

Education in the context of HIV and AIDS

**Training teachers
in an HIV and AIDS context:
Experiences from Ethiopia,
Kenya, Uganda and Zambia**

**Charles Nzioka
Lucinda Ramos**

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Charles Nzioka
Lucinda Ramos

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LIST OF ABBREVIATIONS AND ACRONYMS

ACP	AIDS Control Programme
ACU	AIDS Control Unit
AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
BCC	Behaviour change communication
CE	Colleges of education
CHE	Commission for Higher Education
EFA	Education for All
EMIS	Educational management information system
FBO	Faith-based organization
FDRE	Federal Democratic Republic of Ethiopia
FGAE	Family Guidance Association of Ethiopia
FGD	Focus group discussion
HAART	Highly active antiretroviral therapy
HAPCO	HIV and AIDS prevention and control office
HASP	HIV/AIDS Sensitization Programme
HIV	Human Immunodeficiency Virus
ICT	Information, communication and technology
IEC	Information, education and communication
IICBA	International Institute for Capacity Building in Africa
IIEP	International Institute for Educational Planning
KENEPOTE	Kenya National Association of Positive Teachers
KESSP	Kenya Education Sector Support Programme
KIE	Kenya Institute of Education
KNUT	Kenya National Union of Teachers
KUPPET	Kenya Union of Post-Primary Teachers
MDG	Millennium Development Goal
MoE	Ministry of Education
MoES	Ministry of Education and Sports
NACC	National AIDS Control Council
NASCOP	National AIDS and STDs Control Programme
NGO	Non-governmental organization
NTC	National teachers college

List of abbreviations and acronyms

PIASCY	Presidential Initiative on AIDS Strategy for Communicating to Youth
PLWHA	People living with HIV and AIDS
PTC	Primary Teacher College
PTTC	Primary teacher training college
STD	Sexually transmitted disease
STI	Sexually transmitted infection
SPRINT	School Programme of In-Service of the Term
TEI	Teacher education institutions
TSC	Teachers Service Commission
TTC	Teacher-training college
UAC	Uganda National AIDS Commission
UNAIDS	Joint United Nations Program on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UPE	Universal primary education
VCT	Voluntary counselling and testing

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EXECUTIVE SUMMARY

Under UNESCO's strategy for greater involvement by its education sector in combating the spread of HIV and AIDS, the Paris-based International Institute for Educational Planning (IIEP) launched, in conjunction with the UNESCO International Institute for Capacity Building in Africa (IICBA), three studies to analyze the responses of teacher-training colleges (TTCs) to HIV and AIDS in Kenya, Uganda and Ethiopia. In parallel, the UNESCO Regional Office for Education (BREDA) in Dakar conducted a similar study in Zambia. These studies examined how teacher-training colleges deal with the challenges of HIV and AIDS.

The studies explored how ministries of education and teacher-training colleges and institutions have developed (or not) policy and programmatic interventions in response to HIV and AIDS. The studies' results will be used as an entry point to create regional inter-country information networks on better and more effective responses to HIV and AIDS in teacher-training colleges.

Methodologies

The flexible study design encompassed an interpretative and qualitative strategy. Using a case study approach allowed for examination of current policies and practices relating to HIV and AIDS in teacher-training colleges. Data collection took place in two phases. The initial phase reviewed existing literature on HIV and AIDS within the education sector and in teacher-training colleges and institutions. This entailed an Internet search covering institutional websites, online databases and clearinghouses. The UNESCO HIV and AIDS Impact on Education Clearinghouse and other relevant websites, as well as teacher-training colleges' HIV and AIDS policies, action and/or strategic plans and other institution-based surveys and reports were reviewed. The review of existing literature was important in identifying critical knowledge and research gaps. Additional data were obtained through interviews with key ministry of education officials, college

administrators and HIV and AIDS focal persons. These preliminary interviews validated and filled in gaps identified in the document review.

In the second phase, primary data were obtained at the institutional level through in-depth interviews with principals, deputy principals, heads of departments, selected academic staff, counsellors, HIV and AIDS focal points, nurses, selected trainees, and support staff. Extra data were obtained through separate female and male focus group discussions (FGDs) with selected teacher trainees in the institutions sampled.

The teacher-training colleges covered in these studies are kept anonymous for ethical reasons; but it can be revealed that they included three colleges in Kenya, one in Zambia, three in Ethiopia and one teacher-training college and a public university in Uganda. The detailed characteristics of the colleges are provided in *Chapter III*.

Key findings

Education sector policy response to HIV and AIDS

Kenya, Uganda and Zambia had explicit education sector policies to deal with HIV and AIDS. Kenya's policy was developed in 2004; Uganda formulated its first draft in 2001; and Zambia in 2005. Ethiopia did not have such a policy, but teacher-training colleges had operational policies derived from the broader national HIV and AIDS strategic framework. In all countries surveyed, ministries of education had designated one or more of their staff to serve as AIDS focal points. This structure was replicated at regional, district and institutional levels for most of the countries. Most HIV and AIDS focal points had other responsibilities, with HIV and AIDS education being an additional task to their principal responsibilities. In Ethiopia, the HIV and AIDS response structures are *ad hoc*, comprising mainly steering committees and technical groups. Even when structures are not *ad hoc* - as in Zambia, where two people work on HIV and AIDS in teaching and specialized services within the Ministry of Education - the structures tend to be far removed from national AIDS council activities, resulting in a lack of synergy between

the aforementioned and the Ministry of Education. It was reported that the lack of clear structures undermined the effectiveness of existing HIV and AIDS programmes in the education sector.

Institutional policy responses to HIV and AIDS

Only one college (in Kenya) had an institutional HIV and AIDS policy. Despite this, all the TTCs covered had in place some HIV and AIDS-related activities, operating in an *ad hoc* manner. The majority of institutions had HIV and AIDS focal persons, who carried out this role alongside their other responsibilities. Most institutions argued that HIV and AIDS constituted a minor problem that did not warrant full-time staff, or indicated they did not have money to support a full-time staff member to deal with HIV and AIDS.

Most of the institutions did not appear to have any budget for their HIV and AIDS activities. Such activities, particularly at the regional, district and institutional levels, appeared to be donor driven. While it was not easy to assess the level of local government support to HIV and AIDS activities in TTCs, it was clear that much of it came from non-governmental organizations (NGOs). This funding targeted institutional anti-AIDS clubs and related activities. However, this form of funding was *ad hoc* and its potential impact on the institutional response was difficult to gauge. Occasionally, as was the case in Kenya, the ministry of education would provide grants for training selected staff and students on HIV and AIDS. These staff and students would then be expected to train their peers, and through this cascading model it was hoped that as many staff and students as possible within the TTC would eventually benefit from this training. Much of the training provided in these TTCs focused on life skills, peer counselling and HIV prevention education. In the case of Zambia, HIV prevention education was mainstreamed into certain courses such as biology and geography, and no separate training was provided on HIV and AIDS. Trainees were also exposed to HIV prevention education in the one-day interactive methodologies class offered before undertaking their teaching practice in the field.

Shortage of adequately and competently trained personnel to deal with HIV and AIDS in the education sector was a common problem in all four countries. There was also a lack of strong leadership and commitment to tackle HIV and AIDS effectively at every level within the education sectors.

Only in Kenya had the ministry of education not organized any HIV and AIDS training for TTC staff and students. The training provided at specific levels was externally induced, and not tailor-made to fit the specific needs at each level as would be expected. Similarly, no HIV and AIDS training budgets were available in any of the countries. This implies a need for locally organized professional training courses in HIV and AIDS prevention education for education sector personnel, as well as for students.

Perceived magnitude of HIV infection and AIDS-related illnesses in TTCs

Most TTCs did not have their own HIV testing and surveillance systems in place. This made it difficult to gauge the prevalence and impact of HIV and AIDS on staff and students. Additionally, colleges had not conducted surveys or assessments on the impact of the epidemic on their operations and functioning. There was, however, anecdotal evidence to suggest that HIV and AIDS could have been a major source of attrition in some teacher-training colleges and institutions. Absenteeism and emotional and psychological stress were the most observable effects of the pandemic on college life. However, its impact seemed to affect the teaching staff the most through loss of qualified personnel and rare skills.

Risk factors

Factors accounting for HIV infection rates among staff and trainees appeared to be similar between and across TTCs and countries. Female students and non-teaching staff were perceived to be much more vulnerable to HIV infection than male trainees and teaching staff. A few factors accounted for the vulnerability of teacher trainees to HIV

infection: poverty or lack of money for fees and personal upkeep, peer pressure, a sudden newfound personal freedom, the persistent culture of having multiple sexual partners in TTCs, and sexual exploitation (mostly in the form of transactional sex) of female trainees by both staff and fellow male colleagues. Other factors said to contribute to the spread of HIV among trainees included inadequate information on HIV and AIDS, drug and substance abuse, lack of easy access to condoms, and the incapacity of female trainees to negotiate safe sex.

Impact of HIV and AIDS on functions and operations of TTCs

Staff illness and deaths were reported to lead to increased workload for other staff, diversion of resources from academic programmes for burial/funeral expenses and for supporting ill and bereaved members of the teacher-training college community. HIV and AIDS deaths were said to lead to a reduction in staff and students' morale as they empathized with the infected and affected. In all the TTCs visited, the deaths of tutors disrupted teaching, especially if there was a shortage of trained staff in a particular subject or if the deceased was highly experienced and specialized. HIV and AIDS among trainees and their family members, including siblings, lead to difficulties in payment of fees and concentration on schoolwork. Resources typically earmarked for operational expenditures were diverted to support people living with HIV and AIDS (PLWHA) and the affected members of institutions, as well as to cover the high costs of treatment and the provision of a special diet for the infected. Socially, HIV and AIDS led to social tensions, discrimination and stigma, as well as fear and suspicion in social relationships.

TTCs' response to HIV and AIDS

Except for one college in Kenya, which had a college policy on HIV and AIDS, the other colleges were using a broad education sector policy. However, most teacher-training colleges did report having an AIDS Control Unit (ACU). The purpose of these ACUs was

to plan and co-ordinate the TTC's response to HIV and AIDS, which most often included, according to the ACUs, student and staff peer education programmes, counselling groups, and linkages with other organizations. The results of the ACUs' initiatives appeared rather mixed. Most teacher-training colleges were reportedly employing various means, such as working with clubs and societies and using creative arts, institution-distributed HIV and AIDS materials, external speakers or personnel, video and film, educational talks, suggestion boxes, and designated days for HIV and AIDS awareness and sensitization in institutions.

TTCs did report engagements in community outreach programmes. These programmes would often use creative arts to disseminate information or infuse information into religious messages and invite surrounding communities to college functions on the theme of HIV and AIDS, and arrange visits to neighbouring schools. Except for one TTC in Ethiopia, TTCs in all the other countries did report possessing counselling programmes. All TTCs studied had tried to integrate HIV and AIDS into most subjects with varying degrees of success. Kenya, Uganda and Zambia reported commendable progress in that direction. With financial support from the Ministry of Education, all TTCs in Kenya provided training for tutors and student trainees in HIV and AIDS. In Zambia, Ethiopia and Uganda however, most TTCs had not trained tutors in HIV and AIDS. In most cases, any form of HIV and AIDS training in the TTCs for tutors and students was provided by local or international NGOs.

The capacity of health facilities in TTCs to manage opportunistic infections and sexually-transmitted diseases had improved with appropriate training of the TTC health personnel. In one college in Kenya, infected students were getting special diets. Other colleges organized college open days and offered mobile voluntary counselling and testing services. Anti-retroviral treatment was not available in any of the colleges studied. Condom distribution appeared to be hampered by lack of clear policy direction, except in Zambia where the government was reported to be promoting condom use in TTCs.

Major challenges

One of the primary impacts of the epidemic is that it magnifies existing systemic problems within the education sector. These studies consistently highlighted systemic problems in national teacher preparation and development.

The major challenges found to inhibit the effective response of TTCs to HIV and AIDS were:

- limitations in financial resources to support HIV and AIDS activities in the TTCs;
- lack of training and skills among TTC staff and students;
- lack of HIV and AIDS teaching and learning materials;
- excessive teaching workload;
- lack of HIV testing equipment and adequately trained health personnel to deal with HIV and AIDS;
- lack of a clear policy on condom promotion within colleges;
- institutional silence on HIV and AIDS;
- lack of strict sanctions for teacher-student sexual relationships;
- lack of a workplace policy on HIV and AIDS in TTCs.

Policy and programmatic recommendations

- Only one TTC surveyed (in Kenya) had any institutional policies or strategic plans on HIV and AIDS. All should be encouraged to develop such policies. Where this may not be feasible, either due to technical or financial constraints, they could be encouraged to adapt, customize and implement an existing education sector HIV and AIDS policy.
- Ministries of education should allocate more resources to HIV and AIDS initiatives in TTCs while also encouraging and supporting TTCs to mobilize their own resources for such programmes. This could be done by taking stock of programmes at other colleges and by channelling support to colleges in more disadvantaged positions.
- TTCs should be encouraged to conduct internal HIV and AIDS impact assessments. This would enable them to ascertain the level to which

HIV and AIDS are adversely affecting their functions, activities and resources.

- Since there are currently no established indicators for monitoring and evaluating HIV and AIDS programmes in TTCs, ministries of education should assist in developing such indicators, and encourage TTCs to use them.
- Ministries of education should also conduct periodic external monitoring and evaluation of each TTC's HIV and AIDS programmes to identify 'good lessons' and share such lessons with similar TTCs in the country.
- There is a need for more capacity building in most TTCs studied. College administrators, including principals and focal points on HIV and AIDS, need more training in programme development, planning, and leadership and management, while college teaching staff need training in how to integrate HIV and AIDS prevention education into the curriculum, and in more participatory teaching methods. Student trainees also need skills in effective teaching of HIV and AIDS, especially to young people. Tutors noted that AIDS education is a subject that requires a lot of time and commitment since the information taught is not limited only to the classroom. Rather, it touches on the lives of the students and teachers outside of the classroom, and even the community in which they reside.
- TTC HIV and AIDS response structures should adopt a representative and participatory approach to ensure optimal involvement of both staff and trainees in HIV and AIDS-related activities and programmes. The involvement of people openly living with the virus should also be encouraged.
- Ministries of education should consider giving exams on HIV and AIDS content in TTCs. Such a requirement would help students and lecturers alike to take HIV and AIDS seriously, and encourage the colleges to provide updated curriculum materials. HIV and AIDS reading materials could be developed through students' and teachers' joint initiatives.
- Ministries of education need to make more information, education and communication (IEC) materials on HIV and AIDS available to

TTCs while also encouraging TTCs to be much more innovative and develop their own tailor-made materials. The use of electronic-based interactive methods like the Internet could be encouraged.

- Most college administrators are reluctant to make condoms available to trainees for fear of being perceived to be promoting immorality and sexual promiscuity among students. Ministries of education therefore need to come up with explicit policy directions and guidelines on how to promote safer sex practices in TTCs as a way of protecting student trainees from the risks of unwanted pregnancies and contracting sexually transmitted infections (STIs), including HIV.
- The ILO/UNESCO HIV and AIDS workplace policies for the education sector need to be adapted in all countries, and TTCs (as workplaces) need to adapt the policy for their own use. Sanctions should also be put in place, as well as a zero tolerance approach to transactional sex between lecturers/tutors and their students. Gender-based violence and abuse of power among students and by those in authority in TTCs need to be addressed. If future teachers are witnessing such behaviours during their preparation years, then what kind of behaviour can we expect from them as teachers?
- Ministries of education need to promote guidance and counselling in TTCs, which should emphasize peer counselling and life skills education to address the problems young people face, such as drug and substance abuse and HIV and AIDS. TTCs need to create and facilitate positive peer group norms where male and female students respect each other.
- TTC health clinics should be equipped with qualified staff and referral networks established with other health institutions around the TTC. This will allow TTCs to outsource particular competencies in which they may be deficient.
- TTCs should foster linkages with clinics and NGOs operating within their vicinity to provide staff and students with access to such services as free antiretroviral therapy (ART), voluntary counselling and testing (VCT).

