and despair


Appendix 1. **SADC Ministry of Education responses to HIV and HIV/AIDS (13 countries as at February 2001)**

<table>
<thead>
<tr>
<th>Education sector action</th>
<th>Y</th>
<th>P</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creating a foundation for action</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combined approach: Is equal consideration given to (1) preventing the spread of HIV and (2) reducing the anticipated impact of the pandemic on education?</td>
<td>3</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Leadership: Are political leaders, senior officials, unions, the teaching service, and school governing bodies knowledgeable and committed to action?</td>
<td>4</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Collective dedication: Are partners outside government involved in the fight against HIV/AIDS? Do mechanisms exist for partnerships?</td>
<td>4</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Research agenda: Is information about HIV/AIDS being collected, analyzed, stored and spread? Is there an HIV/AIDS and education research agenda for the education sector?</td>
<td>2</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Effective management: Has a full-time senior manager been appointed? Does a standing structure exist which includes partners in and out of government?</td>
<td>5</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Policy and regulations: Are HIV/AIDS sector policies and regulations in place? Are there appropriate codes of conduct for teachers and learners, and are they applied rigorously?</td>
<td>1</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Strategic plan: Is there an education sector HIV/AIDS strategic plan which covers all levels of the education sector, and is it funded?</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Resource allocation: Are plans being funded adequately? Are funds being channelled to various levels of the system, and to partners outside government who can use them?</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Helping to limit the spread of AIDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate curriculum in all learning institutions: Are learners being guided through the curriculum on safe sex and appropriate behaviours and attitudes?</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Materials developed and distributed: Have materials suitable for learners in schools and post-school institutions been developed and distributed to institutions? Are they up to date?</td>
<td>1</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Serving educators prepared: Are schoolteachers adequately prepared through pre-service and in-service to teach life-skills curricula? Have they accepted this responsibility?</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

The HIV challenge to education: a collection of essays

<table>
<thead>
<tr>
<th>Area</th>
<th>Y</th>
<th>P</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher educators prepared: Have university, teacher-training college and local teacher-support staff been trained in HIV/AIDS issues and curriculum implementation?</td>
<td>0</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Evaluation of curriculum and materials: Have materials and courses been evaluated in terms of content, implementation and outcomes?</td>
<td>1</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Counselling for learners: Can pupils and students who are affected by HIV/AIDS find help from their teachers? Or from someone else?</td>
<td>0</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Counselling for educators: Are teachers affected by HIV/AIDS, and those who are dealing with the trauma of children affected by HIV/AIDS getting help to cope?</td>
<td>0</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Partnerships: Are other partners helping with prevention programmes?</td>
<td>0</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Mitigating the impact of HIV and AIDS on the education sector</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment: Has an assessment been done of the likely impact of HIV/AIDS on the education sector in future?</td>
<td>4</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Risk profile: Is there some understanding of the factors that make educators and learners vulnerable to infection?</td>
<td>0</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Stabilizing: Are steps being taken to sustain the quality of education provision and to replace teachers and managers lost to the system?</td>
<td>0</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Projecting: Have relatively accurate projections been made of likely enrolments and teacher requirements at various levels of the system over the next five to ten years?</td>
<td>2</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Social support: Are children affected and infected by the pandemic receiving counselling and care? Is there a culture of care in schools and institutions?</td>
<td>1</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Responding creatively: Is the system trying to provide meaningful, relevant educational services to learners affected by HIV/AIDS, finding new times, places and techniques for learning and teaching?</td>
<td>0</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Orphan needs: Is planning under way to understand and respond to the special needs of increasing numbers of orphaned and other vulnerable children?</td>
<td>1</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>All sub-sectors: Is attention being paid to the planning requirements of all education sub-sectors – from early childhood development through to university?</td>
<td>0</td>
<td>8</td>
<td>5</td>
</tr>
</tbody>
</table>

Y = Yes, action in being taken.
P = Some action is planned.
N = No action is being taken.
CHAPTER 2. PREVENTING HIV TRANSMISSION THROUGH EDUCATION

Michael J. Kelly

A member of the Jesuit order, Michael Kelly has recently retired from the University of Zambia where he served for 27 years as Professor of Education (and for a period as Deputy Vice-Chancellor). He has been associated with all of Zambia’s post-independence educational reforms and has worked extensively with various international agencies. In recent years, in response to the devastating impact of HIV/AIDS on human well-being and educational provision, he has become increasingly involved in work relating to the interaction between HIV/AIDS and education. He is the author of Planning for education in the context of HIV/AIDS, published by UNESCO-IIEP in September 2000, Challenging the challenger (Understanding and expanding the response of universities in Africa to HIV/AIDS), published by the World Bank on behalf of ADEA in March 2001, and numerous journal articles and conference presentations on HIV/AIDS and education.

Abstract

The paper highlights the significant contribution education, especially formal education, can make to the prevention of HIV transmission and examines four modalities which would enable the sector to play an even more crucial role: meeting the International Millennium Development Goals of universal access to compulsory education of good quality and the elimination of gender disparities.

3 Much of the content of this paper appears in ‘Addressing the susceptibility of youth to HIV infection’, a paper for presentation at an International Policy-makers Conference on HIV/AIDS, New Delhi, India, 11-12 May 2002.
at all school levels; mainstreaming HIV/AIDS into every aspect of education; establishing programmes that run along a continuum from prevention to care; and engaging creatively with others in the public sector and across civil society. Prevention education programmes are considered in more detail in terms of their thrust, context, content, and methodology, channels and communicators. Emphasis is put on understanding, leading to practice, in the areas of responsible sexuality and healthy living. The paper concludes by stressing that if preventive education messages are to have the desired impact, they must be affirmed with a single, unanimous voice, whereas conflicting messages may lead to confusion and lack of action.

Introduction

On 5 June 1981 the United States Centres for Disease Control published a report about a new disease that was hitting gay men. That report ushered in the AIDS era. Twenty-one years have passed since then, years in which the disease has grown to nightmarish proportions, with almost every passing year seeing the need to revise upwards already dire estimates and projections. In 1991, the World Health Organization expectation was that by the year 2000 HIV infections worldwide would amount to some 20 million. The projection was almost three times short of the mark. Since the epidemic began, more than 60 million have been infected with the virus, at least 20 million have died of the disease, and a conservative estimate is that presently some 40 million people are living with HIV/AIDS.

1. Education’s significant contribution to the struggle with HIV/AIDS

Currently there is no known cure for HIV or AIDS. Work on the development of a vaccine is proceeding, but none is yet available and
the likelihood seems to be that 10 years or more will pass before a universally available, affordable and easily applied vaccine comes on to the market. Drugs that hold HIV in abeyance are available, but even with the substantial price reductions that have been effected in the past year, their cost remains very high, their administration requires a well-developed health infrastructure of the kind that several countries do not have, and there are growing concerns about the development of HIV strains that are resistant to the drugs currently in use. Excessive reliance on controlling the epidemic through the provision of antiretroviral therapy for infected individuals also faces massive annual cost increases, since new numbers will be added each year to the ranks of those whose lives are being prolonged by a therapy which must be maintained throughout life.

In this set of circumstances, preventing the further transmission of HIV must be the principal strategy. In its turn, prevention depends very heavily on education. A little reflection will show how every prevention effort, the majority of coping strategies, much of the activity directed towards the mitigation of impacts, and virtually every programme designed to outwit and get ahead of HIV/AIDS, depends in one way or another on education. It is no exaggeration to say that in the current state of scientific knowledge and development, the only protection available to society lies with the ‘social vaccine of education’.

In addition to being part of every information, education, and communication (IEC) approach, formal and non-formal education “offer a window of hope unlike any others for escaping the grip of HIV/AIDS” (World Bank, 2002: 2). There are several reasons for saying so:

1. Education, and above all school education, has been shown to be related to the reduction of HIV prevalence rates among young
people. Uganda and Zambia have both experienced dramatic declines in the infection rates of the sub-group of 15-19 year-old girls with secondary-school education, and in Zambia it has been found that a girl who has dropped out of school is three times more likely to be HIV infected than one of similar age who remained in school (Fylkesnes et al., 2001). The precise mechanisms by which education contributes to this change are not yet clearly understood. They may lie in a combination of enhanced ability to use information, the package of habits and dispositions that learners accumulate throughout their school days, the way school education opens one up to future prospects, and the increased opportunities it provides for economic independence (Coombe and Kelly, 2001).

2. Formal school education reaches the majority of young people in a country. Further, it reaches them at an early age when they are in their most formative years. Therefore it has the potential to transmit significantly important HIV prevention and other AIDS-related messages to young people when they are in their most receptive developmental stage.

3. School education is among the most powerful tools for transforming the poverty and gender inequality environment in which HIV/AIDS flourishes. It is universally acknowledged that growth out of poverty and growth in education are almost synonymous. Likewise, the education of both boys and girls contributes significantly to the evolution within a society of an environment where there is less acceptance of gender inequality and female disempowerment.

4. Girls who remain longer in school tend to commence sexual activity at a later age, are more likely to require male partners to use condoms, and marry at a later age (World Bank, 2002). Each of these factors contributes to the reduction of HIV transmission.
2. Strengthening education’s capacity in the struggle with HIV/AIDS

Education, especially school education, can play an even more crucial role in the combat with HIV/AIDS. Already doing well, it can do even better. Enhancing the contribution that education can make to reducing the likelihood of HIV transmission and managing the impacts of the disease requires attention to the following issues:

2.1 Expand access and improve the quality of provision

Education in the sense of schooling can do nothing to reduce the transmission and impact of HIV/AIDS for children who – for whatever reason – cannot enrol in school. Neither can it promote the knowledge, understanding and attitudes that are fundamental to the reduction of HIV transmission if the quality is so poor that real and meaningful learning achievement does not occur.

Hence the AIDS epidemic underscores the crucial importance of attaining the International Millennium Development Goals that relate to Education for All (EFA). These are:

1. To ensure that by 2015 every child can access and complete free and compulsory basic education of good quality; and
2. The elimination by 2005 of gender disparities in primary and secondary education.

“Full speed ahead on EFA goals is vital … A general basic education – and not merely instruction on prevention – is among the strongest weapons against the HIV/AIDS epidemic ... An urgent, strategic, and education-centred response ... is of the utmost importance.” (World Bank, 2002: 6)
It is also important to take steps that will enable children, especially girls, to continue in school to the secondary level. What is gained at this level appears to make a crucial difference to the protection of oneself and one’s potential partner against HIV infection. Expanded access to secondary education also provides a surer route out of poverty, at both individual and national levels, and through this mechanism provides a more comprehensive defence against HIV transmission.

2.2 Mainstream HIV/AIDS into every aspect of education

The potential of HIV/AIDS to devastate the lives of individuals, the economies of countries, and education systems themselves, is too great for the disease and its consequences to be merely bolted on as some additional consideration within the programmes of already over-worked education ministries, departments and institutions. This is the most devastating disease that humanity has ever experienced. Responding to it is not an optional extra, but must be an integral and accountable part of concerns and programmes at all levels, from the office of the Minister down to the humblest village school.

Accentuating the importance of this mainstreaming is the fact that HIV/AIDS places the entire education system and all its institution under profound threat. An education system that does not mainstream HIV/AIDS into every facet of its operations runs the risk of being overwhelmed by the epidemic and the variety of its impacts. It can become so weakened by the epidemic (through the loss of educators, impairment of quality, numerous negative effects on learners, educators and managers, and constraints on resources) that its ability to provide both general education and HIV/AIDS education could be greatly reduced. In the absence of mainstreaming, the one system that has the potential to provide crucial HIV protection to
society could find that it was unable to do so because it was itself besieged by a network of interrelated, debilitating, and complex AIDS-related problems.

A practical aspect of this mainstreaming is to ensure that education policies, procedures and regulations are reformulated to take account of HIV/AIDS. It will also be necessary to incorporate HIV/AIDS issues into every aspect of an education ministry’s strategic planning process. In severely affected countries, mainstreaming HIV/AIDS will also necessitate dedicated structural arrangements, involving full-time staff possessing considerable authority and backed up with adequate human, financial and material resources, who will maintain the momentum for progress in everything that relates to the interaction between the disease and the education sector.

2.3 Establish programmes and activities that run along a continuum from prevention to care

At the sectoral level, provision must be made for programmes that respond to the prevention needs of employees. If the system is to function, all categories of education staff must know about the disease and how to protect themselves against it. This calls for programmes that address HIV/AIDS in the workplace. At the institutional level, there is need for specific prevention education programmes that teach about HIV/AIDS and such related areas as reproductive health (see below).

Realization is growing that responding to the care and treatment needs of those infected with HIV/AIDS is an essential complement to prevention efforts. There is also growing recognition of the need for attention to the management and mitigation of impacts. Aspects that are of particular relevance to the education sector include responding to the needs of the exponentially increasing number of
orphans, catering for learners, educators and education employees who are HIV infected or whose condition has progressed to AIDS, reaching out to and providing support for infected persons in communities, especially those who are relatives of school personnel, and establishing schools as multipurpose welfare and development centres within affected communities.

2.4 Engage creatively with others

In the past the cardinal error was made of treating HIV/AIDS as being primarily a health problem. To treat it as being primarily a problem for education would be to repeat and compound the error. HIV/AIDS is wider than any sector, but touches the entire range of development and human welfare interests. Responding to it likewise demands the widespread participation and interaction of players from various areas of the public sector, as well as the involvement of the numerous organs of civil society. The walls of territoriality that government ministries/departments build for themselves and that the government sector sometimes uses to effect the marginalization of NGOs, faith-based communities, community-based organizations, business coalitions, and other partners, must be broken down. It is paramount that in the struggle with HIV/AIDS the education sector manifest the fullest co-operation, sharing of resources and facilities, and collaboration in programme design, implementation and evaluation, with these and other potential partners. The problem of AIDS is too large for the sector or any of its partners to deal with on their own. But working together they can succeed in bringing it to heel.
3. Characteristics of the teaching and learning response to HIV/AIDS

In the context of HIV/AIDS an education system has two major tasks:

1. It must maintain itself in a functioning condition that will enable it to provide the services expected of it, in relation to the epidemic and all other areas;
2. It must equip those for whom it has responsibility, above all learners, with the knowledge, skills, attitudes and values that will reduce the likelihood of their acquiring or transmitting HIV infection.

The remainder of this article focuses on the second of these tasks. Moreover, since sexual activity is the principal mode of HIV transmission in Africa, the discussion will centre on this.

4. The objective of preventive education programmes

Almost invariably the literature pre-empts discussion of preventive education by the way it repeatedly speaks about changing behaviour, but rarely about maintaining behaviour. Thus, UNESCO’s strategy for HIV/AIDS preventive education speaks of prevention as “the most patent and potent response, i.e., changing behaviour by providing knowledge, fostering attitudes and conferring skills” (UNESCO, 2001: 10; emphasis added). The presumption appears to be that sexual behaviour, especially among young people, is almost bound to be risky and hence needs to be changed into something safer. This does not sit lightly with the fact that a very high proportion of adults and young people is not HIV infected. In addition, such an approach does not express much confidence in the ability and commitment of the majority of adults and young people to behave in a sexually responsible way.
A more comprehensive approach is to see the ultimate objective of education’s concern in this area as being to promote behaviour that will not put an individual or any partner at risk of HIV infection. For many young people, this will involve helping them to maintain existing behaviour patterns that are safe and do not put them at risk of HIV infection. For others it will involve helping them to replace behaviour patterns and activities that put them at risk of HIV infection, with those that are safe.

Hence the thrust of educational efforts to stem HIV transmission should be to empower those who participate in programmes to live sexually responsible, healthy lives. This implies understanding, leading to practice, in two areas, sexuality and healthy living. These are the two principal areas around which programmes should be developed. They are central to everything else, and from them must flow the values and attitudes that will manifest themselves in information, practices, skills, and techniques.

This means that in the context of the sexual transmission of HIV, a good preventive programme will begin at the proper beginning, that is, in promoting an understanding of sexuality and relationships. Educators should not hesitate to affirm that both of these are very good and beautiful. They should be enabled to lead learners to appreciate that sexuality is a wonderful, extremely powerful energy, experienced in every cell of one’s being as a mighty urge to overcome incompleteness and to find fulfilment in a strong and abiding relationship with another. Recognizing the special potency of relationships for adolescents and young adults, educators should be equally forceful in affirming the value and wonder of a relationship, something that is so valuable that it needs safeguards, whether these be of no sex, deferred sex, or protected sex.

Having sex – or genitality, the physical, genital dimension of sexuality – is a very important aspect of these larger realities of
sexuality and relationships. But it is no more than an aspect. It does not exhaust the full notion of sexuality which can work powerfully and constructively even in the absence of the particularized, physical, short-lived bodily encounter with another that constitutes ‘having sex’. In practical terms this means that it would be a mistake for an educator to focus on protection messages, whether these relate to abstinence, condom use, delaying sexual debut or whatever, prior to establishing a good understanding of the meaning of sexuality and relationships. Too often, preventive education programmes focus too early on the knowledge, attitudes and skills involved in immediate sexual practice, without striving to embed these in a more holistic approach that takes account of the roots of human behaviour. It is not surprising, then, to find that the desired practices may be maintained as long as the programmes last, but do not persist when the programmes end.

The second basic area for consideration is healthy living. Conditions of poverty facilitate HIV transmission partly because the body’s defence mechanisms are already run down through malnutrition, the legacy of other illnesses, a heavy burden of parasites (especially from malaria), and vitamin and trace element deficiency. When HIV succeeds in gaining admission to such an impoverished body its task is greatly facilitated because the defence system is already low. The individual can become infected in circumstances where a better nourished and healthier individual would be able to ward off the infection. Increasing attention to host susceptibility to HIV infection is opening new avenues for understanding the spread of the virus and for the design of effective prevention strategies (Stillwaggon, 2000). What appears to be emerging is that maintaining a healthy way of living is in itself a substantial step in the direction of preventing HIV infection.
Healthy living is also a significant step in the direction of slowing down the progression of HIV to clinical AIDS. All other things being equal, infected persons who maintain a healthy lifestyle are likely to enjoy more years of life than infected persons who do not take balanced nourishing meals, who smoke, take alcohol or use drugs, and who do not take adequate exercise and rest.

Information about the significance of living in a healthy way is an important message that educators can always communicate, without fear of giving any offence to parents or other stakeholders. It could also be a life-saving message since, given the developments in vaccine technology, it might contribute to keeping an infected person alive until such time as a vaccine applicable to infected persons becomes available. But it is a message that is rarely communicated in the context of HIV/AIDS and that may be glossed over even in health science programmes.

5. The context for preventive education programmes

If it is to be effective a preventive education programme must be rooted in the context of the lives and circumstances of the target audience. Certain aspects of that context are vitally important, since by establishing conditions that facilitate the transmission of HIV they actually run counter to what the programmes are trying to communicate. Areas that merit special attention include the school situation, the culture of the home and community, poverty and gender.

In principle the school should provide a health-affirming and safe environment within which learners and educators can develop and fulfil themselves in performing their teaching-learning tasks. In practice the school environment may be neither health-affirming nor safe. Overcrowded, inadequately furnished, poorly lit, with no
assured source of clean water, with minimal sanitation facilities (if any), the school may well be the antithesis of a health-affirming environment. The situation is made worse by the hunger with which many learners (and several educators) begin the school day and with which they must cope during their learning exercises, while that same hunger and malnutrition have the physiological effect of accentuating learning difficulties. By being centres where boys and girls may find themselves being coerced into sex, with teachers or with fellow-learners, schools also fail to provide the safe haven they should.

School should be a safe and happy place for children and adolescents, who should feel that this is where they really want to be. But for far too many, attending school is something negative, all too often being little more than an occasion for experiencing lassitude, pressures, anxiety, fear, and abuse. HIV prevention programmes that take place in a school setting must try to ensure that their messages take account of the real conditions that learners experience.

Educators are usually aware that a knowledge and information gap exists between the home and school. However, they do not always make allowance for an equally wide but frequently much deeper gap between the values, attitudes and behaviours promoted in the school and those enshrined in the totality of life in the community and home. Underlying this gap there may even be a radical difference in philosophical outlook. Bridging this gap can be crucial for the effectiveness of HIV preventive education programmes.

The school may treat HIV/AIDS (and other diseases) as being caused by an identifiable virus. However, the community and home may see the cause lying elsewhere, with spirits, or with powers and forces that are under the control of certain individuals (UNeca, 2000: 36-40). The traditional approach, which interprets diseases and their causes in terms of the cultural world of taboos, obligations, and sorcery, may be much more influential in shaping behaviour than the
rational explanations of modern science. But this cultural perspective is rarely taken into account. This is not a plea to abandon the scientific approach, but a call to root HIV preventive education (and other programmes) more firmly in the Weltanschaung or world-view that has pre-eminent value in motivating the personal behaviour of learners.

Poverty, with its concomitants of inadequate employment opportunities, lack of recreational outlets, and a pervasive sense of hopelessness and ennui, creates a fertile ground for activities conducive to HIV transmission. One who lives in poverty lives for the present. The future is remote and unreal. The long latency period between the time of initial HIV infection and the eventual manifestation of AIDS makes it difficult for young people, but more especially for those who are poor, to appreciate the consequences of their current actions. More than others in the population, the poor may adopt a fatalistic attitude towards infection, seeing it as almost inevitable that they should receive the worst things in life. They may also believe that HIV care and treatment will not be for them and in consequence may not seek such help as might be available. The HIV preventive education programme must take account of these realities. While poverty issues may be addressed in other school disciplines or out-of-school programmes, the prevention programme should also take special note of their significance across the entire prevention-to-care spectrum.

Because of their lower social and economic status, many women and young girls cannot negotiate sexual encounters, experience pressing need to maintain relationships with a sexual partner, and may be required by a variety of economic and other circumstances to engage in commercial sex activities. Each of these situations increases their vulnerability to HIV infection. Other social circumstances, such
as domestic abuse, widespread coercive sex, rape, and child abuse, also increase their HIV risks. Because of these factors, the inequality and lack of empowerment that women and girls experience in numerous areas of sexuality and human relationships can be fatal (Commonwealth Secretariat, 2001). This is the context within which those passing through preventive education programmes will live. Hence it is a context that must be to the fore in the delivery of the programmes, while at the same time stringent efforts are made to root out misconceptions, false attitudes, and harmful practices.

The gender aspect of the context must also recognize that in many respects AIDS is a man’s disease, though women bear the brunt of the impacts. The disease was first observed in men, it has been transmitted worldwide by men, and it is kept going by men. Part of the reason for this lies with false images of masculinity and what it means to be a man. A worthwhile programme will explore these images and help participants to develop an image of manhood that finds its expression and fulfilment in a caring and respecting attitude towards women and girls.

6. The content of a comprehensive preventive education programme

Ideally, the content of comprehensive HIV prevention programme, whether delivered through schools or otherwise, should extend to the following areas:

- Sexuality and relationships, leading to a good understanding of what sexuality means, its role in relationships, and the norms for healthy sexuality.
- Manifesting respect and regard for others in a spirit of equality and power-sharing between males and females that extends to all areas of life.
• Knowledge and understanding of HIV/AIDS, the modes of transmission, what infection does within the human body, how it progresses, and how it can be treated.

• Popular misconceptions, errors and myths relating to HIV/AIDS.

• A core set of psycho-social life-skills for the promotion of the health and well-being of learners. These should include decision-making, interpersonal relationships, self-awareness, stress and anxiety management, coping with pressures, the negotiation of contentious situations, assertiveness, and attitudes of self-esteem and self-confidence.

• Knowledge and understanding of how to manage and protect one’s reproductive health.

• The role and value of abstinence, the development of positive attitudes towards this, and the skills that enable one to abstain from sexual activity.

• The meaning of protected sex, the role it plays in preventing HIV infection, the skills that are implied, and how to access and use condoms and other supplies.

• Other HIV risk-reducing factors, such as delayed sexual debut, reducing the frequency of partner exchange, avoidance of casual sex or the management of such encounters to protect against HIV transmission.

• Fidelity in marriage and management of the marriage relationship if HIV is present.

• The desirability of voluntary counselling and testing, and the importance of early presentation of potential sexually transmitted diseases (STDs) to the appropriate health services.

• The meaning of a healthy lifestyle, its role in making an individual less susceptible to HIV infection, and its role in promoting the quality of life and extending the survival years of an individual who is HIV infected.
Some observations are in order about this comprehensive programme. First, learners should be introduced to it while they are still very young, some would say from the day they commence school. While it may be necessary to begin at a later age for those who are already in the school system, HIV/AIDS-related forms of education should start as early as possible with younger children, and certainly well before they enter the period of puberty. Summary findings from 17 countries, presented to the ADEA Biennial Meeting held in Arusha in September 2001, showed that “countries want programmes to be proposed to students before they become sexually active” (ADEA, 2001: 7). This means that students should be introduced to HIV preventive education no later than middle-primary school. Even earlier would be better. Later would be too late. But whatever is presented to children must be appropriate to their age and grade. It would be foolhardy and counterproductive to expose young children to matters that were beyond their comprehension and experience.

Second, there is need to remain sensitive to the concerns of parents and community leaders. These may express the fear that some elements in the programme that has been outlined might lead learners to increased sexual behaviour and experimentation. They need to be reassured that the overwhelming weight of evidence is that this form of education does not lead to an explosion in sexual activity. On the contrary, careful investigations, in Africa and elsewhere, have found that it contributes to delay in the onset of sexual activity, increased recourse to abstinence, reduction in the number of sexual partners, and a lessening of the incidence of STDs and unwanted pregnancies (Gachuhi, 1999; UNAIDS, 1997). Open discussion with the representatives of parents, and with cultural, traditional and religious leaders, can help to ensure that the messages are communicated within a framework that accords with the best values from these traditions. The participation of these groups in the actual communication process may well be one of the best ways of ensuring
that significant parties are all speaking with one voice, a factor that is crucial to the translation of programme messages into practice.

7. Methodology, channels and communicators

Education about HIV/AIDS and related areas is not an optional extra. It is a matter of life and death. Because of this it is vital that it secure the wholehearted engagement and commitment of learners and educators. Moreover, this commitment must be real and personally assimilated. It must engage the whole person, including but going beyond academic, intellectual knowledge to the spheres of action and behaviour. This makes this kind of education different from all others. In the field of education and communication it is a concrete example of the observation that life in a world with AIDS cannot be the same as life in a world without AIDS. With AIDS it can no longer be business as usual.

These considerations have a direct bearing on the methodologies and channels adopted for HIV preventive education programmes. It is crucial that these be interactive and participative. There should be no room for passive learning, and even less for rote learning and memorization. This is one reason why it can be inappropriate to rely almost exclusively on incorporating elements from the programme into examination subjects as a way of monitoring whether they are being taught and learned. The enduring challenge to such an approach is the risk that the teaching and learning will focus on the examinable aspects, and that they will concentrate on getting much into the head, but comparatively little into the heart.

The challenges from HIV/AIDS are so all-encompassing that they call for an equally wide variety of prevention education approaches. As far as possible a number of these should be used simultaneously, with each approach reinforcing the messages that come from the others. They include such approaches as:
• formal classroom teaching-learning activities of a highly interactive nature;
• programmes for learners and/or educators provided by NGOs and other agencies;
• extra-curricular activities, programmes, and societies/clubs/circles/guilds falling within the normal framework of school activities;
• youth-oriented purpose-designed programmes within communities;
• broader community education activities;
• intensive short duration workshop-like activities; and
• programmes organized by non-school bodies (sports, youth, social service, church, mosque, and other organizations).

Special mention must be made of approaches that capitalize on the power of the media and entertainment industries to reach and exert significant influence on large numbers. Probably the most sophisticated example of these is Soul City, the South African NGO which makes comprehensive use of television, radio and print presentations in a conscious effort to promote socially acceptable behaviour, in all that relates to HIV/AIDS as well as in other fields. The effectiveness of these multimedia campaigns appears to be greatest when they are combined with face-to-face communication, such as through peer education in small groups (Kiragu, 2001). Less sophisticated examples are street theatre and village drama presentations. If properly conceived and presented these can make a highly significant contribution to enhancing the knowledge, skills and positive attitudes of those who are less likely to participate in more organized programmes. There is room also to learn from the Caribbean where “Caribbean popular music has been at the forefront of discourses on AIDS” (Howe, 2000: 88). Music, song and dance present rich potential as channels for HIV preventive education messages.
The fact that HIV/AIDS strikes at every part of a community and society points in the direction of making the most extensive possible use of the expertise available to communicate about it. Teachers have an obvious and important role, but to play this role they need to be assisted with training, resources and the support of dedicated HIV/AIDS educators and supervisors. Significant formers of opinion within society or communities are also important. These include not only civic, traditional, community and religious leaders, but also those with ‘personality’ status, such as politicians, entertainers, and sports stars. A comprehensive HIV prevention programme will also make room for inputs from, and interaction with, parents, professionals, those from the health and legal sciences areas, and those with an understanding of the devastating impacts that HIV/AIDS can make on individuals, families, social service provision, economies and countries.

Two other groups are critically important: peers and persons living with HIV/AIDS (PLWHAs). The involvement of peers is of the greatest importance in programmes for young people. Young people listen more readily to one another than to adults. They also ‘hear’ one another in a language and argot that adults do not use. The strength of peer influence is such that every effort should be made to capitalize on it for the purposes of HIV prevention. Ideally, the involvement of young people themselves in prevention education programmes would embrace two aspects. First, young people themselves should have a large say in the content of what is to be presented. Nobody knows their needs, aspirations and concerns better than they. Second, they should play an important role in the actual presentation of material, a point that is itself related to ensuring that presentations are interactive and participative.

Nobody has a more intimate knowledge of HIV/AIDS and understanding of what it can do than those who live with the disease.
PLWHAs who have had the courage to speak openly about the disease have made significant contributions to efforts to halt the spread of HIV infection, expand understanding of the impacts of the disease, and make care and treatment more widely available. They have also helped to underline more sharply the injustice, discrimination and stigmatization that silence and denial frequently cloak. Their involvement in HIV prevention education programmes can have the twofold benefit of transmitting a message from within the maelstrom of the disease and of purifying the venomous atmosphere of hostility, condemnation and stigma that poisons the lives of so many PLWHAs. In the latter sense, the participation of PLWHAs in programme design and provision would help, as it were, to ‘normalize’ their status and ensure their human rights.

8. Speaking with one voice

In conclusion, it cannot be stressed too strongly that, if HIV preventive education programmes are to be effective, everybody should speak with one voice. There should be no conflicting messages. Conflict and lack of unanimity lead to confusion and lack of action.

The sexual transmission of HIV occurs through behaviour that takes place in very private circumstances. It is also behaviour that is deeply instinctual, giving physical expression as it does to what is probably the most basic and powerful of human energies. Advocacy to modify, shape or change that behaviour is not always welcome. However, it may be effective if the content of the messages is consistently the same. It stands a considerable chance of being ignored if conflicting messages are received. Thus, if one group advocates condom use while another group decries this as immoral, or if one group advocates abstinence while another group disparages this as impossible, the effect will be to leave individuals not knowing...
what they should do. And in such circumstances the majority will continue to behave in the way they always did.

Senegal and Uganda have shown a better way forward. They agreed to sink differences by approving a common menu of approaches from which every group could choose whatever best fitted in with its philosophy and ideology, and agreeing to stay silent about approaches that caused misgiving or offence. In no case did any group belittle or condemn the approach adopted by others. This allowed government, civil society, traditional leaders, and faith organizations to convey non-conflicting messages, a fact that is believed to have made a very positive contribution to the success of these countries – Senegal in containing the spread of HIV, Uganda in rolling back prevalence rates.

In several countries people have become so confused about AIDS, where it originated, what causes it, how it can be prevented, that they have ceased to hear the messages that are being conveyed. In their suffering they are crying out for clarity and unanimity from their teachers and leaders. Every educator has a bounden duty to ensure that they are answered appropriately and that the answers are not in conflict with one another. The sufferings of people, the cry of the poor, and the future of much of the human race demand no less.

References


CHAPTER 3. HIV AND EDUCATION IN SUB-SAHARAN AFRICA: RESPONDING TO THE IMPACT

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Abstract

The objective of this paper is to direct discussion away from issues of measurement of the losses of human resources due to HIV/AIDS, and the effects on schools, to a neglected set of problems that arise as a consequence. These can broadly be described as systemic, i.e. in what ways is the functioning of the education system affected by the HIV epidemic, and how does a general epidemic change what the education system is expected to deliver as well as having the capacity to provide to the society and economy. It is argued that governments and ministries of education (MOEs) in Africa need to examine the complex effects of the epidemic on the functioning of the education system as a whole, recognizing that education does not exist in isolation from the rest of the economy and society, where the HIV epidemic is causing significant structural changes. The issues for
governments and MOEs need to be seen within a context in which radical changes need to be put in place, if the education system is to deal both with the internal effects of the epidemic on institutions and respond to a changing external set of needs.

Introduction

In the past few years concern has mounted at the impact of the HIV epidemic in sub-Saharan Africa (SSA) on sustainable development. This region has an increasing proportion of the world's poorest people. Living standards have generally fallen over the past two decades. The region's performance on many social and economic indicators has regressed, in part as a result of the effects of HIV and AIDS on populations. The most telling general statistic relates to life expectancy, which is falling in many countries. In comparison with developed countries the gap has widened. UNAIDS estimates that life expectancy has fallen to less than 40 years in Botswana, Malawi, Mozambique and Swaziland, while for the region as a whole it is 47 years, compared with an estimated 66 in the absence of AIDS.

In such circumstances key social sectors such as health and education are affected by the epidemic both directly and indirectly. The effects are complex. The interactions between sectors are only now beginning to be identified by researchers and policy-makers in spite of the fact that more than a decade has elapsed since attention was drawn to the probable impact of the epidemic on key sectors such as education. With hindsight it is not hard to understand the lag in response. Nevertheless it has led to unfortunate delays in adjusting the aims, structures, and operational modalities of education systems within SSA.