- TTCs should also collaborate with NGOs whose particular experiences and specialities would be beneficial in increasing TTCs' internal capacities to deal with HIV and AIDS. For example, in Uganda, the national teachers colleges can approach the AIDS support organization (TASO) and the Uganda AIDS Information Centre for assistance in VCT, ART and support for PLWHA. In Kenya, organizations such as the Kenya National Association of Positive Teachers (KENEPOTE) and the Kenya Association of Professional Counsellors (KAPC) could be useful in providing similar services.
- TTCs need to establish more institutionally-based care, support and treatment programmes for affected or infected staff and students.

Recommendations for further research

- More research needs be done to assess the perceived effectiveness of TTC graduates in the teaching of HIV and AIDS prevention in schools. Data from such research would feed back into HIV and AIDS training at the TTCs.
- Following these studies, further research should be conducted to assess the progress made at institutional and central levels.

I. BACKGROUND

Sub-Saharan Africa contains just over 10 per cent of the world's population, but is home to two-thirds of the estimated 42 million people living with HIV and AIDS (UNAIDS, 2004). Of these, 10 million are young people aged 15-24 years and 3 million are children aged less than 15 years. Many African countries have a generalized epidemic, which means that HIV has spread throughout the general population, rather than a fixed socio-sexual category (UNAIDS, 2004).

The extent of the AIDS crisis is only now becoming clear in many African countries, as increasing numbers of people with HIV are becoming ill. In the absence of mass prevention, treatment and care efforts, the HIV and AIDS-related death toll in sub-Saharan Africa is expected to continue to rise. The negative impact of HIV and AIDS will be felt most strongly in the course of the next 10 years and beyond. The social and economic consequences of HIV and AIDS are already widely felt in the health sector as well as in education, industry, agriculture, transport, human resources, and the economy in general.

In some of the heavily impacted countries, HIV and AIDS are undermining the capacity of education systems to function optimally. HIV and AIDS are reducing demand for, and inhibiting access to education by undermining institutional capacities, reducing the availability of financial resources for education and compromising the quality of education. Within the education sector, HIV and AIDS are now a major cause of morbidity and mortality among teachers. Realizing this, the International Institute for Educational Planning (IIEP) launched a four-study project in 2006 to examine the responses of teacher-training centres to HIV and AIDS. The current studies follow the same framework. The Uganda study, which began much earlier in 2003, adopted a case study approach covering one national university and one national teacher college (NTC). The case study was designed to gain an in-depth understanding of the impact of HIV and AIDS in Uganda and the responses of the country's higher education institutions. This

led to a broader, more comprehensive survey of the responses of the remaining 58 higher education institutions to validate the original findings of the case study, and to gain a general overview of how higher education institutions in Uganda have responded to HIV and AIDS.

Using the same framework, in 2006, IIEP expanded the project to cover three TTCs in Kenya, and, in liaison with the International Institute for Capacity Building in Africa (IICBA), conducted a similar study covering three TTCs in Ethiopia, while the Africa Regional Office on Education (BREDA) conducted a similar study in Zambia. All these studies shared common research tools to take stock of the responses of TTCs to HIV and AIDS. The results have been compiled by IIEP/BREDA into this synthesis report.

1. Objectives of the studies

The broad objective was to document the experiences of TTCs in dealing with HIV and AIDS. More specifically, these case studies aimed at examining the real and perceived impact of HIV and AIDS on students and staff; the degree to which these colleges have established HIV and AIDS policies and response structures and mainstreamed HIV and AIDS and life skills education, including their integration into the curriculum; and whether these have created an enabling environment for an effective response to HIV and AIDS. Other aims included examining the level to which TTCs have adapted human resource policies to mitigate the impacts of HIV and AIDS; initiated and implemented workplace programmes; responded to the needs of the affected and infected; and developed partnerships in response to HIV and AIDS.

2. Why focus on teacher training in HIV and AIDS?

Teachers constitute the largest proportion of civil servants in most countries and enjoy the widest possible geographical distribution, ranging from capital cities to the most remote rural village settings. This wide national geographical teacher distribution provides a potential countrywide network for reaching out to huge segments of the national population with HIV and AIDS messages.

Since teachers spend considerable time with young people in their formative years, they can make a lasting, positive influence on a young person's character and personality, during a time of rapid physical, emotional and social development. Teachers are, therefore, increasingly being asked to teach HIV and AIDS education and life skills, as they can be effective communicators of HIV and AIDS prevention education to young people and can substitute for inadequacies in traditional and parental sex education related to HIV. They are also expected to provide care and support to students affected by the epidemic, to act as counsellors to orphaned and vulnerable children, and "are often the advisors, the elders, the leaders and among the most educated people in the village" (Kimani, Kiragu and Mannathoko, 2006: 11).

Teachers are also influential people in their local communities at large; they have power in the community as well as in the school. Consequently, they play an essential role in ensuring an effective response to HIV and AIDS. They can act as credible role models for good practice in promoting responsible behaviour and a healthy lifestyle; advocate for tolerance in an environment where stigma and discrimination prevail; and have the potential to be change agents, assisting in reversing the high incidence of HIV infection among young people within the teaching fraternity and within the local community, as well as providing care and support for people living with HIV and AIDS.

However, just as views on the roles of teachers are culturally and socially embedded, so are barriers to mitigating the disease, such as silence, shame, stigma and discrimination. A teacher needs to be prepared as a professional decision-maker, and must understand and respond to the personal, social, cultural and political context in which the students live. The professional competencies teachers must develop to deal effectively with the epidemic in their professional roles should be acquired in TTCs.

Teachers can also be conduits for spreading HIV in schools and local communities. For example, in rural areas in particular, despite low salaries, they are comparatively wealthy and have a steady income (Kimani *et al.*, 2006: 11), which allegedly leads to sexual exploitation

of students in exchange for better grades or less punishment. Although such behaviour has a higher occurrence among male teachers – who, it has been reported, sometimes intimidate girls’ parents and family members who might question such relationships – some cases have been reported of female teachers approaching male students (Omale, 2000). Students in Kenya are reported to have coined the term STD – ‘sexually transmitted degrees’ or ‘diplomas’, obtained through sex-for-grade arrangements between lecturers and students (see Kimani *et al.*, 2006: 11).

It is imperative that teachers fulfil their role as change agents in society and that they assume their critical role in turning the current tide of HIV and AIDS. Adequately trained teachers can be instrumental in enhancing HIV and AIDS awareness, in addressing social and cultural practices that promote unsafe behaviours, and in the delivery of effective life skills education. To do this, such teachers need adequate skills and training; teachers not trained in HIV and AIDS are highly uninformed and unable to answer students’ questions about HIV and AIDS comfortably and accurately. However, trained teachers bring their newfound knowledge, zeal, passion and participatory learning strategies to the classroom when teaching about HIV and AIDS (USAID, 2007).

Given the critical role of TTCs in teacher formation and in imparting appropriate skills to enable teachers to become effective resource persons and communicators of HIV and AIDS issues, they are given the responsibility of enhancing HIV and AIDS awareness, effecting positive behaviour change among teacher trainees, strengthening the capacity of teachers to deliver the HIV and AIDS curriculum, and reinforcing responsible behaviour among trainees. In this context, these studies have sought to examine *inter alia* how TTCs have developed their responses to HIV and AIDS in Ethiopia, Kenya, Uganda and Zambia, and how they impart knowledge and communication skills to teacher trainees.

3. Specific objectives

The specific objectives of these studies were to:

- identify the impact of HIV and AIDS on the staff and trainees in the selected TTCs;
- identify the existence of institutional policies, structures, action plans, programmes and strategies for addressing HIV and AIDS within the selected TTCs;
- monitor the extent to which these strategies are implemented and the obstacles encountered;
- document the role of different types of management and institutional leaderships in organizing different strategies for responding to the challenges of HIV and AIDS;
- recommend strategies that would help TTCs mitigate the impact of the epidemic and enhance HIV and AIDS awareness among staff and teacher trainees.

The results should assist in the development of policies and training programmes that enhance the capacities of TTCs to respond more effectively to the challenges of HIV and AIDS.

II. LITERATURE REVIEW

The international community is increasingly recognizing the urgent need to focus on HIV and AIDS in order to facilitate the achievement of Education for All (EFA) and the Millennium Development Goals (MDGs) by 2015.

An accelerated education sector response to HIV and AIDS is particularly necessary in sub-Saharan Africa, which is home to 70 per cent of all the HIV and AIDS cases in the world, and where the epidemic threatens to reverse many of the developmental gains made in the social and economic sectors in the recent past. Strong national and sectoral foundations for action constitute the springboard for an effective response to HIV and AIDS, which affect mostly the economically powerless and uneducated people. A vibrant and efficient education sector delivering quality education constitutes a first major step in the response to HIV and AIDS. However, such an education system can only come about if a country has well-articulated national and sectoral policies and strategies on HIV and AIDS. These studies build on the hypothesis that the education sector's capacity to respond to HIV and AIDS is dependant on the way national policies are structured, organized and implemented.

Existing evidence, however, suggests that most HIV and AIDS interventions in school systems tend to focus on learners only; and few, if any, programmes equip teachers to deliver HIV and AIDS education (Akoulouze, Rugalema and Khanye, 2001). Although, according to the Report of the Education Sector Global HIV/AIDS Readiness Survey 2004 (UNAIDS-IATT/HEARD, 2006), 78 per cent of high and 68 per cent of low prevalence countries indicated that HIV and AIDS and life skills were essential components of their teacher-training programmes, even though the training offered was neither long-term nor systematic. Teachers reported difficulties in addressing HIV and AIDS in the classroom. Given the sensitivity of the issue, the apparent

lack of skills of teachers on how to teach HIV and AIDS appeared to pressure teachers into limiting themselves to the transfer of knowledge rather than imparting skills that could result in behaviour change (Education International, 2006: 3). Education International recognizes that the real value of HIV and AIDS education lies beyond the transfer of knowledge. Life skills should be an integral part of teacher training so that teachers are able to pass on crucial competences and not just facts and data on HIV and AIDS (Education International, 2006). Furthermore, the ability to communicate, make decisions, assert oneself, and cope with stress are critical elements to be included in HIV and AIDS education programmes (Education International, 2006). Yet the Global HIV/AIDS Readiness Survey mentioned above found that only in three out of 18 countries did ministries of education make systematic attempts to train teachers in HIV and AIDS prevention education (UNAIDS-IATT/HEARD, 2006). Education International (2005) similarly found that only one of nine countries was offering adequate pre- and in-service training of both primary and secondary school teachers. In most countries, the training of teachers in HIV and AIDS is too short, is of inadequate scale and reach, and the approach to teaching it is neither comprehensive nor systematic.

1. Demand for teachers

Teacher shortages continue to hamper the attainment of EFA by 2015. At least 4 million teachers worldwide are needed between now and 2015 in order to meet the EFA goals. Across all regions (sub-Saharan Africa, Arab States and West Asia), some 76 countries must expand their teaching forces by an additional 2.7 million teachers, with 1.6 million being for sub-Saharan Africa alone (UNESCO, 2006*b*). Currently, the average primary school class in low-income countries has a 60:1 student-teacher ratio, as opposed to the 40:1 suggested ratio upheld by the World Bank and other international organizations (Herz and Sperling, 2004). About 24 million additional pupils will join primary schools by 2015, raising the total figure from 113 million to 137.6 (UNESCO, 2006*b*). It is estimated that in sub-Saharan Africa alone, at least 1.6 million additional teachers are needed to enable governments

to provide universal access to primary education (UNESCO, 2006*b*; Education International, 2006).

Education is a sector that depends on its human resources. The effects of HIV and AIDS on educational personnel can be severe. Infected teachers are often able to teach during periods of good health but are absent during periods of illness, which tend to be more frequent and last longer towards the terminal stages of AIDS (UNESCO, 2002). The World Bank estimates that an infected teacher is likely to be unable to teach for a total of 260 days before dying of an AIDS-related illness. Teacher absenteeism from work could be further aggravated by having to care for sick relatives and attend burials and funerals. HIV and AIDS can worsen a situation where the shortage of qualified and experienced teachers is still a major obstacle to the attainment of the EFA goals.

The realization that HIV and AIDS are a major obstacle to the attainment of EFA – particularly in highly-impacted, less-developed countries – invariably suggests that efforts aimed at achieving the EFA goals of universal primary education (UPE) need to be linked to *inter alia* interventions that address HIV and AIDS and target teachers as well as learners.

Another study in South Africa found that 21 per cent of teachers aged 25-34 are living with HIV (UNAIDS, 2006). Tanzania has estimated that it needs around 45,000 additional teachers to make up for those who have died or left work because of HIV and AIDS. The Tanzanian Government recently revealed that the education sector is in danger of losing more than 27,000 new teachers to AIDS-related illnesses by 2020 (Plusnews, 2006). This report noted that if HIV infection and prevalence were to remain at the current level, 14,460 primary school teachers would die in the next four years, averaging close to 3,600 teachers per year. This would seriously undermine the provision of UPE because the country has a capacity to train only 1,200 teachers annually (Plusnews, 2006). The greatest proportion of staff that have been lost, according to the Tanzania Teachers' Union, were experienced staff between the ages of 41 and 50 (UNAIDS, 2006).

In Kenya, anecdotal evidence indicates that HIV and AIDS undermine the effectiveness of the education sector by increasing teachers' death and attrition rates. The Teachers Service Commission reported that the number of teacher deaths rose from 450 in 1995 to 1,400 in 1999; the most plausible explanation for this sudden rise in teacher mortality has been AIDS. A survey in four districts in Kenya found that in Kisumu, the district most affected by HIV and AIDS, the primary teacher attrition rate had risen from 1 per cent in 1998 to around 5 per cent in 1999 and had remained at that level since. At that rate, a quarter of the teaching force would disappear within five years. While it is difficult to say how many deaths are AIDS-related, most are occurring in districts with high HIV prevalence rates, supporting the hypothesis that AIDS is a major cause of mortality (Carr-Hill, 2002).

A study by Kelly (2000) on the impact of HIV and AIDS on teachers and teaching in Zambia concluded that in 1998, the loss of life among teachers in Zambia equalled two thirds of the teacher output of that year, and an estimated 20 per cent of all teachers were HIV-positive in 1997. The Ministry of Education (MOE) in Zambia reported 680 teacher deaths in 1996 and 1,300 during the first 10 months of 1998 (see Husain and Badcock-Walters, 2002: 92).

Data are scarce on the impact of HIV and AIDS on teachers in Ethiopia, but projections suggest that 10,000 teachers may be HIV-positive and one fifth of the teacher attrition may be due to AIDS (see www.avert.org/aidsimpact.htm). Projections, however, show that the Ethiopian Government will require a 16 per cent annual increase in the recruitment of teachers to sustain a quality education provision. Rural posting of teachers is becoming more difficult because teachers need to be near health facilities and many teachers are being lost to other sectors that also experience AIDS mortality.

A relatively high proportion of staff is affected by the demands and stresses of death and illness in their family and community. They are also affected by the fear or knowledge of their own serostatus (Bennell, 2005). Teacher performance and absenteeism must, as a result, be

understood within the wider context of the community and teachers' lives, and not simply in terms of teacher morbidity and mortality data.

Teachers who are affected by HIV and AIDS are likely to take increasing periods of time off work. Those with sick families may also take time off to attend funerals or to care for sick or dying relatives, and further absenteeism may occur from the psychological effects of the epidemic. When a teacher falls ill, the class may be taken on by another teacher, may be combined with another class, or may be left untaught. Even when there is a sufficient supply of teachers to replace losses, the impact on the students can be significant. This is particularly preoccupying given the important role that teachers can play in the response to AIDS, such as in helping orphans and vulnerable children adjust to schooling. A teacher's attitude can do much towards acceptance or rejection, and stigmatization of an orphan in a classroom. Teachers can also assist in recognizing behavioural problems associated with unsolved grief.

The illness or death of teachers is especially devastating in rural areas where schools depend heavily on one or two teachers. Moreover, skilled teachers are not easily replaced.

2. Teacher costs

HIV and AIDS are also leading to increased teacher costs. Most teachers are civil servants, and under civil service regulations, these teachers are entitled to paid sick leave if taken ill. As more teachers are affected and infected by HIV and AIDS, this results in a large number of persons on the payroll providing little or no service. The financial costs of replacements, both in the short term, through the hiring of part-time substitutes, and in the long term, through the training of additional teachers, is phenomenal.

3. Management capacity and costs of education

In addition, increased absenteeism by teachers and other education sector staff who become ill or have to take care of sick relatives and attend funerals will increase the overall costs for ministries of education.

There will also be other costs to bear, such as costs relating to death benefits, training new teachers, adopting curricula to address HIV and AIDS prevention, and producing teaching materials on HIV and AIDS for education institutions in the country (Bakilana, Bundy, Brown and Fredriksen, 2005; Carr-Hill, Katabaro, Katahoire and Oulai, 2002).

4. Teachers in HIV and AIDS education

Teachers play a key role in developing skills and changing attitudes, and if properly trained can help mitigate HIV infection among young people. Without capacity building of HIV prevention education in TTCs and universities, where future teachers are produced, it is unlikely that the world community will attain the EFA goals by 2015.

Teachers can be instrumental in the delivery of HIV and AIDS education. However, studies tend to show that teachers are reluctant to teach condom use to young people (Kinsman *et al.*, 2001; Gallant and Maticka-Tyndale, 2004). An observation made by one of the researchers in the Zambian study was that tutors/lecturers appeared to focus more on the biomedical aspects of HIV and AIDS, including its modes of transmission. The lecturers, not unlike anyone else, experience personal inhibitions in talking about sexual matters and condoms in particular. In some communities, women, regardless of whether or not they are teachers, may not talk about sex in public without being denounced by the community. One revealing example of the existing socio-cultural barrier was following a demonstration in which both female and male condoms were passed around the student teachers: several of the students did not want to examine them closely or even touch them. The researcher's conclusion was that if a student teacher is expected to go out and teach the subject in primary or secondary schools and is ashamed of looking at or touching a condom, then they will inevitably experience difficulties in teaching the subject effectively (Ramos, forthcoming).

Teachers also deliberately shy away from teaching HIV and AIDS (Kelly, 2000). Teacher-training institutions should, however, make sure they develop and implement HIV and AIDS workplace policies.

Teachers should also participate in well-organized pre-service and in-service teacher training for HIV and AIDS education.

Some teacher-training institutions and universities in the Eastern and Southern Africa regions have succeeded in developing institutional and workplace policies on HIV and AIDS, integrating them into the curricula, and implementing training, support and counselling services for students and staff. Many of the teacher-training institutions and universities, however, have weak structures and training programmes. There is limited available information to date on HIV and AIDS pre-service teacher programmes for teachers in sub-Saharan Africa, and most of the information does not offer hard data on measuring such programmes for their effectiveness (UNESCO, 2006*d*). These institutions need to identify gaps in current programmes, and identify best practices; then, they require assistance in developing policies and implementation strategies.

Research shows that HIV and AIDS and sexual and reproductive health education in schools, if taught by adequately trained educators using appropriate teaching methodologies, can have positive health outcomes among students in both primary and secondary schools (Bennell, 2004; Schenker and Nyirenda, 2002). Teachers not adequately trained in HIV and AIDS, however, have trouble in teaching the subject because it touches on sexuality – a topic barely explicitly verbalized in most communities. In some communities, parents also feel uncomfortable talking about a sensitive subject like HIV and AIDS with their children. Such parents do, however, feel that the school is a trusted institution to teach it to their children (Boler, 2003*a*). Teacher education and training is, therefore, very critical in the development of effective responses in schools and among young people. Research demonstrates that teachers have the ability to influence social rules and patterns and challenge ways of thinking and responding to the epidemic (James-Traore, Finger, Ruland and Savariaud, 2004; Boler, 2003*b*). Research further shows that teachers are instrumental in the delivery of HIV and AIDS education. However, for teachers to be effective change agents, they need to be provided with the necessary content, appropriate instruction methods,

didactic aids, organizational skills and techniques to provide counselling and care.

Pre-service and in-service training are essential for teachers if curricula on sexual and reproductive health, including HIV and AIDS, are to be delivered effectively in primary and secondary schools. Given that most young people spend much of their time, especially in their formative years, in school with teachers, there is consensus that teachers and schools play a pivotal role in teaching young people about HIV and AIDS. The question though remains how can this best be achieved?

Studies have assessed the difficulties that teachers and students confront when teaching and learning about HIV and AIDS (Boler, 2003*b*). Other studies have been conducted on the impact of HIV on the teachers inside the classroom (Carr-Hill, 2002) and in schools in Botswana, Malawi and Uganda (Bennell, Hyde and Swainson, 2002). Some have revealed how teachers also lack commitment to teach HIV and AIDS education in an often over-crowded curriculum (Boler and Jellema, 2005).

These studies sought *inter alia* to identify the approaches taken by TTCs to prepare teacher trainees for the teaching of HIV and AIDS in schools.

5. The role of institutional leadership

Leadership is essential to organize HIV prevention and other HIV and AIDS activities at institutional level. According to Kelly and Bain (2003: 256), effective institutional leadership in HIV and AIDS implies:

- a strong belief and commitment to an AIDS-free institution;
- an authoritative strategic planning and policy development approach;
- commitment of resources to HIV and AIDS;
- establishment of the necessary implementation structures within an appropriate institutional framework;
- a sustained challenge to all forms of on-campus denial, stigma and discrimination, accompanied by steps to facilitate HIV openness;

- effort to ensure that every official of lesser rank implements institutional policies, strategies and interventions aimed to control HIV and mitigate its personal and institutional impacts; and
- a well-developed accountability arrangement to facilitate the identification of bottlenecks or sluggishness in the implementation of institutional plans for responding to HIV and AIDS.

The experiences of one college in Kenya demonstrated the need for the college to openly develop effective responses to protect these young people (Commission for Higher Education, 2004: 61-63). The college leadership realized that between January and March 2002, 69 per cent of students who were absent at different times were absent due to problems regarding fees, and 83 per cent of these had a sick close family member. In an internal survey, none of the students indicated the nature of their illnesses or that of their family members. A significant number of staff members also took compassionate leave to attend burials of close family members. Absenteeism adversely affected staff performance and students' academic achievement. Students' financial problems resulted in declines in college revenue and growth, and indebtedness to suppliers. In July/August 2002, 67 per cent of students indicated that the college health unit could barely meet their medical needs. The college nurse reported rising cases of STIs, with a majority of cases being female students.

Tutors lacked knowledge and relevant skills to pass on to trainees as well as to protect themselves. The college leadership strongly felt that through these initiatives, it needed to assist the government in its implementation of universal free primary education, which had led to a rise in enrolment of children in public primary schools from 5.8 million in 2003 to 7.3 million 2004. In September 2000, TTC 1 started its HIV/AIDS Sensitization Programme (HASP). This programme involved open discussions on HIV, sharing information on AIDS, sexuality, drug abuse, discrimination, stigmatization and health issues between staff and students. Seminars and workshops for staff and students were often organized with assistance from NGOs and other bodies.

In 2003, the college, with assistance from an external donor, developed an institutional policy to strengthen the ongoing activities of HASP. The policy helped the college to:

- plan and prioritize its programmes;
- formulate preventive education and control activities;
- collect and monitor data;
- implement effective interventions;
- monitor and evaluate the impact of mitigation;
- mobilize resources internally and externally; and
- collaborate with partners.

The college leadership felt that an institutional policy document gives legitimacy to internal decisions and actions taken to advance both HIV and AIDS prevention and advocacy (Ojuando, 2004a).

From the foregoing literature review, it is clear that HIV and AIDS are depleting the current stock of trained teachers in heavily impacted countries in the sub-Saharan region. This region is already experiencing teacher shortages and this is likely to impact most negatively on the supply and quality of education. Unless drastic steps are taken to counter the adverse effects of HIV and AIDS, the sub-Saharan Africa region, due to a teacher supply shortage, will not be able to meet the EFA goals and the MDGs by 2015.

In order to maintain the current supply of trained teachers, TTCs need to develop effective institutional responses for dealing with HIV and AIDS. However, the ways in which teacher colleges are organizing their responses to HIV and AIDS are still unclear and undocumented. This study sought to assess and document prevailing TTCs' institutional responses. It is expected that the results of this study will promote policy dialogue and assist TTCs in strengthening their responses to HIV and AIDS.

III. METHODOLOGY

The four countries studied were Ethiopia, Kenya, Uganda and Zambia. This chapter provides the country profiles and details of the research design, methods and forms of analysis.

1. Country profiles

Kenya occupies an area of 582,646 square kilometres and has a population of 32 million, of which 21 per cent are aged 10-19, and an annual growth rate of 2.6 per cent (Central Bureau of Statistics, Kenya; Ministry of Health, Kenya, and ORC Macro, 2004). The country has a national HIV and AIDS policy (Republic of Kenya, 1997), a national HIV and AIDS strategic plan 2000-2005 (National AIDS Control Council, 2000), and a national HIV and AIDS education sector policy (see also Republic of Kenya MoEST, 2004). It has an HIV prevalence rate of 6.7 per cent (UNAIDS, 2004).

Uganda is one of the few African countries where rates of HIV infection have declined most remarkably. The adult HIV infection rate dropped from around 15 per cent in the early 1990s to around 6.7 per cent by 2005 (UNAIDS, 2006).

In higher and tertiary education, there is no Ministry of Education and Sports (MoES)-led or guided HIV and AIDS response. Interventions are *ad hoc* and depend on initiatives by student leadership and NGOs through activities such as the 'health awareness week'. The teaching of HIV and AIDS was first introduced in primary teacher colleges' curricula in 1992. The curricula are now being reviewed with the aim of including all aspects of prevention, care and support, and mitigation of impact.

Under the Presidential Initiative on AIDS Strategy for Communicating to Youth (PIASCY), in-service teachers have been trained in HIV and AIDS. About 539 teacher development management system co-ordinators have been trained in order to train teachers on the job as part of school capacity building. At least three teachers per school have been trained in HIV education (a total of 45,000 primary school

teachers). Teachers have also been advised on how to refer difficult questions to the Straight Talk Foundation (a reputable and prominent youth sex[uality] education NGO); they are also taught how to use music, dance and drama for HIV education.

Ethiopia has an HIV prevalence rate of 4.4 per cent in its adult population. The highest infection rates are concentrated on the 15-24-year-old age category, and within this category, prevalence among females is three times greater than that among males (UNAIDS, 2004).

Zambia has an HIV prevalence rate of 16.5 per cent (UNAIDS, 2004) – 18 per cent female, 13 per cent male, with the majority in urban areas. The Zambian multi-sectoral response is guided by the National AIDS/STI/Tuberculosis Implementation Plan and can rely on provincial and district local government structures. Commitment is high but the implementation of comprehensive action plans is constrained by lack of human resources (UNAIDS, 2004).

The country has a national HIV and AIDS policy and a national HIV and AIDS strategic plan for the education sector. Currently, the country is developing an HIV and AIDS policy for basic teacher-training colleges of education (Ramos, forthcoming).

2. Choice of colleges

The selection of the colleges/institutions studied took account of each of the four countries' wide and diverse geographical characteristics, such as the rural-urban dichotomy, variations in social, economic and cultural lifestyles, and variations in HIV and AIDS incidence and prevalence rates. For example, in Kenya, one TTC in Nyanza Province represented a rural area with a high HIV prevalence with persistent strong cultural norms/traditions such as widow inheritance, which enhance the spread of HIV. Another training college, in the Coastal Province, represented a cosmopolitan urban area with high HIV prevalence heavily influenced by external factors such as tourism, but also an area with a strong Islamic influence. A college in Nairobi Province represented a training college with a formal HIV and AIDS

policy in a high HIV prevalence urban area that is also a melting pot of all cultures (see also Commission for Higher Education, 2004).

In **Uganda**, the national training college was chosen because it is located in a rural setting and is one of the oldest teacher colleges in Uganda - established in the 1970s. In **Ethiopia**, the three colleges/institutions selected represented three different geographical regions with varying HIV prevalence rates. In **Zambia**, the college studied was located in a high HIV prevalence province (18 per cent compared to the national average of 16.5 per cent). However, for ethical reasons, it was decided that the identities of the colleges chosen would be kept anonymous.

3. Methods of data collection

Triangulation, or the use of multiple methods of data collection, was utilized in all the studies to enrich the quality of data and enhance the validity and reliability of the findings. The methods of data collection included: document review and interviews at central level, observations, in-depth interviews at college level and focus group discussions. These methods were sequenced in such a way as to complement each other.

4. Data collection at central level

The initial phase of each type of data collection reviewed existing documents and/or literature on HIV and AIDS within the education sector and in TTCs. The documents reviewed included publications and/or reports by the ministries of education. Other pertinent materials were obtained through Internet searches on institutional websites; online databases and clearinghouses (e.g. UNESCO-IIEP HIV and AIDS Impact on Education Clearinghouse, and other relevant web sites); college HIV and AIDS policies, action and/or strategic plans; institution-based surveys; reports; education management information systems (EMISs), and other relevant documents. The aim of this initial phase was to take stock of existing information and to identify critical research gaps.

In-depth interviews were conducted in this phase with senior MoE officials at the ministry headquarters, including HIV and AIDS focal points. These preliminary interviews elicited information on: MoE policy on HIV and AIDS; statistics on HIV and AIDS in educational institutions including colleges (if any); institutional policy guidelines; current programmes/activities, practices on and responses to HIV and AIDS. Other issues included obstacles to effective response, as well as the ways in which the MoE is assisting in circumventing these obstacles. This information complemented the data obtained through the document review process.

5. Data collection at college level

In-depth interviews

Within the institutions or colleges, primary data were obtained through in-depth interviews with key informants who may have included (depending on the college) the principals, deputy principals, heads of departments, selected academic staff, counsellors, HIV and AIDS focal points, nurses, selected trainees, and support staff.

In-depth interviews covered such issues as institutional policies and guidelines; monitoring HIV and AIDS; the impact of HIV and AIDS on staff and students; and the organization of HIV and AIDS preventive education and programmes. Others included the contents of the HIV and AIDS training curricula; the selection criteria of HIV and AIDS tutors; the impact of HIV and AIDS training on trainees; and sexual attitudes and behaviour of staff and students in the context of HIV and AIDS. The data collection tools are available in each of the individual country studies.

Focus group discussions

Within the colleges, focus group discussions (FGDs) were conducted with teacher trainees. To ensure optimal participation, recruitment into the FGDs was based on willingness to participate, gender, leadership positions, and year of training and age categories. Two focus groups were formed in each college: one male and one female, which allowed

participants to express themselves in English or the *lingua franca*, local dialects, or a mixture of all the languages. The use of group dynamics was encouraged to stimulate informed debate during the course of the discussions. Each FGD was composed of 12 participants purposively selected. On average, each FGD lasted between one and two hours.