There exist excellent summaries of some of the issues raised by the epidemic for education systems. The aim of this short paper is
not to repeat what is now easily accessible electronically and otherwise; rather the objective is to identify some aspects of the problem that have not generally been discussed and are often not seen as relevant for policy and programme development.

1. What is the problem?

Conceptually there is general agreement on what the problem is: that the HIV epidemic is eroding the capacity of the education sector to undertake its primary tasks. There is general agreement also on the trend: that the problem will get worse over the coming decade.

However, at the systemic level there are notable gaps in both knowledge and responsiveness.

- Firm data are lacking from many countries on the loss of human resources throughout the education sector. We do not know the level of absenteeism across the sector caused directly and indirectly by the epidemic, at all levels of education and across skill and experience categories (teachers, assistants and administrative support).
- Important social investments are being lost due to HIV and AIDS. The erosion of human resource capacity cannot be replaced through formal training alone, assuming unrealistically that resources were sufficient for replacing teaching and other personnel. Loss of experience and organizational capacity cannot be simply replaced in the face of the premature deaths of senior teachers, teacher trainers and administrators.
- There are few signs that ministries of education recognize the problems caused by the impact of the epidemic. Only in a few countries of SSA is an attempt being made to estimate what are likely to be the probable losses of teachers over the coming decade. Many ministries of education seem primarily to be concerned with issues related to HIV prevention through curriculum reform, but
do not seem to have realized that whatever the merits of such activities they have to be seen as secondary to sustaining sector capacity. If the capacity to teach is not maintained then over time the curriculum cannot be delivered.

- There is little evidence that ministries of education have the capacity and the resources to grapple with the exacting tasks they now face. Even if ministries recognize the scale of their problems they will be overwhelmed unless they are provided with additional resources.

There are analogous problems in respect of the demand for education. There is little hard data on what is happening to households and children as well as what their needs are now and what they may be in the coming years. For instance:

- What is happening to school drop-out rates and how are these related to the increase in household poverty directly due to HIV and AIDS? What is the actual impact of the epidemic on the pattern of school attendance, and are there gender differences? There is some evidence of higher rates of absenteeism among girls.

- In many countries the age range of primary-school boys and girls is very wide. Classes often contain learners who are much older than the usual age for primary education. Some exceed the normal age for secondary education as well. Forces at work due to the epidemic are exacerbating these conditions, with unknown impact on education performance. HIV prevention may also be more difficult given the mixing of younger with older students, often young men who are well into their sexually active years. A distressing feature in many schools is the increasing number of children who are living with HIV and AIDS. Their numbers are unknown as are the consequences for the children and for schools.

- It is to be expected that the morale of children should be low as a result of the epidemic. There is evidence of this from the Kagera

International Institute for Educational Planning    http://www.unesco.org/iiep
region of Tanzania, for example. This must be partly the result of children’s family experience, since many have witnessed the sickness and death of one or both parents and often of siblings, compounded by increased poverty and the hopelessness of HIV-affected families. But low morale must also inevitably be part of a school culture imbued with the effects of the epidemic. Children mix with other similarly traumatized children and they observe the sickness and death of their teachers. We have no information on what is happening to children’s school-performance achievement under such trying conditions.

- There is some evidence from the World Bank and other sources that the age cohort for education is being affected by both the demographic and behavioural impacts of the epidemic. This information must be taken as preliminary given the uncertainty surrounding demographic projections. Moreover very little is known about the impact of poverty on school enrolments of boys and girls respectively. Efforts need to be made to try and monitor what is happening to the age and gender cohorts relevant for planning educational intakes and attendance rates. Most ministries of education seem to be doing little to address these matters.

- While many countries have developed activities for HIV prevention in schools, and some have established anti-AIDS clubs, there is in fact little evidence of their effectiveness. In part this is because little has been done to monitor and evaluate the effects of life-skills programmes and related curricula reforms, so that evidence on impact is difficult to interpret. But deeper issues have the effect of reducing the effectiveness of HIV prevention in schools: the lack of resources for prevention activities, the inexperience of teaching staff in dealing with HIV and AIDS, and the unwillingness of teachers, parents and others to address issues of sexuality.

- The effectiveness of HIV prevention measures in schools is dependent on whether the sexual behaviour of children can be
influenced by messages aimed at the individual while community and peer values remain largely unchanged. The evidence, imperfect though it may be, is that action is required in schools, among peers and in the community. It is now widely accepted that educational establishments have a role in HIV prevention but there is a wide gap between expectations and achievement in most countries. This situation is unlikely to improve. If anything the reduction of human resource capacity in schools is likely to exacerbate an already serious situation.

Another set of issues is being ignored in most if not all SSA countries:

- There is little knowledge in all countries about the impact of the epidemic on skills and experience in education and other sectors. We know from studies in some countries such as Botswana and Zambia that significant losses of skilled and professional staff are being experienced by the health sector due to HIV-related mortality. The same must be expected in education and the question arises as to what the education sector can do both to meet its own demands for replacement teachers and administrators, as well as the specific needs of other sectors. There is no evidence that any country has begun to address comprehensively the human resource planning issues raised by the HIV epidemic, and whether or not there is capacity domestically or externally to meet the needs for critical skills and training. If countries cannot meet their core needs for specific skills and professionally qualified personnel, how is some sort of ‘residual minimum’ to be met?

- All the systemic effects of the epidemic are bound to have an impact on the performance of the education sector. Again there is no evidence that education systems are aware of the implications of the generalized effects of the epidemic on their own capacity to function. Yet the effects must already be apparent in many countries.
and many educational establishments. It is increasingly recognized that the epidemic erodes productive capacity across all sectors, both urban and rural. It is completely unknown as to what the effects are on educational performance of such things as fewer health-care workers, disruptions to banking and financial services, and losses of transport capacity.

- In no country have macroeconomic and household financial issues received systematic analysis, but they are central to the sustainability of the education sector. These include such questions as the effects of fees on access to schooling, and the consequences that abolishing fees would have on the financial viability of schools and school systems. There is clear evidence that intensified poverty, in part the result of the erosion of the asset base of households and other pressures on current resources, has the effect of reducing school enrolment and attendance. Yet it appears still to be the aim of many governments, often supported by the World Bank, to shift to ‘fee for access’ as a fundamental principle of school finance. Such a principle makes no sense whatever given the constraints faced by families and communities.

- So the whole issue of school funding and the increasing dependence of teachers on fees for payment of their salaries needs urgently to be revisited by governments and donors. Similarly with the macroeconomic financial issues, where there is no quantitative information about the impact of the epidemic on overall costs of education systems, and what would be required to fund the structural changes that need to be implemented. Thus what are the current costs of absenteeism? What are the probable costs of meeting insurance and other obligations to staff employed in the education sector? What costs will be entailed in trying to replace staff that are sick or die, and how will these be met? What budgetary and other needs will be entailed if the education sector is to meet its obligations?
This section may be summarized in three points. First, the epidemic is systematically eroding the capacity of education sectors in many countries in SSA. This makes it even less likely that education will be able to meet its core responsibilities. Indeed, since there is already a gap between educational objectives and targets in almost all countries in SSA, then the HIV epidemic will worsen the performance of an already under-performing sector. Second, the effects of the epidemic on the education sector are complex, and there are few indications that governments and ministries of education understand what is happening to educational capacity. Nor do they seem to understand the need for them to restructure organizations so as to be better able to deal with intensifying constraints and new demands. Third, one of the key issues is how to energize governments and ministries of education so that they understand the issues and develop effective and relevant policies and programmes. It seems highly unlikely that this will happen without substantial external assistance.

2. Alternative perspectives

Given the paucity of information about the situation in SSA it would be unsurprising if there did not exist alternative perspectives and different interpretations of the problem. But these are perhaps more apparent than real and it is possible to reconcile conflicting interpretations of the data.

There are three main elements in the alternative perspective.

2.1 Demographic-based modelling of supply and demand

- World Bank projections of the primary-school-age population and of projected teacher mortality in four African countries (Zimbabwe, Zambia, Kenya and Uganda) lead to the tentative conclusion that, "The change in the number of teachers needed is greater than the..."
change in the availability of teachers” (World Bank, 2000). But as
the Bank notes, “The demand and supply analysis used ... is meant
to be indicative and should be used cautiously ... It does not
consider other impacts of the epidemic on teacher supply, notably
absenteeism ... equally it does not quantify other impacts of the
epidemic on the demand for educational services, e.g. the ability of
HIV-affected households to pay for schooling, and meet related
costs (such as school uniforms, books, etc.).”

There are all sorts of demographic issues and aggregation problems
in making these projections anyway and a good deal of uncertainty
must attach to the underlying results. But even so the picture
presented by the Bank is extremely gloomy: reductions of the
primary-school-age population by 2010 of 24 per cent (Zimbabwe),
20 per cent (Zambia), 14 per cent (Kenya), 12 per cent (Uganda).
The losses of teachers due to AIDS between 2000 and 2010 for the
same countries is estimated annually at 2.1 per cent, 1.7 per cent,
1.4 per cent and 0.5 per cent respectively, which are cumulatively
very large losses indeed. As for orphans, the growth in numbers is
striking. For the period until 2010 the increase in orphans aged 0-14
is 25 per cent, 19 per cent, 17 per cent and 5 per cent in the same
four countries respectively.

On such estimates the balance between demand and supply looks
as if it favours supply (the rate of fall in numbers of teachers is less
than the rate of decline in primary-school enrolments). However,
the Bank agrees that its projections are incomplete, for reasons
noted above. In the real world, unlike that of the demographic
modellers, there is immense diversity, and it is precisely the
variance in situation that needs to be addressed by policy-makers.
Thus information is needed on the balance between capacity and
educational demand within different districts, between private
and public provision, in the alternative levels of education (primary,
secondary and tertiary), and across different disciplines. Only
once these and other data are available will it be possible to reach conclusions on the balance between teacher supply and student demand in any meaningful sense. At present we are a very long way from being able to reach any definitive conclusions.

2.2 Disaggregation – results from a Botswana HIV and education impact study

- The results of a small-scale study for Botswana (Bennell et al., 2000) suggest that the situation is more complex and that disaggregation of data generates a different situation from that presented above. Bennell et al. looked at alternative sources to derive estimates of teacher mortality and came up with rather unexpected results. Note that their estimates are not the result of applying general HIV prevalence rates to teacher populations but come from other sources (such as the records of the Medical Aid Scheme for public servants). What they found is that mortality rates are very different between types of school (teacher qualifications/pay) and gender. Furthermore, mortality rates for teachers may actually be falling, which is quite the opposite of what others have projected for Botswana overall.

- The reasons for what is observed in Botswana are rather unclear since it seems not to conform to other demographic modelling of the epidemic in Botswana by Abt Associates. What seems to be important is access to good medical care. This is reflected in differential mortality between those covered by medical aid and those not. (Only 50 per cent of primary teachers, mainly women, are covered, and 75 per cent of secondary teachers, mainly men, are enrolled.) So a mix of better nutrition, social support, access to generic drugs for environmental illnesses such as tuberculosis (TB), and access to antiretroviral (ARV) drugs, must be part of the explanation of both lower overall mortality rates, and differential gender mortality rates. This is reflected in higher female primary-
school mortality, where women are more important in the labour force.

- What the Botswana study suggests is a need for more detailed analysis of the issues that moves the discussion away from generalities to more complex understanding of the situation. Indeed some of the conclusions from Botswana are also confirmed by related research from Uganda and Malawi (see References). It is evident that the epidemic will vary in its effects depending on many factors. These include urban and rural location of schools, age and gender of the labour force, access to quality health care and social support, internal arrangements for absenteeism cover, and so on. The presence or absence of effective programmes that support families and children affected by HIV and AIDS would be important, and Botswana is reported to have established these.

The Botswana case raises the crucial question of public policy choices in other countries where it may be necessary to ensure that there is differential access to ARV therapy and related services in order to ensure that key staff remain productive. This is a very contentious issue, but it requires an open discussion if there is to be forward movement. At the present time in many countries in SSA there are individuals with privileged access to ARV treatment, often under government-subsidized conditions. The question is should this continue to be the case, given that there has been so little openness on this topic? It is highly unlikely that many countries in SSA have the resources to follow in the footsteps of Botswana, which has announced that everyone who is infected with HIV will have access to the drugs under conditions that ensure effective utilization. Time alone will tell whether this is a feasible objective in Botswana itself.
3. Have there been sustained changes in sexual behaviour?

This is one of the great unknowns in the situational analysis of the epidemic in almost all countries in SSA. In at least Uganda and Senegal new HIV infections among young people have fallen (at least in some areas). The precise reasons for this are unclear, and indeed this issue needs to be the focus of behavioural research so as to untangle what are the causal factors. One aspect of these developments is what is happening to HIV incidence in countries disaggregated by social and occupational group. Here again there is more or less ignorance of trends in HIV infection and guesses have perforce to be made both about the past and the present.

Why is this relevant to the present discussion? Insofar as there is evidence of HIV prevalence by social and occupational class, it suggests that it increases with educational level. But such data are very partial and do not really permit generalization to larger population groups. It may also be very dated and not provide a good indication of recent sexual behaviour among the better educated in Africa. The better educated (including teachers) may have heeded the prevention messages of the past decade and observed the consequences of not changing sexual behaviour, in which case the predicted mortality among the better educated and professional groups may well turn out to be much lower than projections that apply general rates of mortality to these groups.

If this is so, then the erosion of human resources in these countries will be less than predicted, including lower age-specific mortality within the education sector. But no evidence yet permits the identification of trends in HIV incidence disaggregated by occupation and educational attainment. In the absence of these data policy-makers and others must make do with second best, namely estimates derived from the application of overall mortality rates to specific population sub-groups.
Hence one is forced back to the projections based on demographic modelling of teacher mortality and estimates of changes in school-age population. The latter are probably more accurate than the former, although we just do not know what the real situation is in most African countries. What this analysis supports is the need for better HIV prevalence data that generate more policy-related information, as well as improved sources of other data (for example, insurance and medical aid society records, better personnel records in both the private and state sectors, and so on). Until we have these data on teacher and other staff morbidity and mortality, policy-makers will need to manage with information which may contain significant errors both in aggregate and in detail. This is not a sustainable state of affairs since deficiencies of data will make it impossible to design and implement relevant and effective policies and programmes to address the problems facing education.

4. What are the strategic policy and programme options?

This could become a long and unending list of ‘things to do’ but it seems best to set out what seem to be the critical next steps in the form of a set of propositions, and avoid any lengthy discourse.

4.1 Propositions

4.1.1 Partnership

There are very clear and evident limits to what the state can achieve in response to the epidemic. In part this reflects the nature of the problems to be addressed, where the state is often unable to grapple with the issues and has no special expertise to bring to bear on the problems (for example in many aspects of sexual-behaviour change). In part it reflects the accepted fact that in many African countries the state has little effective outreach, and this is mirrored in the
relative impotence of many ministries of education. In part it reflects
the fact that sustaining an effective education sector must entail a
partnership between the state, religious organizations, NGOs, CBOs,
workers’ organizations and the private business sector. So while it
may be somewhat trite it is nevertheless realistic to conclude that
relevant policies and programmes must entail a partnership between
all of the interested partners.

While partnership has to be the way forward it is far from clear
that this is widely accepted, nor is it generally understood what this
means in practice. It means bringing into the effective response not
only the organizations noted above, but also crucially teachers and
their institutions (trade unions and professional associations),
parents and grandparents (including parent teacher associations,
PTAs), and students. Now it is evident that a mobilization of these
varied interests, both to sustain educational establishments in the
face of the epidemic and to engage in effective prevention and support
activities, will have to be localized. It follows that the second main
proposition entails a reduced role for the centre in the policy and
programme response to the epidemic, and a decentralization of
efforts to other more local levels.

4.1.2 Institutional structure and policy framework

Accepting a reduced role for government and ministries of
education does not mean there is no role for state organizations.
Indeed an effective mobilization and localization of response
requires a very active and positive role for ministries of education
and other government departments (such as those involved with the
welfare and support of families and children). It is, therefore, critical
that all relevant ministries integrate HIV and AIDS in their core
activities both at central and local levels, and that financial and other
support be provided to make this possible. Within this framework
ministries of education have critical functions to perform, including educational planning, resourcing of activities and mobilization of partners.

What governments have to understand is the reality that they alone can achieve relatively little, and that partnership has to be the way to an effective and relevant response. But there are two crucial contributions that government can and must make. These are leadership, which goes beyond rhetoric to include management performance, and establishing an enabling environment. These have been the two main distinguishing characteristics of the Uganda experience that marks it out as the only country in Africa where the incidence of new HIV infections has fallen sharply.

An effective response to the epidemic has to include making it possible for people to openly talk about the issues. This is again one of the main lessons to be learned from Uganda. Government has the task of facilitating an open dialogue and discussion about issues that are difficult but which require a supportive environment. In most countries in SSA these conditions are not present and have to be created. Thus teachers need to feel that the government and their communities will support them in their attempts to address HIV prevention within schools. They also need to have in place policies and programmes so that they can address their own HIV infection, and that of colleagues and families, through access to health and psycho-social support. Currently both the policy framework and programme support for those infected and affected within education systems is largely absent, and needs to be developed. It follows that developing a policy framework through consultative processes and ensuring that it becomes the basis of action is the essential first step in meeting the challenge to education systems.
4.1.3 Applied research

Too little research in SSA arises from the expressed needs of policy-makers, yet to be useful research has to feed into the development of policy and programmes. The issue is not whether research on HIV and education is necessary, but rather what research is most needed at this stage of the epidemic. This will vary from country to country, given that countries are at different points in the epidemic cycle, and given that they are responding differentially. Research needs to be timely, relevant to the needs of policy users, and participative. These criteria are not always heeded, with the result that much research is of low value and is often ignored. It follows that establishing a research programme to generate information useful for policy and programme development is an important task of the government and its partners.

Where in the spectrum of useful research are studies of impact on the education sector located? It needs to be understood from the outset that impact studies have very limited value. Their primary role is as an advocacy tool for use with policy-makers and practitioners. Impact studies can be used to generate awareness of the scale of the problem facing the education sector and to shift the focus from HIV prevention to systemic issues of the kind noted above. It follows that countries may need to undertake rapid assessments of the effects of the epidemic on education systems as a means to generating the desired policy response to the epidemic.

Having undertaken an impact study and absorbed its conclusions in terms of policy, what is then required by way of research is a detailed evaluation of structures, regulations, training processes and personnel arrangements, and organizational capacity and performance. In other words what is needed is hands-on research of an intensely practical kind to establish what is happening to
educational organizations at all levels, with the aim of generating the information needed to bring organizational structures into balance with the new situation facing education. This process would also evaluate existing managerial capacity to undertake the required policy and programme reforms that are needed.

As noted above there are many problems relating to the needs of children and parents, and in addition those relating to the changing needs of the users of human resources. Virtually no research has been undertaken on these matters. Yet it is vital that the education sector should respond to the changing needs of its clients, whether they be children and parents or employers across the economy. Identifying through rapid research the changing needs of clients, of children and families especially, is critical if the education sector is to meet its core functions. Such research should go beyond information collection and should identify appropriate policies and programmes. It should also indicate the capacity development needed to make these policy and programme recommendations feasible options, and how these would be operationalized.

4.1.4 Programme development

The HIV epidemic requires a re-evaluation of most aspects of policy and programmes so as to ensure that these are consistent with the changed conditions. It is clear that such reassessment has not been undertaken in most countries and it is urgent that this situation be remedied. But there are clear explanations for the present state of affairs. In part it arises from a lack of awareness of the policy and programme issues raised by the epidemic. The recommendations above are intended to change the underlying awareness of government and others. In part it reflects the capacity constraints and management failures of many organizations involved in education. This is a much more intractable problem but it is at the centre of an
effective response to the epidemic. It follows that what is needed as a first step are capacity assessments to identify the constraints facing the education sector, including human and financial constraints, fully taking into account the ongoing erosion of capacity caused by the HIV epidemic.

Once the various parts of the solution are in place, as noted above, then what will be needed is sustained technical support to the education sector, not just to government and not just to central organizations, that will enable countries to carry through the changes needed for an effective response. This and other activities identified here are appropriate and essential roles for donors. If the education sector is to change what it does and how it does it in ways consistent with a functioning and effective programme, then there will be a need for sustained financial and technical support from donors over the medium term.

As noted above there exists no coherent and systematic estimate of the financial costs facing the education sector caused directly and indirectly by the HIV epidemic. It is clear that many households and communities are facing immense stress largely brought on by their experience of HIV and AIDS. It is also clear that policies and programmes have been slow in responding to the new challenges, and the whole structure for the financing of education needs to be revisited. Inevitably a restructuring of education to meet the changed conditions of both supply and demand will entail significant additional financial resources, and steps need now to be taken to look at existing levels of finance and to bring these into alignment with projected needs.

But there is an important role for organic change if communities are to establish ownership of and responsibility for their own educational provision. This does not flow from decisions taken by
governments but governments can provide a supportive enabling environment of policies and decentralized funding, so that local enterprise and initiative can play its full role. Supporting local structures and shifting the locus of responsibility to those most affected is the way forward.

5. Conclusion

The challenges facing education systems are complex and far from easy to resolve. If the problems were straightforward and on a small scale then countries would have made some progress before now. The fact that in general they have not put in place relevant and effective responses, reflects both the resource constraints that all countries in sub-Saharan Africa face and the intractable nature of the problem. There are no easy solutions, and there are no easily transferable lessons from elsewhere in Africa. To a degree countries will have to find their own way forward by a process of trial and error. But there is some experience to build on and it does need to be utilized. It is also true and an accepted policy rule that it is preferable to address a problem in its early stages rather than wait until pressures overwhelm systems. Africa still has the opportunity to put in place solutions, maybe partial ones at best, but ones that in time will make a difference. It is in everyone’s interests that effective responses be started now.

References

The documents cited below are all relevant to the issue of the impact of HIV on the education sector and with related matters. Many are accessible electronically.

HIV and education in sub-Saharan Africa: responding to the impact


CHAPTER 4. MAINSTREAMING HIV/AIDS IN THE EDUCATION SYSTEMS IN SUB-SAHARAN AFRICA: SOME PRELIMINARY INSIGHTS

Gabriel Rugalema and Vivian Khanye

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Vivian Khanye is South African with experience in the fields of education and public administration. He has previously worked for the Departments of Education and Public Service. He is currently with the UNDP Regional Project on HIV and development for sub-Saharan Africa. His areas of expertise include HIV, human resource management and development, HIV and education, and strategic planning.

Abstract

This article is based on a theoretical exploration of the concept of mainstreaming and actual experience of the African ministries of education in the region. The empirical part of the article is largely based on the initiative of the Association for the Development of Education in Africa (henceforth ADEA) on “Identifying promising
approaches to HIV/AIDS in education in sub-Saharan Africa. The initiative was conceived in April 2001 and it is ongoing. The article examines the application of the concept of mainstreaming in education programming. It argues that even though there is tangible evidence of the process of mainstreaming HIV in education systems, there are still both theoretical or rather conceptual problems as well as problems related to implementation of programmes. Our purpose is exploratory since not all country case studies under the ADEA initiative have been completed. However, available data enable us to ask such fundamental questions as the following. Have the ministries of education managed to mainstream HIV/AIDS in their respective education systems? If so, how? Is the level or phase of mainstreaming reached by respective ministries sufficient? What are the problems facing the process of mainstreaming in the education sector? The rest of this paper seeks to answer these questions by focusing on the process of mainstreaming as attempted by various ministries of education that are participating in the ADEA initiative.

**Introduction**

By the end of 2001 sub-Saharan Africa had an estimated 28.1 million people living with HIV/AIDS, of whom 3.4 million were infected within the year (UNAIDS/WHO, 2001). Uganda is the only country in the region that is experiencing a steady decline in HIV prevalence. In respect to the education sector, the prevalence of HIV and the impact of AIDS are real and are manifested through a combination of indicators ranging from morbidity and mortality of teachers to a huge population of orphan pupils. Ministries of education and other agencies involved in the delivery of education (e.g. faith-based organizations, teacher trade unions, NGOs and CBOs) have responded ‘reactively’ to the epidemic by introducing various programmes to prevent further spread of HIV and to mitigate the impact of AIDS in the education sector. This process is widely referred to as
mainstreaming HIV/AIDS into the education sector. In this article we examine the approaches pursued in the process of mainstreaming HIV/AIDS in the education sector particularly within the public sector, that is, ministries of education.

1. The place of HIV/AIDS in the education system

It is probably not necessary to belabour the statistics on HIV and AIDS in Africa. Suffice to mention that sub-Saharan Africa remains the hardest-hit region of the world. With less than 10 per cent of the world population, sub-Saharan Africa carries over 60 per cent of the global burden of HIV/AIDS. The effect of this massive epidemic on the education sector is increasingly evident in respect to the demand for education, equality of access to education, supply of education, and quality of education services (Kelly, 1999; Badcock-Walters, 2001). Most ministries of education are designing policies and sectoral strategic plans to deal with the problems wrought by AIDS in the education system. In this environment of increased awareness and acceptance of HIV/AIDS as a problem for the education sector, various programmes are being implemented particularly at primary and secondary-school levels. The relevance and significance of such programmes as tools for HIV prevention and impact mitigation is the focus of this paper.

2. The conceptual basis of mainstreaming HIV/AIDS in education systems

At a more general level, mainstreaming of HIV/AIDS is a process of policy change in a systemic manner in order to achieve broad social goals of controlling the spread of the epidemic and mitigating its effects. In the context of the education sector, we conceptualize mainstreaming as a deliberate and strategic change in (education) policy to address the effects of HIV in the education sector.
Mainstreaming HIV/AIDS in education is basically an attempt to systemically integrate HIV/AIDS issues in education policies, programmes, and projects in order to have an impact on the epidemic (that is, prevention of HIV infections and/or mitigation of the impact of AIDS on the system). It is a process of designing programmes and putting in place structures to deliver such programmes.

The formulation of strategic plans and design of programmes are necessary but not sufficient conditions for the process of mainstreaming. There have to be structures and resources to ensure that plans and programmes are followed through and delivered to target groups. Ideally, a good mainstreaming exercise should adhere to three principles, namely:

- It should be systemic. The effect of the epidemic on the education system is systemic. It affects not one but all segments of the system.
- It should be based on a good situation analysis. Without a good baseline it is not possible to ascertain the extent to which the epidemic is affecting the sector. It is also difficult to design monitoring and evaluation tools if the situation to be changed is unknown.
- It should be dynamic. Mainstreaming should not be seen as an end in itself but an evolving process in which policies and programmes are adjusted according to emerging reality. This calls for constant monitoring of the epidemic and its impact, as well as monitoring and evaluation of intervention programmes.
Figure 4.1 A model for mainstreaming HIV/AIDS in the education sector

Overview of core business of the ministry of education
Provision of education services
- Recruitment and retention of education providers (teachers)
- Supervision of the education system
- Provision and management of education infrastructure
- Management of education information system
- Managing the interaction between learners and teachers

Guiding principles
(a) How does the present education policy/environment render 'people in the education sector' susceptible to HIV/AIDS?
(b) How does HIV/AIDS affect the education sector?

Establish structures to facilitate mainstreaming process
- HIV/AIDS units
  - Ministry headquarters
  - Region/province level
  - District level
  - School level
- Allocate necessary resources
  - Human
  - Equipment
  - Financial

Analyze the bi-directional relationship between HIV and the education system. Mainstream HIV/AIDS into the overall education policy to address (a) and (b) above.

Learners
- Curriculum
- Extra-curricular
- Access to education
- Quality of education
- Policy on HIV status

Teachers
- Replacement
- Prevention
- Psycho-social and economic support
- Retraining
- Policy on HIV status

Education managers and support staff
- (macro, meso, micro)
  - Prevention
  - Replacement
  - Psycho-social and economic support
  - Making education institutions safe
  - Policy on HIV status

Management information system
- Monitor HIV prevalence in the system
- Monitor AIDS morbidity and mortality in the system
- Determine changes in supply and demand of education

Continuous feedback (monitoring, evaluation) and policy adjustment
Figure 4.1 shows a model for mainstreaming HIV/AIDS in the education sector. The model is intended to guide the theory and action on mainstreaming HIV/AIDS in the education sector. It is argued that the starting point is for a ministry to look at all its core business and analyze the current and future implication of HIV/AIDS. It is important to focus critically on the bi-directional relationship between HIV/AIDS and the education system (principles a and b in the model). While it is easy to see the impact of the epidemic on learners and teachers, the subtle relationship of education policies regarding, for example, the unequal access of education between girls and boys or the low percentage of transition from primary to secondary-level education, are hardly, if ever, analyzed. Yet such policies play a part in rendering people susceptible to HIV/AIDS through a complex set of interrelated factors ranging from gender inequality and poverty to lack of employment due to poor education.

The next step is to establish a structure to facilitate the process of mainstreaming. In this model the structure is an HIV/AIDS unit. The main objectives are to co-ordinate HIV/AIDS activities in the ministry and to provide technical expertise and momentum to ensure that activities are implemented on time and effectively. Having an HIV/AIDS unit at the ministry headquarters is necessary but not sufficient to ensure that activities permeate all levels of the system. It is therefore important to have such units at administrative levels (regional, district, and even school level).

Another critical role an HIV/AIDS unit should play is that of monitoring the effects on the epidemic on the system and ensuring that feedback is given to policy-makers and programme designers. To be effective HIV/AIDS units should be functional. That is, they should be properly staffed and equipped to operate. As discussed later, this is one of the difficulties facing ministries of education on the continent.
The process of mainstreaming should then proceed based on four fundamental conditions. First is to design programmes that target learners. These should include both curriculum-based and extra-curricular programmes (including, but not limited to, edutainment). There is need to think creatively and design and implement strategies that would ensure the quality of education is maintained despite the effects of the epidemic on the system. Policies that ensure access to education of learners affected by AIDS and/or infected by HIV have to be put in place to ensure that children are not excluded on the basis of being orphans or being HIV-positive or both.

Second is the need to develop policies and programmes that target teachers. It has to be borne in mind that for teachers HIV/AIDS is an important workplace issue. So policies and programmes for HIV prevention are important and so are programmes that would provide psycho-social and economic support to teachers living with AIDS or caring for sick relatives. Another critical policy area is the design and operationalization of the process that would ensure that terminally ill teachers and those who have died are replaced without delay. This would ensure continuity in the learning programme but would also alleviate the problem of increased workload among surviving teachers. Closely related to this, is the design of policy to ensure that HIV-positive teachers continue to work. This might entail putting in place necessary services to support such teachers to live productive lives but such services (e.g. counselling services, antiretroviral drugs) need not be dispensed within the school compound. They could be available and accessed from nearby clinics or through home care and programmes.

The third condition is for the HIV/AIDS prevention and impact mitigation programmes to focus on education managers and support staff working with educational institutions. HIV/AIDS must not only be seen as a problem ‘out there’ but also as a problem ‘within’. Seeing
it as a problem ‘out there’ would lead to designing policies and programmes for learners alone (necessary but not sufficient) while seeing it as a problem ‘within’ would lead to designing programmes targeting teachers and managers (that is, those within the system). Much of what is already discussed above (in conditions one and two) is relevant here. However, critical areas of policy here would include the implementation of strategies to make the education system a safer place, one that does not render those within it susceptible to HIV/AIDS. For example, issues of power relations that enable male teachers to impose themselves on female learners would need close scrutiny not least because evidence shows that inter-generational sex from older men to young girls is one of the important factors in HIV transmission. Another policy area in need of scrutiny would be the frequent transfer of teachers, often unaccompanied by their families.

The fourth condition is the design and sustained operation of a robust management information system on HIV/AIDS. Strategic planning requires a good information base and it is critical that ministries of education should gather information on the effects of HIV/AIDS on the sector and utilize the information in designing a comprehensive sectoral response.

Unarguably any mainstreaming exercise should consider all four conditions. These are not dichotomous blocks but rather they are intricately intertwined or systemically linked. They probably deserve the same level of emphasis when designing a sectoral response. In sum, there is need to ensure that baseline information is collected, analyzed and utilized to design preventive programmes for key actors in the sector. Once this is done, the next challenge is to ensure that preventive programmes are delivered to target groups (key actors in the sector). Equally important is to ensure that a management information system is put in place to inform preventive and impact-mitigation interventions.
3. Approaches in mainstreaming HIV/AIDS in education systems

In this section an attempt is made to show how the process of mainstreaming has been attempted in the education sector in sub-Saharan Africa. But before we present the evidence of the initiative on ‘identifying promising approaches’ it is necessary to present a brief background of the initiative and the approaches employed in conducting country case studies.

In April 2000 the ADEA secretariat invited African ministries of education to analyze the different interventions (policies, projects, programmes, etc.) being implemented to control HIV and/or mitigate the impact of AIDS. The broad objective of the initiative was to identify promising approaches with the view of sharing knowledge and experience within and across country borders. The initiative is premised on the assumption that there is a wealth of experiences, information and analyses within ministries of education that could be used to guide innovative, cost-effective and vigorous interventions to confront HIV/AIDS in the education sector.

The ADEA initiative was guided by three principles: (a) identify promising approaches, placing more emphasis on process rather than outcome; (b) learn from within by focusing on useful experiences that have been locally tried and adapted; and (c) utilize available local expertise and build capacity in the process.

Even though over 30 countries expressed the intention to join the initiative, less than 20 countries have submitted proposals to ADEA for funding. The programmatic focus and topics proposed by respective countries are summarized in Table 4.1.