The issues explored during the FGDs included: perception of the magnitude of HIV in different socio-sexual categories; predisposing factors; HIV and AIDS training; modes of training (oral, video, books, pamphlets); teacher trainees' perceptions and evaluations of the training offered; tutors' effectiveness in teaching; the impact of training on trainees' sexual behaviour; and perceived strengths and weaknesses of preventive education programmes.

Observations

The direct observation method was used during institutional visits to gain a visual appreciation of the institution *vis-à-vis* its operations. The method allowed, for example, for observation of the location of the college *vis-à-vis* other institutions or towns, trainees' residence, availability of HIV and AIDS posters, condom dispensers, and other visually verifiable indicators of institutional response to HIV and AIDS. These observations permitted a contextualized holistic appreciation and understanding of existing institutional responses.

6. Data analysis

The preliminary interviews, in-depth interviews and FGDs were tape recorded and then written out manually in notebooks. The data collected were then transcribed and analyzed for meaning. Verbatim excerpts representing the voices of the respondents are used to support specific arguments. Visual observations were described in notebooks or recorded through audio-visual means. Data from the desk/document review were analyzed manually for content.

7. Limitations of the studies

First, records on HIV and AIDS within the institutions were not available, or if they were, they were inadequate and incomplete. Second, in some colleges, data collection took place at the end of the semester when teaching was over and students were preparing for examinations. This created tension on the part of students and meant that some of the lecturers were away. Third, these studies did not include the perspectives of in-service students, which would have made a valuable contribution, especially on the practical aspects of teaching HIV and AIDS in schools. Finally, the scope of these studies was limited; they only covered a few sampled TTCs in each country.

Each study adopted a case study approach, and utilized in-depth approaches to assemble rich data that could adequately inform our understanding of TTC responses to HIV and AIDS. The concurrence in the findings presented, by country research teams at the regional workshop in Nairobi, while also demonstrating intra- and inter-country differences, is an adequate testimony of the methodological rigour applied in each study. The use of researcher triangulation and inter-method triangulation enhanced the validity and reliability of findings. For example, the results of the two case studies in Uganda were later validated using survey data obtained from 58 higher education institutions distributed all over the country. This is clear evidence that these case studies provide an adequate insight of the situational response of TTCs to HIV and AIDS in the countries covered.

IV. NATIONAL POLICY RESPONSES TO HIV AND AIDS

The first AIDS case in **Ethiopia** was identified in 1984, but it was not until 14 August 1998 that the final national HIV and AIDS policy was ratified by the Council of Ministers. The objective of the national policy was to prevent the spread of HIV, reduce the vulnerability of individuals and communities, provide care for those living with HIV and AIDS, and mitigate the adverse consequences of HIV and AIDS (FDRE, 1998). In 2000, the government established a national HIV and AIDS Prevention Council (HAPCO) to co-ordinate and direct the implementation of the country's HIV and AIDS policy. In partnership with all stakeholders, HAPCO designed Ethiopia's five-year strategic plan to combat the epidemic, and administers government grants for HIV and AIDS programmes and research. The government also developed a national Strategic Framework for the National Response to HIV and AIDS, covering the period 2000-2004 (FDRE, 2001). In this framework, the government pledged to:

- intensify efforts on risk-reduction interventions, such as information, education and communication (IEC), behavioural change communication, condom promotion and distribution, STI control and management, and voluntary counselling and testing (VCT);
- intensify care and support and other impact mitigation efforts for infected and affected individuals, families and communities, by focusing on the most vulnerable populations such as commercial sex workers and young people, especially out-of-school youth;
- design gender-sensitive interventions, particularly as they relate to behavioural change communication, STI control, VCT, care and support, and impact mitigation;
- enhance the mainstreaming of HIV and AIDS in all interventions by government, non-government and private actors;
- establish a functional institutional framework from the federal to the community level, using national and regional HIV and AIDS councils and secretariats to co-ordinate, facilitate, monitor and evaluate;

- enhance community-level responses through risk and vulnerability reduction activities;
- track ongoing activities, propagation of diseases and trends in the epidemic over time, follow-up on contributions from all stakeholders and partners, and build a functional information sharing and dissemination system as a crucial step towards success in the response to the epidemic (FDRE-MoE, 2002).

The strategy also seeks to promote sectoral integration of HIV and AIDS. One of its key medium-term goals is to reduce the level of HIV transmission by 25 per cent in five years.

In 2003, WHO/UNAIDS estimated Ethiopia's total treatment need to be 200,000 people, and this number rose to 211,000 people in 2004. The government targeted 93,000 people by the end of 2005. In January 2005, the government launched a programme to provide universal access to free ART and made a commitment to roll out the programme across the country. The national road map for scaling-up access to ART targeted 100,000 people by the end of 2006. Some 88 health facilities were identified as providing ART in 2005. In September 2004, 9,500 people were reported to be receiving treatment, a number that increased to 16,400 in 2005. Through assistance from the Global Fund, the United States President's Emergency Plan for AIDS Relief and a host of NGOs, there are plans to provide 210,000 people with ART by 2008 (WHO, 2005a).

The first case of AIDS in **Kenya** was identified in 1984, and in 1985 the Kenyan Government established the National AIDS Committee to advise the Ministry of Health on matters related to HIV and AIDS control (Stover and Johnston, 1999). In 1986, the Ministry of Health formulated policy guidelines on blood safety. The first major government policy document to discuss HIV and AIDS in Kenya was the seventh National Development Plan issued in 1994, and a chapter on HIV and AIDS was placed in all district development plans. A national HIV and AIDS policy, also known as Sessional Paper No. 4 of 1997 on *HIV and AIDS in Kenya*, was launched in September 1997 (Republic of Kenya, 1997). Dovetailing this was the declaration of a national disaster, and the creation of the

National AIDS Control Council (NAAC) to provide overall co-ordination and leadership in a multi-sectoral response to HIV and AIDS in 1999. One major, immediate task of the NACC was to formulate the Kenya National HIV and AIDS Strategic Plan that was published in December 2000. This National HIV and AIDS Strategic Plan provided a sound institutional framework for integrating the HIV and AIDS issue into all core processes of government in Kenya (National AIDS Control Council, 2000).

The key targets of the national strategic plan are to:

- reduce HIV prevalence by 20-30 per cent by the year 2005;
- increase access to care and support for the people infected and affected by HIV and AIDS; and
- strengthen institutional capacity and co-ordination to respond to HIV and AIDS at all levels.

In the effort to reach all the people targeted to receive ART, the Ministry of Health adopted the goal to “progressively deliver effective ART, reaching 50 per cent by 2005 and 75 per cent by 2008, in order to prolong and improve the quality of life of affected people, to reduce HIV-related hospital admissions by 60 per cent, and to enhance prevention efforts.” (WHO, 2005*b*). The total number of patients receiving ART by the end of January 2006 was 65,000, up from 2,000 in 2003 and 10,000 in 2004. Some 22,000 of these patients benefited from free ART funded by the Global Fund and government funding, while 28,000 benefited from the President’s Emergency Plan for AIDS Relief (PEPFAR) funding, and the rest from funding by the Clinton Foundation (4,000 patients), the private sector, NGOs and faith-based organizations (FBOs). The government’s target was to reach a total of 140,000 people by 31 December 2006 (WHO, 2005*b*).

Uganda was one of the first sub-Saharan countries to be affected by the HIV and AIDS epidemic. The first AIDS case was reported in the country in 1982. Following this report, zealous efforts were made to deal with the epidemic. These efforts included *inter alia* an open policy in managing the HIV and AIDS epidemic declared by the

National Resistance Movement Government after it assumed power in 1986. Since then, there has been high-level political and donor support, backed by resources for AIDS control. The Multi-Sectoral AIDS Control Approach and the National Operation Plan reflected the recognition by the government and civil society of the need to scale-up a multi-faceted and multi-sectoral response from all sectors of the government and society.

In response to the epidemic, the government developed and implemented a number of plans and strategies to avert the looming development catastrophe of HIV and AIDS. These plans include the National Strategic Framework for HIV/AIDS Activities in Uganda 2000/2001-2005/2006, and the National Strategic Framework for Expansion of HIV/AIDS Care and Support in Uganda 2001/2002-2005/2006. Furthermore, the impact of HIV and AIDS on development in Uganda was outlined in *Vision 2025* and addressed in the medium-term poverty eradication action plan.

The Uganda National AIDS Commission (UAC) was established in 1992 to co-ordinate the implementation of a multi-sectoral approach to HIV and AIDS in the country. This multi-sectoral approach calls for the active contribution of public and private sectors in the control of HIV and AIDS. The primary mission of the UAC is to enhance HIV and AIDS activities in Uganda that include policy formulation, planning, information dissemination, resource mobilization, and national awareness.

The UAC has since developed a National Operation Plan, formulated policies on major HIV and AIDS issues, prepared national guidelines for the clinical management of HIV infection, and established a National AIDS Documentation and Information Centre. The UAC is also co-ordinating the operations of over 600 organizations involved in HIV and AIDS activities countrywide. These include religious bodies, NGOs, and local and international agencies. To achieve greater community involvement, district AIDS co-ordination committees have been developed at district (regional) and lower administrative levels. In addition to the AIDS Control Programme (ACP) in the Health Ministry,

12 other ACPs have been created by the UAC in different government line ministries, in order to institutionalize the multi-sectoral strategy. In 2003, the Government of Uganda, through the Ministry of Health, developed a national policy on ART in Uganda. In 2003, WHO/UNAIDS estimated that there were 110,000 people in need of treatment in the country, which rose to 114,000 people in 2004 (WHO, 2005c). In June 2004, an estimated 20,000 PLWHA had access to ART in Uganda. By the end of June 2005, the Ministry of Health reported that 63,896 patients were receiving ART, of which 10,600 were receiving free treatment *via* the Ministry of Health (WHO, 2005c). The Ugandan HIV Drug Access Initiative was launched in 1997, with five accredited centres in the region around Kampala. As of June 2005, the number of accredited health facilities had increased to 146 centres, of which 114 were providing ART. Antiretroviral therapy has been available in Uganda since 1998, but provision was confined to NGOs, commercial providers and research and pilot projects. With the announcement of the government initiative to provide free treatment to PLWHA in 2004, antiretroviral drugs are provided in the public sector through regional referral hospitals and other accredited district and mission hospitals. By May 2005, antiretroviral drugs had been distributed to 10,600 people through this initiative. Treatment is provided through research programmes and NGOs. Bilateral and multilateral partners support many of these organizations. FBOs also provide treatment (Republic of Uganda MoH, 2003).

In **Zambia**, the government has developed and implemented several national plans in response to HIV and AIDS. These include the Second Medium Term Plan 1994-1998, the National Strategic Framework 2001-2003 and the National HIV/AIDS Strategic Plan for 2002-2005. The National Strategic Plan (2002-2005) identifies eight critical areas that require immediate attention: behaviour change; prevention of mother-to-child transmissions; ensuring blood safety; improving the quality of life for PLWHA; provision of care, support and treatment to PLWHA; programmes for orphans and vulnerable children (OVC); HIV and AIDS information management; and the adoption of a multi-sectoral

approach. Objective number 5 of the strategic plan is to introduce ART for PLWHA in public and private health facilities. Highly active antiretroviral therapy (HAART) has been available in the private sector in Zambia since the early 1990s to those who could afford to pay themselves, although the total number currently accessing ART through this channel is unknown. Public provision of HAART is new, and thus represents the latest addition to the public sector's continuum of care for PLWHA. The national policy document on ART observes *inter alia* that:

“The non-availability of ART in the public sector in Zambia cannot continue while the economic and development gains achieved by Zambia since independence are being wiped out through illnesses and deaths attributable to HIV/AIDS.” (National AIDS Council, 2002: 3)

In this policy document, the Government of Zambia declares its intention to provide HAART to 10,000 patients in nine health facilities in the first programme year. The government further observes that the costs of ART in Zambia would be contributory through a cost-sharing mechanism. In 2002, two pilot programmes were initiated: one at the University Teaching Hospital in Lusaka and one at the tertiary hospital in Ndola (Copperbelt province). Expansion to seven other hospitals began in 2003 (Kombe and Smith, 2003). In July 2005, there was a change in government policy, which made ART services free for all Zambians through public healthcare facilities. This policy change saw ART – including free ART and associated laboratory testing – become available to a significantly larger proportion of Zambians. Because of this treatment plan, by the first quarter of 2006, 80,000 people had received life-saving ART and 25 per cent of HIV-positive expectant mothers were on a full course of ART (WHO, 2005*d*). Zambia's current responses to HIV and AIDS include expanding VCT, providing ART, developing home-based care, managing opportunistic infections, strengthening laboratory capacity, ensuring blood safety, managing STIs and encouraging behaviour change. These responses were made possible through such initiatives as the Poverty Reduction Strategy Programme, the Highly Indebted Poor Country Initiative, the Zambia

Social Investment Fund, and grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

It is clear from the foregoing that all the governments in the four countries studied have made significant progress in developing national responses to HIV and AIDS. Most countries have created a national policy context from which to spearhead the nation's response to the HIV and AIDS epidemic. Each followed the same pattern of having commenced the national response to the epidemic in the mid- to late-1980s through the National AIDS Control Programme, located in the Ministry of Health. The first National Strategic Plan (MTP-I) was primarily health-focused, ensuring the safety of the blood supply, prevention of infection of healthcare workers, and development and dissemination of information, education and communication (IEC) materials. In almost all the countries, the national AIDS commissions or councils are now in charge of co-ordinating national responses to the epidemic.

The existence of an explicit education sector HIV and AIDS strategic plan, either in draft or in completed form, demonstrates movement toward the development of a sectoral policy context for addressing HIV and AIDS in the countries studied. In addition, each country has a management structure designed to facilitate the implementation of the sectoral strategic plans. These structures are located in the central ministries.

1. Education sector policy response to HIV and AIDS

Ethiopia has no explicit HIV and AIDS policy for the education sector, but the national HIV and AIDS strategic framework (FDRE, 2001) does provide a broad framework that also covers HIV and AIDS within the education sector. According to the national strategic plan, the role of the education sector in HIV and AIDS control should include inter alia:

- providing HIV and AIDS education in primary and secondary schools through the school curriculum;

- developing IEC materials and interventions on reproductive health and HIV and AIDS to prevent high-risk behaviour;
- producing new, youth-friendly IEC materials in local languages and based on the experience of involving PLWHA in IEC interventions;
- designing, printing and distributing age-appropriate materials, such as posters, leaflets and brochures on AIDS/STIs that students can easily understand;
- involving students in curriculum development of HIV and AIDS/STI education;
- strengthening the existing anti-AIDS clubs in secondary schools and establishing new ones;
- involving families, religious organizations and other social organizations in the planning of HIV and AIDS/STI education for youths;
- developing in-service training, guidelines and materials on HIV and AIDS for school teachers.

The Ministry of Education works closely with the Ministry of Health, HAPCO and NGOs in the response to HIV and AIDS. HAPCO co-ordinates national efforts and provides the framework for funding, monitoring and evaluation, while the Ministry of Health provides health personnel to work with education establishments. In addition, NGOs work with schools and support anti-HIV and AIDS clubs by providing training and facilities.