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4. For a detailed discussion on the progress of country case studies see Akoulouze, Rugalema and Khanye (2001) or visit ADEA’s web site: www.adeanet.org/biennial/papers/
Table 4.1  **Summary of the country case studies by programmatic area and topic**

<table>
<thead>
<tr>
<th>Country</th>
<th>Programmatic focus</th>
<th>Topic</th>
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<tbody>
<tr>
<td>Angola</td>
<td>Educational</td>
<td>Evaluation of HIV/AIDS curriculum for schools and teacher-training colleges</td>
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<tr>
<td>Burkina Faso</td>
<td>Educational/</td>
<td>Assessment of the experimental programme to involve the Gaoua community in HIV/AIDS and STD control</td>
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<tr>
<td></td>
<td>community</td>
<td></td>
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<tr>
<td>Burundi</td>
<td>Educational</td>
<td>To appraise HIV/AIDS educational programmes with the view to identify a promising intervention</td>
</tr>
<tr>
<td>Congo (DR)</td>
<td>Educational</td>
<td>Appraisal of HIV/AIDS educational programmes to identify the most promising</td>
</tr>
<tr>
<td>Ghana</td>
<td>System management</td>
<td>Documenting the process and politics of formulating a sectoral strategic plan for HIV/AIDS in the Ministry of Education</td>
</tr>
<tr>
<td>Lesotho</td>
<td>Educational</td>
<td>Assessment of the workshop module and curriculum-based HIV/AIDS interventions among pupils in Lesotho schools</td>
</tr>
<tr>
<td>Liberia</td>
<td>Educational</td>
<td>An inventory of HIV/AIDS interventions in Liberian schools: towards identifying a promising approach</td>
</tr>
<tr>
<td>Mali</td>
<td>Educational</td>
<td>An analysis of the impact of ‘club anti-SIDA’ in schools in Mali</td>
</tr>
<tr>
<td>Namibia</td>
<td>Educational</td>
<td>An impact assessment survey of the school-based HIV/AIDS programmes in Namibia with particular reference to ‘My future is my choice’ programme</td>
</tr>
<tr>
<td>Niger</td>
<td>Educational</td>
<td>Inventory of ongoing school-based HIV/AIDS with a view to identifying the most promising</td>
</tr>
<tr>
<td>Senegal</td>
<td>Educational</td>
<td>Evaluation of HIV/AIDS-related activities in the areas of: (i) training; (ii) information dissemination/creation of awareness; and (iii) production of didactic materials</td>
</tr>
<tr>
<td>South Africa</td>
<td>Educational</td>
<td>An assessment of the impact of the ‘Life-Skills programme’ on school-going children in South Africa</td>
</tr>
<tr>
<td>Swaziland</td>
<td>Educational</td>
<td>An assessment of the School HIV/AIDS Intervention Programme in Swaziland</td>
</tr>
<tr>
<td>Tanzania</td>
<td>Educational</td>
<td>An evaluation of the school youth programme on HIV/AIDS in Magu District, Tanzania</td>
</tr>
<tr>
<td>Togo</td>
<td>Educational</td>
<td>An assessment of the impact of the HIV/AIDS programme implemented by PSI in Togolese schools</td>
</tr>
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</table>
Table 4.1 provides a picture, albeit a partial one, of the attempts being made by ministries of education to mainstream HIV/AIDS in the education sector. Information in the proposals submitted for funding indicates that a lot of emphasis has been placed on programmes targeted at learners and most programmes are school-based. In the following discussion we present and analyze evidence from country case studies with a view to measuring the progress of mainstreaming HIV/AIDS within ministries of education.

Methodological approaches to country case studies differed from country to country. Broadly most studies were conducted through questionnaire surveys, individual interviews and focus-group discussions. Despite these seemingly ‘rigorous’ methods, most study reports are actually very descriptive. The emphasis is put more on respondents’ replies to questions about programmes being analyzed rather than the process through which those programmes are implemented. This is partly a reflection of weak analytical capacity within ministries but, more so, it is a reflection of the accidental nature of implementation of the interventions analyzed.

4. Educational programmes

Evidence from Table 4.1 clearly shows that, with the exception of Ghana and Burkina Faso, ministries of education have focused more on educational programmes for learners. Two approaches are evident,

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5 Even among learners emphasis has been placed on primary and secondary-school levels, leaving out tertiary-level learners who are certainly more active sexually and therefore more likely to be susceptible to HIV than primary and secondary-school learners.
namely, curriculum-based HIV/AIDS education (including issues of sexuality, sexual health and life-skills) and extra-curricular activities designed to impart knowledge on HIV and AIDS. Besides the theoretical premise that sex education is most effective when taught long before the first sexual encounter (Gachuhi, 1999) the overwhelming focus of the ministries of education on learners is built on practical and pragmatic reality. The overarching responsibility of any ministry of education is ‘to teach’ or provide educational services. It is therefore understandable that ministries of education have reacted to HIV/AIDS through education programmes, an area they know best and are good at. In practical terms there is no easier way to reach young people than through schools. Thus school-based education on HIV/AIDS and related issues reaches a wide audience of young people not only within school walls, but also outside schools through interaction and sharing of information between pupils and their peers, siblings and parents.

The curriculum approach has entailed reforming the formal school curriculum to integrate HIV/AIDS. Lessons on HIV/AIDS are given either through a stand-alone subject or as an integral part of other school subjects such as biology, religious studies, family-life education, social studies, and counselling and guidance.

The terms of reference of the ADEA initiative did not provide room for analysis of the dynamics of school-based HIV/AIDS programmes. However, according to Schenker (2001), ministries of education should be in the fifth generation of the school-based programmes for HIV/AIDS prevention. Schenker points out that the first generation of school-based programmes to prevent HIV/AIDS lasted until the mid-1980s. In that period responses were local, non-organized and driven mostly by fear and blame. Educational materials were produced to give basic facts on HIV and AIDS but no particular attention was paid to age, gender and vulnerability of groups of
learners. In the late 1980s the second generation of school programmes came into being. These were characterized by more organized responses, development of curriculum by governments and other educational agencies, initiation of training programmes for teachers to deliver the new curriculum. However, since no needs assessments were done, the HIV/AIDS curriculum was designed in a vacuum and the process was driven by the belief that ‘knowledge’ will do the work.

The third generation of programmes surfaced in the early 1990s and these were designed to surmount the problems and shortcomings observed in the first two generations. In the third generation it was appreciated that prevention is not only about knowledge, but also about attitudes, skills, and values. It was also finally acknowledged that sex education is different from AIDS education. It is in this period that HIV/AIDS control programmes were designed based on theory.

By the early 1990s, school-based programmes for HIV prevention were increasingly common in sub-Saharan Africa. Thus the fourth generation of programmes dominated the mid-1990s and were characterized by multi-dimensional activities including classroom skills-building sessions, school-wide peer education activities, and social norm-changing programmes. The fifth generation, according to Schenker (2001: 3), is characterized by ‘further improving what works’, dissemination and sharing of lessons learned, capacity building, and sustainability.

Although the objective of the ADEA initiative corresponded to Schenker’s fifth generation of programming for HIV/AIDS in the education sector, country case studies are not all that clear whether the fifth generation has indeed been reached. What emerges from country case studies is a mixture of all the various phases or generations of programming. Some countries have not reviewed their AIDS curricula since they were introduced. In such cases the
curriculum-based HIV/AIDS education has remained static. In some other countries ministries of education are not the sole providers of (HIV/AIDS) education. Training programmes and materials are developed and delivered by different authorities (NGOs, religious groups). If it were possible to harness the synergy of these various institutions, such multi-institutional programmes would be the best way to go. Most evidence points to the existence of some form of co-ordination of programmes (for example, mainland Tanzania and Zanzibar) but there is also evidence of weak linkages between various agencies (for example in Swaziland, Lesotho and Liberia).

Remember the objective of the ADEA initiative was to identify promising approaches and provide explanation as to why such approaches were promising. Curriculum-based approaches are said to show promise in the sense that they have exposed a large number of pupils to issues related to HIV/AIDS. However, the most popular programmes for pupils are the extra-curricular ones. These include the Health Youth Clubs (Zanzibar), the peer-education component of the School Youth HIV/AIDS programme (Tanzania), and My Future is My Choice programme (Namibia).

The common feature of the three programmes cited above is that they are organized by young people for young people. These peer education approaches are modelled on the theory of social influence or social inoculation whose basic premise is that societal influence and peer pressures do influence and shape (sexual) behaviours of individuals within society (Howard and McCabe, 1990). The influence of peer pressure is very significant in children even before the teenage years. It is argued therefore that using child role models is the best way to change children’s behaviour.

Evidence from country case studies reveals that children enjoy peer-led HIV/AIDS sessions (small-group discussion, drama groups,
Mainstreaming HIV/AIDS in the education systems in sub-Saharan Africa: some preliminary insights

and so on) because they not only provide opportunity for discussion but they very well capture the playground dynamics. As opposed to the ‘chalk and talk’ curriculum-based lessons, peer sessions are informal and conducted in the language children understand and use in the informal setting. In other words, peer education sessions provide room for effective communication about issues and problems faced by young people at school. Most ministries of education have complemented curriculum-based programmes with non-formal peer-led programmes.

An issue that would bedevil the initiative to identify promising approaches is that except for South Africa, countries introduced HIV/AIDS programmes without any baselines. Neither is there data that capture variables such as HIV risk perception and risk discounting among schoolchildren, susceptibility to HIV within and outside the school environment, HIV/AIDS knowledge and attitude among teachers. Without such baseline data it is difficult to ascribe ‘change’ in knowledge, behaviour and attitude to a particular programme. This is further complicated by the fact that many other public education programmes are ongoing and schoolchildren are constantly exposed to them. Against this complex set of issues it is no wonder that country case studies are shy on concluding that programmes being implemented are indeed ‘promising approaches’.

4.1 Programmes for teachers

Teachers are a central pillar in any education system. Their survival and well-being is essential for the sustainability of the system. The surprise from the country case studies is how ministries of education have been silent about teachers’ needs in the HIV/AIDS epidemic. Except for South Africa (the Tirisano programme), Ghana and Botswana, other countries have proceeded as if HIV/AIDS is not a problem among teachers. Yet evidence to the contrary abounds.
During a subregional workshop to review the progress of country case studies in Southern Africa (held in Ezulwini, Swaziland, July 2001), it was pointed out that some countries have started designing HIV/AIDS programmes for teachers. If this is the case, such programmes are still in their infancy, certainly too late for many teachers who have already succumbed to the epidemic. One initiative is that of Lesotho Teachers Association, a teachers’ trade union that has taken a leading role in organizing annual workshops on HIV/AIDS for its members. The coverage is low, content is basic, and workshops are infrequent but there is cause for hope that teachers are becoming concerned about the epidemic and are beginning to respond.

This paper argues for the need to view and respond to the epidemic in a systemic manner. Evidence from country case studies shows that the reform of the school curriculum to integrate HIV/AIDS has not been followed by concerted and consistent efforts to re-train teachers to deliver the new curriculum. The only exception is the South African Department of Education that has trained over 10,000 teachers to offer a life skills and HIV/AIDS education programme in schools (Magome, Louw, Matlhiooa and Jack, 1997/1998). Kenya and Tanzania indicate that re-training of teachers to offer an HIV/AIDS curriculum has progressed haltingly and there is no evidence from other countries that such a thing is being attempted. Recently Tanzania mainland and Zanzibar have introduced HIV/AIDS course programmes in teacher training colleges (TTCs) to equip pre-service teachers with necessary skills.

Despite the good intention of governments and ministries of education in integrating HIV/AIDS in the school curriculum, questions have been raised about the suitability and preparedness of teachers to deliver HIV/AIDS information and impart knowledge to learners. This is a genuine concern in the light of the (a) ubiquitous tardiness in capacitating teachers; (b) evidence that teachers are
culprits in sexual exploitation of learners; and (c) many instances which show that teachers' beliefs on HIV/AIDS are conservative, mythical, and counter-productive. These significant shortcomings will have to be overcome for teachers to play a useful role in HIV prevention among schoolchildren. It is difficult to think of any other approach through which learners could be consistently engaged if teachers are left out. Leaving out teachers in HIV/AIDS prevention could prove counter-productive in the sense that they would be unable to play their traditional role as informers, educators, and counsellors. If teachers were bypassed in the delivery of HIV/AIDS information and knowledge they would be disempowered. Communities and learners would no longer see teachers as reliable sources of information and knowledge. The concerns about the suitability of teachers to deliver the HIV/AIDS curriculum should be addressed through deliberate and well-focused in-service and pre-service training programmes, as well as deliberate management strategies to ensure that schools are not risk areas, but safe places for children.

4.2 Programmes for education managers and support staff

Again, evidence to show that ministries of education have or are setting up programmes to ensure the survival of key people within the ministry (at headquarters level, provincial/district level, and lower levels) did not emerge from the case studies. Arguments advanced for this are that where they exist, such programmes are in their infancy, thus the difficulty to analyze them as promising approaches. Here we can only say that HIV/AIDS programmes for managerial staff are either non-existent or too weak to warrant the attention of country teams which conducted country case studies. Yet this is a worrying situation. The survival of the education system is dependent on the availability of learners, availability and quality of
teachers, and availability and quality of education managers (administrators, supervisors and support staff). These are the three pillars of any education system and they interact to ensure that the wheels of the system keep on turning. The neglect of programmes for education managers is hard to explain except to say that HIV/AIDS is still seen as a problem ‘out there’ among learners, and in the wider society. The threat to the very foundation of the education system (that is the management of the system) has not been appreciated, yet anecdotal evidence indicates that education managers too are dying of AIDS.

One approach being piloted in Tanzania mainland and Zanzibar is the involvement of local communities in school HIV/AIDS programmes. In the School Youth HIV/AIDS programme being implemented in Magu District in Tanzania, local communities are represented in school HIV/AIDS committees. Sawaya and Katabaro (2001) argue that the active involvement of communities has played a part in strengthening school-based HIV/AIDS programmes. Instead of having parents as antagonists, they are actually playing a part not only in contributing resources for the programmes, but are also supportive of the teachers responsible for guidance and counselling. Similarly, Mwinyi (2001) points out that the strength of School Health Clubs (in which HIV/AIDS is the significant part) lies in the support they get from local communities. Parents support their children to participate in club activities but the most exciting finding is that children are increasingly sharing HIV/AIDS information with their parents and siblings. Such experiences are few and they were not fully captured by the two case studies (Zanzibar and mainland Tanzania respectively) yet they provide evidence that school-community collaboration in HIV/AIDS programmes is necessary and would be mutually beneficial.
4.3 Management information system

No case studies under the ADEA initiative yielded evidence of there being a deliberate effort within ministries of education to manage and plan for preventive and impact-mitigation programmes. This is partly due to lack of human resources. Although case studies indicate that every ministry of education has a professional designated as HIV/AIDS Focal Point this is normally a ‘one-person show’. One person is expected to push the HIV/AIDS agenda and activities through the Ministry’s bureaucracy and to ensure that activities are being implemented on the ground. Besides the lack of human resources, HIV focal points are severely underfunded. Focal points are unable to initiate activities because of lack of funds and equipment. How then can focal points do their work?

It is clear that without sufficient human and financial resources, ministries of education will not be able to achieve much. Focal points should certainly be upgraded into functional HIV/AIDS units whose remit cuts across various layers of the sector. More important, HIV/AIDS units should focus a significant part of their effort in designing and maintaining management information systems to ensure that information to guide policy and programmes is readily available. We are placing emphasis on this aspect not only because it is currently a very weak area but, more important, because the efficiency and flexibility of the management system within ministries will certainly depend on the quality of information.

5. Conclusion: problems and opportunities

In view of the multitude of programmes on HIV/AIDS in the education sector, the Association for the Development of Education in Africa piloted an initiative to identify promising approaches with a view to sharing ‘what works’ not only within countries but also
across borders. We have argued that what works in the education sector, as in any other sector, should be part of a systemic approach to the problem of HIV/AIDS in the sector. Evidence shows that ministries of education have been strong in designing and implementing programmes for learners while little has been done for teachers and education managers. While programmes for learners are justified, their success depends on teachers (to offer the curriculum) and education managers (to monitor programmes and supply necessary support services including didactic materials). Ministries of education have been fairly slow in recognizing the impact of the epidemic on teachers and managers and hence the lack of programmes for these two groups. Training of teachers to offer the new curriculum has generally been slow and this does not augur well for the quality and effectiveness of knowledge to be imparted to learners.

One of the most telling lessons to emerge from the country case studies is that the ADEA initiative provided the first avenue through which HIV/AIDS programmes implemented by ministries of education could be evaluated. In the case of Lesotho, the initiative covered programmes implemented by the Scripture Union and the Lesotho Association of Teachers. Monitoring and evaluation of programmes is generally weak and this is an area in need of urgent attention. Proper monitoring and evaluation of programmes is essential for policy adjustment as the situation on the ground changes constantly. For example, in Tanzania, the peer education programme makes use of one edition of the *Mshauri wa Rika* booklet (ca. 30 pages) for classes 5-7. This means that children read and discuss the same material for three years. No one has examined the impact of such recycling on children’s perception of the seriousness of the HIV/AIDS programme, but the Tanzanian country team indicated that reading the same things over and over again is not very amusing to children.
It is worth recalling that in the African education environment HIV/AIDS is one problem among others. It might be the biggest problem, but one has to bear in mind that part of what the epidemic is doing is to exacerbate existing problems. And this provides an unprecedented opportunity for reforming the education system in a way that can withstand future shocks.

We have indicated that the above inventory is a preliminary one. This is so for a number of reasons. One, the ADEA exercise is still ongoing and lessons are emerging as many more countries complete their case studies. Two, the implications of HIV/AIDS for the education sector are also still emerging and so are the responses. Three, the concept of mainstreaming and its application are still evolving. However, available experience is fairly clear that ministries of education have not completely grappled with the issues involved in mainstreaming HIV/AIDS in the education system. Scratching the surface has been done, but what is needed to address HIV/AIDS and all its ramifications is not scratching the surface but deep ‘tillage’ and this will entail looking at the problem from a more systemic perspective. Unless planners and policy-makers in the sector are ready to change their world views and value systems, the road ahead will be bumpy and the opportunity could be lost.

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CHAPTER 5. INSTITUTING GENDER EQUALITY IN SCHOOLS: WORKING IN AN HIV/AIDS ENVIRONMENT

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Abstract

This paper compares the experiences and effects of an HIV/AIDS and gender equality intervention through the use of drama in two black working-class schools in the greater Durban area. The paper engages with two bodies of theory on social capital and school effectiveness that seek to explain ways to enhance educational outcomes. We argue that the two schools under discussion exemplify, each in its own way, one of these two models for understanding schools as organizations. Social actors in both schools appeared equally able to receive and internalize messages about HIV and AIDS. On the other hand, messages about gender equality were taken up in different ways in the schools. The school exhibiting high levels of social capital appeared to be more able to utilize the language of gender equality. The school that was more embedded within school-effectiveness discourses appropriated gender-equality aspects of the intervention in more limited ways, yet had features of efficiency and good management which, within the boundaries of the school itself, had some capacity to transform gender relations. The paper poses questions about the extent to which having or not having a language of gender equality enables practice in this area to develop. We conclude that having social capital, a language of gender equality or good management may each be necessary conditions for development of transformative practice. However, neither one of these on its own is sufficient. We suggest the need for further research to investigate the form of relationship between the three, which might produce sustainable and transformative HIV/AIDS interventions.

Introduction

This paper explores the role of school cultures in sustaining or undermining initiatives concerning HIV/AIDS education. To the best of our knowledge, a focus on schools as organizations and their social location has not previously been a feature of any of the published...
research on HIV/AIDS and education. The paper draws on two case studies of responses to the HIV epidemic in two black, working-class schools in the greater Durban area.\textsuperscript{6} It contrasts two approaches to understanding schools as organizations, which have been influential in the past decade, one emerging from theories of social capital and the other linked to the analysis of school effectiveness and school improvement. The two schools in the study exemplify the two differing discursive frameworks and the paper examines the implications of different understandings of the nature of the school for forms of response to messages concerning HIV/AIDS and gender equality.

Central to this analysis is a concern that education about HIV/AIDS must entail education about gender inequities and attempt to develop approaches to gender equality. This is a focus that has been noticeably underdeveloped until very recently in writings on the HIV/AIDS epidemic worldwide. Nonetheless, the HIV/AIDS pandemic in South Africa has striking gendered features. Women are estimated to comprise approximately 56 per cent of those infected with HIV with the single largest group of women comprising those aged 15-34 (Whiteside and Sunter, 2000). In KwaZulu-Natal it is estimated that among 15-19 year-olds, the vast majority of whom are in school, 15.64 per cent of African girls were likely to be HIV-positive compared to 2.58 per cent of African boys (Morrell, Unterhalter, Moletsane and Epstein, 2001: 51). The equivalent figures for other teenaged schoolchildren were 1.25 per cent for white girls and 0.26 per cent for white boys and 1.29 per cent for Indian girls and 0.26 per cent of Indian boys.

\textsuperscript{6} This study was funded by the British Council through its Higher Education Link programme and by the University of Natal, Durban.
Higher rates of infection among girls and women in particular age groups have their origins partly in heterosexual relationships marked by power inequalities. A growing body of research indicates how coerced or violent sexual relationships mean that women are not able to insist on condom use, making them particularly vulnerable to HIV infection (Jewkes and Abrahams, 2000; Jewkes, Penn-Kekana, Levin, Ratsaka and Schreiber, 1999). Messages about safe sex are unlikely to be put into practice unless men and women understand the need for gender equality in personal relationships, and enabling political, economic and cultural conditions sustain commitment to gender equality (Gordon and Crehan, 1999; Garcia-Moreno and Watts, 2000).

The first section of the paper locates the study in relation to literature on social capital, school effectiveness and the nature of school cultures. The second section briefly introduces the two case-study schools and outlines the methods used in data collection. The third section draws out detailed differences between the schools and considers these in relation to the responses of learners and teachers. The conclusion examines the importance of historically situated school cultures in relation to the sustainability of interventions regarding HIV/AIDS and gender equality, drawing out some of the implications of these findings for policy and practice.

1. Social capital, school effectiveness and the micro-politics of the school

In the past 10 years development theory and approaches to analyzing poverty have been concerned with the ways in which societies utilize social capital to enhance wealth, broadly conceived (Putnam, 1996; Grindle, 1996; Knack and Keefer, 1997; Dasgupta and Seregedlin, 2000). Social capital, that is the resources social actors have because of their affiliation to various groups, is seen as key to enabling a full participation in society. Children’s educational
achievement is often ascribed to the amounts of social capital they draw on while in school, that is the extent to which their learning is enhanced by the action of parents’ committees or networks of teachers (Teachman, Paasch and Carver, 1997; Francis, Adelabu, Agi, Alubo and Akbo, 1998). Some writing on HIV/AIDS in South Africa suggests that the groups most at risk are those with low levels of social capital, that is groups that have weak affiliations to organizations that produce well-being, be they religious, ethnic, political or professional (Barnett and Whiteside, 1999).

Much of the theoretical writing on social capital is gender neutral, although assertions are sometimes made regarding the ways women can enhance their access to wealth by joining associations (Povertynet, 2001). Some feminist writers deploy a form of this argument, without recourse to notions of social capital, when they consider how women’s organizations can enhance women’s strategic gender interests, that is interests that seek to transform a social order that is oppressive and exploitative (Kabeer, 1994; Molyneux, 2001; Moser, 1993; Sen and Grown, 1987).

A significant weakness in the writing on social capital is that it fails to take account of the gender politics of groups and associations. It does not engage with the extensive literature pointing to the difficulties many women and men from subordinated groups have in articulating their interests in organizations that have not consciously addressed issues of gender equality (Molyneux, 2001; Goetz, 1997; Kabeer and Subrahmanian, 1999). A second weakness in the theory is the way in which analyses of the associations of civil society that bear the explanatory weight of arguments for the importance of social capital are generally discussed in ahistorical terms. Indeed, as Ben Fine has pointed out, the theory obscures concerns with political economy and a detailed investigation of the histories of particular forms of associations (Fine, 2000).
Little of the writing on social capital and education has been concerned with gender equity. Moreover, while claims are made that low levels of social capital predispose some South Africans to HIV infection, there are no studies as to whether access to social capital, for example through association with an organization in a school or a teachers’ organization, improves the capacity to understand health-promotion messages, minimize risk and protect against HIV. This paper reports an investigation on these matters.

Writings on social capital tend to treat schools as unproblematic institutions where human capital is produced. By contrast some writing on school effectiveness sees schools as highly complex institutions that have crucial potential for enhancing educational outcomes, and often claims that well-managed schools have dramatic effects on children’s achievement (e.g. Mortimore, 1998). Writers in this field differ on what constitutes good school management. Nevertheless many of their assumptions have been taken up in South Africa, as by an expert team assembled by the *Sunday Times* in 2001 to identify the country’s ‘most improved schools’. The team noted dramatic improvements in the pass rates in certain schools that exhibited the following traits, among others:

- they may have sound buildings, but on the inside facilities are limited;
- they have charismatic principals who are strong managers;
- they value discipline (including uniforms);
- they use sport and culture to enhance academic performance (*Sunday Times*, 23 September 2001).

The importance given to school management in the literature on school improvement and school effectiveness is similar to the way the literature on social capital views membership of an organization. Both view the resources of an organization – be it good management
or a form of social interaction – as key to overcoming the exclusions linked to poverty or class. However, as with writings on social capital there has been little attention in the school-improvement literature to gender equity (see David, 2001, for a comment on how such concerns might be addressed). In addition, writers on school effectiveness and school improvement have not yet investigated health indicators or social participation (as opposed to success in public examinations) as indices of success.

It is easy to overlook the ways in which schools are also sites for micro-cultural negotiations of identity, struggles over meaning and over the boundaries and transmission of knowledge. Such micro-political struggles and negotiations have been traced in a range of international literature. Stephen Ball (1987, 1994), for example, explores how processes of change in schools are negotiated, struggled and fought over through a myriad of micro-political interactions between actors within the school’s population (teachers, principals, children, parents, school governing bodies). The outcomes of such processes, he argues, are not predictable in any simple way but can be understood through an analysis of the small, often seemingly inconsequential actions and relationships developed in a school. These depend on both styles of management and dominant discourses, as well as the ways in which learners and teachers resist and accommodate them.

“We are interested in how schools operate as sites of cultural, political and social struggle and identity-making, how they are conceived by official bodies (like national and provincial government) and how they are experienced by those who spend significant amounts of time in them as teachers or learners. This is not simply because such processes provide the context for interventions in relation to HIV/AIDS education – although they do - but because we see both the general and particular
characteristics of schools as important ingredients in the process and practice of education. Changing sexual behaviour and attitudes to gender equality in schools is not a simple process or an easy project. The processes associated with behaviour change are deeply embedded in expressions of identity and such identities are produced in and through schooling as much as in the students’ and teachers’ outside worlds.” (Epstein and Johnson, 1998: 108)

One of the questions this paper examines, then, is how the framing of the schools by school effectiveness or social capital theory affected gender equity discourses among learners and teachers. We will not argue that either form of framing makes for better interventions on HIV/AIDS and gender equity. Rather, we trace how the discursive practices in different schools produced different effects. These are complicated and it is not easy to judge them as ‘good’ or ‘bad’. To understand the ways in which interventions are received it is crucial to understand the context of the school and the negotiations entailed in its micro-politics.

2. Methodology and data-collection methods

The project used various qualitative methods to develop a ‘thick description’ (Geertz, 1983) of two working-class, black, township schools in the Durban Metropolitan area in relation to gender, violence and HIV/AIDS. We began by exploring the extent of existing HIV-prevention initiatives and anti-violence work in KwaZulu-Natal schools7 and undertook a review of research literature on HIV/AIDS, gender and/or violence8 internationally. We selected two schools for in-depth case-study research because of their location in working-class townships in Durban with high levels of poverty – Lillian Ngoyi

7. These studies were carried out by Julie Douglas and Vusi Mahlobo in 2000.
8. This report was compiled by Jo Manchester.
High School and Dingiswayo High School (pseudonyms) in KwaMashu and Umlazi respectively. These schools were selected partly for pragmatic reasons. The chief director of the region and the respective principals consented to research being conducted there. The schools were also appropriate for the conduct of in-depth case-study research as they were functional compared with others in the same townships that, in 2000-2001, scarcely operated because of crime and poor management. Teachers in both schools agreed to take part in the study.

The case studies used a range of methods. In 2000-2001 two surveys were conducted in both schools to try to establish the extent of sexual activity among young people and learners’ knowledge of HIV/AIDS. A series of discussions with single-sex groups of grade 9 and 10 learners took place to explore themes relating to understandings of violence and schooling. Thereafter discussions were held with six to eight learners in each of the two schools. Teacher researchers began to document aspects of each school’s history, organization, and day-to-day events, particularly with regard to violence and education about HIV/AIDS.

In 2001 we commissioned DramAIDE (Drama-in-AIDS Education), an HIV/AIDS and sexuality-education NGO based at the Universities of Natal and Zululand, to develop, implement and evaluate an HIV/AIDS and gender-education project in the two schools. DramAIDE used drama methodologies to teach life skills, gender and AIDS-related themes to learners and a group of teachers in each school. The organization’s aim is to encourage “young men to become involved in health promotion care thus demonstrating personal responsibility

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9. Pseudonyms have been used to protect the identities of the schools and respondents.
10. A questionnaire survey was conducted among 450 learners at the two schools in September/October 2000 by Robert Morrell.
11. To protect the identity of the schools and learners, the names of the teachers who compiled these reports have been kept confidential.
Instituting gender equality in schools: working in an HIV/AIDS environment

for their own behaviour” (DramAIDE, 2000: 9). In discussion with DramAIDE we believed this could be adapted to take on a wider gender-equity scope. The intervention comprised 15 workshops conducted over one month by a DramAIDE facilitator. Thirty volunteer learners in each school were selected to participate in the workshops conducted by a DramAIDE facilitator. A researcher worked with DramAIDE to evaluate the processes and procedures of the intervention. The workshops at Dingiswayo High involved grade 8 learners, while those at Lillian Ngoyi High involved grades 9, 10, and 11. Teacher workshops on the same themes were also conducted, using similar drama methodologies.

Six months after the DramAIDE workshops another set of single-sex focus-group discussions were held with learners who had taken part in the DramAIDE project. Some interviews were also held with learners and teachers who had participated. These explored participants’ perspectives on their lives, reactions and actions in relation to the DramAIDE project both within the schools and beyond (Neuman, 1997).

The case-study methods raised difficult ethical issues. Some schoolgirls disclosed experiences of sexual violence. Some teachers revealed their complicity in corporal punishment, shaming of schoolgirls who became pregnant, and protection from the police of children who were involved with criminal gangs. As researchers we took a decision to assist schoolgirls with access to counselling and appropriate social services, and to voice our disagreements with teachers on corporal punishment and attitudes to schoolgirl pregnancy.

12. This evaluation was undertaken by Mark Thorpe, who reported his observations in a working paper for the project (Thorpe, 2001a).
At the centre of our analysis is a concern that the context in which schools operate is critical for understanding their micro-politics and the ways in which learners and teachers engage with messages relating to HIV and gender equality. The next section examines the context and micro-politics of the two schools and the different ways it might impact on the ways the intervention was understood and put to use.

3. Schools and contexts: Lillian Ngoyi High and Dingiswayo High

Lillian Ngoyi High and Dingiswayo High are located in the two largest townships in the Greater Durban Area. KwaMashu, where Lillian Ngoyi is located, is the older of the two, established in the wake of the Cato Manor removals from 1958-1965 (Moller, Schlemmer, Kuzwayo and Mbanda, 1978: 3). Umlazi, where Dingiswayo High is situated, was constructed a few years later (in the late 1960s). Initially there was little to distinguish one township from the other. Both attracted residents looking for job opportunities in the city, both were overcrowded (household sizes in both were 7-8 per tiny two bedroom abode) (Moller et al., 1978: 6; May, 1986: 119), both initially were poorly resourced. From the start, both sprawling townships had high levels of crime that remain a feature to this day (Moller et al., 1978: 19; Ndabandaba, 1987: 83). And yet, relative to squatter camps, both were places where the better resourced, frequently employed lived (May, 1986: 31; Freund, 1996: 131). The townships are situated in KwaZulu-Natal, which is the province with the highest HIV prevalence in South Africa. In 2000 this was estimated to be 36.2 per cent. (The Western Cape, with 8.7 per cent, has the lowest provincial incidence in South Africa. http://www.und.ac.za/und/heard/Stats/WEB%20stats.pdf).
In Umlazi township the recent dominance of traditionalist politics with a strong patriarchal bent (Waetjen and Maré, 1999; Waetjen and Maré, 2001) and the failure of community and student organizations (like the Congress of South African Students (COSAS)) to gain a foothold, has had an influence on the ethos of Dingiswayo High. In the mid-1980s the school principal resisted COSAS’ efforts to organize the school. He brought order by using corporal punishment and a zero-tolerance approach towards lateness, drug-usage and gangster entry into the school grounds. In 2001 corporal punishment continued to be used freely. In August of that year the rate of absenteeism was 5.3 per cent. The school itself has little relationship with the surrounding community. It operates rather like an island or a fort. In this enclosed environment, key features of the school-effectiveness model are apparent. Learners are expected to benefit from a school that functions efficiently. Efficiency is understood to emerge from the institutional arrangements of the school alone and is therefore the responsibility of the principal and teachers.

Lillian Ngoyi High similarly reflects the recent past and the influence of the surrounding community, where the legacies of struggles against apartheid and the former government of the KwaZulu homeland are still to be seen. The school was unable to collect school fees until 1994 because students and parents refused to pay. Non-payment has continued at a high level. Absenteeism, calculated by headcount in August 2001, is close to 20 per cent. Learners have resisted corporal punishment. In 2001 learners and parents chased from the school a teacher known for his ruthless punishment methods. Community organizations and the South African Democratic Teachers’ Union (SADTU), to which teachers belong, exert influence on the running of the school. The influence of social capital is evident. Teachers do not consider that they are operating in an isolated institutional environment. They are sensitive
to outside pressures and draw on discourses of democracy, liberation and equality, which are the salient legacy of the anti-apartheid struggles. Educational outcomes are not considered to be the sole result of the school’s efforts. Both teachers and learners operate within a porous institutional context and acknowledge that learners’ futures are affected by school and non-school linkages.

Both schools are poorly resourced compared to middle-class, formerly white suburban schools, though by national standards they would probably be considered to have reasonably good facilities.

Both schools are headed by African, Zulu-speaking male teachers who have been in office for over a decade. They are relatively orderly. School bells signal the beginning and end of lessons. Most learners are in class during stipulated teaching periods though at Lillian Ngoyi much more latitude seems to have been extended to (or taken by) learners.

At Lillian Ngoyi, the environment is ‘freer’. Teachers are not particularly authoritarian and talk informally and joke with learners. Learners seem inclined to ‘do their own thing’, including being out of class during lessons or leaving the school in an unauthorized manner.

At Dingiswayo learners’ dress and behaviour are more orderly. There is an attitude of ‘respect’ towards the principal and substantial social distance between learners and teachers.

The schools have very similar examination results. Competence in English is significantly better at Lillian Ngoyi, but in other national examination subjects learners’ performance seems comparable. However, drawing conclusions is difficult because there are so many variables, the most important being class size. In 1999, when
Dingiswayo had 91 matric candidates, the pass rate was 65.9 per cent. In 2000 there were 174 candidates and the pass rate increased to 73.6 per cent, a quite unexpected achievement. In 1999 Lillian Ngoyi had a very large matric cohort of 202 learners and its pass rate was only 42 per cent. In 2000 when the number of candidates dwindled to 84, the pass rate shot up to 82 per cent.

A comparison of matriculation exemption rates shows that at Dingiswayo’s achievement was steady (despite the class size) whereas Lillian Ngoyi’s performance was uneven though clearly linked to class size. Dingiswayo learners’ matriculation exemption rates remained stable at 18.7 per cent in 1999 and 18.4 per cent in 2000. Lillian Ngoyi’s rates mirrored the pass rate, with 10.9 per cent in 1999 when the matric cohort was large and 34.5 per cent in 2000 when it was relatively small.

These figures suggest that Dingiswayo has a more stable learning environment, able to cope with additional demands. Lillian Ngoyi delivered good results under optimal circumstances but was not able to handle a very large matric cohort.

The way in which learners in the respective schools responded to the DramAIDE intervention reflected a similar pattern.

The participant observer recorded that in the workshops at Dingiswayo High “… the atmosphere was far more subdued and ‘respectful’ in the old fashioned educative terms. People didn’t speak out of turn. They were slower in responding” (Thorpe, 2001a: 39). Some learners, mainly girls, did not once answer a question in a group context. The most dominant girl at the school never challenged the boys’ views. The DramAIDE evaluation notes record that “[T]hough it may sound sour to say so, most of her actions in front of the class seemed entirely to impress boys” (Thorpe, 2001a: 12).
By contrast, at Lillian Ngoyi girls’ higher levels of confidence were noted at all stages of the research process, before, during and after the DramAIDE intervention. The DramAIDE evaluation notes record that “An atmosphere of openness developed and at times students were sharing things, often passionately, about their views, and even their own experiences” (Thorpe, 2001b: 9). In addition, girls were willing to express their opinions and challenge the views of boys:

“I was struck by the lack of the ‘victim’ image from some of the girls, such as one saying she went for ‘status’ in a relationship, which was followed by a ‘whooping’ like on an Oprah Winfrey show.” (Thorpe, 2001a: 18)

An interesting finding was that confidence levels in interview, focus-group discussions or workshops did not have a strong relationship with reported levels of sexual activity. Girls reported high levels of sexual activity at Dingiswayo High, but when the figures are disaggregated (see figures below) a more complex picture is revealed. More Dingiswayo girls claim to abstain, though when they do engage in sex, it is with more frequency than their Lillian Ngoyi counterparts. On the other hand, the apparent openness of Lillian Ngoyi girls in interviews and the workshops is to some extent contradicted by their unwillingness to disclose the extent of their sexual activity (see the large number of ‘blank’ returns for Lillian Ngoyi girls).
The marked contrast in assertive, almost boisterous public behaviour of Lillian Ngoyi girl learners may be attributed to the social capital of their school. Their school is connected to the surrounding community and the gender messages of that community (ANC, SADTU), even if contradicted by patriarchal practice, has a potentially emancipatory effect. Their Dingiswayo counterparts, on the other hand, learn in a stern, cut-off and regulated environment where ‘school effectiveness’ is the watchword. This causes them to be publicly passive, almost submissive (though in private their self-reported sex lives reveal a somewhat different picture).
4. Understanding, utilizing and instituting gender-equity interventions

In this section we examine the ways in which teachers and learners at the two schools responded to the intervention, particularly its focus on gender equity in the context of HIV/AIDS. We use the respondents’ self-reported accounts of engagement with the intervention to assess the extent to which it impacted on their understanding (knowledge) and utilization of gender-equity discourses as well as on gender relations within the schools, and what implications this might have for sustained change in terms of the schools’ ability to effectively respond to the HIV/AIDS pandemic.

5. Teacher responses

On the one hand, in both schools the interviewed teachers’ understanding of the HIV messages from the DramAIDE intervention was very high, by and large. On the other, unless specifically probed, teachers’ responses were generally devoid of any gender-equity discourse and acknowledgement of the role played by gender inequality in the pandemic. The following comments by two Dingiswayo School teachers illustrate their perceptions of what the intervention was about:

“It went very well because it was dealing with the issues, which the students are familiar with. AIDS, abuse and things like that. After the training the students became enabled to talk about it to their peers.” (Norma)

“And also it highlighted some of the issues in terms of how the teachers are supposed to get involved in terms of this killer disease. So it was sort of a reinforcement. It made us to be aware of the fact that we are like an integral part ... I think the teachers have
Instituting gender equality in schools: working in an HIV/AIDS environment

more time with the kids. I think they are the ones who are supposed to teach the kids on how to, like to prevent this killer disease.” (Sandile)

Note that AIDS was seen as the major point of the intervention, not gender equity.

In teaching about HIV/AIDS after the intervention, teachers did not seem to be clearly addressing gender equality. Talking about her Guidance lessons, Thuli, a teacher at Lillian Ngoyi, said:

“I talked to the Grade 10s ... about AIDS in Guidance. I asked them, ‘If you found out you are positive what would you do?’ One boy said, ‘No, I’d go on with my partner because I know that she is positive as well’. ‘Will you use a condom?’ He said, ‘No, I won’t ... because I know that I have AIDS so what’s the use?’ But other boys, you know, said, ‘No, it’s wrong if you don’t use a condom even if you know that you are positive. You have to use it to prevent re-infection.’ So I saw that [the intervention] had an impact on both boys and girls…”

While she shows a sophisticated understanding of HIV/AIDS, she says very little about the importance of gender equity and the use of condoms. The strategy is advocated mainly for self-preservation rather than respect for the other person’s dignity and equality in the relationship. By not questioning the learners’ stance, she displays a level of ignorance regarding the importance of gender equity in relationships.

It was only when directly questioned on gender equality that teachers reflected on whether there had been any changes since the intervention. Gender equality was thus somehow seen as detached from learning about HIV/AIDS. However there were some interesting
similarities and differences between the schools in how gender-equality issues had been taken on board. At both schools teachers spoke of girls’ confidence being enhanced. At Dingiswayo this was not seen as anything particularly new. Teachers felt the intervention had a more positive impact on girls than on boys. One female teacher explained:

“It’s always the case, men are backward. They take time, you know ... I mean girls always take the initiative. Even in church you find many more women than men.” (Thandi)

Vuyo, her male colleague agreed, “Yes, it’s a fact”.

Teachers at Lillian Ngoyi also spoke about girls’ confidence being enhanced by the intervention and teachers providing new openings for girls because of this. Thus, after the intervention a group of girls who had participated had offered to address a school assembly on similar issues, and this had taken place. In addition a girls’ football club was now running. It can be seen that girls’ enhanced confidence appeared as a matter for individuals at Dingiswayo, but was taken to new levels of association – through the assembly or the football team – at Lillian Ngoyi.

At Dingiswayo there was a level of acceptance of gender inequality. A teacher noted how some staff members took gender inequalities as commonplace.

“Yes, [the DramAIDE intervention] did deal with sensitive issues and that even here at school there are some teachers who think that women are inferior.” (Norma)

She did not think the DramAIDE intervention would have any lasting impact on her male colleagues’ attitudes towards women:
“Men will always think that they are superior. Maybe it will change after some time because these things are new.”

The changes in gender discourses among staff at Lillian Ngoyi seemed more profound. An example from an interview with a male teacher illustrates this:

“Before we closed [for the June holidays] there was one learner who could not write my English paper. We got a report that she was raped on her way to school. As a result she could not come. What we did we spoke to the principal to kind of refer these learners to the police so that a case can be opened. The nurses and whatever, the proper channels, were followed. So I’m saying as an institution we are responding to that corner whenever there is a need for us to do so ... I think the effect with the elder, let me call them the elders, is that they are seeing things that they have buried, particularly in this institution. There is always an open talk that ‘I’ve buried my friend last week’ or ‘my relative that other week’. So that has had a lot of impact on their minds such that when you talk HIV and AIDS all of us are willing to assist no matter whether it’s male or female.” (Sicelo)

It is evident here that the girl’s problem with learning is not seen as hers alone. The teacher responds to reports that she was raped. He works with other teachers (“we spoke to the principal”). Rape is not seen as the girl’s fault. The case is referred to police and health officials. He takes pride in using ‘proper channels’ and in contributing to building social capital: “as an institution, we are responding”. The results of the high numbers of AIDS deaths are described in terms of the losses of friends and relatives, that is in terms of social relationships lost rather than individuals. Gender equity is seen in terms of “all of us are willing to assist no matter whether it is male or female”. This is framed in terms of building social capital, the
institutions of civil society, the school, the networks of friends and associations as gender-inclusive structures.

In contrast, the Dingiswayo teachers spoke about some of the effects of the intervention in terms of the failures of the intended ‘cascading effect’:

“Yah, it made a difference, but unfortunately [only] to those who were exposed to the DramAIDE … because there were no discussions after that. There were no internal workshops after that.” (Thandi)

In contrast to the Lillian Ngoyi teacher, who put the new learning to work when the girl was raped on her way to school, the Dingiswayo teachers waited for management directives and further internal workshops. While the Dingiswayo teachers generally accepted gender inequalities, the Lillian Ngoyi teachers reflected on how issues about gender equality were affecting them in their personal lives as well as new processes they were putting in place in the community.

“… there is also an impact [of DramAIDE] because we as teachers when we discuss things people who used to brag about having so many girlfriends, nobody now wants to sleep around. Everybody just sticks to one partner. They’ve just come to value their relationships now and the feelings of their partners because now they are afraid of these things, of AIDS.” (Thuli)

Sicelo, one of her male colleagues, agreed and added:

“And also dealing with cultural stereotypes. For example, in our culture a man could have more than one girlfriend or woman. It has been an acceptable norm, but this workshop was able to deal with that at the level of educators as well as the learners.”
Encouraged by her male colleague’s support, Thuli went further:

“Even the stereotypes in terms of using condoms because there were people who were saying, ‘I will never use that. I won’t use the plastic’ and so forth. All those things now have changed. And the fact that there are people that they know of who have died of this disease now, it’s no longer a myth. It’s a reality.”

It is evident that the Lillian Ngoyi teachers were making connections between their personal behaviour, the way they discussed this in the staff room, and ‘cultural stereotypes’. They appeared to be more confident about making such connections than the Dingiswayo teachers. This might be because many of the organizations in which they are active in their area (for example, their SADTU branch, and the Learner Representative Council (LRC)) used this approach. Another reason might be the school’s active engagement with social issues in the curriculum through Guidance lessons and a welfare desk run by learners. By contrast the fatalistic acceptance of gender inequalities by male and female teachers at Dingiswayo echoes the more conservative cultural ethos of the locale of the school, and the teachers’ approach to their work, which they see as professional and technical, rather than personally and politically engaged. Guidance had been dropped from the curriculum at Dingiswayo, and the teachers all lived some distance from the area in which the school was located.

At Lillian Ngoyi teachers were particularly proud of changed attitudes to the distribution of condoms, which was often referred to as the criterion for measuring the success of the intervention.

“The effect has been quite great because thereafter kids have been coming to us demanding condoms ... which is a positive development. Before the schools closed for June recess, we had had to decide as the staff where to put these condoms so that we
place them in toilets or in offices. The strategic points where it will be easier for them to access them because we had identified one weakness, because they are kept by the Deputy Principal, that it might happen that there are those learners who may be shy to come forward and request them.” (Sicelo)

Once again we see teachers picking up the initiative from the DramAIDE intervention and working to change some social relations in the school, with potentially important consequences for gender equity. By contrast, at Dingiswayo, actions after the DramAIDE intervention seemed steeped in a moralistic stance, in which ‘doing the right thing’ was the main lesson being drummed into the learners:

“Yes … We had our Miss Dingiswayo [pageant], we were fund-raising ... So, we called upon one of the stars from Yizo Yizo [a TV soap opera that worked with a number of HIV/AIDS awareness messages] just to tell them and mould them towards the right direction. Telling them that as they [the actors] are playing Yizo Yizo, it does not mean that it’s not real life. What they are showing is that there are people who are doing such things [and] in the end they end up in jail.” (Sandile)

In terms of the literature on school effectiveness, such activities could be regarded as highly motivating to the learners, but they seem remote from gender equity.

Since teachers implement educational interventions, their perceptions enable us to understand the potential for sustainability. The views of learners, who are the target of such interventions, enable us to go deeper (Tinto, 1993). The next section examines how learners perceived the DramAIDE intervention and particularly its impact on gender equity in the school.
6. Learner responses

Learner responses had many similar features to teachers’ responses. At Lillian Ngoyi, girls were unreservedly positive about the intervention, speaking about the way they had found it personally empowering. For example, one of the girls asserted:

“... I’ve learned that if you, like you’ve been abused, like raped don’t ... ahhh – break the silence, you have to talk about it. Stand up and talk about and tell everybody that this and this and this and that people have abused me...” (Thembi)

The same girl reported that she had helped a friend to put her abusive stepfather in jail:

“[My best friend’s stepfather] was abusing her. Like her mother passed away and she was living with him ... He was abusing her in different ways, sexual abuse and all that ... I told her, ‘no don’t stay, break the silence. Just go stand up and tell the police what he is doing to you’. So he’s locked up.”

She attributed her ability to help her friend to the intervention. When asked, “do you think that’s because of the workshop?” she enthused: “Yes, yes, yes, ‘cause Mark said if you don’t want to do something, don’t do it. It’s okay for you to say no.”

A third girl reported that she was able to stand up to an authoritarian (and abusive) stage manager in a drama club she belonged to:

“We used to have argument with my stage manager, Skiri ... He used to say to me I’m so young to be in drama. And I said, ‘You know what, maybe I’m too much matured than you.’ ... ‘Skiri what I don’t like is when you talk to us and talk like you talking to the
younger kids or younger babies or just too harsh [to] us like that.
He [used to beat] us when he [taught] drama and I told him, confront[ed] him and I said, ‘You know Skiri this is not good ... We are not [children] anymore. We are matured. We are in high school ... Listen here Skiri, I’m a girl. I’ve got my own rule. I’ve got my own thing on tight.’ So this is girls’ power.” (Bongi)

One of the girls at Lillian Ngoyi criticized the way the disease was portrayed in the plays the learners produced and presented to the school. Her character, who was HIV-positive, dies. According to her, the play suggests that being HIV-positive means instant death. Identifying with and claiming her feminine agency, she declared, “I [wanted my character] to continue to live with that disease”. According to her, this would teach people to live with the disease in ways that enhance their own lives and protect others’. This is a powerful statement as Gugu Dlamini was stoned to death in KwaMashu in 1999 for declaring that she was HIV-positive.

What is evident in these responses is the girls’ developing sense of agency, their ability to challenge discriminatory and abusive practices, and select the appropriate institutional intervention be it the police or a family member.

By contrast at Dingiswayo School, the girls’ responses to the intervention indicated a wish to preserve a ‘good girl image’, and to mirror their teachers’ concern with teaching them morally acceptable behaviour. A comment by the most outspoken girl is illustrative:

“I liked a lot that some of us were showing other children how to behave because I like people who [respect] each other ... what I hated about [Thabi’s character] was ... because she wasn’t respecting her parents ... she even became pregnant because of not listening to her parents.” (Ntombi)
These girls were inclined to seek change within existing gender parameters. Their ages and status as the youngest class in the school, and cultural norms and taboos constrained them from speaking to elders about sex. Philile commented:

"In the drama I was a teacher, teaching children to respect the teachers at school and [Nonto's character did not want to respect her teachers]."

One of the girls was not able to contemplate challenging boys in a relational context and endorsed abstention instead:

"Some of the kids have stop[ped] having boyfriends. They just started waiting, [started] a new life." (Thobile)

Only one girl reported sharing her experiences with her parents in a positive and affirming way.

"I didn’t tell others] because they say, ‘you are a young child, what do you know about HIV? Because we know about HIV. Don’t tell us about sex because you are too young.’" (Thuli)

At Dingiswayo it can be seen that there was less of a sense of personal empowerment or drawing on the resources of social capital. Rather the girls are obeying the rules for an effective school laid down by appropriate elders.

Boys’ responses, on the other hand, did not display such striking differences between schools. At Lillian Ngoyi boys talked about improved relationships with girlfriends:

"I’m [now] speaking to my girlfriend. Last time I was not using a condom [when having] sex with her, but now I know that it is not good not to use a condom. Now I use a condom if I do it." (Thulasizwe)
Two other boys added:

“[There] is change about myself and with my girlfriend. You have to use condoms. You have to talk about sex before we do anything about it. We have to talk about it and we have to give each of us an opinion how to use a condom when I like to have sex with her if she don’t like I mustn’t force her to do sex. We have to talk to each other and agree one another about using a condom, having sex or not to have sex.” (Thulani)

“Yah. [My relationship with my girlfriend] improved a lot because I wasn’t respecting [her]. If she told me she wanna go to town if I don’t agree she [couldn’t] go ... now I know [we] have to respect each other and give her a chance to ... live her life together.” (Bongani)

At Dingiswayo the boys spoke less about changes in their personal relationships and more about how they had learned to obey rules. Responding to a question about the fatal refusal of some learners to heed HIV warnings, two of the Dingiswayo boys had this to say:

“It means that if you behave well at school and respect your parents, everything just...” (Siyabonga)

“If you have good friends who are well behaved, you should have good friends who will contribute to your education.” (Khanya)

Yet among the boys at Dingiswayo, there were also heartening signs of reflection and change.

“... I am confident now and I can decide if something is wrong or right. I am able to make decisions that will make other people happy as well.” (Nhlanhla)
“Boys like grabbing girls but they don’t do that anymore. We treat each other as friends.” (Khanya)

7. Conclusion

Our analysis indicates that Lillian Ngoyi, the school exhibiting high levels of social capital, appeared to be more able to utilize the language of gender equality. Dingiswayo, the school that was more embedded within school effectiveness discourses appropriated gender-equality aspects of the intervention in more limited ways. However, other effects of the Dingiswayo school environment (e.g. the disciplined environment) may well provide a stronger base for building on the achievements of the DramAIDE intervention. The fact that more learners attend school regularly and do so in an orderly way increases the chances of success for a life-skills curriculum. Efficiency and good management may be able to help transform gender relations within the boundaries of the school, but the Dingiswayo management has not given these issues attention yet. Given the location and history of the school, learners seem unable or unwilling by themselves to engineer gender transformation.

At Lillian Ngoyi, much rests, tenuously, on the mercurial interventions of certain teachers and learners. There is a language of gender equality in the school, but it may not have the necessary stability to change the school culture profoundly and enable new practices in this area to develop.

We therefore conclude that having social capital, a language of gender equality or good management may each be necessary conditions for the development of transformative practice with regard to learning about HIV/AIDS and gender equality. However, neither one of these on its own is sufficient. Further research is
needed to investigate what relationship between the three might produce sustainable and transformative HIV/AIDS interventions.

References


CHAPTER 6. THE INTERNET AND SOCIAL DEVELOPMENT: AFRICAN VOICES ON HIV/AIDS AND EDUCATION

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Abstract

This paper draws policy conclusions from a four-month experiment to bring information technology to bear on the problem of HIV/AIDS in Southern Africa during preparations for the Dakar World Education Forum in April 2000.
A UNDP-sponsored interactive virtual e-dialogue among sub-Saharan African voices addressed 14 major issues currently facing educational policy-makers. By networking through a neutral, user-friendly medium, this project generated surprisingly wide regional interest. Among more than 600 subscribers from 54 countries, almost half were from sub-Saharan Africa.

Postings provided new and compelling evidence of institutional and individual coping behaviours throughout the subregion. The List offered an opportunity to share difficult but ultimately successful experiences, such as formation of associations of PLWHAs, and collective action to affect public policy. Vivid personal encounters with the effects of the epidemic were courageously shared, and major ‘missing’ issues needing policy attention identified.

Scholarships were provided to two especially articulate list representatives so that they could present discussion summaries at the Dakar World Education Forum. Initial misgivings as to the suitability of an Internet-based virtual information-exchange on this sensitive subject proved unfounded. The Internet proved a viable policy tool for development in the subregion, and helped offset negative effects of the African diaspora.

Introduction and background

No problem facing Africa today is more serious than HIV/AIDS. Recent research suggests that HIV/AIDS is the leading cause of death in South Africa (SAMRC Report, 2001). It is about 20 years since the virus was first identified, and according to UNAIDS (the United Nations agency consortium formally addressing this problem) more than 40 million people worldwide are living with HIV or AIDS, the majority of them (28 million) in sub-Saharan Africa. More than
11 million Africans have already died from AIDS-related diseases. Like a ‘wildfire’ racing through the region the pandemic has posed for too long an unprecedented threat to development at all levels, and in every sector.

Nowhere is the impact more critical than in the education sector, for two reasons. First, education is a main line of defence against HIV/AIDS. Although different age groups have differing needs for information concerning the epidemic (and information by itself is not enough), everyone, regardless of HIV status, can benefit from outreach, advocacy, and improved knowledge on the epidemic’s ethology, course and treatment protocols. In a rapidly shifting informational environment, routinely updated knowledge is essential to any individual’s or community’s coping strategy. Education, at its interactive best, can provide a flexible two-way information conduit between national ministries and localities where knowledge is most needed and the citizenry most at risk. So the entire education infrastructure – including ministry staff, teachers, and teacher-training institutions – is central to this information exchange and rapid response capability.

Second, education systems are themselves acutely vulnerable. Morbidity and mortality among personnel is a huge and growing problem. Ironically, the role of education in combating HIV/AIDS is seriously and deeply compromised.

Both these types of impacts have been recognized throughout the southern African subregion. But little opportunity has been afforded for engaging people and institutions in constructive discussion – especially across national borders – so as to share

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experiences and inform educational policy. HIV/AIDS is a different and catastrophic type of disease, requiring different, and innovative approaches. Demographic and epidemiological studies have documented the HIV/AIDS effects\(^\text{15}\), and macro-economic analyses have shown broad impacts on productivity (Over, 1992). Yet, as it turned out, little research or inquiry has been conducted into the extent of teachers affected, the impacts on ministries of education and, perhaps most importantly, on the developmental aspects of the lives of families, schoolchildren and young people whose early years were being dramatically transformed. Despite alarms sounded by international agencies (Shaeffer, 1993; Cohen, 1999), and by countries themselves (Kelly, 1999), ministries are in many cases hamstrung by serious difficulties in resourcing and implementing essential studies on which to base their policies.

So, in March 2000, in advance of the World Education Forum (WEF) in Dakar, and in the face of overwhelming evidence that human resources development systems were being rapidly incapacitated, UNDP and partners set up an electronic forum for urgent communication and information-sharing around this problem, and the identification of coping strategies that appeared to be working. The purpose of this paper is to outline this pioneering initiative, summarize its findings, and comment on the value of such e-networking to social development policy.

1. **The list**

A major obstacle to effective national responses to HIV/AIDS seemed to be the unwillingness of many governments to face the problem openly, and reluctance even to discuss the epidemic. One

\(^{15}\) See UNAIDS/WHO global surveillance data at: http://www.unaids.org/hivaidinfo/statistics/june00/fact_sheets/index.html
way of quickly sharing ideas, and of informing policy, was an open e-forum list, proposed to participants and endorsed by a coalition of United Nations and partner agencies.  

In the context of ‘breaking the silence’ (the theme of the AIDS 2000 Conference in Durban) the list was intended to be inclusive of all major constituencies, but phased, highly focused, and confined as far as possible to the African voice. While other regions were not actively discouraged from bringing experience to bear on Africa’s needs, emphasis was placed on opening up the discussion specifically within the subregion itself. It was this aspect of ‘African-ness’ that was intended to distinguish this effort from others that had largely been dominated by northern input. It was also hoped that the introduction of e-dialogue into the ongoing African experience, building on earlier efforts by UNAIDS and bilaterals, would help boost Internet backbones and connectivity in the subregion.

The welcoming statement, rationale, archives of the discussion, and summary report are available on the web at: http://www.undp.org/poverty/forums/hiv-impact.htm

Named the HIV-Impact List, the forum was designed to “provide anonymity to those who wish to learn more through serious discussion, and a global stage to those who wish to share effective adaptive, coping experiences, from teachers, students, school administrators, researchers and policy-makers”.  

The purpose of the list was to provide input from the subregion to the Dakar World Education Forum on the crucial issues surrounding HIV/AIDS and education. In addition, a limited number of scholarships

16. Including, at various times, UNDP, UNESCO, UNICEF, UNAIDS, WHO, the World Bank, and bilaterals such as DFID, CIDA and USAID. The Education Development Center (EDC), Newton, Massachusetts designed, managed and moderated the list.
17. UNDP Welcoming Statement, HIV-Impact List.
were offered to assist particularly active and articulate list members to attend the WEF venue in Senegal.

Messages were posted in English and French. Efforts were made to contact known organizations and individuals, and to encourage extension. Although messages came from all over Africa, Western African and Southern African responses dominated. Subscribers came from a wide range of organizations and positions, including NGOs, student organizations, teachers’ organizations, health-care professionals, school administrators, government officials, the media, and multilateral organizations, as well as ordinary people whose families and friends are facing the challenge and personal tragedies of HIV/AIDS.

One rewarding aspect of this participation was the demolition of what could be called the negative e-connectivity myth of Africa. Initial resistance from some quarters to the idea of a list rested on assurances that e-infrastructures in Africa were minimal and, where they existed, too embryonic, expensive, fractionated or unreliable to sustain serious list discussion within the subregion. This was clearly not so, as this report details.

Rather, the Forum provided an extraordinary window on the depth of expertise, experience and commitment (in some cases over more than a decade) existing within African countries. It was as though finding ‘soul mates’ suddenly became possible in a previously barren wilderness devoid of e-communication. The serious dedication of Africans to self-generated solutions was also eye opening to some northern participants. A correspondent from the USA magazine *The Nation* wrote to the list:

“I have been reading your posts and am filled with awe at your expertise and depth of thinking on the subject of AIDS. Very rarely
do people in the USA get the impression from the media that African doctors, scientists, social workers and educators play an active role in fighting the disease and its effects. Mostly, the USA hears about Africans only as victims of AIDS."

The EDC final project report to UNDP can be found on the project web site. The present analysis goes into greater depth by reporting, in respondents’ own terms, what seems to be of most direct and immediate policy relevance for education sectors facing the HIV/AIDS crisis.

Implications of two kinds are offered:

1. conclusions, suggestions and recommendations concerning the substance of the discussion, namely the ways that education systems are trying to respond more effectively to the various impacts of the pandemic on system functioning at all levels; and

2. the relevance of ICT to helping countries in Africa overcome the crisis and, specifically, the implications for policy-makers of e-networking issues such as HIV/AIDS.

2. List structure

2.1 Method

The methodology for list design and implementation followed earlier successful collaborative efforts between the Education Development Center and UNDP. These are outlined in the EDC final report (referenced above) and Lawrence and Brodman (2000). Invitations were sent to organizations identified by UNDP and EDC.

Standard e-mail list protocols (as outlined on the archive web site) were explained to prospective participants. Individuals joined, participated or just ‘lurked’ according to their preference.

Experienced facilitators prepared the agenda, and guided or moderated the discussion through the thematic issues. Weekly topical subjects were introduced, and summaries of previous interchanges were prepared weekly. Extensive outreach was conducted for the list, especially in Africa, where institutions and individuals were contacted and encouraged to participate. This background maintenance and list management is resource intensive in the early stages of any successful list, but is essential to effectively establishing a list and engaging in serious dialogue.

3. Conceptual structure

The list discussion comprised two sequential phases. Firstly the list ran uninterrupted from 20 March until mid-May 2000. Its main focus was to prepare for the April World Education Forum in Dakar. Secondly, on 16 May, the decision was made to put additional resources into the list to permit it to consider follow-up to Dakar, as well as provide some guidance to list designers about future e-networking options related to the Durban AIDS 2000 Conference. Messages from these two phases were merged, and the database treated as a single entity. This permitted summaries of the numbers and regional representation of respondents, as presented in the next section.

The structure of the list comprised around 53 ‘threads’ and 14 issues, some of which were suggested ‘externally’ by the moderators, while most emerged chronologically from subscribers’ suggestions. The six ‘moderator’ issues were:
• resistance to acknowledgement of HIV/AIDS;
• assisting PLWHAs;
• best practices;
• cultural beliefs;
• relevance of information and communications technologies (ICTs);
and
• the future of the list.

The seven ‘subscriber’ issues were:

• specific local values and customs;
• testing;
• gender sensitivities;
• private-sector engagement;
• human resources development (HRD) policy;
• the role of international agencies; and
• keeping families intact.

The list followed this broad sequential structure but also went beyond it. Sometimes participants contributed personal and anecdotal accounts that went outside the frame in interesting ways and offered important insights. There was often a perceptible lag of a week or two as respondents came late to an issue or chose to express more thoughts and reactions about prior postings. But despite open invitations to list members to propose issues that might have been forgotten, the issue frame was essentially designed and managed by the moderators (EDC and UNDP) and represents the need of the list organizers to structure information.

This article analyzes key points and recommendations from the discussion, including additional subjects raised by participants, categorized in 53 subjects or threads listed in the archives. Based on the experience of the list it considers the utility of electronic
discussion formats for networking and social policy formulation. It relates the list to the explosive growth of ICT in Africa, and makes some suggestions.

4. Overall list response

All posted messages are contained in a keyword-searchable database at: http://www.edc.org/GLG/hiv-impact/hypermail/

In addition, the database can be ordinably displayed by author, date, thread or subject, providing the essential classification scheme, as well as the ‘raw’ text of each message for review in compiling this report.

Participation in the list was encouraging, with 667 subscribers that represented 54 countries of which 25 were from the subregion. More than 60 per cent of subscribers (and of total messages posted) were identified by e-mail addresses or e-mail content as from sub-Saharan Africa. This is probably an underestimate, because others may have been Africans using northern servers to access the list. Although individual cases were clear, it was difficult to be precise about the source of every posting, since people might sometimes identify themselves as from country ‘A’ while posting from a computer in country ‘B’. Sometimes the server or domain name was quite remote from the user. In most cases, however, it was possible to identify a respondent’s location from his/her institutional identification or information in the posting.


While 667 people or institutions subscribed to the list, the archives show that a total of 227 postings were received from 86 active participants who sent messages. The distribution of postings is shown in the accompanying graph. About two-thirds (70 respondents) posted only one message. About a quarter (59) were from the moderators. Respondents posting between two and five messages accounted for 40 responses, and those posting more than five accounted for 57 responses. The highest number of postings from a single member was 14. Four other list members posted between 9 and 13 messages.

It is important to note that there are relatively few voices. The discussion tends to reflect the perceptions and interests of a limited number of subscribers. Yet the high number of single postings mitigates this finding and illustrates the breadth of substantive coverage, since many of these single postings raised additional issues. Also, an analysis of issues that generated most interest (defined as most postings) shows a broad engagement, not dominance by one or two members.  

Weekly summaries of the discussion were posted to the list and are available at the archive site. A steady stream of requests for information and responses complemented the discussion. Thus the archives also include compilations of:

- information requests sent to the list (which were posted separately so as not to interfere with the flow of the discussions); and
- resources of potential interest to list members (such as references, web sites, project announcements).

These represent a strong contribution to our knowledge of how people cope with policy initiatives in the subregion.

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21. In the seven issues gaining the most postings, even in the one with the most postings (N=19), no more than 25 per cent of postings were from the same respondent.
Table 6.1 provides an overview of the 14 main issues in chronological order (for ease of reference back to archived source material) and recommendations stemming from them. The empirical structure of the list is evident from the table. The six moderators’ issues (Column 1) acted as ‘bookends’, reflecting a need to get the list going and to help effect closure. In the middle (Column 2) are the eight issues emerging from respondents’ advice. The number of respondents’ postings to each issue is in parenthesis in each column. The asterisk against Issue No. 13 means that no single response was identified solely (or mainly) with this subject, though many responses touched on it in part. Column 3 contains brief summaries of the policy recommendations on each issue.