In **Kenya**, the Ministry of Education has developed the Education Sector Policy on HIV and AIDS which formalizes the rights and responsibilities of every person involved, directly or indirectly, with HIV and AIDS in the education sector (Republic of Kenya, MoEST, 2004). This policy supports the creation of HIV and AIDS policies in schools and other institutions of learning. Presently, institutions such as Mombasa Polytechnic, High Ridge Teachers' College and the University of Nairobi have institutional policies on HIV and AIDS.

The MoE has an ACU that provides proactive leadership and ensures that HIV and AIDS prevention and control priorities are integrated into mainstream ministry functions. The ACU in the Ministry of Education

also works alongside the ACU in the Teachers Service Commission (TSC) – the principal employer of teachers in public institutions – and the ACU in the Commission for Higher Education (CHE) that is in charge of tertiary institutions such as universities. The ACU and the MoE Headquarters also work closely with the Kenya National Union of Teachers (KNUT) and the Kenya Union of Post-Primary Teachers (KUPPET). These are the main teacher-training unions in the country. In addition, the ACU at the MoE works closely with the Kenya National Association of Positive Teachers (KENEPOTE) – an association that represents the welfare and interest of all teachers with HIV and AIDS in Kenya. The ACU within the Ministry of Education is proactive, well-managed, has permanent staff, and has ensured that HIV and AIDS are included in the 23 investment programmes under the Kenya Education Sector Support Programme (2005-2010). HIV and AIDS have a budget line, and the ACU is now able to support HIV and AIDS initiatives in the education sector, including in the TTCs.

In **Uganda**, the political leadership of the MoES has not given urgency to the need to address HIV and AIDS in the education sector. Responses to HIV and AIDS are therefore not funded through the sector budget as is the case in Kenya. Most of the HIV and AIDS initiatives in the MoES in Uganda are donor dependent; this means that such programmes and initiatives are not sustainable. There are also departmental/sub-sector focal points, but they are not empowered with the necessary skills and financial resources to do their job.

Uganda has a draft national education policy on HIV and AIDS that is now with the Cabinet for approval. This draft policy was developed in 2001 and revised in 2004 (Republic of Uganda, MoES 2004a). This protracted inertia and delay in the development and adoption of the education sector policy on HIV and AIDS was arguably to allow the widest possible consultation among all stakeholders in the country. However, it does also demonstrate a lack of political will on the part of the leadership of the MoES to respond to HIV and AIDS (Kamugisha, 2007). The policy mandates the Ministry of Education to integrate HIV and AIDS education into all levels and institutions within the sector

(Republic of Uganda, MoES, 2004*b*). This HIV and AIDS policy covers all learners, employees, managers, employers and administrators, and other providers of education in all public and private, formal and non-formal learning institutions, at all levels of the education system in Uganda. The country also has an education sector HIV and AIDS workplace policy that was finalized in 2006 with financial and technical assistance from GTZ, Irish AID, USAID, the Uganda HIV/AIDS control project (World Bank) and the Uganda AIDS commission. This workplace policy has not, however, been disseminated to all schools due to lack of funding (Kamugisha, 2007).

Zambia has a specific HIV and AIDS policy and an education sector HIV and AIDS strategic plan. There is also a national committee responsible for co-ordinating the education response to HIV and AIDS. The MoE has an HIV and AIDS workplace policy, but most education institutions in the country have yet to develop their own workplace policies (Ramos, forthcoming).

The Ministry has a policy of non-discrimination with regard to recruitment, advancement, continued employment and benefits for personnel affected by HIV and AIDS, and confidentiality of information about such employees is enforced in the country.

Box 1. National and education sector responses

	Ethiopia	Kenya	Uganda	Zambia
National policy	Yes	Yes	Yes	Yes
National strategic plan/framework	Yes	Yes	Yes	Yes
Multi-sectoral approach	Partially	Yes	Yes	Yes
Education sector policy	No	Yes	Yes	Yes
Education sector strategic plan	No	Yes	Yes	Yes
MoE HIV/AIDS structures	Yes	Yes	Yes	Yes
Education sector workplace policy	No	Yes	Yes	Yes

2. TTCs' response to HIV and AIDS

Institutional policies in TTCs

A key response of TTCs to HIV and AIDS is the establishment of an institutional framework that defines and legitimizes actions and programmes on HIV and AIDS within the institution. An institutional policy framework that locates HIV and AIDS within the mission and core business functions of a TTC is essential for the success of HIV and AIDS prevention education (Boler and Aggleton, 2005).

Box 2. An institutional HIV and AIDS policy framework

- defines the institution's position with regard to HIV and AIDS and sets clear guidelines on how the epidemic can be managed within the institution;
- defines the rights, obligations and responsibilities of all stakeholders in an institution, including the affected, infected and their partners;
- sets the behavioural standards expected of each institutional member;
- sets institutional standards for communication about HIV and AIDS;
- identifies the human, material and financial resources to be used for HIV and AIDS-related activities;
- legitimizes institutional actions on HIV and AIDS and aligns the institutional responses to the broader national policy framework;
- provides guidance to institutional managers and other players and provides an overall framework for action;
- indicates commitment to deal with and control HIV and AIDS;
- ensures consistency with national and international practices.

Source: Crewe and Nzioka, 2007.

A wider institutional policy needs also to recognize the particular needs of both staff and students. Institutional policies on HIV and AIDS, however, need to conform to country-specific legal and social contexts. Institutional policies must align with national policies and strategies in the education sector to ensure a continuous and comprehensive response. Experiences drawn from one college in Kenya in developing an institutional policy on HIV and AIDS demonstrate that such a policy

can make a difference in mobilizing resources and guiding concerted actions (Ojuando, 2004b). However, policies and action plans are only as good as the leaders and individuals committed to their execution.

3. Structure of teacher education

In **Kenya**, all trainees in primary teacher-training colleges must hold the Kenyan Certificate of Secondary Education and have completed four years of secondary education. The teacher-training course lasts two years, at the end of which students are awarded a P1, P2 or P3 certificate, depending on their success in centrally set examinations. The training of secondary school teachers is carried out at two levels. In universities, graduate teachers are trained in four years for the Bachelor of Education Degree (BEd). Graduates holding a BA, BSc or BCom take a one-year post-graduate course in education. Teachers are also trained at two diploma colleges. The three-year course leads to a diploma in education.

In **Uganda**, primary school teachers are prepared at three points: in primary teacher colleges (PTCs) over a period of two years; at the national teachers colleges (NTCs) as up-graders for a period of two years; or at university for a period of three years. They are then awarded a Grade III teaching certificate, a diploma in education (primary), or a Bachelor of Education degree. Secondary school teachers attend the NTCs or universities for a period ranging from one to three years, after which they are awarded a Grade V diploma or a postgraduate diploma in education (PGDE), a Bachelor of Science with an education degree (BSc.Ed), or a Bachelor of Education degree (BEd). These graduates are then eligible to teach in secondary schools, PTCs, NTCs or universities.

Table 4.1 Structure of teacher preparation in Uganda

Level	Training institution	Admission requirement	Course duration	Award	Teaching posting
Primary	PTCs	S4 & S6 leavers	2 years	Grade III Certificate	Primary schools
Secondary	NTCs	Grade III & S6 leavers	2 years	Grade V - Diploma	Primary schools, Secondary schools, PTCs
Tertiary	Universities	Grade V, S6 leavers and graduates	1-3 years	PGDE, degree	Primary schools, secondary schools, PTCs, NTCs & university

In **Zambian** primary schools, certificate teachers follow a two-year training course at any of the 11 primary school teacher colleges. There is no specialization *per se* for this pre-service programme because teachers teach all subjects offered at primary school. Primary school diploma teachers train at the national in-service training college after completing the initial training from a primary school teacher college and after having served in schools for some years. Primary school diploma teachers may obtain a diploma in special education from the Lusaka College for Teachers of the Handicapped.

Secondary school diploma teachers are qualified to teach at the junior secondary education level. Another category of secondary school diploma teachers follows a three-year course in agriculture at the Natural Resources Development College and is qualified to teach agricultural science up to the senior secondary school level. Secondary school degree teachers are trained at the University of Zambia and are qualified to teach up to the senior secondary level. They can also teach at the TTCs and as staff development fellows. During their studies, they take two teaching subjects and professional courses in education.

In **Ethiopia**, all teacher-training programmes are co-ordinated by the Federal Ministry of Education. The training of primary school teachers and TVET teachers falls under the Teacher Education Department of the General Education sub-sector. The training of secondary teachers is co-ordinated by the Higher Education Department. The Ministry of Education also provides guidelines for the training of pre-school teachers.

Table 4.2 Structure of teacher education programmes in Ethiopia

Level	Achieved qualification	Admission criteria	Course duration	Training provider
Certificate	Pre-school	8 years of primary education + 2 years of secondary education	10 months	TTC/private institutions
Certificate	First cycle primary Grades 1-4	8 years of primary education + 2 years of secondary education	One year	TTC/private institutions
Diploma	Second cycle primary Grades 5-8	8 years of primary education + 4 years of secondary education	Three years	TTC
Degree	Secondary education Grades 9-12		Four years	University

The private sector is increasingly taking up teacher education for primary levels. Currently 80 per cent of first-cycle primary teachers are trained in private institutions. The Ministry of Education provides the curriculum and the syllabus for the TTCs, and regions certify the graduates from private institutions. The Ministry of Education holds regular meetings with the private institutions to co-ordinate the activities. Currently, there is no responsible body in the Ministry of Education to co-ordinate teacher training for pre-primary education.

Teacher training and HIV and AIDS

In **Ethiopia**, 14 TTCs train teachers at the 'certificate' level to teach primary classes, and five TTCs train at the 'diploma' level for the second part of basic education. Education faculties train at the 'degree' level to prepare teachers to teach in high schools and colleges (UNESCO, 2005). The Ministry of Education in Ethiopia recognizes that teacher education institutions (TEIs) produce teachers who are important change agents in society, hence the need to support the role of the teacher in the community. To realize the objectives of the new pre-service teacher education system, there are proposals to overhaul the curricula to reflect and address better the educational and social realities of Ethiopia, giving particular attention to developing the

rural community and creating equity for women. The new pre-service programme is also committed to producing competent teaching staff with the desired academic knowledge, sufficient professional skills and attitudes, and the ethical values enshrined in the Ethiopian Constitution. The new curriculum is designed to include only what will enable teacher trainees to teach well – especially in the first cycle at primary level. The three envisaged common courses that focus on the development of practical skills and teaching strategies will include the following:

- Professional studies

Covering all the areas which students need to know regarding education, classroom management and organization, learning theories and psychology.

- Civics and ethical education

Dealing with all the areas concerned with the role of the teacher and the ethical dimensions of teaching and education.

- Life skills

Providing a dynamic way of helping student teachers to develop crucial skills for present day society such as decision-making, problem-solving, critical thinking, creative thinking, interpersonal skills, self-awareness and coping with stress, etc.

In particular, professional studies and life skills are aimed at equipping student teachers with teaching methods in HIV and AIDS, health and hygiene, personal safety and rural development issues.

In Ethiopia, teaching HIV and AIDS and life skills is an integral component of the curriculum for teacher preparation (Ashebir, Tadele and Cherinet, 2007). There is, however, no systematic monitoring and reporting system on the implementation of HIV and AIDS teaching in TTCs. Student trainees in TTCs also learn about HIV and AIDS through the Ethiopian Basic Education Strategic Objectives, an initiative to improve the quality and equity of basic education by supporting reform at the national and regional levels. Evidence from the regions still indicates that teacher trainees do not receive adequate training in HIV and AIDS

prevention or even in teaching methodologies (UNAIDS-IATT/HEARD, 2006).

Several UN agencies, NGOs and FBOs are currently supporting teacher training in HIV and AIDS, such as the International Red Cross, PACT Ethiopia, the International Organization for Migration, UNICEF, Pathfinder (in collaboration with teachers' unions) and the UNESCO International Institute for Capacity Building in Africa (IICBA). In particular, IICBA, with financial assistance from USAID, has attempted to enhance HIV and AIDS awareness by developing learning materials in Amharic, and an HIV and AIDS preventive education manual for Ethiopian teachers. IICBA is also producing videos on HIV and AIDS for children and adults and for teacher-training colleges throughout Africa. Effective teaching of HIV and AIDS in TTCs is, however, undermined by an existing view that teaching about HIV and AIDS is not a primary concern for TTCs.

“The HIV/AIDS response is generally seen as an intervention that exists outside of the ‘traditional’ educational planning domains. It is considered the prerogative of the specialized agencies set up specifically for that purpose. As a result, HIV/AIDS is left outside the mainstream issues of educational planning and management. Consequently mainstreaming of HIV/AIDS in the education sector has not been achieved, and even those appointed as focal points on HIV/AIDS do not see it as their primary responsibility.” (Abebe, 2005).

Other bottlenecks to the effective teaching of HIV and AIDS in TTCs include a lack of finances, inadequate co-ordination and management structures, stigmatization and discrimination with respect to HIV and AIDS and gender, a lack of adequate regional data on the impact of HIV and AIDS for planning purposes, and a lack of commitment and urgency among college administrators. Support for teaching HIV and AIDS in TTCs outside the government system is, therefore, donor- or supply-driven rather than demand-driven.

In **Kenya**, there are 29 primary teacher training colleges (PTTCs) comprising 21 public and 8 private. In addition, there are three diploma TTCs: Kenya Science, Kagumo and Kenya Technical Teachers College. In 2004, the enrolment in the PTTCs was 17,618, while private colleges had 2,330 (Nzioka, Korongo and Njiru, 2007: 15). HIV and AIDS constitute one of the 23 national investment programmes identified in the Kenya Education Sector Support Programme (KESSP) 2005-2010 (Republic of Kenya MoEST, 2005). KESSP defines the major education reforms to the Government of Kenya that it wishes to effect in the next decade. The identification of HIV and AIDS as a key issue to be addressed stems from a realization that the bulk of in-service teachers may have completed their pre-service training before HIV and AIDS became a national problem and, consequently, have little or no knowledge of HIV and AIDS. Since lack of adequate knowledge on HIV and AIDS is likely to weaken the teachers' capacity to deliver effective HIV and AIDS education in schools, the MoE plans to organize both pre-service and in-service training. This concern is reflected in the MoE Education Sector Policy on HIV and AIDS, which recognizes that:

“Teacher education curriculum (pre-service and in-service) must prepare educators to respond to HIV and AIDS within their own lives and as professionals to build positive attitudes and skills for HIV and AIDS prevention and control among all their learners.” (Republic of Kenya, 2004: 15)

Pre-service training in HIV and AIDS is offered in both private and government-run TTCs in the country, while in-service training is offered mainly in government-run colleges, and takes place during school holidays to avoid interference with the normal school teaching programme. Through the Primary School Action for Better Health programme, the Ministry of Education has implemented a range of school-based HIV education and behaviour change interventions in primary schools since 1999.

Recognizing the role of institutional leadership in HIV and AIDS prevention and control, the MoE has already provided training on HIV and AIDS to all principals and deputy principals of both private

and public TTCs in Kenya (Education International, 2006). The idea is that all primary TTCs, both private and public, follow one national curriculum on teacher training, thus rendering it easier for principals to initiate similar programmes and approaches for dealing with HIV and AIDS in the colleges (Republic of Kenya, MoE, 2005). The Kenya Institute of Education (KIE)/MoE has also developed a national AIDS education syllabus for schools and TTCs (Republic of Kenya, MoEST, 1999*b*). HIV and AIDS are now part of the TTCs' curriculum integrated into carrier subjects including biology, social education and ethics, Christian religious education and home science.