### Table 6.1 Issues in chronological order, and major recommendations

<table>
<thead>
<tr>
<th>1. Moderators’ issues</th>
<th>2. Respondents’ issues</th>
<th>3. Major policy recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Resistance to acknowledging HIV/AIDS (N=18)</td>
<td>Don’t focus on fear, but on encouragement; address/overcome inappropriate responses (e.g. stigma, shame, superstition), increase educational outreach in formal and non-formal settings; and link national to local strategies;</td>
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<tr>
<td>2. Assisting those living with HIV/AIDS (N=20)</td>
<td>recognize HIV/AIDS not just as a health problem; identify/foster PLWHA’s associations and local care-giving efforts; expand PUWHA’s engagement in upstream as well as downstream programming; facilitate access to affordable treatment;</td>
<td></td>
</tr>
<tr>
<td>3. Best practices (N=5)</td>
<td>critical analysis/dissemination; review/disseminate institutional (e.g. university) policies;</td>
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<tr>
<td>4. Local values, customs (N=13)</td>
<td>‘bottom-up’ planning; understand community interests; involve traditional healers; tailor national approaches; support local research to assist in evidence-based planning;</td>
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<tr>
<td>5.</td>
<td>Testing (N=9)</td>
<td>make voluntary; assure confidentiality; offer home-based testing; extend and cluster support services;</td>
</tr>
<tr>
<td>6.</td>
<td>Gender (N=3)</td>
<td>identify needs by gender; emphasize girls' education</td>
</tr>
<tr>
<td>7.</td>
<td>Private sector (N=5)</td>
<td>facilitate/foster private/public coalitions;</td>
</tr>
<tr>
<td>8.</td>
<td>HRD approaches (N=2)</td>
<td>conduct impact studies; build on institutional experience on the ground; ensure inclusion of HIV/AIDS into all educational planning; integrate strategies into HRD management;</td>
</tr>
<tr>
<td>9.</td>
<td>International agencies' role (N=5)</td>
<td>give HIV more prominence; help info-sharing across national boundaries; second staff; complement national efforts;</td>
</tr>
<tr>
<td>10.</td>
<td>Keeping families intact (N=2)</td>
<td>recognize family as key; support family caregivers; enable families to participate in planning programmes;</td>
</tr>
<tr>
<td>11.</td>
<td>Orphans (N=8)</td>
<td>prioritize schooling; support community responses;</td>
</tr>
<tr>
<td>12.</td>
<td>Cultural beliefs (N=15)</td>
<td>open discussion and strengthen schooling role; recognize adverse aspects of local culture (e.g. gender discrimination and sexual violence or exploitation); engage parents; use peer education and children as teachers; use drama, role playing, street-theatre;</td>
</tr>
<tr>
<td>13.</td>
<td>IT next steps (*)</td>
<td>network across regions; expand African connectivity;</td>
</tr>
<tr>
<td>14.</td>
<td>List future (N=7)</td>
<td>continue for networking purposes with explicit focus on additional areas.</td>
</tr>
</tbody>
</table>

Management and structuring of the list were critical to its functioning, and seemed to have met with members’ approval. Several messages illustrate these reactions, expressing appreciation to:

“the moderators for the job well done. Without their unfailing efforts to structure the debate we probably might have meandered for weeks on end.”

and noting that:

“this forum has been remarkable for the clarity and wealth of information ... and particularly for its implications pertaining to HIV and AIDS in sub-Saharan Africa. The moderators are to be commended for providing this service and keeping it on target.”

Any attempt to summarize the thoughtful, constructive dialogue from the list is inevitably faced with the problem of what to leave out. Many constructive ideas were proposed, difficult to summarize in a short paper. Categorization by issue topic is an imperfect mechanism for sorting or classifying responses, because many issues might be covered in one posting. This is an inherent shortcoming of the archiving process. There is no substitute for searching and reading the actual postings to fully experience the list’s diversity and depth of engagement. Yet it is important to try to capture some of the key findings and recommendations, especially those of direct significance for immediate policy action.

5. Key points from the ‘voices’

5.1 Assisting those living with HIV/AIDS; fostering acceptance of HIV/AIDS

One way to measure the importance of an issue to respondents is to count the number of postings. The two subjects receiving the greatest attention were ‘assisting those living with HIV/AIDS’ and ‘fostering acceptance of HIV/AIDS’. The first generated considerable personal and anecdotal information on individual cases. The second was consistent with ‘breaking the silence’, the central theme of the Durban AIDS 2000 Conference. They are closely linked, and are addressed together below.

A striking finding was the demonstrated commitment, energy and experience in the subregion, in spite of still limited diagnostic, treatment and communication facilities. A major value of the list was to help link practitioners, professionals and other concerned respondents. Information was shared about how institutions were coping, with emphasis on critical analysis of best practices that emerged as examples in many of the discussions. Recommendations on how policy should be directed and services improved were most important.

The Copperbelt University in Zambia has openly faced HIV/AIDS, and the problems of people living with HIV/AIDS (PLWHAs) for many years, and has developed a careful and effective response over time. A medical officer with long experience put it this way:

“AIDS has greatly affected educational institutions in our part of the world. Teachers and students have died from AIDS, the former suffering more. Our first task as a health unit was therefore to get a recognition of the problem from our governing council at the university. This having been done, we then prepared a policy guideline for the institution on AIDS. Our policy on AIDS stresses that there shall be no discrimination ... and that those with AIDS shall be treated like all other individuals suffering from other illnesses. Secondly, there is no pre-employment screening for AIDS ... The medical centre acts as a resource base ... [and] has a 12-bed admission facility and a well-established laboratory and pharmacy. Unfortunately we cannot treat all patients with antiretrovirals because of the cost but on occasion those able to pay have managed to source the drugs.”

Another respondent endorsed this approach, suggesting collaboration with the private sector:

“I support the model proposed by Dr Oscar Simooya not only for learning institutions, but also for large corporations which have an HIV/AIDS workplace policy to also host a health centre which is made available to those infected and affected by the disease, including family members.”

Other institutional efforts included the following:

“From 1995 to 1999 we in the Mutare City Health Department, Zimbabwe, have been working on the development of guidelines for nutritional support for people with HIV. As little useful information was available on the subject at that time, we discussed, tested and amended whatever was available in co-operation with members from the local AIDS support organizations during weekly nutrition courses. As we thought our experiences were extremely useful, we published a booklet, to be able to share our experiences with other people with HIV and their care-givers.”

An academic physician in Ethiopia outlined collaborative efforts of PLWHAs to help each other:

“Recently people living with HIV grouped themselves and established a society. In a short time, their members have increased significantly and they [have] in fact been teaching others on how to protect themselves from HIV and what does it mean to have HIV. It is indeed exemplary to notice such a progress in a country where sex is not discussed openly even among adults, for people living with HIV/AIDS to come forward and teach others openly...”

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about HIV prevention and even go further to discuss their illness. I think the same initiative can be tried elsewhere especially in places where antiretroviral drugs are not available.”

In Kenya also, local and professional collaboration averted a negative outcome, and resulted in adjustment in education-sector policy:

“The Teachers Service Commission, the government department where all teachers fall (apart from university lecturers) on its hand has resolved to isolate those teachers living with HIV/AIDS. In a recent circular to all the districts, the commission directed all education officers to determine teachers living with HIV/AIDS and develop lists. However, the intentions of this directive were not clear as the method of determining the health status of teachers was not specified. The teachers’ union was quick to intervene to save the situation with a strike threat. The commission came to its senses in time and withdrew the circular.”

Taboos against talking about HIV/AIDS were discussed by several participants.

“Sadly, many developing societies are unwilling to accept that AIDS is wiping out their citizens. A doctoral student from Kenya told me that in a particular faculty department of 25 professors (or faculty members) at Moi University in Kenya, only two or three of them are left, as the others have been wiped out by AIDS. Yet, when these people died, their families insisted that their death certificates should read otherwise, i.e. by heart attacks, ulcers, etc.

Is this helpful, where true statistics are concerned? There are cases, whereby HIV/AIDS-infected persons are deemed bewitched by ‘bad’ or ‘powerful’ family members! I remember giving boxes of condoms to some friends somewhere in Africa, but many of them looked at me and said something like: ‘You really want to curtail my sexual enjoyment,’ or ‘You want to reduce my child-production abilities. These rubbers are for white people, not for black men ...’ Just, imagine! My wife and I have also heard some people saying: ‘Those who will get AIDS will get it, no matter what. It’s a matter of destiny...’"29

And from another country,

“AIDS is still known as a disease for others (tourists, sex workers, gays and drug addicts) ... Silence kills in Mauritius.”30

A participant from the National University of Lesotho noted:

“It is true that HIV/AIDS is a rampantly increasing disease in Southern Africa; however, capturing the statistics of the illness is still much of a problem in Lesotho. The problem emanates from the resistance of accepting that the disease really exists and that through proper prevention measures we can lower the spread. The way the awareness of the disease in our country has been introduced since the early 1980s has created a negative stigma to it, so much that people do not want to open up and talk freely of the disease or rather even accept their condition when they are diagnosed HIV-positive.”31

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A Ugandan national currently working at the University of Vienna said:

“Fear is the consequence of insecurity. How can a person be willing to know and publicly declare his [or her] sero-status in a society in which chronic diseases, and particularly STDs, are highly stigmatized and easily lead to isolation (loss of self-esteem, loss of a job, spouse, loved ones, etc.), if one is not well prepared and supported to do this?”32

Yet courageous individuals were still willing to share their own personal concerns and experiences with avoidance of the reality of HIV/AIDS:

“I am an African born and grew up in Tanzania. I have no medical background but have so much interest in HIV/AIDS because I have been touched by its vengeance and scars still remain. I would like to share my personal experience which might shed some light ... and maybe help those who are trying to combat the disease in Africa. I have lost many relatives to AIDS but this is not discussed in the family. I would like to share with you one of the [incidents]...”33

A senior United Nations adviser adds another personal story on the extraordinary risks to women:

“Nobody is safe; for the first time, rural and urban women are on the same side on this issue. I know a friend who in an effort to protect herself lied to the gang of robbers who came to her house to rob her that she was HIV-positive and the robber replied that he was HIV-positive as well so there was no problem and raped her. She is now HIV-positive.”34

Not everyone agreed that Africans were reluctant to acknowledge these problems. A native of Côte d’Ivoire currently working at the FAO Regional Office for Africa in Accra said:

“No, there is no resistance in most African countries to acceptance of HIV/AIDS as a reality.”

Nevertheless, where it exists, as a matter of public policy, stigmatization needs to be approached within the local context, and in relation to the extent to which the pandemic has progressed:

“... the extent of stigmatization of individuals living with HIV/AIDS is closely related to the stage of [the] epidemic. In areas where the epidemic is mature (Uganda, N.W. Tanzania) stigma no longer exist. In areas where the epidemic is young, stigmatization is, to most people living with HIV/AIDS (hereafter PLWHA) and their families, quite common. This broad categorization is also applicable in the education sector. I have no evidence of pupils shunning a teacher because he is suffering from AIDS or vice versa. At local level families and even non-relatives may provide help to a teacher who is sick from AIDS ... [In] Bukoba district, N.W. Tanzania, this is not uncommon.”

The same respondent felt that public-sector policies often fall short:

“... local and central governments in many African countries are not doing their job to help and support education employees affected by AIDS. While this is neither marginalization [nor] ostracism of PLWHA, it is a tactic, a sort of quiet abandonment of PLWHA by the same government they work for.”

Not surprisingly, some municipal efforts have been targeting PLWHAs effectively.

“From 1995 to 1999 we in the Mutare City Health Department, Zimbabwe, have been working on the development of guidelines for nutritional support for people with HIV. As little useful information was available on the subject at that time, we discussed, tested and amended whatever was available in co-operation with members from the local AIDS support organizations during weekly nutrition courses. As we thought our experiences were extremely useful, we published a booklet, to be able to share our experiences with other people with HIV and their care-givers.”38

Human resources policies in education ministries, especially to assist those living with HIV/AIDS, were singled out for special attention (Issue No. 8, Table 6.1). Despite scattered references and suggestions in messages that tended to focus on other issues, this topic did not seem to arouse much interest.

Other questions perceived as having been generally avoided, or noticeably missing, in education policy debates, were raised, such as:

“Why is it that some of the highest levels of HIV infection in sub-Saharan Africa are being seen in the teaching profession? Can it be attributed to their position of power over young people and ability to coerce them into sexual relationships, as some commentators have suggested? If so, wouldn’t we see a significant difference between prevalence among male and female teachers?”39

Again, gender differences in experience, and implications for setting policy, were separated out (Issue No. 6, *Table 6.1*), eliciting few specific responses, but several references in other messages. Answers to the above questions included the following:

“The view that teachers are more affected than others is only partly correct ... [They] are more likely to sleep with strangers because of high mobility. It is also partly incorrect because teachers are socially visible. They are few (not more than seven teachers at an average Tanzanian primary school), they earn money (a significant sum in impoverished villages), and are therefore in a socio-economic class of their own in rural areas. If one teacher dies at a school with seven or even ten teachers you are talking of a loss of more than 10 per cent. If three of them die, you are talking of around 50 per cent loss! Mortality among teachers, especially if measured in percentages, is not a good indicator or rather wouldn't be a good indicator of differences in HIV positivity between teachers and the general population.

That said, I tend to be cautious about the claim on power relations and forcing pupils into sex. If this was true we would be witnessing a high number of HIV+ girls (below 20). My long-term epidemiological data from Tanzania (1983-1998) show that the HIV+ graph for girls begins to rise after age 19 and peaks between ages 25-29 (these are obviously not schoolgirls, are they?). I would be the last to disagree that some teachers have sex liaisons with their pupils/students. But ... these are very few, well known, and could be easily dealt with.”

Another perspective was expressed by a university professor in West Africa, who regretted:

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“how sex has come to school with the stink and stain of disaster, almost subverting the goal of schooling.”

Among concrete solutions to the problems of receptivity and assistance are those offered by a research officer for an NGO in Sexual and reproductive health in Swaziland, who suggested that we need to:

“Carry out research that will assist in evidence-based planning for IEC strategies and messages.

Involve teachers in revamping the education system. The educational programmes for HIV should not only be directed to the child but also to the teacher.

Community-based initiatives should be encouraged as these will incorporate all those that are in the community: teachers, pupils, parents, leaders and the general public.

The media is a very important aspect of addressing the problem. Relevant and appropriate media should be used. Where computers are available, let them be used. In Swaziland, access to computers is very low but the potential to use them is there so long as these could be available.”

Clearly, the major focus must be on the school and formal education for participatory intervention methods and information dissemination and sharing. But in many Southern African countries the reality is still that significant numbers of children never enter the schoolhouse door (UNICEF/ESARO, 1998). Thus alternative, non-formal educational approaches, sensitive to the diversities of local contexts and schooling strategies, must also be central to national policies.

The social, economic and psychological aspects of HIV/AIDS necessitate going well beyond just a health-sector approach.

“Any HIV prevention programme that does not deal with human beings in their social environment is likely to hit a wall.”

5.2 Local values and customs; cultural beliefs

List discussants recognized the importance of considering ‘local values and customs’ and ‘cultural beliefs’, two issues also generating relatively high levels of messages. In Uganda (a country with some demonstrated success in coping with the epidemic) a recent study, available on the Internet, documents a culture of sexual risk taking among the young involving male irresponsibility and female disempowerment (Population Council, 2000).

And the scope of the problem for school-aged children is starkly presented in results of a new South African study:

“Adolescents are sexually active when they are young: in rural KwaZulu-Natal, 76 per cent of girls and 90 per cent of boys are reported to be sexually experienced by the time they are 15-16. Boys start sexual intercourse earlier than girls (13.43 years versus 14.86 years), have more partners and nearly twice as often have an STD history. In Free State, teenagers reported they were sexually active at around 12 years old, due to experimentation or peer pressure, and relatively few practised safe sex.”

Thus it is critically important to find ways to improve the socialization of school-age children in this threatening sexual environment.

44. Coombe, C. Re: Cultural beliefs and customs, 6 June 2000.
Examples were given of young people teaching young people in a co-educational secondary school in the city of Ibadan, Nigeria, among out-of-school settings in Dakar, Senegal, and among young men in Botswana.

“Supported by a local NGO with a particular focus on sexual health, each class in this large secondary school had appointed two peer educators – one boy and one girl. At the level of each class, these two young people became the knowledge base in relation to all aspects of sexual behaviour, STDs, HIV/AIDS, etc. They worked on a weekly basis with the whole class, and were engaged in individual discussions with class members about particular issues. In addition, and to our amazement, these young people took responsibility for presenting on some aspect of sexual health to the whole school during assemblies. This involved them speaking to around 2,000 students, in the open air, using a public address system – something they seemed able to achieve with great skill and not a little confidence. We met with the whole group of peer educators and were moved by (a) their commitment, (b) their technical knowledge and (c) their confidence to speak about difficult issues.”

Measuring success in these programmes is difficult. One short-term indicator used in the Senegal case was:

“whether the ... participants ... are themselves more capable of communicating around issues of sexuality, relationships, AIDS/HIV – and whether they do communicate (with peers, sexual partners, family, etc.). The theory is that those who are empowered to discuss issues, to bring up questions and confront situations and to negotiate verbally, are less likely to be pressured into decisions
they are not ready for or do not want to take. A lot of ‘unspoken’
manoeuvring goes on in relationships which allows power plays
by those who have an edge in age, gender, status, and personal
assertiveness (there can be implied violence, shaming, threats and
so on, as well).”46

Role playing, art and dance, using local languages can also be very
persuasive. A South African faith-based organization describes the
use of “a truly African piece of drama which puts the messages across
in a very powerful way”.47 Another example is the Theatre for
Development (TFD) project in Nigeria:

“As it has been observed in TFD communiqués, theatre is a very
vital means of social education in African communities, and has to
be enlisted in tackling local African problems. The power of
visuality that theatre commands is particularly appropriate in
addressing schoolchildren on HIV. Such visual practice is even
more realistic and effective when the actors are drawn from the
age range of the target audience, and when it is constructed in a
non-sophisticated way.”48

Local cultural norms require that affordable and credible
treatment include traditional medicine and faith healers. (This is not
just an African issue. One respondent noted the use of six forms of
medicine, including homeopathy, in India.49) If, as one participant
noted, almost 70 per cent of Ugandans depend on herbal remedies
for disease, such treatment is indispensable on social as well as
economic grounds. A regional task force on traditional medicine and
AIDS in East and Southern Africa was inaugurated in Kampala, Uganda,
on 10 April 2000.50

48. Oha, O. Re: Lessons learned from local approaches, 13 April 2000.
“In some countries (Zimbabwe, South Africa, Liberia, Mozambique – to name a few) traditional healers have served on the front lines of HIV education and prevention. There have been several cases in these where HIV/AIDS prevention programmes, local ministries of health, international health organizations, researchers, etc. have collaborated with the traditional health sector with a good degree of success. Here, healers were trained as HIV educators and served to educate not only their communities, but also other healers as well. The World Health Organization even released guidelines on training and utilizing traditional healers as HIV/AIDS educators.” 51

However, uncertainty about the efficacy of traditional healers and resistance to their use should not be underestimated. In Tanzania, for example, a respondent reported that:

“... during ... fieldwork I initially encountered silence and resistance when I asked respondents about their use of traditional medicine. Why? Many people felt that use of traditional medicine is contrary to the teachings of the church ... The real problem facing the advance of this alternative branch of medicine is lack of recognition from governments and church groups.” 52

Prevailing customs and a social climate condoning abusive sexual behaviour are among the most troubling aspects of local cultural practice reported by respondents. In a 1995 survey by the National Progressive Primary Health-Care Network in South Africa,

“... semi-structured interviews with youth, mothers and policemen in one town found that gaining and keeping boyfriends and girlfriends were critical to status and position within peer groups. Even when aware of it, mothers did not interfere with

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violence committed within relationships by their sons; the police were reluctant to press charges in cases of gender violence; and authority figures such as teachers were often responsible for sexual exploitation of teenage girls.  

And further:

“Without wanting to stereotype or simplify, there seems to be a strong connection between violent masculinities, forced (non-consensual) sex and the spread of HIV. […] High levels of sexual activity amongst adolescents (with multiple partners) is worrying, but when this is often conducted upon a foundation of uneven gender power, the problem assumes colossal proportions…”

Perhaps most disturbing of all is:

“… child abuse which seems to be on the increase with the pandemic … as men think that either they can avoid AIDS by having sex with a child, or they can be cured if they are already infected.”

While there are no easy or quick answers, the consensus of list participants seemed to be around opening up dialogue at local levels, and engagement of community leaders.

“We are totally convinced that the community is the context for healthy sexuality – and that programmes need to address individual behavioural changes, the family, and also the community norms. But it isn’t the programme that does this – it is the participants themselves who do it.”

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A Malawian who has been a senior adviser in education emphasizes that schools have both the opportunity and the responsibility to address the epidemic at local levels, especially with girls:

“These issues need to be dealt with and discussed openly. Because of the stigma and taboo nature of the subject, girls feel guilty about coming forward when they are attacked. If the schools find this subject too impolite to tackle, more women and children will die, and girls will have no place to go. I think educators have a responsibility here to teach girls how to deal with these problems. And schools have a responsibility to establish trust and offer counselling to the girls who are brave enough to come forward.”

5.3 Testing

Testing was the third issue that attracted most attention.

“There is no doubt at all that there is widespread resistance to HIV testing in most African countries.”

Reasons for this vary, and range from distrust or inability to access or afford reliable testing sources, to normal reluctance to determine undesirable outcomes.

“There is only one HIV testing centre in Mauritius, and an average of 150 voluntary tests per year. (HIV testing is illegal in private clinics or laboratories.)”

The process of testing and its benefits compared with its disadvantages were questioned:

58. Simooya, O. Re: HIV testing and women’s risk of infection, 10 April 2000.
“As an educator, a health worker and individual, I still have mixed feelings about the importance and advantages of HIV testing. My experience has shown me that as health practitioners we often encourage our clients or patients to go through this traumatic test without considering the other implications of the test to clients. These implications are not totally medically dependent; rather, about 80 per cent of them are socially and emotionally dependent. Thus, we often ignore the participation of other professionals who could indeed assist the individual before and after the test, e.g. social workers, psychologists, etc. What most of us do, at least in Botswana, is to conduct pre-test counselling and post-test counselling. No concrete follow-up is made to ensure that the individual’s life goes back on to track. In other words, we mess up his life and leave him like that or offer him antiretroviral therapy ... like it is the only solution.”

No mention is made of women in the previous posting. However, a female respondent pointed up the problems a man may have with adjusting to negative test results:

“I am reminded of how this subject is serious. One student had gone for HIV testing and he tested HIV-positive. That same evening, he committed suicide. That was the end of him. Cases like these seem to be common and many go unreported.”

The complexity of the testing process, and its varying effects on behaviour, necessitate great care in carrying out the testing process as a matter of public policy:

“In my professional life I have experienced homicidal and suicidal reactions related to positive test results. On the other hand, I have
experienced rapid exposure and spread of HIV infection when individuals who were tested negative the first time, believed they were ‘untouchables’ and celebrated sexually and unsafely. In the case of medical screening, unless a client has comprehensive and affordable access to all services from psychological support to medical care and treatment, family support, etc., it does not seem to make any difference in that person’s life to be tested.”

Suggested solutions included making available home test kits where only the individual taking the test will know the result, or using privately based institutions to provide counselling and testing services away from public institutions and hospitals. Mandatory testing, especially as a precondition for employment, was contested. A case of successful litigation against pre-employment testing in South Africa was cited. But all agreed that a cluster of supportive services must be available surrounding any testing procedures.

“In the past few years I have discussed these issues with the medical fraternity in Kenya and Tanzania ... [Pre]-and post-test counselling is geared towards lessening pain around the disclosure of one’s HIV status. Perhaps more could be done. I believe all of us, medical doctors, religious leaders, academics, researchers, policy-makers, NGOs, bilaterals and multilaterals, have a role to play in breaking the silence about AIDS. There must be a less painful way through which silence could be broken.”

Finally, two additional issues with valuable policy-relevant insights were explored by a smaller number of list members. These addressed the startling growth in the number of HIV/AIDS orphans, and the role of international organizations.

64. Rugalema, G. Re: Strategies and programmes of HIV testing, 28 April 2000.
5.4 HIV/AIDS orphans

“The special case of orphans, family structures and livelihoods, led to several ideas and case examples. Orphans are part of a broader population of families and children affected by HIV and AIDS, and they are severely affected in many ways - economic, social, cultural and psycho-social - before they are orphaned.”

Evidently, the problem is growing:

“USAID, in Children on the Brink, estimates that in nine sub-Saharan Africa countries at least one of every five children will have lost one or both parents by the year 2000, with AIDS being the major cause of death. An increasing number of children are being pushed by poverty, parental illness, and death on to the street or are struggling on their own to scrape by in rural villages. Family and community safety nets are not sufficient for some children, and child protection and care interventions are needed if the most vulnerable children are to survive and have a chance for healthy development. But with the large and growing number of orphans, there will not be enough resources available to make direct service delivery the primary type of intervention for the majority of orphans and children made vulnerable by HIV/AIDS.”

“Psycho-social, economic, nutritional and health-related factors of orphanhood interact with one another.”

“Encouraging school enrolment and continuation for those who are suddenly orphaned is an important if partial solution. Bursaries such as those provided by the Zambia Education Capacity Building Programme (ZECAB) are targeted towards orphaned children,

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especially girls. ZECAB supported about 1,000 children from Lusaka, Kitwe, Samfya and Mpika in 1999. 68

“The CINDI network brings institutional resources collectively to bear on the needs of affected children.” 69

Community response is again an essential element in coping strategies at local levels, as noted by a South African respondent:

“One of our bishops went to Burundi a couple of years ago, and he saw that families had large numbers of same-age children. He asked if there was a tendency to multiple births in that culture, and they said no, the Christian families had been challenged to take in orphans as part of their families. ‘Hello, South Africa?’ he said after that.” 70

5.5 Role of international organizations

The role of international organizations is inherently a delicate one, as summarized in the few responses that dealt with this issue. Notwithstanding the micro-macro gap, and sensitivities about intervening in social policies, especially in areas of sexual behaviour, it is clear that:

“... it is time for agency personnel to recognize that HIV is not just a health issue; it is a social, economic and cultural issue which is battering the very foundations of our communities and governments. In this regard at least, agencies have a responsibility, because of their financial and professional resources, and because of the opportunities they have for regular and systematic interaction, to: (1) be much more proactive about the planning

68. Elbers, F. Re: Addressing the needs of orphans, 7 June 2000.
70. McDonald, C. Re: Solutions in addressing AIDS orphans, 4 May 2000.
issues involved; (2) help move the discussion away from purely health issues; (3) create more arenas for advocacy, sensitization and training vis-à-vis socio-economic planning; and (4) promote and sustain a practical research and development agenda in this regard. At the present time, it seems to me, it is only international agencies – or ministries through international agencies – which have the time, resources and clout to address HIV-impact issues at the level of magnitude now necessary. We may all accept that national ministries must initiate impact assessments in-country. But international agencies must surely feel themselves under an urgent moral obligation to go to scale at least regionally without further vacillation.”

“International agencies can initiate advocacy forums and promote information sharing; help governments and NGOs see beyond HIV/AIDS as just a health problem; encourage and support sector impact studies; exchange or second staff; and assist MOEs construct education-sector policies and action programmes that address: (1) increasing numbers of orphans, traumatized teachers and parents, and (2) increasing randomness in education as communities and families fall apart.”

6. Conclusions

The responses showed strong participant support for the objectives of the list. The list had a positive impact on the Dakar World Education Forum. Two African professionals participating in list discussions attended the Dakar HIV/AIDS panel, supported by scholarships funded by CIDA. They each presented summaries of their
perceptions of the list, providing direct evidence of its utility. First,
neither would have attended Dakar unless the list had offered the
opportunity. Second, the panel (and audience) were able to hear from
actual list participants as to the value added to African professional
discourse on HIV/AIDS and education. Recommendations from the
panel went forward to the drafting committees for the Dakar
Framework for Action, and were reflected in the final document. The
list is now part of UNESCO’s official electronic documentation web
site for the Dakar Conference at:
http://www2.unesco.org/wef/f_conf/00000050.htm

The direct and practical utility to subscribers include the pre-
publication on the list of the South African education sector policy
paper, which allowed for wide circulation, input and subsequent
refinement of the ultimate draft,74 and the bibliography and web
addresses contained in the list annexes. Discussions off-line, but
stimulated by the list, are referred to as ‘sidebars’, after televised court
proceedings in the USA that show impromptu conferences between
participating lawyers and the judge out of the hearing of the jury.
Several examples were encountered, in addition to those around the
South African education policy paper. Another ‘spin-off’ of the list
(using a transportation analogy) was the spawning of local ‘railhead’
strategies, whereby e-information from the list, having reached the
computer ‘terminus’, could be packaged or transformed in various
ways. These include translation into local languages and
dissemination through a variety of methods to additional (and e-
unconnected) readers. For example, a development agency (CIDA)
shared list issues with project leaders working on peer (workplace)
education among commercial sex workers and truck drivers, as well
as ‘single women’s groups’.

In the Ugandan mother tongue of a list participant, there is a proverb, *Lewic weko icamo awola*, meaning “Those who are shy miss the opportunity to express their problems and learn from others”. The HIV/IMPACT forum allowed such shyness to dissipate, and for ideas to be shared in a virtual space which preserved individuality and respect.

The quick-response capability of the list provided almost instant answers to respondents’ questions. For example, a simple two-line answer provided a web address in response to a request for published handbooks for schools:

“Versions in English, Afrikaans, isiZulu, isiXhosa, Sepedi, Sesotho and Xitsonga are available on the Internet at: http://education.pwv.gov.za”

The fact that this was in many ways a ground-breaking effort in electronic connectivity in the region did not seem particularly relevant. The speed at which access to the Internet is expanding in Southern Africa is difficult to document accurately, but it is proceeding unabated. One 1998 survey showed that at the end of 1996 only 16 countries had access, but in the following two years, over three-quarters of the 53 capital cities were online (Jensen, 1998). One currently functioning web site has operating hyperlinks to all 53 countries. Another site periodically updates the Internet status of each country. As cell phones proliferate, and the technologies for linking hand-held devices to the Internet become more widely available and cheaper, the possibilities for applications, at least in large urban settings, become more realistic throughout Africa.

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76 http://www.woyaa.com/
77 http://paradigm.wn.apc.org/africa/counsrch.cfm
As responses to this list have shown, there is a hunger for information and networking among (often disparate) professionals, educators, and PLWHAs working in the area of HIV/AIDS. The list demonstrated that Internet-based communications can stimulate and implement multi-way information-sharing among various constituencies within the region, and with the rest of the world. People can communicate interactively and share concerns, experience and advice. Speed of information-processing is critical in a fast-changing world, and a well-managed e-mail-based list is a practical means for coping with fast, easy, and relatively cheap knowledge exchange. In addition, these kinds of virtual networking illustrate ways in which the African diaspora can be ameliorated, and professionals working outside their home countries can contribute meaningfully to policy development in their countries of origin. Current estimates suggest that Africa has lost a third of its skilled professionals in recent decades due to emigration, many of whom have been replaced by expatriates at a cost of US$4 billion per year. Some 23,000 qualified academic professionals are reported to emigrate from Africa each year (Saasa, 2001).

Despite its acknowledged disadvantages (widespread lack of access in poorer communities, and even ‘cheap’ Internet pricing that nevertheless is beyond the reach of the majority of even urban Africans) this method of opening up discussion has another great advantage. It permits, if not anonymity, at least a modicum of distance between the communicator and the message, which may be a really useful factor in addressing sensitive public-sector strategies on coping with HIV/AIDS. Participants who ‘lurk’ and do not respond directly can still use the ‘sidebar’ and ‘railhead’ strategies to their advantage.

Links should be strengthened between this kind of electronic discussion process and policy decision-making at all levels. As long as
The discussants are academics, scholars, technical staff, and practitioners, the connection to policy is serendipitous at best. The list was influential in bringing HIV/AIDS impacts on education sectors to the fore in two major international conferences, the World Education Forum in Dakar, and (to a lesser extent) AIDS 2000 in Durban. Yet direct participation by executives and staff in education ministries was very limited.

The involvement of policy bureau representatives in some United Nations agencies resulted in list discussions, case histories, studies and resource lists getting wider attention. But there is no direct evidence of the list having any direct effects on policy in these agencies. Furthermore, policies at country level, which are ultimately where the focus must lie, remained remote from the list process. Next steps in this kind of electronic networking, if it is to have positive influence on policy, must find ways to connect directly with senior policy-makers in governments, non-governmental and civil-society organizations, educational institutions, and the international community. Links outside the region, for example with policy and programme initiatives in other parts of the world, must also be explicitly targeted and fostered.

The references gathered during the list process and summarized in the archives constitute an important resource. Sharing of these kinds of information sources as they become available is a crucial element in a substantive network of this kind, particularly where information is so lacking. As new research (academic theses and competitively funded professional studies) and new treatments become available, speed in communicating the best of these to practitioners is essential.

But so is quality, and there should be a clearing-house function, with quality control built into the network. Unscreened information
soon becomes a burden simply because of its volume. One of the reasons the list functioned as well as it did was due to careful, skilled round-the-clock moderation.

Finally, electronic networks have the capacity, still under-utilized, to provide just-in-time responses to questions about programme design, policy options, and determination of research priorities. As already outlined, the list provided a useful forum for ‘floating’ a trial balloon in the form of a policy paper for the South African education sector in addressing the impact of HIV/AIDS. Much of the ensuing discussion and exchange of reactions took place off-list, but would not have been possible without the list as catalyst. Moreover, questions – about documents, handbooks, manuals, training aids and prior experience in peer education programmes – were posed and answered on the list. These are among the best examples of practical utility that came out of the list initiative.

References


South African Medical Research Council (SAMRC) Report. 2001 (July).