In March 2006, the MoE also organized training for heads of the counselling departments and their deputies, and one other tutor in all of the 29 public and private TTCs in the country. Thus, about 65 participants were trained in different aspects of HIV and AIDS. These heads and deputies of counselling departments were then encouraged to develop college-specific proposals outlining projects and activities to be funded by the MoE. The budget limit for each college was Kshs.300,000 per annum (approximately USD4,000). Projects identified in these proposals included: peer education; developing IEC/BCC materials; outreach programmes; use of music, plays and drama; purchase of materials, films and videos; and field visits. The HIV and AIDS focal unit at the MoE headquarters continues to monitor, supervise, and provide backstopping services to colleges in implementing these activities.

The MoE is also planning to strengthen guidance and counselling services in all learning institutions and also within the Ministry to enhance their capacities to deal more effectively with HIV and AIDS. The MoE and UNICEF are organizing in-service training for teachers to induct them in life skills education in schools.

Zambia has 14 colleges of education. In the primary school teachers' course, students are in college for the first year while the second year is spent in school, practicing teaching. All subjects, as they appear in the primary school curriculum, are regrouped into six so-called study areas. HIV and AIDS and life skills are considered as a cross-cutting issue to be

dealt with in all six study areas. A manual on interactive methodologies for HIV and AIDS prevention in Zambian schools was developed in 2003; however, training all teachers in interactive methodologies and life skills for psychosocial competencies remains a challenge. A lack of high-level commitment, curriculum congestion and inadequate training of trainers are the three main reasons for this problem. Generally, there are few HIV and AIDS activities in colleges of education, and HIV and AIDS materials are not available to all students in tertiary education.

Several strategies to reach teachers with in-service training for HIV and AIDS have been developed. Teacher group meetings in the School Programme of In-Service of the Term (SPRINT) share information and methodology on the disease. SPRINT is a school-based system that delivers in-service training through a cascade model, involving heads of schools, zonal resource centres and district resources centres. The Primary Diploma, provided through distance learning, has a specific module on life skills, and the Primary Reading Programme has introduced HIV and AIDS-related texts. Several books have been produced and printed, and are being distributed to help teachers to integrate HIV and AIDS education in their lessons.

In **Zambia**, between 2002 and 2004, some 21,600 in-service teachers were trained through a programme known as the Teacher Training Programme to Prevent HIV Infection and Related Discrimination. This is a skills formation and development programme developed jointly by the World Health Organization (WHO), Education International and the Education Development Centre (EDC) in close collaboration with teachers' unions, the ministries of education and health, and with some support from UNESCO (Pevzner, 2005). There are also other strategies in place for in-service training in HIV and AIDS. Teacher group meetings in the SPRINT share HIV and AIDS information and methodology.

In **Uganda**, more than a half (3,450) of the 7,050 teacher trainees in primary teacher colleges have received a two-day training covering general aspects of HIV and AIDS. According to the Uganda National Teachers' Union, another 18,820 primary teachers have also received at least 16 hours of in-service training on general knowledge and skills

relating to HIV and AIDS (Education International, 2006: 8). Primary school teachers receive training through the Ministry of Education, under the Teacher Development and Management Systems programme. During that training, they receive the PIASCY teachers' guide and log book for monitoring the implementation of activities.

The PIASCY also assists teachers by giving them guides for the implementation of its strategy on HIV and AIDS prevention at primary school level. Teachers are expected to convey messages to children through school assemblies and by putting up posters around the school compounds on the prevention of HIV and AIDS (Education International, 2006: 9).

The government has also developed an HIV and AIDS workplace policy for the education sector. However, more information on life skills, such as assertiveness, need to be provided to susceptible school children. HIV and AIDS messages have been integrated into the primary teacher-training curriculum, but it still needs to be incorporated into the actual school curricula (Education International, 2006).

V. HIV AND AIDS IN TEACHER TRAINING COLLEGES

1. Perceived prevalence of HIV and AIDS among college staff and students

In all the TTCs visited during these studies, top administrators, staff and students did not appear to rank HIV and AIDS among the institutions' top priorities. There appeared to be a general feeling that these institutions had other, more pressing problems requiring more urgent attention than HIV and AIDS, such as student accommodation, finances to run the college, and poor staff remuneration.

“How can HIV/AIDS be a priority when even our basic needs are not being met? We do not even know where food for students is going to come from! We have financial constraints. I would rank it as number six on my list of priorities.” (College administrator, TTC, Uganda)

Similarly, a head of department in one TTC in Kenya observed that HIV and AIDS were not a visible problem among academic staff within the college.

“We do not perceive HIV and AIDS as a big problem here because we have not lost many members of staff due to AIDS. If we were losing many, it probably would be of concern to us.” (Head of Department, TTC 3, Kenya)

Within the student population, HIV and AIDS appeared less visible because infected students often withdrew from their studies or simply left college. A majority of students considered lack of money to buy books, stationery and other necessities while in college as much more serious problems to them than HIV and AIDS. Other major fears of more immediate concern included failing coursework, tests and final exams. Interestingly, some female students perceived unwanted pregnancy as a much more real and serious problem than HIV and AIDS.

Unlike the academic staff, support staff did mention HIV and AIDS, arguing that their colleagues were infected or affected. In fact, they also

reported seeing their colleagues have trouble accessing VCT services and treatment for HIV and AIDS. They attributed this to the silence and denial that continues to characterize the epidemic.

2. Perceived magnitude of HIV and AIDS among TTCs

None of the TTCs visited had surveillance systems. Most TTCs did have clinics or medical units for their staff and students, but these clinics did not have HIV testing kits, neither were the staff manning these clinics trained in HIV and AIDS diagnosis. Even if such systems did exist, evidence gathered during these studies suggests that both students and staff would prefer receiving VCT services outside their own institution for fear of information leaking into the institution on their HIV status. This was the case in the higher education institution surveyed in Uganda where VCT services on campus were under-utilized. Staff and students indicated that they would rather pay for the VCT service outside the TTC and be assured of confidentiality than risk the possibility of their HIV status leaking to other members of the institution.

In the absence of on-campus VCT services that monitor HIV-related cases, absences, withdrawals and mortality, all assessments of the prevalence of HIV and AIDS in TTCs was done through 'indirect' and 'subjective judgements'. One indirect method, used by both staff and students, was watching out for colleagues who suddenly developed poor physical health and presented overt signs of possible symptoms of HIV and AIDS. Such ailments could include coughing, diarrhoea, weak physique and body wasting. Other possible indirect indicators of HIV and AIDS in a TTC included a student or a staff members suffering from prolonged illness or absent from the TTC without an explicit disclosure of type of ailment. Others were a complete disappearance of a student from the TTC, followed by rumours of subsequent death. It was, however, difficult to gauge student mortality in non-residential colleges, such as one college in Ethiopia. The problem of assessing the incidence of HIV in most TTCs was aggravated by the fact that the duration of the training was limited to a maximum of three years. This

made it difficult to gauge the effects of a progressive disease like HIV and AIDS.

In other cases, students on special diets in one college in Ethiopia, and another in Kenya, were suspected to be HIV-positive. Interviews with college officials showed that while this could be true in some cases, it was not always the case as some students were allergic to certain foods. While this social discourse around possible HIV infection was more based on suspicion than biomedical diagnosis, it did appear to be the most commonly applied method for assessing those thought to be HIV-positive in TTCs. Such diagnosis would often be collaborated by the perceived sexual behaviour of the individual concerned, such as type and number of partners he or she would spend time with and perceived level of promiscuity. This discourse would then be sustained through rumours and gossip.

3. Levels of vulnerability

Data from all the colleges in the four countries appeared to indicate that student trainees were likely to be much more at risk of HIV infection than members of the teaching staff. For example, in the NTC in Uganda, it was alleged that because of the low positions they held in the college, female support staff members were easy prey to sexual exploitation and harassment by senior college staff. Non-teaching staff often occupy non-skilled jobs such as cleaning or sweeping. They can, therefore, be easily dismissed and replaced. This factor makes them the most vulnerable to abuse and manipulation by their seniors. They allegedly consent to sexual relations with their seniors, and are reluctant to report it for fear of losing their job (Katahoire and Kirumira, 2007). These power-based sexual relationships potentially expose those involved with junior or senior staff to greater risks of HIV infection.

In **Kenya**, more than half of the deaths reported by respondents, arising from illness perceived to be HIV and AIDS-related, were said to have occurred among the non-teaching staff. This did not imply any fewer deaths among students, but given that the trainees take only two years to complete their studies, in the event that they do become

infected in college, deaths may occur long after they have left college. Deaths may be more visible among non-teaching staff because they have been there for a longer period than the trainees have. The shared view among the college administrators and tutors was that non-teaching staff (cooks, cleaners, technicians, drivers, secretarial staff, etc.) were more affected by HIV and AIDS. The following excerpts support this observation:

“About three years ago, things were bad here. We lost members of staff and trainees suspected to have been ailing from AIDS. A number of trainees were also reported to have died upon leaving college. It is not that bad now.” (Tutor, TTC 1 from Kenya)

“The number of non-teaching staff has declined because of deaths. We are burying them every term.” (Administrator, TTC 2 from Kenya)

In the Ugandan TTC, one head of department, who had been at the college since 1996, avidly remembered:

“In 1994, one of the male lecturers passed away, and then the farm manager, then another male lecturer also died in 2000, and the caterer died in 2003.”

The studies found increasing evidence of health problems among staff and trainees in the frequency of visits to institutional clinics, and manifestations of visible HIV and AIDS signs and symptoms. Cases of trainees going to clinics with STDs and other suspected opportunistic infections were reported. It was also argued that many trainees might be seeking medical attention in health facilities outside their colleges for fear of disclosure:

“We get many cases of STDs here at the dispensary. However, in most cases, trainees shy away from coming here and would rather go elsewhere for treatment. The cases we receive here may not show the true picture.” (College nurse, TTC 3, Kenya)

The study also found that suspected HIV and AIDS-infected trainees were dropping out of colleges and dying outside, without the

knowledge of the colleges. This scenario was more real in TTC 3 in Kenya where it was reported that at least two trainees suspected to be HIV-positive left the college mysteriously, never to come back. Indeed, more than two thirds of college administrators and tutors interviewed showed that some trainees might be dying outside of the college either after graduation or after dropping out.

“It’s difficult to say the actual magnitude of the problem because of the stigma. We have lost about three trainees, at different times. Others suspected to be positive just disappear, never to appear.” (Female tutor, TTC 3, Kenya)

“There are two cases of trainees who left college and were later reported to have died. Their frequent hospital visits were worrying but never caused alarm. They were suspected to be positive.” (Dean of students, TTC 3 Kenya)

There were an increased number of trainees orphaned by AIDS or whose parents and guardians may have been ailing. In TTC 2 in Kenya, where the problem was acute, reports indicated such a high number of AIDS orphans that this had created problems in payment of fees. Trainees from Nyanza province were most affected because of the high rates of infection in the province. However, there were no statistics to support this claim. This phenomenon was observed in other colleges where a number of trainees were reported to be caregivers to infected family members.

While it is very clear from the findings above that HIV infection and AIDS-related illnesses are major problems in the colleges, the magnitude cannot easily be quantified.

4. Factors fuelling HIV infection among trainees

Poverty and scarcity of resources

Poverty and relative material deprivation did emerge as key factors contributing to HIV infection among trainees. In Kenya, for example, primary school teaching is neither a prestigious career nor highly financially rewarding. The most affluent families would rather sponsor

their children for a diploma or degree programme in a university. This means that those who secure admission to TTCs tend to be children from impoverished backgrounds. The TTC trainees are, therefore, children of guardians and parents who can hardly afford the trainee's college fees and personal upkeep. Narratives show that these students report to college without the statutory college fee and with a bare minimum of resources for their upkeep.

“When I was coming to college, my mother had only ten thousand shillings and that was all she gave me. She told me that if she got more money she would send it to me, but she was unable to, and the semester ended without she sending me any more money. I am not a lone in this kind of situation, and this is how we young girls end up in relationships with men.” (Female first year student, TTC, Uganda)

Relative deprivation also forced other students into unsafe sexual relationships. Driven by a desire to live a life commensurate with that of their colleagues from affluent family backgrounds, poor students resort to unsafe transactional sex with well-to-do colleagues or elderly, well-off men.

“When girls come to college, they want to start living nicely. They want mobile phones, airtime, good meals, and nice dresses. Most of our tutors can afford what these girls want so it's not surprising they end up getting these girls.” (Male second year, TTC 2, Kenya)

“The meals we get in college are so poor. There are, however, hawkers in college who sell us food. Some girls who cannot afford to pay for this food acquire boyfriends who can buy them the food or in worse cases, some of these girls enter into sexual relations with the hawkers.” (Female second year TTC, Uganda)

The Guild President (female) at the Ugandan TTC further observed:

“The problem is money. Girls have to treat hair; they have to look nice. Most of those who come here do not have that money ... So the main issue is money.”

In these transactional sexual relationships, female trainees are more vulnerable to infection due to powerlessness to negotiate condom use during sexual encounters. Cases of male trainees engaging in homosexuality for financial gain were also reported in one of the Kenyan colleges.

In the Zambian college, transactional sex was also an issue. The Principal, a member of the academic staff and both focus groups, admitted that lecturer-student sexual relationships did occur.

The Principal recalled that three lecturers had, in the year preceding this study, been accused of professional misconduct for having sexual relations with female students. Although most girls are not willing to talk about it openly, some do and will complain about it, but are unwilling to take action formally and put it in writing; this is a prerequisite for implementing the institutional rules for sexual misconduct. The girls, she explained, “do not want to be tagged as the person responsible for the dismissal of the lecturer. They are too afraid.” “Lecturers have too much power”, the Principal quoted the girls as saying. In the end, only a warning is given to the lecturers, and out of those three accused, not one of them was suspended or dismissed. The Principal explained that, in one instance, the exam had to be changed at the last minute because a female student had sex with the lecturer in exchange for the exam paper. Other students reported this misconduct and the exam was replaced, but the lecturer was not sanctioned.

Location of TTCs

The geographical and physical location of TTCs did predispose staff and trainees to HIV and AIDS. For example, TTC 6 in Ethiopia is located near a vibrant roadside town (very close to well-known resort areas in the country) with high HIV and AIDS prevalence. This is a town where many NGOs frequently hold workshops, seminars and conferences. One interviewee said, “there is an ongoing workshop in this town almost everyday”. The workshops are potential attractions, mostly to female trainees in TTC 6. Given that the college does not have accommodation, vulnerable female students often entice the workshop participants into

sex in exchange for money to meet their housing and other costs. In Kenya, colleges 1 and 3 are located in city environments, just like the higher education institution in Uganda. The following are extracts from FGDs with female and male students that seem to reaffirm the risks presented to students by the trappings of urban life.

“This institution is located in an urban area with night clubs, restaurants, cinemas, and other forms of entertainment where many young people want to hang out ... but the costs involved are very high, so young people end up getting partners who can give them money to enjoy these facilities.”

Several staff members expressed similar sentiments. The Deputy Dean of the School of Education observed that:

“This institution is in the middle of growing commercial centres and spots. These centres’ life is inextricably linked to the life of this institution. Therefore, students get girlfriends and boyfriends from in and outside the university. There are men and women who specifically target university students and are ready to woo them using whatever means, especially money.”

These urban environments provide student trainees with anonymity that easily permits them to engage in unsafe sexual practices. Young trainees also have easy access to wealthy people who often take advantage of these young and innocent college girls by enticing them into a glamorous lifestyle with money and attractive propositions.

“Trainees are bound to engage in sexual activities due to the carefree lifestyle they find in the city. The college is just a few minutes drive to the city centre, and trainees, especially the females, have many contacts within the city and every time they are seeking permission to go out. Our suspicions are that many engage in sexual activities.”
(Dean of students, TTC 1, Kenya)

Other TTCs, such as TTC 2 in Kenya and TTC 4 in Ethiopia, are located in border towns where trainees quickly interact with cross-border traders, refugees and security forces.