International Institute for Educational Planning http://www.unesco.org/iiep
CHAPTER 7. THE BLACK, WHITE AND GREY OF RAINBOW CHILDREN COPING WITH HIV/AIDS

Liesel Ebersöhn and Irma Eloff

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Abstract

This article explores the complexity of the inquiry process concerning South African children coping with the effects of HIV/AIDS. The aim is to start a debate on this issue and to review coping literature relating to children and HIV/AIDS. The article makes use of the metaphor of a tapestry, in order to convey the intricacies, complexities and multiplicity of facets of this process. The article commences with a rationale for the exploration, and assumes that understanding these children’s coping methods might facilitate early identification and support of their psycho-social stress, as well as increase their resilience. The article subsequently explores what coping is by integrating the different theoretical standpoints and the...
assumptions of the authors. It illustrates how our current theoretical constructions of the coping process fall short in understanding the unique coping process in South African children who are dealing with HIV/AIDS. This is done by sustaining the tapestry metaphor, posing rhetorical questions and also by referring to some observations made in the initial phase of this research process. However, the article also illuminates the contributions that generic coping theories can make in the construction of a theoretical framework for understanding coping in this context, namely the transactional coping process, individual experiences of stress, the coping repertoire of children, and the fact that children under threat revert to primary emotional coping strategies. They also depend on adult support to assist them in coping. Protective factors that might buffer the effects of trauma are explored. The article next relates the complexities of HIV/AIDS to the coping of traumatized South African children. It concludes with the notion of not being a ‘comfort’ text (because there are more questions than answers), but it underscores the need for persistence in the inquiry process.

Introduction

The much-lauded South African rainbow nation is threatened by the presence of the HIV/AIDS pandemic. How does a child cope if the colour has gone from her life? How does a boy consumed by unwarranted guilt on account of a parent’s death handle everyday life without carefree play?

Not much has been published on children coping with HIV/AIDS in South Africa. We do not presume to present models or programmes for coping. Our aim is to enter the debate on children’s coping with HIV/AIDS. We seek to explore some of the questions related to the
lives of South African children infected and affected by HIV/AIDS. These questions are: (1) What is coping? (2) How do children cope? and (3) How could traumatized South African children cope with the effects of HIV/AIDS?

HIV/AIDS constitutes a chronic stressor in the lives of many South African children. They live with the stress of being without the familiar care of a mother. They have to bear hardship and responsibility on account of parents' unemployment. They face being stigmatized by peers and treated as social outcasts. They are burdened by grief for lost family members, lost homes and lost opportunities. Traumatized children are prone to feelings of inadequacy and depression and may suffer Post-Traumatic Stress Disorder (Ndethiu, 2001a). The early identification of such psycho-social stress could lead to timely support and care. Effective coping reinforces a sense of competence and encourages coping responses in future (Zeitlin and Williamson, 1994). Thus, the cared-for children of today have a better chance of becoming the resilient adults of tomorrow.

What are the black and white HIV/AIDS facts South African children have to cope with? We highlight some of the effects of HIV/AIDS to contextualize the predicament of these vulnerable children (UNAIDS, 2000b; Hepburn, 2001; Foster and Williamson, 2000; Hunter and Fall, 1998; Coombe and Kelly, 2001; Goliber, 2000; Hay, 2001; Fox, 2001; Ndethiu, 2001b; Kelly, 2000b; Smart, 1999; Hunter and Williamson, 2001).

- **Demographic effects**: Half of South Africa's 38.8 million population (16.3 million) are children. An estimated 61 per cent of them live in poverty. Because of the close association between

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78. *Infected children* may have been infected vertically, sexually or as the result of unsafe sex. *Affected children* may be abandoned or orphaned as a result of HIV/AIDS, may be from an HIV-infected family, may be vulnerable to becoming HIV infected, or may be from an uninfected family in an affected community.
poverty levels and HIV infection this figure can serve as a proxy for the number of HIV/AIDS-affected children. AIDS-related illnesses and mortality among adults are adversely affecting dependency ratios. In sub-Saharan Africa children under the age of five are expected to outnumber adults over the age of 44. Higher infection rates and mortality in women are shifting the gender ratios in some age groups.

- **Health effects:** Children living in infected communities suffer from poor nutrition and ill health, and show signs of failure to thrive. Children’s nutritional status suffers in rural areas that are dependent on household labour for subsistence agricultural production. Where social services, hospital and home-care systems are stretched or absent vulnerable children have inadequate access to health care. Infected children have to battle the symptoms of the illness, including diminishing strength and advancing death. Common illnesses (measles, diarrhoea and respiratory infections) are more severe, frequent and persistent.

- **Family-life effects:** The traditional structure of households is changing in affected communities and vulnerable children are required to adapt to the demands of non-traditional families and deepening poverty. The loss of a mother as primary family caregiver has a profound effect on children’s well-being. As young or middle-aged fathers and mothers die, grandparents take over the full-time care of young children and the latter assume unfamiliar adult roles at home for which they are ill prepared. Sometimes they are the primary care-givers of their infected elders, assuming adult responsibilities, washing, cooking for and feeding sick elders and younger siblings, taking care of cattle, and growing mealies for sustenance. A common consequence of strain and pressure exerted on weaker households is a drastic reduction in the family’s ability to care for and protect its children, who become prey to neglect and abuse.
• **Welfare effects:** Economically children and their families are hard hit. On account of poor health, productive members of the family are often unable to continue work. Families are impoverished and rendered more vulnerable by the costs of illness and care. Their meagre funds are used to buy local medicines and palliative care, leaving less for food, housing, clothing and education. Even when care-givers attempt to protect children by not discussing economic difficulties with them, the children are attuned to their emotional environment and readily adopt the anxiety, fear and frustration that accompany financial strain.

• **Educational effects:** A marked decline in school attendance already characterizes the South African education landscape. HIV-infected children shy away from disclosure. There are many causes, among them illness, morbidity and death, fear of discovery and shaming at school, increased demands for child labour, including caring for sick relatives (both within and outside homes), and inability to pay school fees. The long-term impact of poor early-childhood development and limited literacy on South Africa's social, economic and political systems is inestimable.

• **Psycho-social effects:** Children's psycho-social distress and trauma is often not as visible as that of their health, education and economic needs, but it is of fundamental importance. The psycho-social challenges children face include coping with grief, loss of identity (self-, family- and cultural identity), coping with shame, stigmatization and fear of abandonment, rejection, death.

• **Orphanhood effects:** The disruption of families and death of parents and close relatives have created an unprecedented number of destitute and abandoned South African children. By some calculations, on current mortality trends, orphans will comprise 9-12 per cent of South Africa's total population by 2015. Orphans may live in child-headed households with older siblings looking after younger ones, thus assuming parenting roles they are ill-
prepared for, others are taken care of by communities, some are placed in institutions, and still others lose all contact with carers and become street children. In such circumstances even uninfected children, lacking nurture and sustenance and needing to feed themselves or others, run a high risk of becoming infected through abuse or prostitution.

These stark black and white data omit the grey areas where the children themselves live out their lives. In exploring the shadows a tapestry of psycho-social emotions and interactions can be constructed. We seek to understand how the children see themselves, how they feel, what they think, believe and ultimately do in the face of HIV/AIDS. The process depicted in this article forms the first phase of a larger Participatory Learning Assessment (PLA) project aimed at understanding the coping experiences of HIV/AIDS-infected and affected children in South Africa.

1. What is coping?

There is a comprehensive body of coping literature representing various perspectives (Snyder, 1999; Zeitlin and Williamson, 1994; Lazarus and Folkman, 1984; Salovey and Sluyter, 1997; Ozer and Bandura, 1990). At its most basic conception, coping implies adaptation by an individual to demands. Our assumptions defining coping are based on literature review, interviews with experts and our professional experience as educational psychologists.

- Our approach to coping is eco-systemic (Donald, Lazarus and Lolwana, 1997). Coping is framed as a process of interaction between an individual and an environment, each with its own set of resources, vulnerabilities, potential and needs. Coping is what people do when they successfully manage transactions with their environment.
Coping is our reaction to the question: What do I do? Before one can cope other psycho-social processes occur, not necessarily sequentially or consciously, in answer to the following questions: Who am I (identity formation)? How and what do I feel (emotion regulation)? How and what do I think (cognitive regulation)? What are my beliefs (normative regulation)?

Coping is acquired by learned adaptive actions. Children are unique individuals but they learn by following examples. Significant others (parents, aunts, grandmothers, older siblings, teachers, social workers) cue children on coping options. Diversity in traditional beliefs, rural or urban settings, and socio-economic resources determine a variety of coping responses.

Depending on the person and the situation a coping response can be located on a continuum from consistently ineffective to consistently effective. Characteristically, people prefer certain coping responses to others (coping style).

Some people are more resilient in matching available resources with specific environmental demands on them. Protective factors in the environment (a child's disposition, a responsive family milieu and external support for the child and family) could act as buffers against the impact of stressors on a child.

The fundamental process of coping is the same for everyone, although people differ in age, gender, culture, and socio-economic situation. The transactional coping process in Figure 7.1 illustrates these universal stages.
Figure 7.1 Stages in the transactional coping process

Demand → Internal or external event

→ Stress

→ Experience (physical, mental, emotional tension)

Cognitive appraisals*

(a) gives meaning to tension based on personal system of beliefs and values,
(b) guides decision making, and
(c) evaluates outcome of coping response

→ Emotional reactions

(reciprocal influence between emotion and cognition)

→ Coping response or reappraisal**

* Even young children make appraisals according to their developmental stage (Zeitlin and Williamson, 1994).
** Reappraisal is the result of a changed belief because of new information or new perceptions (Lazarus and Folkman, 1984).

Source: Adapted from Zeitlin and Williamson, 1994.

According to the transactional coping process the environment makes constant demands on the individual. The individual experiences these demands as stress (anxiety, tension). The individual has to decide how to manage the stress. The outcome of decision-making is either a coping response or reappraisal. (For example, a boy's infection may become less threatening to his teachers when the teachers acquire knowledge that encourages them to believe his presence is not harmful to others.)

A certain coping response will influence the child’s environment. It may in turn present new demands on the individual or alleviate the
stress. The evaluation of the effectiveness of the outcome should be based on its developmental appropriateness, its applicability to the situation, and the outcome generated.

The following example illustrates the reciprocity in the transactional coping process. A girl with an infected mother may decide to cope with trauma by having sexual relations with a teacher. Her choice increases her susceptibility to infection, yet provides her with lunch money and passing grades. Her stigmatized family, seeking social acceptance, may strengthen her acquaintance with an admired community figure. If she becomes pregnant, or infected, or both, she may be abandoned by the teacher and add her personal trauma to the distress already experienced by the family.

2. How do children cope?

Children’s coping equals the integration and application of developmental skills (motor control, communication, cognitive and socio-emotional skills) into their daily living (Miller and Byrnes, 2001; Zeitlin and Williamson, 1994). In fact a primary developmental task in childhood is to transform early adaptive behaviours into mature coping styles (Masten and Coatsworth, 1998; Salovey and Sluyter, 1997).

In their initial dependent life-phase, children’s transactions are more reflexive and universally undifferentiated – crying, cooing and sucking are examples. Children’s motor, affective, and cognitive skills are refined as their central nervous systems mature and they acquire experiences in the environment (Zeitlin and Williamson, 1994). The presence of stress is natural. Stress creates tension and motivates a child to develop by interaction with the environment. Thus by learning to cope children gradually gain more autonomy and interdependence. Because of their limited coping repertoires,
children’s coping is a simplified version of the mature transactional coping process portrayed in Figure 7.1.

As stated, we do not assume that all children cope in the same way. A four-year-old Tswana boy living in rural Bushbuckridge with his unemployed aunt will not cope in the same way as an eleven-year-old Zulu girl living in a state institution in Durban. The differences in their ages may mean that he would prefer to be comforted and she might focus on solving problems. The difference in their gender may lead to her preferring to talk with peers and for him to choose to play out his grief, anger and frustration with sand, stones and water. Based on their environment he may find support from an established kinship network, whereas she may find solace from social workers. Culturally they will both be influenced by the accepted rituals and beliefs ingrained in their separate communities.

According to resilience theory, children should have access to resources (internal and external) to cope effectively – to change what they can, or make the best choices regarding things they cannot change. Figure 7.2 illustrates the interrelatedness between protective factors that might buffer the effects of trauma on a child (Kilmer, Cowen and Wyman, 2001; Garmezy and Rutter, 1988). These protective factors become crucial when children are under threat (Ndthiu, 2001).
Figure 7.2 Protective factors that act as buffers to the effects of trauma on children

<table>
<thead>
<tr>
<th>Child</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>One consistent</td>
</tr>
<tr>
<td>Age</td>
<td>primary care-giver</td>
</tr>
<tr>
<td>Beliefs and values (culture)</td>
<td>Warm, supportive, nurturing</td>
</tr>
<tr>
<td>Self-concept</td>
<td>Family</td>
</tr>
<tr>
<td>Physical health (ill, malnourished)</td>
<td>Income</td>
</tr>
<tr>
<td>Affective state (anxiety, grief)</td>
<td></td>
</tr>
<tr>
<td>Knowledge and skills</td>
<td></td>
</tr>
<tr>
<td>Coping style</td>
<td>Supportive environment</td>
</tr>
<tr>
<td></td>
<td>Human support (kinship networks, peer support, <em>sangomas</em>)</td>
</tr>
<tr>
<td></td>
<td>Material support (health, welfare and education services)</td>
</tr>
<tr>
<td></td>
<td>Environmental support (infrastructure, e.g. school building)</td>
</tr>
</tbody>
</table>

* A *sangoma* is a South African traditional healer. Besides remedies, traditionally they also offer counselling.

Based on Figure 7.2, ideally we should explore the coping of boys and girls in all age groups, representing a range of different family circumstances, in both urban and rural areas, including all cultural South African groups. Realistically, we know that this is not a viable research strategy. Our research observations, interpretations and reflections should therefore be guided by our knowledge of this complexity and diversity. We strive to remind ourselves continuously of the larger tapestry and not get lost in multiple grey threads.
3. How could traumatized South African children cope with the effect of HIV/AIDS?

Mentally and emotionally children lack the capacity to manage demands of the magnitude HIV/AIDS presents. Poverty, malnutrition and illness probably inhibit the maturation of children’s central nervous systems. If their development is stunted this would predictably have a detrimental effect on their ability to acquire coping skills.

In times of crisis children revert to primary emotional coping strategies. Their dependence on adult support to assist them in coping is critical. Traumatized children in Rwanda and Thailand found the environmental and personal demands unmanageable (Devine and Graham, 2001; Ndethiu, 2001a). Children survived in zombie-like states. By means of emotional detachment they separated themselves psychologically from the harsh reality of their daily lives. Unidentified and unsupported the outcome of this psychological trance could predict a future of emotions, cognition and behaviour in discord.

Following the 1998 bombing in Nairobi a model was developed to train teachers and care-givers of traumatized children (Bovard, Mwiti and Oasis Counselling Centre Writing Staff, 1998; Bovard and Pfefferbaum, 2000). In Table 7.1 we present this model’s interpretation of traumatized children’s coping.

Table 7.1 integrates the essence of the transactional process (Figure 7.1) with protective factors (Figure 7.2). The emphasis is on emotion, basic solutions and support from adult care-givers for children’s effective coping. In the absence of such support (child-headed households, abandoned orphans, street children) children’s repeated experiences of helplessness will result in despair at their lack of control. Experiencing that they consistently cope ineffectively
may generate an unwillingness to try managing similar situations, may bring about additional stress and create feelings of inadequacy.

Table 7.1  Coping stages of traumatized children

<table>
<thead>
<tr>
<th>Stage one</th>
<th>Stage two (similar to stage one, but less intense)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Initial shock</td>
<td>• Less crippling emotional state</td>
</tr>
<tr>
<td>• High level of distress</td>
<td>• Poor solutions may be maintained</td>
</tr>
<tr>
<td>(anxiety, helplessness)</td>
<td>because they lack other options</td>
</tr>
<tr>
<td></td>
<td>• Support from adults means that fears</td>
</tr>
<tr>
<td></td>
<td>can be voiced and options explored</td>
</tr>
</tbody>
</table>

HIV/AIDS triggers multiple anxieties in a child. Stressors may be environmental demands such as exclusion from school, or having to find money for a funeral. Internal challenges may be bewilderment at drastic changes in family circumstances, profound grief at the loss of a mother, or having to suppress expressions of sadness because the father does not cry in public. The challenges could be the physical changes of a weakening body. More often than not the stressors coexist in the tension-fraught lives of children poorly equipped to deal with these demands.

A child may experience anguish trying to find out what is happening to her when she is removed from a familiar community and placed in institutional care. She will wonder how these changes will affect her well-being: Who will cuddle her now? Who will tell her comforting stories? Where will she get food? What will happen to her brothers and sisters? Will she see her grandparents again? What is expected of her now?

Cultural beliefs and values are fundamental guidelines in the subsequent cognitive process of determining what an event means. We assume that certain universal principles of coping will be relevant across cultures. Yet we acknowledge that traditional indigenous coping in South Africa will probably differ from the much-published
American frameworks of coping. Coping cannot be separated from its particular context. (This is reflected in our contextualization of the predicament of vulnerable children in South Africa.) Therefore we anticipate that South African children's coping will differ from that of their counterparts elsewhere. Little documentation of indigenous coping beliefs and practices exists (UNAIDS, 2000a). We wonder if a child deprived of community care (not to mention maternal care) has sufficient exposure to traditional beliefs and values to inform her coping responses? We also question if young children in the process of determining who they are (forming their identities) will be able to assess their capability to cope?

A child's perception of stress is closely linked to reactions in the family unit. When a mother dies after a long period of deterioration the whole family is affected by a range of feelings. A little boy's perception may be in accordance with a single individual's reaction (the unfamiliar sight of his crying father means he perceives the particular event as harmful and threatening). Or he could follow the example of the whole family (he does not talk about the reason for his mother's death, because no one else is disclosing her status). Another way would be for him to focus on how the family members react to one another (he is afraid because all his worried sisters and brothers argue about their future).

In the subsequent decision-making phase of cognitive appraisal another child may ask herself what she can do. (What can I do to stop my hunger?) Older children will be able to appraise cost effects in terms of time and effort. (It will be quicker and easier for me to beg for food than to grow and harvest it myself.) Children will have certain expectations regarding their decisions. (If I take food from Aunt Nomsa's cupboard I will not be hungry any more, but she may be angry.)
The subsequent implementation of decision constitutes the observable outcome of the coping process. What a child does is the only indicator of the unobserved psychological processes that preceded the coping response. Developmentally we presume that younger children may cope by expressing their emotions of insecurity, bewilderment and sadness. We wonder if this expression of emotion is accommodated within cultural coping beliefs? Emotionally younger children will also seek solace and support. We question whether traditional kinship systems can be maintained when whole communities are devastated by HIV/AIDS? Where will children seek solace and support? Do teachers, sangomas and community leaders support children? Are they able to mobilize and sustain support networks for children (Bovard et al., 1998)?

We wonder if some traumatized children might be able to cope in a problem-solving fashion? Can a child put aside anxiety, fear, anger and sadness and solve problems logically? Or does a child cope by merely continuing with daily activities like fetching water, maybe attending school, merely surviving within a specific environment? Does an institutionalized child know to whom to go for comfort?

Physiological coping is common in children, even more so in those traumatized (Ndethiu, 2001a). If a child does not know how to express his feelings of helplessness or worry, and how to act to alleviate such feelings, a child can naturally reach out for comfort by means of somatic symptoms such as headaches, pains and allergies.

Will rural children make use of nature in their coping? Will urban children be more prone to escape their fear, pain and frustration by turning to high-risk avenues such as child prostitution or drugs?

And we wonder whether traumatized children cope at all? The words of a colleague quoting a counsellor echo in our minds: there are children who merely ‘swallow their despair’ (Coombe, 2001).
To continue this debate we propose the following lines of future inquiry:

- an inquiry into existing cultural coping practices in South Africa;
- case studies exploring and describing children’s coping with HIV/AIDS;
- ecosystemic descriptions of community-based coping practices as supportive environments;
- inquiries exploring the relationship between coping and consistency of caring;
- case studies exploring and describing the manifestation of protective factors in South African communities;
- an inquiry into the role of leaders (e.g. sangomas, teachers, faith-based leaders) in supporting children’s coping with HIV/AIDS;
- an analysis of the relationship between children’s care placement (e.g. extended family, foster care, institution) and their coping strategies;
- an analysis of the relationship between coping and independent variables such as age, gender, disability, health status and socio-economic background.

4. Conclusion

This research is in the exploratory phase of trying to understand the coping experiences of South African children with HIV/AIDS. So far this process has brought us to this particular stage in which we observed the resilience of vulnerable children. During several field visits we sought to discover some of the colours of a psycho-social coping tapestry. We saw children stubbornly refusing to let go of colour. In a rural community we played with boys and girls aglow in the presence of caring volunteers. In an urban hospital setting we saw children flourishing under the loving supervision of grandmothers and aunts who had taken over their care. We talked
with a 10-year-old boy who proudly displayed a homework assignment on a torn piece of paper. We were privy to black moments also: a young boy desperately crying for his mother in a shelter for abandoned children, a 15-year-old girl in a hospice struggling with the pain of AIDS without the comfort of her family.

Reflecting on our discussion it is clear that our answers are not black and white. We have to admit that in fact we have no answers. Our attempt at producing answers is merely a tapestry of multiple questions possibly pointing the way to future inquiry into the phenomenon of coping. We concur with the vision of Patti Lather (1997: 51) when she advocates working against the ‘comfort text’ that may provide the consolation of certainty and set meanings and the romance of knowledge as a cure. This article reflects the complexities of research processes in which we seek to find answers, but only tend to find more questions. We do, however, believe that our journey has started by weaving together some of the questions regarding children’s coping.

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CHAPTER 8. INCREASING PRIMARY EDUCATION ACCESS FOR CHILDREN IN AIDS-AFFECTED AREAS

Amy Hepburn

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The constraints affecting orphans' and other vulnerable children's (OVC) access to primary education in AIDS-affected areas are numerous and differ in magnitude from one community to another. This article briefly explores the orphanding crises in sub-Saharan Africa and the importance of primary education as a tool for fighting the spread of HIV. It examines, in more depth, the barriers to OVC educational access in AIDS-affected areas. Six primary obstacles limiting children's access to primary education in AIDS-affected areas are discussed: the lack of affordable schooling, increased familial responsibilities, family scepticism regarding the value of education, poor educational quality, stigma and trauma, and fear of infection.

To meet the many challenges HIV/AIDS poses for delivering primary education, this article suggests community leaders, policymakers, and donors collaborate to (1) revise the role and content of the curriculum; (2) restructure the traditional organization of primary schools to become more flexible in delivering instruction; and (3) explore cost-effective community-based initiatives. Community schooling is introduced as an example of a local initiative that is increasing education access in AIDS-affected areas by incorporating these three programming and policy considerations.

1. HIV/AIDS in sub-Saharan Africa: more than a development crisis

Sub-Saharan Africa has suffered greatly as AIDS has earned the dubious distinction of being the leading killer in the region. Within sub-Saharan Africa, countries in the Eastern and Southern Africa region (ESAR) have experienced rapid growth in HIV infection. The average HIV prevalence rate for those aged 15-49 in 15 Eastern and Southern African countries is estimated at approximately 14 per cent
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compared to 8 per cent for the entire sub-Saharan Africa region and approximately 1 per cent for the world (Kelly, 2000c).79, 80

Responding to the high rates of orphaning and increases in children’s vulnerability due to HIV/AIDS in sub-Saharan Africa in a decisive way is essential for the survival of both the millions of children affected by AIDS and the community and social structures that serve them. The AIDS pandemic in sub-Saharan Africa is more than a development crisis – it is a humanitarian emergency with long-term political and economic consequences. As UNAIDS director Peter Piot recently noted, “By overwhelming Africa’s health and social services, by creating millions of orphans and by decimating health workers and teachers, AIDS is causing social and economic crises which in turn threaten political stability” (UNAIDS, 2001: 1). The reduction in national productivity and growth that accompanies this pandemic has quickly begun to reverse the development gains of the past 20 years. While most governments in sub-Saharan Africa have pledged increased support to address the needs of vulnerable children and their families, social infrastructure investments declined in the 1980s and 1990s as the region suffered severe economic deterioration (UNAIDS, 2001).

Improving primary-education access for all children and particularly orphans not only honours a child’s basic right under international law, it also reflects economic sense. In countries that

80. While 95 per cent of all children orphaned by AIDS are living in sub-Saharan Africa, it is not a problem unique to Africa. Experience has shown that the increase in orphan rates lags behind HIV infection levels by about 10 years. In fact, countries such as India, Cambodia, Myanmar and Viet Nam are beginning to experience a similar orphan crisis. Former Soviet countries and Central Asia have experienced a six-fold increase in the number of HIV infections since 1995 and high levels of orphaning are expected to follow. In the USA, increased rates of HIV infection in poor urban and rural communities over the past decade have also caused a correlated rise in the number of children orphaned (Hunter and Williamson, 2000).
are quickly losing their human capital, the failure to provide children with basic educational skills only exacerbates a failing economy. The economic and social impacts of HIV/AIDS have manifested in the deterioration of the region's education systems. Valuable financial and human resources are siphoned off, leaving few resources for education. In several countries, the budgets for educational materials and equipment have been reduced to zero (Graham-Brown, 1991; UNAIDS, 2000). Without an educated populace, Africa will continue to struggle to make economic and development gains. While this deterioration in education has affected the quality and access of primary education for all children, those living in areas heavily affected by AIDS are particularly disadvantaged and deserve special consideration.

2. Orphaning in sub-Saharan Africa

No reliable, comprehensive data are available on the demographics, health, and care of orphans in sub-Saharan Africa. To understand the negative economic, social and physical impact orphaning by AIDS has on children, researchers must rely on a variety of small-scale country assessments and community field analyses. The majority of data are available from Eastern and Southern African countries.

‘Orphan’ is a socially constructed concept and varies among cultures and countries. For some it refers to children who have lost one parent while, to others, the term is reserved for those who have lost both. While quantitative data are important, statistics on orphans do not measure the full impact of AIDS on children or the magnitude of the problem caused by AIDS. For example, orphan statistics do not track the number of children who are caring for a sick parent and experiencing physical and psycho-social stress similar to their orphaned counterparts. As a result, it is widely acknowledged by many
experts that interventions and programmes designed to assist children should not seek to serve only those orphaned by AIDS, but all children affected by AIDS, orphans and other vulnerable children (OVC).

Programming designed to assist orphans in areas heavily affected by AIDS should not ignore those orphaned or made vulnerable by other causes. Singling out children based on the serostatus of their parent(s) can intensify discrimination and further stigmatize them. Moreover, children whose deceased parents’ serostatus is uncertain or negative should not be denied assistance (Lorey, 2000).

Year 2000 estimates from the US Census Bureau suggest that, in 34 countries with high HIV prevalence, more than 15 million children worldwide under the age of 15 have lost their mother or both parents to AIDS or other causes. Of these 15.6 million children, 13.6 are living in sub-Saharan Africa and this number is expected to grow to almost 22 million by 2010 with AIDS being the primary cause (Hunter and Williamson, 2000).

These statistics highlight one of the most disturbing elements of this crisis: its rapid and continued growth. In 1990, in 34 countries with high HIV prevalence, AIDS was the cause of orphaning for 16.4 per cent of the children whose mothers or both parents had died;

81. Of these 34 countries, 26 are in sub-Saharan Africa.
82. Countries with high HIV prevalence are defined as having above 5 per cent of the population infected with HIV.
83. These statistics include orphans of all causes. Estimates include all orphans since it is consistent with policy decisions in many countries to devise programmes that assist all orphans not just those due to AIDS. However, in eight Eastern and Southern African countries, AIDS is responsible for over 60 per cent of orphaning. In Zimbabwe and Botswana, over 80 per cent of the orphans lost a mother or both parents to AIDS (Hunter and Williamson, 2000).
84. Children who lose their fathers (paternal orphans) are also disadvantaged. USAID has developed estimates of the numbers of children who will lose either or both parents from all causes in countries with high HIV prevalence. USAID has estimated that in at least eight sub-Saharan African countries between one-fifth and one-third of children under 15 have lost either or both parents to AIDS or other causes (Hunter and Williamson, 2000).
by 2010, that number is expected to rise to 68.4 per cent. The Census Bureau estimates that half of all HIV-positive children in 34 countries with high HIV prevalence will die before their first birthday, and many more will die before their fifth birthday. As a result, the majority of children orphaned by AIDS are HIV-negative.

While all of sub-Saharan Africa is experiencing high orphaning rates due to AIDS, the ESAR is the most seriously affected. Table 8.1 details the projected growth in these rates in 15 Eastern and Southern African countries over two decades.

Table 8.1 Orphans in the Eastern and Southern Africa region: 1990, 2000, 2010

<table>
<thead>
<tr>
<th>Year</th>
<th>Children under age 15 (millions)</th>
<th>Maternal/ double orphans from all causes (millions)</th>
<th>Maternal/ double orphans as% of children under 15</th>
<th>% of maternal/ double orphans caused by AIDS</th>
<th>Number of children orphaned by AIDS (millions)</th>
<th>% of children under age 15 orphaned by AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>95.3</td>
<td>4.2</td>
<td>4.5</td>
<td>23.3</td>
<td>11</td>
<td>1.2</td>
</tr>
<tr>
<td>2000</td>
<td>115.6</td>
<td>8.2</td>
<td>7.8</td>
<td>60.1</td>
<td>4.6</td>
<td>4.6</td>
</tr>
<tr>
<td>2010</td>
<td>85.3</td>
<td>9.0</td>
<td>11.6</td>
<td>71.5</td>
<td>7.3</td>
<td>9.8</td>
</tr>
</tbody>
</table>


Poverty is the primary barrier to caring for orphans locally and nationally. Without adequate resources to feed, clothe and counsel children, their basic needs go unmet. The poverty barrier is exacerbated by the lack of management capacity of providers both in and out of the government to address orphan and vulnerable

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85. The number of children orphaned by AIDS is expected to grow through at least 2020 (Hunter and Williamson, 2000).
86. These 15 countries include: in Southern Africa: Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. In East Africa: Burundi, Ethiopia, Kenya, Rwanda, Tanzania, and Uganda. Data detailing the percentage of orphaning due to AIDS are only available regarding maternal and double orphans, not paternal and double orphans (Hunter and Williamson, 2000).
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children’s issues effectively and comprehensively. While some governments and organizations are addressing aspects of orphaning, most countries lack an integrative and comprehensive strategy to meet the education, health and psycho-social needs of children in AIDS-affected areas. In addition, the stigma that isolates orphans in many communities discriminates against them, further decreasing their access to quality health care and education. The fragility of the education and health systems and their inability to provide quality services in the face of HIV/AIDS is yet another serious barrier in orphan assistance.

3. Importance of primary education for orphans and vulnerable children

Access to primary education is a basic need and right of every child. For orphans, well-designed primary educational opportunities are critical, since they offer children an outlet where they can socialize and develop behaviourally. Well-crafted educational opportunities also provide children with adult supervision and attention, emotional support, nutritional and health care, and the life-skills training they need to protect and support themselves.

Coombe and Kelly (2001) note that primary education has the ability to play a role in fighting the spread of HIV by enhancing students’ potential to make discerning use of information and plan for their future while promoting favourable sociocultural changes, such as gender equity. While there are many possible ways in which education can help stem the spread of HIV, it is difficult to discern

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International Institute for Educational Planning   http://www.unesco.org/iiep
from the research exactly how and if the ‘education vaccine’ works.\footnote{88} Some experts argue that HIV/AIDS education in the curriculum should be credited, while others note that basic education equips individuals (especially women) with important skills to gather information and translate knowledge into behavioural change. In both cases, education helps to break the deadly silence that surrounds the disease. As Vandemoortele and Delamonica (2000: 3) point out, “The four allies that make the virus so prevalent in many developing countries all start with ‘S’. They are Silence, Shame, Stigma and Superstition. These four S’s thrive on a climate of ignorance and illiteracy. Education is key to defeating this deadly alliance.”

4. **Obstacles to schooling in areas heavily affected by AIDS\footnote{89}**

AIDS affects the access and quality of learning for all children, particularly orphans. The impact of orphaning on children and their access to quality primary education is multi-faceted and begins when a parent becomes sick. The trauma and hardship of orphaning on children manifests both economically and emotionally with ramifications on their physical and psychological health.

Although no comprehensive data compare the enrolment rates of all orphans and non-orphans in sub-Saharan Africa, World Bank (1999) country assessments suggest that orphans have lower primary-school enrolment rates than non-orphans. There are several overlapping reasons for these lower enrolment and completion rates:

\footnote{88} Several research studies conducted in the late 1980s and 1990s when the AIDS pandemic was emerging, as well as more recent studies, contest the validity of the ‘education vaccine’ and argue that a direct and positive relationship exists between education level and prevalence rate (Melbye et al., 1986; Filmer, 1998; Ainsworth and Semali, 1998; Hargreaves and Glynn, 2000). Vandemoortele and Delamonica (2000) have argued that the correlation is spurious since evidence from countries at different stages of the pandemic was combined, making it difficult to discern a clear correlative pattern between education and HIV infection.

\footnote{89} This section relies heavily on two works by Michael J. Kelly: (1) Planning for education in the context of HIV/AIDS. Paris: UNESCO/International Institute for Educational Planning; and (2) HIV/AIDS and education in Eastern and Southern Africa: The leadership challenge and the way forward. Addis Ababa: United Nations Economic Commission for Africa.
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- lack of affordable schooling;
- increased familial responsibilities;
- family scepticism regarding the value of primary education;
- poor educational quality;
- stigma and trauma of orphans; and
- fear of HIV infection on school grounds and on children’s way to and from school.

4.1 Lack of affordable schooling

Since primary education is not universally free in sub-Saharan Africa, families, through locally imposed fees, must pay a substantial proportion of the costs of operating a school. In addition to school fees, families are often required to pay for teaching materials and supplies, uniforms, recreational activities and levies for school development, maintenance and construction. While paying these expenses is difficult for many families, it is particularly burdensome for households seriously weakened by AIDS. Reasons for this include:

- the loss of income from employment and other activities;
- in rural areas, a reduction in farming which decreases income-generating potential;
- high costs for health care and medication; and
- a growing number of households affected by AIDS are headed by children.

(Foster and Germann, 2000; Kelly, 2000a; Williamson, 2000a).90, 91

90. Child-headed household situations are particularly vulnerable to the loss of education access because their average monthly income is substantially below that of non-orphan households, making schooling costs prohibitive. For example, in Uganda, orphan households’ per capita income was 15 per cent less than in non-orphan households (Foster and Germann, 2000).

91. While there is ample evidence suggesting that financial burdens are a significant barrier to primary education access for children living in areas heavily affected by AIDS, a recent UNAIDS study in Tanzania suggests that cost may not be the most significant barrier in all communities. After examining the impact of orphan status and adult deaths on primary enrolment in Tanzania, the authors found that maternal or adult deaths delay first-time enrolments of children in primary school, but they eventually do enrol. They also did not find a direct correlation between dropping out of primary school and the loss of an adult. Considering that Tanzania has one of the lowest primary-school enrolments in Africa, it is difficult to know how easily one can generalize these results to other countries (Ainsworth, Beegle and Koda, 2000).
To supplement household incomes, children may drop out of school and engage in income-generating activities making them vulnerable to sexual and physical exploitation and HIV contraction. In addition, as household income falls, families are often forced to consume less nutritious foods and lack basic health services. All of these factors contribute to the neglect of children’s basic needs resulting in stunted growth and an overall decline in health contributing to lower school enrolment rates (World Bank, 1999).

### 4.2 Increased familial responsibilities

Failing to finish school compounds financial difficulties by reducing the future economic possibilities for children and their families. Many children in AIDS-affected households delay or drop out of school because they are expected to assume the responsibility of caring for a sick parent and/or siblings left behind (Ainsworth et al., 2000; Foster and Germann, 2000; Kelly, 2000a; Williamson, 2000a). These responsibilities increase the opportunity costs of sending a child to school, particularly if the quality of education is perceived as poor. As the demand for a child’s labour increases, tardiness and repeated absences affect his/her ability to learn and often lead to dropping out of school. In Zambia, a recent study showed that 32 per cent of school-aged orphans in urban areas were not enrolled in school, compared to 25 per cent of their non-orphaned peers (UNICEF and UNAIDS, 2000). In Mozambique, 24 per cent of orphans were attending school, compared to 68 per cent of children with both parents still living (Kelly, 2000c).

Girls are more likely than boys to drop out of school to assume household and care-taking responsibilities. This is disturbing in light of research suggesting that girls and society as a whole benefit significantly from their education (UNICEF and UNAIDS, 2000; Rugh, 2000). For example, a research study on sub-Saharan African found...
that a 10 per cent gain in female literacy resulted in a proportional drop in infant mortality (Williamson, 2000b). A Kenyan study found that for every 1,000 girls completing an additional year of school, two maternal deaths and 45 infant deaths would be prevented (Williamson, 2000b).

### 4.3 Family scepticism regarding the value of primary education

A growing sense of AIDS-driven fatalism among parents and caregivers is deterring school enrolment (Kelly, 2000a). In many areas, adults question the value of basic education if the children will eventually succumb to the disease before they receive the economic benefits of their education. This scepticism is reinforced by the fact that (1) schooling quality is perceived as poor in many countries; (2) the curriculum taught in government-sponsored schools is not directly relevant to their children’s or community’s needs; and (3) there are few opportunities for employment after schooling. In some cases, families recognize the value of education for boys but not for girls and are less likely to send their daughters to school (Kelly, 2000a).

### 4.4 Poor educational quality

Educational quality is negatively affected in AIDS-affected areas by (1) the decreasing supply of trained teachers; and (2) the loss of teacher productivity when they become ill. As a result, parents and caregivers choose not to educate the children because educational materials are rare, teachers are often absent, and the learning environment is disorganized.

High teacher mortality rates have a serious impact on the future and quality of primary education, and without trained teachers it is difficult to maintain high-quality instruction and keep schools open. The result is that often schools are forced to combine students in
different primary grades into one classroom. While estimates of teacher mortality vary from country to country, a striking trend towards increased teacher HIV infection levels and mortality (Kelly, 2000a) is emerging.92

In Zambia in 1998, teacher deaths were equivalent to the loss of approximately two-thirds of the annual output of newly qualified teachers. Overall, there was no net gain of teachers in an education system that continues to grow. A recent study revealed teacher mortality to be 4 per cent – almost 70 per cent higher than the general population – with AIDS being the primary cause. In Botswana, 1999 estimates suggest the country was losing up to 5 per cent of its teachers annually. A 1992 study in Tanzania predicted more than 14,000 teachers would die from AIDS by 2010, and the number was projected to grow to 27,000 by 2020. In 1999, research suggested that Malawi was losing approximately one teacher per day to AIDS (Kelly, 2000a).

When teachers become ill, their teaching capacity decreases, further limiting the quality of instruction. As HIV progresses into full-blown AIDS, teachers are often forced to take long absences to recuperate from illnesses. Since substitute teachers are rare, classes are often suspended. If teachers are able to physically attend classes, the emotional stress is traumatic and lesson preparation, homework correction and classroom interaction are often a last priority.93

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92 While there is no conclusive research as to why this trend is emerging, one explanation is that increased educational training resulting in higher income levels and physical mobility leads to increased HIV infection risk (Kelly, 2000a).

93 A recent study has shown that an infected teacher loses approximately six months of professional working time before succumbing to the illness and approximately one year elapses between the clinical onset of AIDS and death (Kelly, 2000a).
4.5 Stigma and trauma

The psycho-social effects of losing a parent to a debilitating illness are severe and can have long-term effects on a child’s behavioural development. As they endure the loss of parental support and nurturing, many orphans experience anxiety, depression and despair. Further complicating these emotions, siblings are often divided among several households within an extended family to mitigate the economic burden of caring for the children. Relatives or neighbours who have agreed to care for the orphans may contribute to the despair by taking their property or inheritance and leaving them more vulnerable to exploitation (Williamson, 2000a).

Despite the prevalence of HIV infection in sub-Saharan Africa, the stigma associated with AIDS is still very real and tangible. Community members who fear orphans are HIV-positive or believe that their families have brought shame to their community, often discriminate against the children and deny them social, emotional, economic and educational support. Orphaned children may also be treated poorly or abused in their new home, furthering their emotional distress and contributing to poor mental and physical health (Williamson, 2000a).

While the psycho-social needs of children are well documented, they regularly go unmet in school settings. Research suggests that two often-overlooked impacts of AIDS are the increasing number of children who do not wish to attend school because of (1) the stigma and scorn they experience coming from AIDS-affected households; and (2) the psychological trauma and shock they feel after the death of a family member (Gilborn and Nyonyintono, 2000). While the need for counselling and support is obvious, few schools have the resources to offer services and care for these children.
4.6 Fear of infection

Many families are reluctant to send girls to school because they have a greater vulnerability to HIV infection. The high HIV-infection rate of teachers and an increasing concern about HIV transmission from teacher to student or peer to peer on school grounds, discourages school participation – particularly for girls (Kelly, 2000). In Tanzania, one quarter of primary-school girls reported having sex with teachers, relatives, or an adult known to them, and another 23 per cent with ‘strangers’ (Shell and Zeitlin, 2001). ‘Forced sex’ accounted for one-third of all primary-school girls’ first sexual experience and nearly half reported having ‘forced sex’ at some point (Shell and Zeitlin, 2001).

One South African study notes that approximately 23 per cent of HIV infection in the region is acquired between the ages of 10-19 years and suggests that schools are major sites of HIV transmission (Shell and Zeitlin, 2001). A second study documents cases of rape, assault, and sexual harassment committed by both male teachers and students and suggests that violence and abuse are an inevitable part of the schooling environment for many South African girls. This study notes that girls who encounter sexual violence in schools were raped in school toilets, empty classrooms and hallways, and in hostels and dormitories (Human Rights Watch, 2001).

94. The prevalence of HIV infection among women of reproductive age is generally higher than among men, as much as 20 per cent higher in some countries (Rihani, 2000). In South Africa, for example, young women have significantly higher HIV-positive prevalence rates (25 per cent) than young men (less than 12 per cent). One study noted that girls aged 15-19 in sub-Saharan Africa were approximately eight times more likely to be HIV-positive than their male counterparts. Between the ages of 20-24 years, women in sub-Saharan Africa are still three times more likely to be infected than men their age (UNICEF and UNAIDS, 2000).
5. Meeting the challenges of HIV/AIDS in primary education

Maintaining the process of learning in a traditional, formal setting is difficult in AIDS-affected communities. As an increasing number of children are forced to drop out of school and teachers become ill, the quality of the learning environment declines and becomes increasingly chaotic and unproductive. In addition, hostility and distrust towards teachers who are viewed as a dangerous source of HIV/AIDS transmission in the community, decreases the credibility of education in the eyes of children and adults. Considering these concerns, Kelly (2000b) notes:

“Education in a world with AIDS must be different from education in an AIDS-free world. The content, process, methodology, role and organization of school education in a world with HIV/AIDS have to be radically altered. The entire educational edifice has to be taken down, every brick examined and where necessary re-shaped before being used in a new structure that has not yet been designed.”

Community leaders, teachers, policy-makers and other local and national stakeholders should work to accomplish three things in order to create a responsive education system, sensitive to the needs of children in AIDS-affected areas: (1) revise the role and content of the curriculum; (2) revise the organization of primary schools; and (3) explore cost-effective community-based initiatives.

5.1 Revise the role and content of curriculum

As AIDS continues to spread, so too does the need to integrate HIV/AIDS education material in the curriculum. To help students avoid risky sexual behaviour, schools should integrate instruction and activities on important ‘life skills’ that promote positive social
behaviour, eliminate AIDS-related stigma, and break the silence surrounding HIV/AIDS issues.

As the pressure on children to assume income-generating activities increases, non-formal education or apprenticeship programmes should be included in formal schooling programmes allowing students to gain literacy, numeracy and vocational-skills education. The concept of lifelong learning (such as peer or distance education) and adult basic education in both institutional and non-institutional settings should also be considered.

5.2 Revise the organization of primary school

Taking into account the variable needs of students, primary schools need to adopt a more flexible calendar and curriculum. Education providers need to rethink their approach to education and explore new initiatives that reach out to children unable to attend government schools, such as community schooling and interactive radio education. Finally, schools may need to explore ways to decrease the HIV transmission risk between students, teachers and others. Possibilities include creating same-sex classrooms, reducing student/teacher ratios, and training teachers to be sensitive to the vulnerability of girls to HIV contraction on school grounds and in the community.

95. Interactive radio education has been piloted in Zambia and targets out-of-school youth in AIDS-affected areas. Interactive lessons targeting elementary English and mathematics skills are broadcast for a limited number of hours per day targeting out-of-school youth in community centres. Minimal support from printed materials is offered, and trained, literate community mentors, most of who have completed secondary school and participated in a three-day training programme, are matched with students to provide instructional support. Families are expected to contribute in cash or in kind to provide for the upkeep of the educational centres. The pilot programme follows the Zambian curriculum and the objective is to cover the entire grade 1 mathematics and English language curriculum in 100 thirty-minute radio lessons. Specifically, this pilot is designed to reach vulnerable children who are currently out of school and provide a less costly alternative to formal education. Students meet for a short time each day and receive instruction from both the radio and the mentor. Mentors are also provided with lesson plans and instructions on how to prepare (Education Development Centre Inc., 2000).

96. A more complete discussion of initiatives attempting to increase primary-education access for orphans and vulnerable children in AIDS-affected areas can be found in Hepburn, 2001.
5.3 Explore cost-effective community-based initiatives

HIV/AIDS affects both the short and long-term financing of national primary education systems. Beyond the loss of experienced teachers, a rapidly increasing number of HIV-positive teachers has serious financial consequences. Since many Eastern and Southern African countries have extensive sick-leave policies, a large number of unproductive teachers’ salaries are subsidized by the state. The additional costs of replacement teachers or short-term substitutes increase these expenses and divert resources away from the schools themselves (Kelly, 2000a).

The depletion of private funds worsens this financial crisis. A growing sense of donor fatigue and frustration surrounding the seemingly intractable problem seriously threatens the infusion of badly needed private funds into the development of educational reforms and alternatives. National and community leaders must explore cost-effective and sustainable initiatives to increase school participation in AIDS-affected areas at the grass-roots level utilizing local resources, in addition to promoting better educational access for OVC at the national level.

6. One example: community schooling

Community schooling is one example of an initiative that is attempting to meet the educational needs of children in AIDS-affected areas. Community schooling is a popular approach in many AIDS-affected areas, particularly in Mali, Malawi, Uganda, and Zambia. In many cases, local communities or churches run schools and do not charge fees, do not require uniforms, provide educational materials, and use local leaders as teachers, often on a voluntary basis. This approach is almost solely reliant on community commitment and support. In certain cases, such as in Zambia, community schools have
partnered with their national Ministry of Education for financial and administrative support (Hepburn, 2001).

Community schooling offers many benefits, including that it (1) allows communities to take charge of their own affairs, making decisions on what is best for their children without having to wait for outside direction; (2) is less expensive per pupil than government schools (Webb, 2001);97 (3) increases access for all children within a community, especially OVC who are unable to attend government-sponsored schools (DCOF, 1999; Donahue and Williamson, 1998; USAID, UNICEF and Sida, 1999);98 and (4) can create a safe learning environment for girls by having low student/teacher ratios, increased community supervision, and a community location that decreases the risk of travelling long distances.

To effectively increase access, schooling can be tailored to communities’ scheduling needs and flexibly structured to accommodate non-traditional students with increased familial responsibilities. Community schools can also provide contextual psycho-social support for children and design the curriculum to include formal, non-formal, and life-skills education.99 Community schooling can be particularly effective in AIDS-affected rural areas, where the school calendar is tailored to reflect communities’ agricultural cycles and half-day lessons for certain students are provided (Hepburn, 2001).

97. However, to maintain low costs, significant community resources are required such as trained volunteer teachers, donated or locally constructed/rented buildings, and basic teaching materials. Without these inputs, the cost to students’ families increases dramatically.

98. By increasing access for all children, orphans are less likely to be discriminated against by their peers, and non-orphans are less likely to be dislocated.

99. The author defines formal education as that which focuses on basic mathematics, reading and writing skills, while non-formal education includes vocational or skills training, apprenticeships and professional mentoring.
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Overall, community schools are flexible in meeting children’s formal educational needs in a local setting. To ensure effectiveness, communities must demonstrate a collective commitment to increasing children’s access to quality primary education. In addition, a large number of volunteer or para-professional teachers must be identified and trained. Implementing agencies need to secure donor or government support to supplement community resources and provide coherent oversight to maintain educational quality and effectiveness. Extensive community mobilization and training are also necessary to ensure the effectiveness and sustainability of this approach.

While there are many ways in which community schooling meets the needs of children in AIDS-affected communities, it is possible that it may hurt educational quality as poorly trained volunteer teachers could compromise standards. In addition, there is a danger that governments may dismiss the need to address the lack of OVC access to state-sponsored schools by noting that community schools are serving them. One Zambian study suggests that a plan is needed to integrate community and government schools, bringing together the best qualities of each (USAID et al., 1999).

Community schooling could also isolate children based on their orphan status, if they are the only ones in the community who cannot afford government-sponsored schools. This could enhance stigma, particularly if their quality is perceived to be lower than government schools.100

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100 For example, in Zambia community schools were established to provide basic education for children who did not enter school at the usual age of seven and were now ‘too old.’ As a result, community schools offered children the opportunity to compress six grades into three years, which enabled them to enter grade 7 on par with their age-mates. These schools were affiliated with Zambia Open Community Schools (ZOCS), a national NGO. Recently, a number of new community schools have opened that do not necessarily maintain the same quality standards as those affiliated with ZOCS and are viewed by many as ‘parallel schools for poor children and orphans’, which receive no funding from the government (USAID et al., 1999).
While evidence suggests community schooling is cost-effective, it is highly dependent on donor inputs and community management. Volunteer community teachers may leave if offered paid jobs in the state-sponsored school system, and many schools ‘borrow’ buildings, which may eventually be recalled for other purposes (USAID et al., 1999). In sum, as the AIDS epidemic continues to deplete valuable human and material resources the sustainability of community schools is threatened.

7. **Looking forward**

To respond effectively to the impact of HIV/AIDS on education in sub-Saharan Africa, initiatives to increase primary educational access for orphans and other vulnerable children should address the obstacles noted above. Initiatives should accommodate children who need to learn income-generating skills and participate in school programmes that are flexible and sensitive to their community and familial responsibilities. Successful educational initiatives will need to overcome the many obstacles limiting children’s access in AIDS-affected areas and capitalize on community strengths. Most importantly, comprehensive and co-ordinated management strategies need to be in place at the community and national level to develop and encourage educational programmes that equip children with critical learning skills, while taking into account their need for security, stability, personal growth and development.
Increasing primary education access for children in AIDS-affected areas

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CHAPTER 9. SCHOOL-BASED GENDER VIOLENCE IN AFRICA: A RISK TO ADOLESCENT SEXUAL HEALTH

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Abstract

This paper examines the prevalence of gender-based violence in African schools, drawing on a small number of studies. It questions the suitability of the school as the location of HIV/AIDS prevention campaigns, given that schools are the site of high levels of gender violence, most of it directed at girls. If adolescents, especially girls, are indeed a high-risk group for HIV infection, then the existence of widespread sexual activity in conditions of intimidation, harassment and in some cases rape is likely to contribute to its spread. Far from discouraging high-risk sexual behaviour, the school may actually encourage it through a culture which promotes the development of stereotypical masculine and feminine behaviours and strong peer pressure to conform. This makes girls in particular vulnerable to
aggressive sexual advances from male pupils and teachers within the school and adult men outside it. There is therefore a contradiction between the school as a location for high-risk sexual practice and the school as the forum for teaching about and encouraging safe sex.

Introduction

Over the past decade or so, those struggling to raise awareness about the risks of HIV/AIDS infection, in particular in sub-Saharan Africa, have seen the school as the obvious site for educating adolescents about HIV prevention and the need to change sexual behaviour. AIDS is now the leading cause of death in sub-Saharan Africa and it is estimated that 60 per cent of all new infections worldwide is in the 15-24 age group (www.panos.org.uk). This makes the school an obvious priority for initiatives and campaigns to reduce high-risk sexual behaviour and infection rates. However, it is now widely acknowledged that reliance on the school as a vehicle for changing attitudes and sexual behaviour has been somewhat misplaced. The school may have been relatively successful at passing on information about HIV/AIDS, especially in countries which have run high-profile government campaigns, but these messages have largely failed to change sexual behaviour. In a study of the impact of the HIV/AIDS epidemic on the education sector in Botswana, Malawi and Uganda (Bennell, Hyde and Swainson, 2002), it was found that only in Uganda was there any clear evidence that school-based HIV/AIDS education had changed sexual behaviour. Within the school context, various reasons have been advanced to explain this (Bennell et al., 2002; Mirembe and Davies, 2001), including lack of appropriate materials, lack of time in crowded curricula, lack of training in how to teach about HIV/AIDS, teachers’ reluctance and embarrassment to address the issue explicitly, the adverse school culture and parental objections to their children being taught sex education. There also needs to be greater realization that dominant teaching styles in
African schools (teacher-led lessons, excessive reliance on repetition and rote-learning, discouragement of pupils’ questioning) are not conducive to encouraging attitude and behaviour change among pupils.

Recent research has highlighted another reason why schools may not be best suited to educate young people about HIV/AIDS. Many schools are in fact the site of high levels of gender violence, most of it directed at girls. The existence of serious sexual harassment and abuse in schools in sub-Saharan Africa has been documented as early as 1993-1994 (Gordon, 1993; Hallam, 1994) but it is only recently that a number of in-depth country studies have been carried out. These include studies in South Africa (Human Rights Watch, 2001; Morrell, 2000), Zimbabwe (Leach and Machakanja, 2000), Kenya (Omale, 2000), Botswana, Uganda and Malawi (as part of the study of HIV/AIDS and education by Bennell et al., 2002), Namibia (Daniel, 1998), and in Ghana (Leach, Fiscian, Kadzamira and Lemani, forthcoming).101 There is evidence that school-based abuse in many locations is institutionalized, an ‘accepted’ part of school life.

If adolescents are indeed a high-risk group for HIV infection, then widespread sexual activity in conditions of intimidation, harassment and in some cases rape is likely to contribute to its spread. Furthermore, some research (Leach and Machakanja, 2000; Mirembe and Davies, 2001) suggests that the school, far from discouraging high-risk sexual behaviour, actually encourages it through a culture which allows the development of stereotypical masculine and feminine behaviours and promotes ‘compulsory’ heterosexuality. This makes girls vulnerable to aggressive sexual advances from male pupils and teachers within the school and adult men (‘sugar daddies’) outside it. Research in Malawi shows that children as young as 10 years may be

101. The Guardian Weekly, 30 August-5 September 2001, reported on research by UNICEF in the Central African Republic which revealed that the widespread practice of teachers having sex with schoolgirls was the main cause of the spread of AIDS in schools.
engaging in regular sexual activity (Kadzamira, Banda, Kamlongera and Swainson, 2001). There is no doubt that strong influence is exerted by the peer group within the school, which increases the pressure on young people to enter sexual relationships, sometimes with multiple partners. Condom use among adolescents tends to be low (Coombe, 2000; Bennell et al., 2002). This poses a serious threat to the sexual health of girls in particular, given that in the worst-hit countries they are five to six times more likely to be HIV-positive than boys of the same age (www.panos.org.uk). There is therefore a contradiction between the school as a location for high-risk sexual practice and the school as an effective forum for teaching about and encouraging safe sex.

This article explores some of the issues surrounding gender violence in school, drawing on a study carried out in 1998-1999 in four junior secondary schools in Zimbabwe, which involved interviews with 112 female pupils, 59 male pupils, 27 teachers (including headteachers), 37 parents and a number of Ministry of Education officials (Leach and Machakanja, 2000). A small number of other recent studies are also drawn on. Although all these studies originate in sub-Saharan Africa, there is no doubt that gender violence in schools is widespread and is to be found throughout the world (www.id21.org/gender_violence/index.html provides further reference to studies of sexual harassment in schools, including in the USA and UK). It may take different forms, some of them specific to certain cultures, e.g. in India and Pakistan there are horrific reports in the media of schoolboys scarring girls for life by throwing acid in their faces when the boy’s proposal of marriage has been rejected.

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102 McAuliffe (1994) has reported that 46 per cent of primary school and 66 per cent of secondary students who were surveyed in Malawi were sexually active and most had initiated sexual activity between 10 and 14 years of age. In 1996 almost 60 per cent of secondary-school students interviewed by Bandawe and Foster said they were sexually active with a mean age of first intercourse of 15 years old.
The term ‘gender violence’ is used here to include all forms of sexual harassment, whether physical, verbal or psychological, forced sex, assault or rape.

1. Gender violence in schools

The fact that the school can be an unsafe place for young people, in particular for girls, is only recently being recognized by policymakers, planners and development agencies striving to increase educational participation. Throughout the 1990s, efforts at getting more girls into school were directed at addressing the economic, social and cultural barriers to girls’ schooling (e.g. Colclough, Rose and Tembon, 1998; King and Hill, 1993; Brock and Cammish, 1997). These barriers were almost always external to the school (e.g. poverty, distance to school, early marriage, etc.). What happened to children once they got into school was largely ignored, apart from some acknowledgement of the role played by the curriculum, school organization and teachers’ attitudes in socializing young people into the gender roles that they could expect to play in adult life. For girls (and sometimes for boys, as Kutnick, Jules and Layne, 1998, have shown in the Caribbean), this has certainly created a culture of low aspiration, low self-esteem and negative self-perception, with under-achievement and early drop-out being the consequence. However, missing in the policy-makers’ and planners’ analyses and subsequent strategies has been the contribution played by abusive behaviour and violence in the school in creating and perpetuating this culture of low self-esteem, drop-out and failure. The threat to adolescent health by the AIDS pandemic has turned a new spotlight on the school and in so doing has helped to uncover sexual violence.

Gender violence is an important aspect of the reality of school life for many young people. It both contributes to and is a consequence of their socialization as male and female. Girls are disproportionately
the victims. Even though many governments signed the Convention on the Rights of the Child in 1989, committing them to protect children’s right to free education and to freedom from exploitation, they have done little to protect their rights in schools. In many locations, the school culture tolerates gender violence to the extent that it has become an integral and institutionalized part of school life, to be regarded as ‘normal’ or ‘inevitable’. Perpetrators go unpunished; in this way young people learn that violence is legitimate. While there is general acknowledgement now around the world that serious abuse of children exists in the home, the community and the labour market, there has been a particular reluctance to admit that it also goes on in school and, most shockingly, that some of it is perpetrated by teachers, who are seen as figures of respect and authority, the guardians and protectors of our children. We want to believe that the school is a safe place for children, a haven against abuses perpetrated elsewhere. Sadly, this is not always the case.103

2. What types of gender violence exist in African schools?

Gender violence refers to any form of violence that is directed against a male or a female because of their sex. It is usually overtly sexual in nature and is often tied up with the individual’s perception of socially accepted norms of male and female behaviour. It is usually physical (assault, forced sex or rape) but may also be verbal, emotional or psychological. Even where it manifests itself in a relatively mild form (if that is possible), e.g. isolated incidents of verbal abuse, it has the potential to escalate and lead to physical assault, even rape, if nobody seeks to control and punish it.

106. The most dreadful case to receive international media attention was probably the massacre of 19 schoolgirls and the rape of 71 others by boys at St Kizito School, Kenya, in 1991.
Evidence from studies in a number of African countries (Leach and Machakanja, 2000; Human Rights Watch, 2001; Omale, 2000) suggests that on a daily basis the greatest threat of gender violence in schools is to girls and it comes from sexual advances by older male pupils (as is described in the next section). Sexual violence by teachers is widespread but less frequent numerically, despite the impression created by high-profile reports in the African media of teachers and headteachers impregnating, and in some cases raping, girls in their school. It is however more shocking because of the position of trust that the teacher is placed in and the fact that the relationship, whatever the age of the girl, is an illegal one. It is also almost certainly true that many cases go unreported, prosecutions are rare and few teachers are dismissed for having sexual relationships with female pupils. It is therefore difficult to gauge the real extent of the problem. There is no doubt, however, that the sexual abuse of girls by teachers is pervasive in many African countries (Insights, 2001), it tends to be clustered in certain schools and it goes largely unreported. Interviews with parents in Malawi (Leach et al., forthcoming) revealed the opinion that it is not so much the number of cases of teacher abuse in a locality which is important; rather the negative impact that one single case could have on parents’ willingness to send their daughters to school.

As it is, statistics are hard to come by. Human Rights Watch (2001: 37) states in its South African report that interviews with educators, social workers, children and parents revealed that “the problem of teachers engaging in serious sexual misconduct with under-age female students is widespread”, and they provide a number of disturbing case studies of schoolgirls raped by teachers. The medical journal The Lancet published findings in January 2002 from a 1998 study of rape among a sample of 11,735 South African women; of the 159 women who had been victims of child rape (those below the age of 15), 33 per cent had been raped by teachers (Jewkes, Levin,
Mbananga and Bradshaw, 2002). In the Zimbabwe study (Leach and Machakanja, 2000: 27), it was recorded that in one province within a two-month period during 1999, 11 cases of ‘improper association’ by teachers had been reported to the provincial ministry, one involving a 13-year-old girl and another a 10-year-old. There was also a five-year backlog in dealing with cases, and for the first six months of 1999, there were already 15 recommended cases for dismissal awaiting approval by the central Ministry of Education.

Interviews with girls and boys in the three co-educational schools which were part of this Zimbabwe study, revealed the widespread opinion that certain named teachers propositioned girls on a regular basis. A total of 14 out of 73 girls reported that they had been propositioned by male teachers and 48 girls said they knew of someone who had been propositioned by a teacher (Leach and Machakanja, 2000: 17). Boys who were interviewed named the same teacher seven times in one school and six times in another. Two boys reported that they had found a teacher having sex with a schoolgirl in his office after school one day. Both boys and girls claimed to know of girls who had got pregnant by a teacher and dropped out. One girl’s older sister had been made pregnant by the headmaster of her school. During a group interview in a Malawi school as part of a follow-up study, a member of the school management committee revealed that her daughter had been impregnated by a deputy head, who is in fact now head of another school; she is herself bringing up the child (Leach et al., forthcoming). Although the extent to which girls are forced into such relationships rather than entering into them freely is not clear, the teacher’s position of authority in the school makes intimidation or entrapment likely. In Ghana during recent fieldwork (Leach et al., forthcoming), the headteacher of a peri-urban school chosen at random was found to be routinely demanding sex of girls, some still at the primary level. (This headteacher’s behaviour
has subsequently been investigated and he has admitted his offences – his likely punishment is to be transferred to another school.)

It is likely that there exist other targets of sexual harassment and abuse, e.g. boys (by male and female teachers or by other boys), young female teachers (by male teachers and older male pupils in rural areas – some evidence of this is reported in Ghana by Casely-Hayford (2001), and lesbian and gay teachers and pupils, especially given the dominant culture of heterosexuality and of bullying that prevails in most African schools (Coombe, 2000). However, the author does not know of any research studies investigating these groups as targets of abuse.

Beyond the boundaries of the school, sexual harassment and abuse are also perpetrated by sugar daddies, these being men who prey on girls for sex in exchange for money or gifts. In the Zimbabwe study, pupils talked freely about men who wait outside the school gates to engage girls in conversation as they leave the premises or follow them to and from school. Amazingly, 92 per cent of the sample of 112 girls interviewed said that they had been propositioned by adult men, sometimes strangers and sometimes neighbours or relatives. Seventy-four per cent of the sample reported that they knew girls who had sugar daddies; some claimed to know of many girls (Leach and Machakanja, 2000). Kadzamira et al. (2001: 25) also comment on sugar daddies and high levels of transactional sex among schoolgirls in Malawi. It is also possible that younger girls enter into conversation, accept small gifts and perhaps take rides in cars with strange men without realizing that they will be forced into sex at a later date. Such men are guilty of abuse, even if the girl enters freely into a sexual relationship, not only because she may well be under age, but also because he is taking advantage of her circumstances, whether in terms

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104. Coombe refers to literature which questions the reluctance to address the issue of same-sex relationships in developing our understanding of the HIV/AIDS epidemic and interventions to stem its spread (2000: 26).
of gender, poverty, age, immaturity or vulnerability due to family circumstances (e.g. domestic violence or neglect). Although sugar daddies are not a new phenomenon, the HIV/AIDS epidemic has caused their numbers to rise dramatically as men perceive schoolgirls to be usually virgins and free of the virus. The virgin myth - that having sex with a virgin (or with an infant) is a cure for HIV/AIDS - is widespread in Southern Africa (Human Rights Watch, 2001: 24-26; The Lancet, 2002: 274). Increasingly, there are accounts of rape of very young infants, with three rapes of infants under the age of one reported recently in the South African media (The Lancet, 2002: 274).

What are the factors that contribute to this tolerance of gender violence and abuse in schools, which in turn increases young people's risk of HIV infection? Are schools complicit in increasing the pupils' vulnerability to the infection and to other sexually transmitted diseases? Gender violence is considered in this paper as being linked to other forms of violence in schools; gender violence in the wider society; the construction of adolescent sexual identity; peer group pressure; poverty; and an authoritarian school culture. Each of these will be briefly examined.

3. Other forms of violence tolerated in school

Sexual abuse and violence would appear to be inextricably linked to other forms of physical violence in school, in particular to widespread bullying by pupils and corporal punishment by teachers, and also to verbal abuse (Human Rights Watch, 2001; Gordon, 1993). In many African countries, corporal punishment is either totally banned, as in South Africa and Namibia, or only sanctioned under strict conditions, e.g. in Zimbabwe where it can only be administered by the headteacher in the presence of another teacher, and only on boys, and in Botswana where teachers can only use it if specifically authorized by the headteacher. Despite this, it is an institutionalized
feature of school life throughout much of Africa, and is practised by female as well as male teachers and on girls as well as boys (Tafa, 2001, on Botswana; Olfe, 1997, on Namibia), where its use in schools is supported by many teachers, parents and pupils themselves. It usually passes unnoticed unless it results in serious physical injury or official complaint. It is interesting to note that girls in the Zimbabwe study complained that teachers who were liberal in administering beatings for quite minor offences rarely punished boys for assaulting or behaving aggressively towards girls.

This research suggests that an environment which tolerates one illegal type of violence, e.g. corporal punishment, is also likely to be permissive of other forms of violence, e.g. sexual abuse. Indeed the two are linked – a girl who grants sexual favours to a teacher will normally avoid being beaten, whereas a girl who has turned a teacher down might risk being singled out for beating. Teachers may even get sexual gratification from beating pupils. Where bullying, corporal punishment and sexual abuse are all more or less tolerated by school authorities, this means that their practice is implicitly sanctioned, even approved of.

4. Gender violence in society

Gender violence in school is a reflection of gender violence in society. South Africa is often cited as an example of a violent society105, but domestic violence, some of it sexual, is a global phenomenon. Both male and female pupils in the Zimbabwe study reported high levels of verbal abuse in their homes, and some reported physical and sexual abuse. Both girls and boys may be at risk of sexual abuse.