“This college is placed near a border town, and there are lots of people crossing the border daily such as truck drivers, fishermen and matatu (touts) people. These people have money and easily entice our poor college girls into sex.” (Deputy Principal, TTC 2, Kenya)

In such geographical settings as a small urban centre, a rural setting and border towns or villages, student trainees can easily get involved in unsafe sexual activities.

Peer influence and peer pressure

Peer influence and peer pressure did emerge as possible predisposing factors to HIV infection among student trainees in all the colleges. Peer pressure is exerted in a variety of ways, ranging from persuasion to coercion. On their arrival at the college, first year female trainees are either persuaded, manipulated or goaded into sex by senior male colleagues or by male tutors as a way of ‘welcoming’ them into college life. Since a majority of the trainees admitted are young, unexposed people, often from rural areas, they are susceptible to these manipulations. Such trainees are easily sucked into unsafe sexual practices, alcoholism and drug abuse by their peers. This phenomenon is common among both male and female trainees.

“Some people come here [the college] when innocent. By the time, they leave this place, many have become alcoholic and engage in sexual immorality, all because of influence from friends. When a friend has many boyfriends or girlfriends, you also want to be like them.” (Female second year trainee, TTC 1, Kenya)

In the higher education institutions in Uganda, one student leader agreed that both male and female students experienced incredible pressure to get partners once in college:

“Students who do not have sexual partners in college are often regarded as failures. If a girl does not have a boyfriend they ask her what is wrong with her. So she also makes herself available to someone. When the first years come in, the boys rush for them and drop the female second years they had been having affairs with

and this change in sexual partners puts them at great risk of HIV infection.”

Equally, on entering college, most students, who are used to parental authority, for the first time experience personal freedom and space. This increased freedom is often accompanied by peer pressure from continuing students. Students from impoverished rural backgrounds are expected to adapt into ‘college culture’, and adopt expensive lifestyles. Students interviewed in Uganda talked about the ‘five Cs’: *chips, chicken, cell phone, clothes and car*. Examples were given of female and male students who willingly engaged in unsafe inter-generational sex in order to remain financially comfortable and maintain what they perceived to be a fashionable modern lifestyle.

This phenomenon, also reported in TTCs in Ethiopia, tends to be much more prevalent among non-resident students. In one FGD in the higher education institution in Uganda, students argued:

“Girls go out with ‘sugar daddy’ in order to lead a lavish lifestyle, others even have multiple partners. For example, they may have a student on campus that they hope will marry them when they complete and they also have a sugar daddy on the side that provides them with the money that they need to buy what they want.”

Discussions of students wanting to dress in the latest fashions, have the latest hairdo, and go to the movies and discos every weekend were also reported. These activities often require financial resources often beyond the reach of the students, obliging them, therefore, to find all kinds of ways of making money.

In all the institutions studied across the four countries, it was felt that female students in particular had a higher propensity for material possessions and flashy lifestyles and were willing to engage in unsafe sexual relationships to acquire them. In an FGD with second and third year male students in the higher education institution in Uganda, the following statements were made:

“Some of these girls come from poor families in rural areas and when they join higher institutions of learning, and look at what other girls have they feel they too want the same things.”

“Girls resort to going out with working men who can meet their material needs. What is unfortunate is that these same girls also have boyfriends who are students and in the end they may get infected from their men friend and in turn infect the poor male students.”

Cases of male students having sexual relations with sugar mummies were also reported, but were not considered pervasive.

“There are business women in this city who have a lot of money and who also get into relationships with young men. You know students cannot afford to drive cars but these women give them their cars to drive and they pose with them on campus.”

“Some of these women are even married. They take out the students, buy them good meals, and give them a good time. The students do not even know who else these women are sleeping with.”

Urban lifestyle and materialism were generally reported as factors thought to fuel unsafe, inter-generational sex between students and older men/women. Other trainees keen on acquiring marriage partners in college succumb to sexual advances from such prospective partners. The pressure to secure a marriage partner is relatively higher among second year female trainees who feel ‘old’ and fear they may not easily get such partners once out of college.

“When girls get into their final year, they start slowly [to lose] appeal. As such, they will try to pin themselves onto a man. Some will even decide to have sex with you so that you impregnate them. They will then make sure they are posted to a school near your home areas. After that, you are as good as married. These are pretty dangerous girls and could even infect you when they are looking for a partner.”
(Male first year, TTC 2, Kenya)

Sexual experimentation in search of the ‘right partner’ was also mentioned as a risk factor to HIV infection. Male trainees expressed

a desire for sexual experimentation with a number of partners before eventually marrying the 'right one'. Such affairs are equated to a 'test drive', the absence of which could lead to a failed marriage.

"The qualities you look for are like the alphabet. A for age, b for beauty, c for character, d for denomination ... up to s for sex. If you do not do that, you will end up divorcing soon. I tell you, it is very important to try out your partner before marriage." (Male second year, TTC 3 from Kenya)

Academic pressure

Academically weak or just lazy female trainees unable or unwilling to do all their assignments were reported to grant sexual favours to male tutors in return for good grades. This has resulted in what has euphemistically become known within the student fraternity as *sexually transmitted diplomas or degrees* (see also Kimani *et al.*, 2006: 11). In one of the colleges in Kenya, the research team was told that most of these grades were awarded in the teaching practice assessment, largely because the greater part of the grades are internally determined (i.e. by the college), and tutors therefore have a greater influence on the final grade.

"The tutors here take our girls and give them marks for sex. During teaching practice, their work is approved immediately. For a male trainee, work is not easily approved." (Male trainee, second year, TTC 1, Kenya)

"Since during teaching practice we come back late in the day say 4 p.m., and have to prepare our work plans for the following day that same evening, we have to meet our tutors right into the night. Again, you have to meet the tutor alone in their offices to discuss your work plan. It is during these times that some male tutors take advantage of the female trainees and negotiate for sex in exchange for better grades. We male students are not so lucky." (Male trainee, second year, NTC, Uganda)

A recent UNICEF study in Kenya found that sexual relationships between teachers and students were very common phenomenon (Kimani *et al.*, 2006: 42). In Uganda, sexual harassment of female students by male tutors was reported to abound. The girls involved would succumb to pressure from tutors in fear of failing their assignments. Others were lazy and unable to hand in their assignments on time. Some girls said it was very difficult for them to report such cases to the TTC's administration for fear that nothing would be done to the concerned tutor, and it would create more problems if the tutor found out that they had reported the matter to the administration. In all the countries, there was a general feeling among students that it was better to accept the tutor's advances or to deal with him 'skilfully', because reporting the tutor to the administration only antagonized the student, as most principals prefer to side with their tutors in such cases.

"Imagine a lecturer who is as old as your father comes and tells you that, 'I love you' and if you refuse his overtures, you lose your Diploma. So some girls end up going in for those men. As students, we are insecure because we know that the moment one refuses to give in, the Diploma is gone." (Female student leader, second year, TTC, Uganda)

Media reports also indicated that sexual harassment in TTCs is often shrouded in silence. Few students are willing to report sexual harassment by their lecturers for fear of victimization by the concerned staff members. In Uganda, male lecturers were said to take advantage of female students' academic shortcomings, such as failing tests or poor coursework grades, to demand sexual favours in exchange for better grades (Ssempijja, 2004).

In one of the institutions of higher learning in Uganda, female students from rural areas, single-sex schools and poor family backgrounds were easily prone to sexual exploitation from tutors and male colleagues because they were in great need of money or were unaware of their rights. Cases of sexual harassment by female students were reported among male students, especially those from single-sex schools not used to studying with girls (Ssempijja, 2004).

Another phenomenon reported in Zambia, Kenya and Uganda was the 'sex for work' exchange. The 'dependency syndrome' was said to arise when students are given assignments and instructed to work in study groups. The lazy or academically weak girls would then ask their male peers to do all the research and complete the assignment on their behalf in exchange for sex.

Generally, it was observed that transactional sexual relations between male tutors and female trainees were common in the colleges. The tutors' code of ethics and the colleges' rules and regulations do not permit the existence of these sexual relations. However, flouting this regulation appeared to be the norm in virtually all the colleges. There was only one reported instance in one TTC where, in the past, a male tutor was interdicted and a female trainee discontinued. This occurred when the two did not report to the college after a sports event in a neighbouring institute, and investigations revealed that the two had spent the night together. It was also reported that trainees and/or tutors were reluctant to report sexual relationships for fear of having a colleague interdicted or a trainee discontinued from the college. In any event, it was observed that college trainees are adults who have a right to consent or not. In fact, there exists a silent understanding, among both trainees and staff, that these relationships were consensual unless it could be proved that the female student had been coerced into such a relationship.

Limited knowledge of HIV and AIDS

Despite evidence of increased knowledge of HIV and AIDS, many misconceptions persist among trainees in the colleges. This was pointed out as a predisposing factor of HIV infection among the trainees, although this view did not feature prominently. In TTC 2, about half of the respondents observed that some trainees continued to subscribe to the long-held belief by a local community that HIV and AIDS is *chira* (a curse). A few trainee respondents appeared to construe ART as a 'cure for AIDS'. To them, HIV and AIDS were nothing short of a 'normal' disease; hence there is no need to adopt protective behaviour. The following was a characteristic response:

“I recall there is a time I and my friends were discussing about AIDS. I pointed out that if I got AIDS now I would be much stressed. One of my friends said, AIDS is a very nice disease because it is not like leprosy and it is not air borne. You will stay for long if you eat well and therefore it does not matter if you get AIDS.” (Female second year, TTC from Kenya)

Such misconceptions are bound to influence perceptions of the risk and contribute to rigidity in the adoption of appropriate HIV and AIDS preventive behaviour among the trainees.

Sexual violence and drug and alcohol abuse

Another factor identified as leading to unsafe behaviour is excessive alcohol consumption. Although it was not possible to establish the magnitude of this problem among trainees, staff and students interviewed indicated that those who consumed alcohol excessively were at a greater risk of contracting HIV. Male students and staff were singled out as being more vulnerable because they mostly went to drink outside of the college premises, and would then end up having sex with the women who brewed and sold the alcohol. In their drunken state, most of the alcohol abusers did not use condoms, thus exposing themselves to possible HIV infection.

“I think there is a lot of liberty here, some students start taking alcohol and as you know, when they get drunk they lose control and can sleep with anyone or end up getting raped.” (Student leader, NTC, Uganda)

“There are some students who go out and drink in the surrounding villages and get drunk. Those are at a higher risk because they end up sleeping around with partners whose history they do not really know.” (Administrator, TTC 2, Kenya)

In TTC 3 in Kenya, both staff and students interviewed reported that drug trafficking took place openly in a town right at the gate of the college.

“Being near a city that is also a major tourist attraction and close to some slum areas of the city, we have had cases of alcohol consumption among our trainees. We believe this can expose them to HIV infection because of irresponsible sexual activities.” (HIV focal point, TTC in Kenya)

Drug abuse was often aggravated by the presence of slum areas around the TTCs. These slums attracted many students, as cheap illicit brews were easily available to students with not much money to spare. In TTC 2 in Kenya, staff observed that some trainees would sneak into a slum area near the college to consume cheap alcoholic beverages.

“Trainees sneak out of college and end up in a slum area of the town by the name ‘Padipieri’ that is notorious for bhang and *chang’aa* (illicit brew). Here they smoke bhang and take *chang’aa* practice that puts them at the risk of infection.” (Male Tutor, TTC 3, Kenya)

Besides cheap alcoholic brews, students would take drugs such as *cannabis sativa* and marijuana. In TTC 6 in Ethiopia, students were reported to take a drug known as *khat*. Consumption of these drugs tends to predispose some trainees to unsafe sexual behaviour, encouraging multiple sexual partnerships and unprotected sex, or even exposing them to sexual violence and rape – all of which could lead to HIV infection. TTC 4 in Ethiopia had even formed a gender club to deal with issues of sexual harassment among female students. The club also discusses violence against women particularly, as it relates to HIV and AIDS (Ashebir *et al.*, 2007). In the higher education institution in Uganda, drug and substance abuse was also associated with rape and other forms of sexual violence. First year female students did report being raped by male students in the halls of residence. The rape of female students was further exacerbated by the sudden personal freedom and space they experienced when they started their college life (Katahoire and Kirumira, 2007). Drug and substance abuse, though on a limited scale in colleges, was reported to be a more prevalent phenomenon among males.

Freedom and exposure

In all the countries, student trainees did report that college life comes with increased exposure to personal freedom. Many trainees, therefore, try out new, fulfilling sexual experiences and adventures under this newfound personal space that includes sexual pleasure. Many male students did report taking pride in the number of girls they had slept with. In TTCs located near main urban centres, many trainees were reported to regularly visit the hot spots and sample city life, as was reported to be the case at the higher education institution in Uganda.

“Some of us come from upcountry and have the mentality that Mombasa is *Raha* (Fun). When they get here, there are beaches, hotels, white men, and tourists on the beaches so we always try out different spices.” (Male first year, TTC 3 from Kenya)

A myriad of factors appeared to put student trainees at risk of HIV infection. Exposure to one or a combination of these factors increases their vulnerability, especially since many trainees may not be using any protection.

VI. INSTITUTIONAL RESPONSES TO HIV AND AIDS

1. Impact of HIV and AIDS on TTCs

It is not easy to quantify the impact of HIV and AIDS on the selected colleges. The qualitative data from the eight TTCs studied show no regular record-keeping system in any of the colleges on HIV-related absences, withdrawals, or mortality of teachers and student trainees. Available information is based on rumours, gossip and speculation because of the silence shrouding the epidemic.

Despite the lack of reliable data on HIV and AIDS, most respondents agreed that HIV and AIDS have potential negative consequences on TTCs and on the education sector. Evidence suggested that academic work is adversely affected by absenteeism of affected and infected staff and trainees; there is an increased workload on staff due to absenteeism and deaths; resources are diverted away from academic programmes to HIV and AIDS-related psychological problems; and there is a loss of a highly trained and specialized work force. Economically, there are difficulties in payment of fees, diversion of college resources to support PLWHA and the affected members of institutions, high costs of treatment and provision of a special diet to the infected. Socially, the disease leads to discrimination and stigma, fear and suspicion in social relationships. The impact of HIV and AIDS on the colleges is, as a result, great, requiring that measures for impact mitigation, both at ministerial and college levels, be strengthened.

Based on the above observations, as a coping strategy, ministries of education might consider having in place a pool of substitute tutors in specific subject areas that colleges could call on short notice to teach, if and when faced with staff shortages. This would ensure that the quality of teaching was not adversely affected by illnesses or deaths caused by other diseases as well as HIV and AIDS. In Kenya, for example, ill teachers are entitled to three months of full pay and three more on half pay when ill. Only after this can they be retired on health grounds. However,

tutors circumvent this regulation by making intermittent appearances in class during these months so that they are not recorded as having been on continuous absence, and thus avoid forced retirement. In the end, the trainees suffer because they merely get a semblance of what should have been taught (Nzioka *et al.*, 2007).

Table 6.1 Summary of impact of HIV and AIDS on TTCs

	Ethiopia			Kenya			Uganda		Zambia
	TTC 4	TTC 5	TTC 7	TTC 1	TTC 2	TTC 3	NTC 1	University	TTC
Impact									
What was the perceived impact of AIDS in terms of absenteeism of staff and students?	L	L	L	L	L	L	L	L	L
What was the perceived impact of AIDS in terms of deaths of staff?	L	L	L	L	L	L	L	L	L
What was the perceived impact of AIDS in terms of deaths of students?	L	L	L	L	L	L	L	L	L
What was the perceived impact of HIV and AIDS in terms of psychosocial strain?	H	H	L	H	H	H	H	H	H

Key: H = High; L = Low.