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105 Human Rights Watch (2001: 21) cites 1996 South African Police Service sources which reveal that, in a study of 114 Interpol member countries, South Africa was the leader in the incidence of murder, rape, robbery, and violent theft. In 1999 the South African Police Service recorded 51,249 cases of rape. The Lancet reports from the same source a figure of 221,072 sexual offences in 1999 against persons aged below 17 years (The Lancet, 2002: 274). Such statistics have however been disputed by the South African Government.
by step-parents or other relatives. Where violence exists in the home and the community, it unfortunately prepares young people to expect and to accept violence as a part of their everyday life, including at school. In some social contexts, beating is perceived as an acceptable strategy for punishment and a way of gaining ascendency and control: husbands beat their wives, parents beat their children, and teachers beat their pupils. Violence becomes legitimized in this way in the eyes of children.

5. Adolescent sexual identity

The school is a key arena for the construction of masculine and feminine identities (Epstein and Johnson, 1998; Mac and Ghaill, 1994). At this formative age of adolescence, it is easy for pupils to develop the view that masculine identity is associated with aggressive, dominant behaviour and feminine identity with submissive, dependent behaviour. The school itself has an important role to play in forming and perpetuating these views. The ethos of the school, the way the school day is organized, the ways in which responsibilities are allocated and the role models that it offers pupils all play a part (Mirembe and Davies, 2001). Given the wider context of gender violence in society, it is not surprising that violent behaviour in the school is most commonly associated with the male identity, with boys acting out their beliefs of what it means to be male. In the construction of the male adolescent identity, peer pressure requires that older boys aggressively demand the attention of younger girls. Having a girlfriend and competing over girls are essential features of the peer culture. The Zimbabwe study showed this very clearly (see further on).

In the co-educational junior secondary schools which featured in this study, there was strong peer pressure on boys to obtain girlfriends and to boast about their conquests. Through a highly developed ritual,
older boys from the upper forms would make sexual advances or ‘propose to’ the new girls in Form 1. They would send them love letters, enter their classrooms uninvited during break times to demand that they respond to their advances, and accost them in the school grounds and on their way to and from school. Sometimes boys' advances were accompanied by small gifts of money, or a boy might buy a girl a drink or snack during break-time. In doing this, he may well be showing that he is ready to pay for sexual favours. Threatening or violent behaviour, or sexually explicit verbal abuse designed to humiliate her were often the consequence of a girl turning down a boy’s proposal. Much is at stake for the boy in terms of establishing himself within the male peer group.

Some of this violence was purely gratuitous, an affirmation of male dominance over females. Boys would corner girls in corridors, in the school grounds and in empty classrooms, trying to touch them provocatively on the breasts and buttocks, or lock them in a physical embrace, shouting obscenities, and behaving and speaking in class in a manner intended to demean or humiliate them. Forty-seven per cent of the 73 girls who were interviewed a second time reported that they had experienced unsolicited physical contact such as having their breasts or buttocks grabbed or pinched by boys in their school, even of being hit or beaten. In one peri-urban school, girls reported that they had to run a frequent gauntlet of boys waiting to ambush them as they left school, while other boys would look on and laugh (Leach and Machakanja, 2000: 15-16). Boys talked about the acquisition of girls as a proof of manhood, as if they were booty to be won in battle: “If you have one girl, boys will laugh at you. If you have more than one, you are seen as a great guy who shows his machoism”, “Boys fight over girls, threaten each other”, and “You tell lies about your competitor – say he takes drugs, drinks, has no money – you undermine the competition” (2000: 67). Boys would sometimes show condoms to girls in class and speak about them provocatively or
make drawings of people having sex to embarrass girls. Outside the school gates, girls experienced similar treatment, with men offering them gifts or money, seeking to entice them into having sex. In crowded public places such as markets and bus stops, they were often harassed or molested by complete strangers (drunken men in particular). Over half the sample of 112 girls interviewed in the first round reported that they had experienced unwelcome and unsolicited physical contact by strange men, usually at the bus stop or while walking home. Twenty girls reported specific incidents of being pinched or grabbed on the breasts or buttocks (2000: 18).

Wood and Jewkes (1998) have made a fascinating study of violence in adolescent sexual relationships in a South African township, based on a group attending two schools in Eastern Cape. In this location, physical assault, rape, and coercive sex have become the norm in male-female relationships, making it very difficult for young women to protect themselves against unwanted sexual intercourse, pregnancy, HIV infection, and other sexually transmitted diseases. Masculinity was largely defined by numbers of sexual partners, choice of main partner, and ability to control girlfriends. As a result, multiple sexual partners featured in intensely competitive struggles for position and status within the male peer groups. The boys clearly saw sex as their right – forced sex was legitimate. Girls found it difficult to escape from violent relationships because of the status attached to being in a relationship and fear of reprisals. In another study (CIET, 2000), a survey conducted in Johannesburg in 2000 with 30,000 youth found that one in four males claimed to have had sex without a girl's consent before the age of 18 years. At least half of those interviewed, both female and male, believed that forced sex was not sexual violence, it was just ‘rough sex’.

Within the Zimbabwean schools, pupils reported that male teachers who engaged in sexual advances towards girls also
manifested aggressive behaviour in terms of invading their private space. They would take the opportunity of daily close physical contact with girls, e.g. putting an arm round a girl on the pretext of reading her exercise book so as to touch her breasts, ordering a girl to come to his office or to a store room and then molesting or assaulting her (Leach and Machakanja, 2000: 17). In Ghana, examples of predatory behaviour by one headteacher were provided by girls: “He asked me to take some papers from the cupboard [in his office] for him. He then held me from behind and touched my breast and said ‘Today the two of us will be together after school’ – he used his fingers to signal ‘lovemaking’” (Leach et al., forthcoming). Teachers appeared to pursue their amorous activities both inside and outside the classroom quite openly; in the classroom, boys and girls would whistle or hiss if a teacher called on a particular girl known to be of interest to him to read out loud or come to the front of the class (Leach and Machakanja, 2000: 17). Boys were loud in their condemnation of such teachers, not for moral reasons, but because they saw it as unfair competition. The teacher was abusing his position of authority; the girls were their peers and therefore ‘their property’ (Leach and Machakanja, 2000: 20-21). Most seriously, male teachers and older men preying on female students provided negative role models and conveyed the message to boys that young girls were ‘fair game’.

Girls in these schools appeared unable or reluctant to take direct action, whether through lack of confidence, absence of a support system or fear, when harassed or physically assaulted. Fear of further violence and reprisals, knowledge that they were unlikely to get sympathy and support from teachers or parents, a desire not to draw attention to oneself, and a certain resignation, an acceptance that this was how things were, all contributed to this lack of response. Girls seemed to feel that they were always at fault, even when they became pregnant through forced sex. It was surprising that, when asked whom they would blame if a girl got pregnant, 68 per cent of girls
compared to 66 per cent of boys would blame the girl alone (rather than share the blame equally or blame the boy). A third of the parents and a quarter of the teachers would also place the blame solely on the girl. Even if she was made pregnant by a teacher, barely half the teachers asked would blame the teacher alone; the others said the blame should be shared (Leach and Machakanja, 2000: 40-41). “She should have said no”, “she allowed it to happen”, “she should have known better” were frequent comments. Interestingly, a number of mothers spread the blame more widely across the female sex, suggesting that all women were flawed and weak. There was a general reluctance to blame males. Not surprisingly, therefore, girls also tended to accept male aggression as their fate and did not think to report it.106

However, girls should not necessarily be seen as passive victims of aggressive male behaviour. According to the pupils interviewed, some girls entered freely into relationships with sugar daddies or teachers, primarily they said for money. Research in Malawi showed that it was common for girls to have multiple partners (Kadzamira et al., 2001). Poverty certainly plays a part in encouraging girls into relationships with older men. There was also a desire among some girls to be associated closely with a teacher, especially the popular younger ones and those who appeared eligible for marriage. It is also the case that student teachers and newly graduated teachers may only be a year or two older than the girls themselves – there is much over-age enrolment in schools in the poorer African countries. A young unmarried teacher may view it as legitimate to find a marriage partner from among his pupils.

106 Communities too find it difficult to take action against an abuser in their midst. In the Ghanaian case reported above, it was an ‘open secret’ that the head teacher, who himself came from the community, was abusing schoolgirls, but no action had been taken to confront him or report him to the authorities.
6. The adolescent peer group

The construction of male and female identity is strongly influenced by the adolescent peer group culture. It is this that encourages pupils to conform to certain stereotypical behaviours and makes girls particularly vulnerable to sexual violence. Boys who do not conform to dominant views of what it is to be male may be bullied and in some cases themselves subjected to sexual violence. Pressure to conform influences sexual practice and in so doing may serve to increase young people's exposure to the risk of HIV infection.

The Zimbabwean research revealed that the materialistic aspects of the peer group culture made girls vulnerable to exploitative sexual relations and to forced sex. This peer culture attached much importance to money. The interviews and the subsequent workshops with girls revealed that those who had pocket money to spend on snacks and drinks during or after school were much admired or envied: “She brings money, 20Z$, 50Z$ and buys lots of eats” (girl's interview). Gifts or money from teachers, male pupils or sugar daddies were used to draw girls unwittingly into a dependent and exploitative sexual relationship: “You show off money, especially 100Z$”, “You buy the girl lunch or snacks” (boys' interviews) (Leach and Machakanja, 2000: 66-67). Even girls from more affluent middle-class homes were seen to be drawn into the sugar daddy trap by the desire to be seen as grown up, receiving gifts and having fun - not unlike teenagers everywhere. However, with fewer income-generating opportunities for teenage girls in Africa, they were very much dependent on men to provide for them. While being condemned by boys for their interest in money, in one sense the girls were merely anticipating their future role as adult women in a society which teaches them to look to men for physical, financial and moral support. Boys, also, were fulfilling the role into which they were being socialized by aggressively demanding the girls’ attention and
sexual favours, and being ready to pay for them. As one boy said “Girls want money, boys want sex” (Leach and Machakanja, 2000: 21). Kaim, in her research into adolescent views of sexual health in Zimbabwe (1997: 24) states:

“Money plays a key role [in adolescent sexual relationships]. In an area where most families are struggling to make ends meet, adolescents are left to their own devices to get a little money to spend on themselves. In this environment, sex becomes an exchange commodity where the girls expect cash in return for sex and boys earn that money in order to be able to buy the pleasure. Even when a girl and boy are meeting regularly, this exchange is considered normal. ‘Prostitutes’ are different in that they work for money at the township, usually having sex with older men.”

Girls engaging in transactional sex to finance their education is not new, nor is it confined to Africa.107 It is however the case that poverty, economic decline and the increased cost of schooling are all likely to result in ever-younger girls (and boys in some cases) being involved in such transactions. The low economic power and social status accorded women generally in African societies, backed up in some cases by legislation restricting ownership of property or custody of children, means that females are generally dependent on men for their survival and are considered to be their property, to serve and obey them. By not controlling anti-social and gendered behaviour, the school is in fact implicated in the construction of aggressive forms of masculinity and of perpetuating the culture of violence.

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107 The UK’s Times Higher Educational Supplement of 3 May 2002 reports that a large number of students in Thailand prefer to take a ‘sugar daddy’ to finance their studies rather than a student loan.
7. Poverty

As is well known, there is a clear link between HIV/AIDS and poverty. There is also a strong link between sexual abuse and poverty, with poverty itself being gendered. Girls are more vulnerable to sexual exploitation than boys where, as with adult women, they are financially dependent on men. Boys have greater opportunities to earn money from casual labour. As already indicated, adult men, whether male teachers or sugar daddies, take advantage of some girls’ poverty to bribe them with money or gifts in exchange for sex. A girl may respond to such advances because her family is unable to provide her with school fees and other necessities. A pupil is likely to be sent home until he/she can pay the fees. Where girls live at some distance from the school and do not have money for bus fares, they may solicit lifts from car and truck drivers, which increases their chances of being assaulted or raped. Girls from less privileged backgrounds know the opportunity of obtaining a well-paid and secure job are slim and may see their best chance for securing a comfortable future in finding a man to support them. The opportunity of a comfortable lifestyle, even outside marriage, could be very attractive to a girl. It is now common in some sub-Saharan African countries for girls who become pregnant by an older man to settle, often though parental negotiation, for accommodation and/or maintenance.

8. The authoritarian school culture

It is somewhat ironic that it is the very authoritarian nature of the school which allows gender violence to flourish. The culture of authoritarianism and discipline which dominates many African schools is reminiscent of the English Victorian school. In such schools, caning was a frequent occurrence and instilling rigid respect and obedience towards parents, teachers and one’s elders was an important part of the informal curriculum. Most African schools have
retained this authoritarian culture to a greater extent than have schools in Europe, some would say because it is in tune with cultural views of how to bring up children (Tabulawa, 1997; Tafa, 2001). One’s parents and one’s elders generally should not be questioned or doubted, especially if they are male. Similarly, parents are discouraged from complaining about the school. This passes on the message to pupils that the teacher is a figure of authority who should not be questioned. By perpetuating the fictional picture of the model teacher, the school is guilty of helping to perpetuate this abusive behaviour. For girls, this means that they are expected not to question inappropriate behaviour by male teachers on two accounts: firstly, the latter are in a position of authority in the school and, secondly, they are male. The fact that some girls have an ambiguous attitude towards male teachers’ sexual advances further ensures that they will not openly question this behaviour.

Sexual harassment and abuse of girls in school exists in large part because it exploits the difference of power between the perpetrator and the victim, power which is largely but not exclusively that of male over female. For example, a teacher who is attracted by a girl can clearly exploit his position of power to force her to have sex with him, e.g. by threatening to beat her for faults in class (to avoid being beaten was one reason given by girls in the Zimbabwe study as to why a girl might enter a sexual relationship with a teacher) or to fail her in her examinations. A boy can pick on a girl who has annoyed him by organizing his gang to assault her physically.

The authoritarian culture of the school has implications for the teaching of sexual health and HIV prevention. As Mirembe and Davies

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108 Sexual abuse of children exists in other authoritarian institutions involved with minors (such as children’s homes, religious orders). There have been many recent high-profile cases reported in the media involving child-care workers and priests in Europe and more recently in the USA.
(2001) show in the Ugandan context, a school culture which reflects male dominance through extensive gendered practices also constitutes a risk to girls’ sexual health. The male domination and power imbalance inherent in the school culture means that the high knowledge that Ugandan schoolchildren have concerning HIV infection may be worthless given the reality of the risky school environment. Gendered practices at school may include preference for male pupils and male teachers in leadership roles, restricted access for girls to high-status knowledge (for example science), different disciplinary measures against boys and girls, and strict ‘policing’ of girls’ sexuality by the school authorities (e.g. what to wear, how to sit in public, how to talk to boys). Furthermore, sexual harassment of girls by boys goes unchallenged by staff; in class boys control the language and physical space of girls, forcing them into silence; girls have to put up with insults whenever they speak up in class, and they have to tolerate abusive graffiti on walls outside.

The new AIDS curriculum in Uganda contradicts these common gendered practices in schools. Central to the ‘official’ message on AIDS is that negotiation and partnership in sexual relationships are fundamental to HIV prevention strategies. Negotiation and partnership, however, require equal power and status between partners. Endemic harassment denies girls the right to make a choice, voice independence, or to fight back on an equal standing. The inevitability of boy-girl relationships, the fact that girls have no choice but to follow a boy’s lead, puts them in the direct path of HIV infection, pregnancy or a violent relationship. To refuse a boy’s advances is courting the risk of taunting, abusive language, physical harassment or assault (Mirembe and Davies, 2001).
9. Why is gender violence not tackled within the school?

Through their failure to take disciplinary action wherever it comes to light, whether against sexual abuse, bullying or corporal punishment, schools and ministries are condoning, even encouraging, gender violence and exposing their pupils, in particular girls, to sexual health risks. Sexual abuse often only comes to light if a girl has become pregnant by a teacher. If the girl or the parents complain, then an official report might be submitted by the school head to the Ministry and disciplinary action taken. Evidence from Southern Africa (Human Rights Watch, 2001; Bennell et al., 2002; Leach et al., forthcoming) suggests that very few teachers are expelled from the teaching profession; most are merely transferred to another school.

The Zimbabwe study showed that the school culture is one in which teachers tend to protect each other so that any misbehaviour does not come to the attention of the school head. Teachers either choose to ignore what is going on or like to think that the teacher is only joking with girls and not engaging in any serious sexual advances. Female teachers, including headteachers, also choose to turn a blind eye. Heads are reluctant to take the matter further because of the cumbersome process of putting the complaint in writing and, in the event of a criminal investigation, giving evidence in court. A head might even be accused by education officials of being a troublemaker for bringing the affair to light, or of being an opposition party member. In such circumstances, a head will probably prefer to give an informal warning to the teacher. The current shortage of trained teachers in many countries also makes the authorities reluctant to prosecute offenders who know all too well that they are needed in post.

By not punishing pupils who behave aggressively or male teachers who take sexual advantage of girls, the school is presenting male
aggression as something normal and to be expected. The Zimbabwe study showed that there is clearly a lack of trust by pupils in their teachers and few appear to seek advice from them. For girls, the frequent use of beatings and abusive language, male teachers’ inappropriate behaviour which goes unchecked, the suspicion that teachers gossip about them in the staff room and perceived favouritism (usually by male teachers towards certain girls) in awarding grades, does not encourage positive sentiments towards teachers. Very few girls reported incidents to a teacher because they expected to be told it was their fault – they had been ‘asking for it’ by behaving provocatively.

As for parents, there was some general recognition that sexual abuse by teachers existed in schools and they expressed their extreme disapproval. However, if a teacher gets a girl pregnant, parents in low socio-economic circumstances may feel obliged to ask the school not to make a complaint because they are arranging for him to marry the girl or to pay maintenance (Leach and Machakanja, 2000).

10. What can be done?

The tolerance of violent behaviour in schools is a violation of a child’s right to an adequate education in a safe environment and exposes him/her to sexual-health risks. There is an urgent need to break the silence surrounding school-based abuse. Although governments may be tempted to refrain from taking action because of the absence of large statistical surveys (this is a subject that is particularly difficult to research through survey techniques), they need to urgently tackle this potential source of HIV infection with vigour, given the vulnerability of the school-age group.

Within the school, efforts need to be made, both through the curriculum and through school management and discipline, to
encourage collaborative relationships between pupils and to punish teachers and pupils who engage in abusive or violent behaviour. Aside from the inevitable consequence of girls dropping out of school or under-achieving, boys’ aggression may well encourage girls to look for boyfriends elsewhere. Contrary to what one might expect, encouraging mature relationships within the school, whether sexual or not, might well lead to increased participation and achievement by girls, and possibly also by boys, as they would be able to help each other with their studies and would be more likely to attend school regularly. The opportunity to encourage adolescents to practise safe sex with a single partner is also greater. Acknowledging that school-going adolescents engage in sexual activity, curbing male teachers’ sexual misconduct and eliminating the negative role model that this provides to boys may also lay the ground for teaching about sexual health in a more constructive environment.

In terms of HIV/AIDS education, there is an urgent need for it to be taught more effectively and sympathetically (Coombe, 2000) and for pupils to have access to counselling services, either through a cadre of full-time AIDS counsellors, as suggested by Bennell et al. (2002), or through better training of guidance and counselling teachers. Teachers need to take responsibility for listening to both boys and girls and encouraging a constructive and collaborative relationship between them. Sex education and guidance and counselling as school subjects should be used to create a more positive conceptualization of what it is to be female or male. In this, men and boys need to be seen as part of the solution and not just the problem. Teachers also need to understand the seriousness of an ‘abuse of trust’ and to be trained to teach these subjects properly, as well as how to tackle abuse within their school.
Given the lack of preparation of teachers in appropriate methods for teaching and counselling in the field of HIV/AIDS, the use of outside personnel, peer educators and participatory approaches involving drama, multimedia and workshops may have more impact in the short term (Bennell et al., 2002). Such teaching and awareness-raising approaches can build on constructive engagement by pupils in a deeper understanding of adolescent sexual identity and notions of negotiated and responsible sex. Moving from dependency to partnership in sexual relationships can form the basis of disease-prevention strategies (Mirembe and Davies, 2001).

At the Ministry level, there needs to be a greater level of responsibility for tackling harassment and abuse in school (Coombe, 2000; Human Rights Watch, 2001). In Uganda (Hyde, Ekatan, Kiage and Barasa, 2001), where Ministry of Education resolve to address the issue has led to the dismissal/expulsion and imprisonment of some teachers and male students who have had sex with under-age girls, sexual misconduct in schools is less prevalent. If perpetrators are prosecuted firmly and quickly, this sends a clear message that abusive behaviour by either teachers or pupils will not be tolerated. At the same time, corporal punishment and bullying need to be stamped out, as there is a clear connection between these unauthorized manifestations of violent behaviour and sexual abuse.

The implications from all of the above is that the authoritarian school culture should be replaced by a more open and democratic one, in which pupils, teachers and parents can discuss issues, including those relating to sexuality, openly together. This will also encourage the creation of more consensual adolescent identities. To achieve this, however, teachers will need to serve as positive role models to both boys and girls. There are important considerations here for the content of teacher education.
The HIV challenge to education: a collection of essays

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PART II
CONVERSATIONS
CHAPTER 10. UNESCO AND HIV/AIDS: TEN LESSONS

Gudmund Hernes

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On 5 June, 1981, Michael Gottlieb, an assistant professor of immunology at the University of California Los Angeles School of Medicine, published an article, in the Centers for Disease Control, Morbidity and Mortality Weekly Report, on five cases of a rare disease, pneumocystis carinii pneumonia, in homosexual men. These were the first five cases of what was later to become known as AIDS, caused by the human immunodeficiency virus or HIV. What was not known was this: though only five cases were reported, thousands more were already infected. The very nature of this disease continues to inhibit discovery of its true extent, for the incubation period between infection and its manifestation is considerable. Those who are infected may show no outward signs of the disease for years following infection.
Lesson 1. **The virus has always been way ahead of the disease.**

Twenty years after the identification of AIDS, some 60 million people have been infected by HIV, a number corresponding to the entire population of France, the United Kingdom or Thailand. Those who have died equal the population of Norway, Sweden, Finland and Denmark combined. Those currently infected – more than 40 million – number more than the entire population of Canada. The number of children thought to be orphaned by HIV/AIDS – some 14 million – is already more than the total population of Ecuador. Over the coming decade their numbers may rise to a staggering 50 million worldwide. In other words, the extent of this pandemic is unprecedented in human history. And the worst is yet to come, for many millions more will be infected, many millions more will die, many millions more will be orphaned. On September 11 2001, more than 3,000 people died in the New York bombings. Every day, around the world, HIV infects at least five times that number. But it is not only individuals who are at risk. The social fabric of whole communities, societies and cultures is threatened. The disease is certain to be a scourge throughout our lifetime.

Lesson 2. **The disease has always been way ahead of the response.**

The global response to HIV and AIDS has been slow and, in effect, the silence of leaders has assisted the disease to spread. Strategies for low-cost treatment have been underfunded. Resources for confronting AIDS have been available in the North, while the pandemics run rampant through countries of the South. What resources have been committed have been inadequate for coping with the daily increasing needs of those infected and affected by HIV and AIDS – those who suffer from the range of opportunistic infections that accompany HIV, those who are orphaned by the disease, those
who care for the terminally ill, and those who are dying slowly from the ravages of AIDS. Funds have also been lacking for countering the institutional impacts of the disease, particularly in the social sectors, to cover the loss of teachers, social-welfare officers, and health workers. The loss of teachers in particular has profound implications for education provision and quality.

Lesson 3. There has been a gap between the devastating impact of HIV/AIDS and investment in ameliorating those consequences.

HIV/AIDS is not just a health problem. In less than two decades it has become a social, economic, cultural, developmental and political catastrophe of unprecedented proportions, with consequences as ravaging as any war. It not only hampers development, but reverses it by destroying productive capacity, by decimating the most productive and by increasing the burdens of those caring for the sick and orphaned. AIDS is wiping out decades of investment in education and in human resources. Even rich countries would be hard-pressed to cope and care, to provide the treatments they now offer, if their infection rates were similar to those in the world’s most affected regions. As AIDS reduces the capacity of the body politic to respond to its challenges, the capacity to cope may be overwhelmed.

Lesson 4. HIV/AIDS is not only a disease, it is a development disaster.

HIV/AIDS is the most paradoxical of pandemics. The greatest global killer is a virus that is not particularly contagious. Many common infectious diseases like flu, measles or mumps are highly contagious. Simple proximity to someone infected by one of these diseases may be sufficient to transfer the infection. Getting infected by HIV is much
more difficult. Everyday social interaction with and care for the infected is safe. Moreover, for those at risk of contracting the virus through unsafe sex or drug abuse for example, many can choose not to be infected if they know how transmission takes place.

Lesson 5. The greatest killer pandemic in modern history is due to a virus not particularly contagious.

There are clearly problems however. First, most of those infected by the disease do not know it. They have not been tested for HIV either because there is no medical service to do it, or because there are few tangible incentives to be tested as long as there is no treatment available, or because of the social stigma associated with being infected. The nature of the disease itself inhibits discovery, for the incubation period between infection and its manifestations is long, and since there may be no outward signs of disease, those infected and those around them are unaware of their status.

Second, most of those affected by or exposed to the virus do not know what the disease is. Even in the most advanced education systems children learn little about infections or viruses during their first five years of schooling. But most of those exposed to the virus in the developing world do not have even five years of education. The billion people in the world who are illiterate do not readily have access to adequate information. Among literate populations many more are scientifically illiterate – including many teachers.

Third, in many communities beliefs about the disease and its transmission are misinformed. Actions taken to escape infection or to attempt cures can be misguided, counterproductive for the infected, and destructive for others. Misconceptions, beliefs and customs lead many to use ineffective or damaging preparations, or resort to sexual practices involving innocent children.
Fourth, *misconceptions lead to prejudice, discrimination and exclusion*. Political and social silence has already resulted in soaring prevalence rates. Faulty knowledge has resulted in careless behaviour. Lack of knowledge has led to further spread of the disease and lack of appropriate care for those who are infected – and to stigmatization that turns those infected, and those who care for them, into outcasts. The silence, stigma and denial that accompany HIV and AIDS hasten death.

The uneven infection rates worldwide are in no small part due to uneven distribution of knowledge.

**Lesson 6. Inadequate or flawed knowledge is a major reason why the pandemic is out of control.**

*The need for intensive and extensive education about HIV and AIDS flows from the ignorance associated with the pandemic, particularly in high-risk developing countries.*

There are millions who, although they know about the virus and the risks associated with it, do not adopt safer practices. They either close their eyes to the risks, or make themselves susceptible to infection with their eyes wide open. In wealthy countries, exposed groups have sometimes reverted to unsafe practices thinking mistakenly that drug treatments can now keep them alive indefinitely. Prevention programmes must address such behaviours and the social cultures within which they are embedded in order to generate the attitudes, provide the skills, and sustain the motivation necessary for changing behaviour and reducing risk and vulnerability.

Changing conceptions and attitudes requires effective communication – knowing the audience, targeting the message, and getting it across. The validity of the message is essential. But what is
understood and absorbed depends not only on its scientific soundness, but also on the frame of reference within which it is interpreted. Comprehension and appreciation depend on many social and economic factors such as age, gender, status, educational attainment and access to learning, economic well-being, and cultural and religious beliefs. Messages must be customized to recipients, taking cognizance of the understanding they already possess and the material context and social environment in which they live. The essential thing is that those who hear the message must grasp it, act on it and pass it on.

If the knowledge, attitudes and skills transmitted are not culturally adapted, preventive programmes can be undercut and defied by traditional creeds and customary ways of life. Precepts and practices embedded in local mores are further reinforced by comprehensive systems of behaviour and thinking. They are buttressed by norms of propriety, customs of marriage and religious beliefs. All of these may serve to sustain silence surrounding HIV/AIDS, its causes and its consequences.

Communities and cultures interact with the epidemic and undergo changes from this interaction in a complex set of circumstances. HIV/AIDS-prevention programmes must not only take account of the social context in which the pandemic is rolling out, but also keep pace with the social and cultural changes occasioned by the dynamic of the pandemic itself.

Lesson 7. Knowledge is not enough to change behaviour.

If HIV/AIDS education is to be effective, the specifics of the social and cultural context within which communication takes place must be taken into account. Social context is not just an encumbrance but a potential resource. Yet, as Kofi Annan has said, “All cultures will be pushed to put cultural mores aside to save lives”.

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There is no cure for HIV/AIDS. The virus can be held at bay and progression towards AIDS can be slowed. But treatments are still complex and costly, and least available where they are most desperately needed. Neither is any vaccine in sight although vaccination has provided protection against many other infectious diseases, from smallpox to polio. Vaccination against HIV, as for the common cold, is still only a hope. HIV-related treatments are still too costly and difficult to deliver in developing countries with high levels of poverty and infection, and low educational attainment levels and incomes. Change in behaviour can contain the spread of HIV/AIDS, and education is still the most effective vaccination against infection. In Brazil, Senegal, Thailand and Uganda, a combination of education, prevention measures, and medicines has led to some dramatic declines in HIV incidence.

**Lesson 8. Preventive education works.**

*If done right, it is effective. If done immediately, in the early stages of the onset of the disease in a community, it will have long-term impacts. If done massively – intensively and extensively – it can turn the tide.*

Given the sometimes forbidding cost of treatments, and the complexity of delivering them, a debate has arisen as to whether money should be directed (1) towards prevention and cutting down the number who will be infected; or (2) towards treatment to help those already infected to continue to play a role as parents and workers. Treatment can turn a deadly infection into a manageable, though admittedly problematic, chronic disease. There are three arguments for treating the infected:

- **The humanitarian argument:** We cannot allow millions to die. People have a right to treatment, help and care.
• The economic argument: Lack of treatment means loss of breadwinners, mothers and fathers, and expensively-trained and hard-to-replace professionals. The cost of replacing them, even if this were possible, is often greater than the cost of supplying the treatment.

• The incentive argument: If knowing one is HIV-positive makes one’s attitude to life negative, there is no incentive to change behaviour. Nor if it results in discrimination and stigma and little else, is there any use in being aware of one’s HIV status. Under such circumstances there is no point in knowing. Treatment provides hope for a longer life, a better life, for a productive life.

Lesson 9. There is no inherent conflict between prevention and treatment strategies.

Treatment is not only possible, it is imperative for it supplements and complements prevention campaigns to create a holistic approach to management of the pandemic.

The HIV/AIDS pandemic is not only dynamic, it is also exceptionally complex. One can argue that we are dealing with not just one country’s epidemic but a number of similar epidemics whose causes and contexts vary between countries and communities, and which together constitute a worldwide pandemic. The pandemic is driven in some places by intravenous drug users who must be approached in a different way from sex workers. Teenagers’ needs vary from country to country and between rural and urban areas. There is neither one silver bullet to stop infections nor one sharp shooter to do the job of halting this onslaught. This is a pandemic of such proportions, stretching out far into the future, that everyone must be involved. Contributions from all quarters are required: There is enough to do, and enough experience to be shared for the effort. Those involved must work closely with affected countries and
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communities, with civil society and NGOs, and with UNAIDS and its co-sponsors. Co-operation must be based on a clear division of labour and a focused commitment to tasks.

Lesson 10. **The response required is no single-point programme and no single-factor affair.**

The twentieth century was the most amazing in the history of human health. Never before have so many survived infancy, never have so many lived so long, never before have so many had such healthy lives. The devastations of many infectious diseases were reduced. Vaccines were invented. Treatments were improved. Enormous gains were made in reduced infant mortality and enhanced life expectancy. Many of the gains were achieved because of change outside the health sector, because of economic development, improved nutrition and sanitation, and increased access to education.

At the beginning of this new century we are facing the most devastating epidemic in human history. In less than two decades, HIV/AIDS has been transformed from a medical curiosity into an international humanitarian and development crisis which threatens to undo the dramatic improvements to life quality attained during the previous century.

The mobilization now taking place is unprecedented in the history of the United Nations. Twenty years after the disease was first identified, a global fund for HIV/AIDS, tuberculosis and malaria has been established. All members of the United Nations have been summoned to do their utmost to support those most severely affected. Non-governmental organizations have been called to action and many are already enlisted at national community levels. Private corporations and individual citizens are joining this great enterprise. All United Nations agencies have been enlisted to do their utmost where they can make the greatest difference.
UNESCO, as one of the co-sponsors of UNAIDS, has decided to focus its activities on five core tasks:

- advocacy at all levels, particularly to elicit unrelenting commitment from all who have authority in UNESCO’s areas of competence: education, science, culture, and communication;
- customizing the message to reach targeted audiences, particularly the young at risk, whether they are in school or not;
- changing risk behaviour and vulnerability by effective programmes that can reach all, particularly those most exposed, vulnerable and at risk;
- caring for the affected and infected by supporting affordable treatments and providing information to reduce stigma and trauma;
- coping with the impact of HIV/AIDS and in particular protecting the core functions of systems and institutions, notably within the field of education.

Much is still not known about the HIV/AIDS pandemic. Much remains to be learned and our understanding in many respects remains deeply flawed. But enough is known to act. We know we must act immediately, decisively and massively – to offer treatment, provide care and maintain the viability of governments and our institutions. At the same time, we must respect the human rights of all.

Above all we must do our utmost to stop the spread of the epidemic through programmes for preventive education that reach all, and particularly those most at risk. There is no time to be lost. There are no lives not worth saving. Now is the time to set aside complacency, and to opt for compassion and care. Now is the time not for hesitation, but for action.
I pledge the full support of UNESCO where it can make the greatest difference. This global organization will mobilize all its sectors for effective preventive education targeted at all those at risk around the world. A coherent overall strategy is crucial, for the critical test of UNESCO’s efforts will be the measurable impact of its efforts in the most infected countries, in the most affected communities, and for the most vulnerable groups.

Not acting now, on the basis of what we know, would be a moral failure of unprecedented proportions. Every moment lost can only be counted in terms of increasing misery and more deaths. We must act together – urgently and decisively.
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