2. Institutional leadership on HIV and AIDS

Effective institutional leadership is necessary in order to address HIV and AIDS in forthright terms; to confront stigma, silence and denial; to address gender and age-based dimensions of the epidemic; to enhance the involvement of NGOs; and to ensure full participation of college members living with HIV and AIDS in care, treatment and support programmes.

Available literature argues that developing an effective response to HIV and AIDS requires a strong and visionary leadership. A strong and

committed leadership can inspire action, mobilize resources, establish policies and set responsive organizational structures (Kelly and Bain, 2003). In instances where institutional leaders have made HIV and AIDS a priority, the response has been immediate, effective and visible.

The involvement of top institutional leadership in HIV and AIDS activities is synonymous to institutional commitment. The evidence from TTCs in Kenya demonstrates that strong institutional leadership in HIV and AIDS makes TTC communities take HIV and AIDS activities much more seriously (Nzioka *et al.*, 2007). Where top institutional leadership is actively involved, decision-making and programme management structures have been established, networks have been created, resources have been found and the climate of silence and denial about AIDS has thawed. However, the level of involvement by top TTCs' leadership in HIV and AIDS did not appear to be consistent, and was sometimes completely lacking. At TTCs 4, 5 and 6 in Ethiopia, respondents did not believe that enough attention had been given to HIV and AIDS. For example, in TTC 4, efforts to deal with HIV and AIDS mainly came from the HAPCO Regional Bureau and local NGOs, who would invite college staff and students to HIV and AIDS workshops and seminars. The general feeling of the respondents was that the college administration needed to do much more to demonstrate effective and genuine leadership (Ashebir *et al.*, 2007). The key elements of effective leadership are a high level of personal commitment and a high level of awareness.

“Leadership is the capacity to effect change by inspiring other people to become involved, effective, and often, enthusiastic in doing what needs to be done. It is based on knowledge of a situation, commitment to act in relation to the situation, willingness to manifest that commitment publicly, willingness to commit personal resources (including time and energy) to the situation, ability to provide personal example and encouragement, and preparedness to work with and through others, showing confidence in their contribution and making allowances for their differences.” (Kelly and Bain, 2003: 177)

In most TTCs, the leadership provided the meeting hall and an office for the co-ordinator and a minimum of other material resources, as described by Kelly and Bain (2003). However, it did not appear that the leaders were seriously committed to HIV and AIDS. Most TTC administrators acknowledged their lukewarm support to HIV and AIDS, arguing that their institutions were experiencing more pressing problems.

Table 6.2 Leadership and collective action in response to HIV and AIDS

	Ethiopia			Kenya			Uganda		Zambia
	TTC 4	TTC 5	TTC 7	TTC 1	TTC 2	TTC 3	NTC 1	University	TTC
Leadership and collective action in response to HIV and AIDS									
Does the principal openly talk about HIV and AIDS?	Y	Y	Y	Y	Y	N	Y	Y	Y
Is the top institutional leadership committed to responding to HIV and AIDS?	Y	N	N	Y	Y	P	P	P	Y
Is there a specific member of staff designated to deal with HIV and AIDS matters in the college?				Y	Y	Y	Y	N	Y
Are staff members willing to be involved in HIV and AIDS-related activities in the college?	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is the student anti-AIDS group active?	Y	Y	Y	Y	Y	Y	Y	Y	Y

Key: Y = Yes; N = No; P = Partially.

Leadership in the response to HIV and AIDS should, however, not be left only to top institutional management. Such leadership should cross all levels, from deans, heads of departments and staff to the students. It should also be manifested in a variety of activities including student anti-AIDS clubs, professional student associations, peer groups, and possibly from PLWHA.

3. Institutional structures and policies in response to HIV and AIDS

Except for one teachers college in Kenya, no other TTCs visited had any institutional HIV and AIDS policy. The reasons for this appeared to vary across countries and colleges. In Ethiopia, for example, the absence of HIV and AIDS policies or guidelines was seen as a direct extension of the inertia on the part of the Ministry of Education to the federal level. Some key factors cited as an explanation for the lack of HIV and AIDS policies in TTCs included: lack of HIV and AIDS awareness on the part of the administrators; the TTCs' satisfaction with the activities and programmes of anti-AIDS clubs; and the outright failure on the part of TTCs' administrators to appreciate the need for such policies (Ashebir *et al.*, 2007).

Most colleges also cited lack of financial resources. At the time of the study, however, TTC 7 in Ethiopia was in the process of developing a HIV and AIDS policy in consultation with the Regional Education Bureau and HAPCO. In Kenya, the two colleges studied that did not have a policy indicated they had adapted and customized the wider education sector policy to meet their needs. There was, however, consensus that lack of institutional policies and guidelines on HIV and AIDS meant that colleges had to rely on personal initiatives of instructors/tutors to develop action programmes on HIV and AIDS. This had resulted in *ad hoc*, ineffective and unsustainable activities and programmes.

The case of the TTC in Kenya demonstrates that institutional leadership can play an important role in developing an effective TTC response to HIV and AIDS. In the course of preparing its institutional policy, a number of challenges were, however, identified by the college leadership. First, the college did not have funds to support its policy development and other related HIV and AIDS activities. Second, there was a long bureaucratic procedure of accessing funds from the National AIDS Control Council through the Ministry of Education. This process was long, frustrating and time-consuming. The college principal circumvented this obstacle by using her personal networks to seek out external assistance from a donor. There was also no other TTC in the

country which had developed its own HIV and AIDS policy. The college leadership had, therefore, to be very innovative in the way it solicited ideas and views from staff, students and other stakeholders. This prompted the college administration to adopt a highly participatory approach in soliciting views and opinions on how to develop the college HIV and AIDS policy.

Table 6.3 Summary of TTC policies, structures and funding mechanisms

	Ethiopia			Kenya			Uganda		Zambia
	TTC 4	TTC 5	TTC 7	TTC 1	TTC 2	TTC 3	NTC 1	University	TTC
TTC policies and structures									
Does the college have an HIV and AIDS policy?	N	N	N	Y	N	N	N	N	N
Does the college have an HIV and AIDS action plan?	N	N	N	Y	N	N	N	N	P
Does the college receive adequate support from the MoE and district level office?	N	N	N	N	N	N	Y	N	P
Does the college have a workplace policy that addresses HIV issues?	N	N	N	Y	Y	N	N	N	N
Is there an active AIDS club/committee?	Y	Y	Y	Y	Y	Y	Y	Y	Y
Funding and partnerships									
Are funds consistently available for HIV and AIDS college activities?	N	N	N	YL	YL	YL	YL	N	N
Do colleges fundraise for HIV and AIDS activities?	Y	Y	N	Y	Y	Y	N	P	N

Key: Y = Yes; N = No; P = Partially, L = Low.

Despite the apparent lack of policy, all the TTCs studied appeared to have in place certain structures and programmes to respond to HIV and AIDS, albeit limited. Most TTCs reported having HIV and AIDS control units and AIDS co-ordinators to plan and oversee the implementation of projects and programmes in response to HIV and AIDS. Most of the

selected or appointed co-ordinators also double as heads of departments and are, therefore, over-burdened. The designated focal points also tend to assume office without the requisite skills and training (Ramos, forthcoming). Other colleges had trainee and staff peer education and counselling groups, but there are no records on their activities, and there are no clear lines for reporting.

Box 3. Leadership in developing institutional response to HIV and AIDS: The case of TTC 1 in Kenya

- It was noticed that HIV and AIDS impacted negatively on the quality of teaching, performance and academic achievements, and drained family and college resources.
- College HIV and AIDS sensitization programme formed in 2002 to encourage tutor-student discussion in and outside of the classroom.
- Consultant hired to conduct a baseline survey to assess knowledge, attitudes and practices relating to HIV and AIDS among staff and students.
- College began providing an egg and a glass of milk to students with medical problems.
- College held an HIV and AIDS sensitization and awareness day (twice a year) and invited facilitators from outside.
- College established an outreach programme in surrounding primary schools within the vicinity of the college where TTC trainees and staff held HIV and AIDS talks, showed movies or conducted question and answer sessions with pupils, especially during teaching practice.
- Peer counsellors were trained among staff and students.
- HIV and AIDS infused and integrated into all college curricula.
- HIV and AIDS policy developed in 2003.
- A college HIV and AIDS Unit established in 2004 to develop a strategic plan.

Source: Commission for Higher Education, 2004: 61-63.

Other TTCs had established close working relations with NGOs dealing with HIV and AIDS near the college. The ACUs in TTCs had established activities including drama, plays and games conveying HIV

and AIDS messages. Other TTCs would invite guest speakers to give talks on HIV and AIDS during major college events and activities such as open days. Most of these activities and programmes were, however, characterized by resource constraints and administrative bottlenecks.

Box 4. Obstacles to effective operations of an institutional HIV and AIDS policy

- Lack of skills or training
- Lack of motivated staff
- Lack of financial resources
- Lack of physical space for operations
- Excessive workload for focal points
- Lack of clear institutional structures and reporting systems
- Lack of institutional legitimacy to liaise with NGOs and other organizations.

Source: Interviews with TTC administrators and tutors.

4. Mainstreaming HIV and AIDS

One aim of these studies was to examine the degree to which TTCs had mainstreamed HIV and AIDS prevention into their core functions and operations, including its incorporation into the formal curricular and extra-curricular activities. Mainstreaming HIV and AIDS education implies ensuring that it has centre stage so that institutional “policies, plans, and decisions are informed by, and take full account of, the relevant HIV [and AIDS] considerations” (Commission for Higher Education, 2004: 12).

Evidence shows that TTCs have made efforts to mainstream HIV and AIDS education both in the formal and informal curricula. For example, HIV and AIDS prevention is now part of professional studies at the NTC in Uganda and at TTC 2 in Kenya. HIV and AIDS education also forms part of extra-curricular activities, such as sports and creative arts or debates.

Below, the specific ways in which TTCs are trying to mainstream HIV and AIDS education into their functions, operations and curricula are examined.

Box 5. Necessary steps for mainstreaming HIV and AIDS education

- Put in place policies and practices that protect institutional staff and students from HIV infection while also supporting the infected to live with HIV and AIDS and their impact.
- Ensure that training and recruitment takes into consideration possible future staff depletion rates and disruption likely to occur by increased morbidity and mortality due to HIV and AIDS.
- Refocus the work of the institution to ensure that the infected and the affected are still able to be optimally productive.
- Ensure that the institution's activities do not increase the vulnerability of its staff and the communities working with or around it.
- Examine how the institution is influencing the spread of HIV.
- Teach the subject and raise awareness about HIV and AIDS.

Source: Crewe and Nzioka, 2007.

Integration of HIV and AIDS into existing subjects

These studies did not find evidence of HIV and AIDS education being infused into the curricula of all the TTCs. This was largely because all TTCs offer similar courses and subjects. There was also no evidence of it either being taught as a stand-alone or examinable subject. However, HIV and AIDS education had been integrated into existing subjects of relevance, such as civics, religious education, social ethics, social studies, or health education.

Curriculum-based HIV education programmes have been shown to be effective in significantly delaying reported first sexual experiences, reducing the frequency of sex, decreasing the number of sexual partners, and increasing condom use or reducing incidences of unprotected sex. Interventions led by teachers reported a strong impact on behaviour (Kirby, Laris and Roller, 2005).

Out of the 16 subjects taught at the TTCs studied in Zambia, the subject of HIV and AIDS was taught in four subjects, namely: science, biology, geography and religious studies. When asked if HIV and AIDS education was taught in courses, a lecturer, who was part of the Anti-AIDS Committee, in one college said:

“Lecturers try to incorporate material on HIV/AIDS in the classroom so that students can be sensitized, but now the curriculum is being reviewed so it should be integrated more”.

When asked how HIV and AIDS prevention was being taught in Zambia, the Head of the Teacher Education Specialized Services remarked:

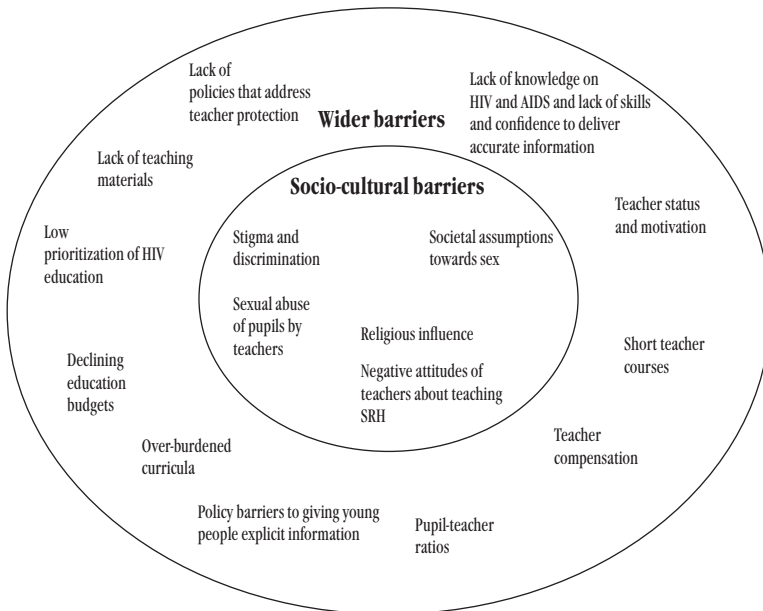
“HIV and AIDS are not formally in the curricula now but have been introduced as addendums. Their teaching materials are mostly informal in the form of information booklets. The teacher unions, NGOs, and the MoE prepare most of these. In some subjects, HIV and AIDS are completely integrated like biology and math. At one point there was an attempt to create a ‘special issues’ unit in each college, but it was felt that adding more layers and units at institutional level was unnecessary and would slow down the response. Instead, lecturers have been burdened with the additional responsibility of teaching HIV and AIDS into their curricula. Teacher trainees are examined at the end of each term and some questions related to HIV are asked in some subjects.”

The advantage of this approach is that the carrier subject teachers are likely to see the relevance of the topic to the subject. Given that students trainees are prospective teachers, they need to be “HIV-aware, HIV-competent and HIV-safe” (Coombe, 2004). As such, they need to fully grasp, understand and internalize pertinent facts and practices relating to HIV and AIDS. This might, however, come about only if these institutions have competent and effective systems for delivering HIV and AIDS education. To ensure students take the teaching of HIV and AIDS seriously, it might also be necessary to make it a compulsory and examinable subject in the TTCs’ internal and external examinations.

5. Teaching of HIV and AIDS

A few social and cultural factors have been identified as constraining the effective teaching of HIV and AIDS prevention (Boler, 2003*b*; Boler and Aggleton, 2005; Car-Hill, 2002; Bennell *et al.*, 2002). *Figure 6.1* presents a framework developed from existing literature to show the key factors a teacher educator and teacher trainee deal with when teaching and learning about HIV and AIDS.

Figure 6.1 Factors influencing the teaching and learning of HIV and AIDS for teacher educators and teacher trainees



Data gathered from in-depth interviews with administrators and tutors in TTCs did show that tutors experienced problems in teaching HIV and AIDS education. However, this is aggravated by rigid local customs, traditions, and lack of appropriate teaching devices. In Zambia, one member of a TTC anti-AIDS committee observed:

“Cultural norms are a big barrier. If I have a daughter or niece in the classroom then I am not so free to express myself. I may be constrained and do not say what I want to say.”

Another member added:

“Cultural norms state that I cannot say certain things in presence of my daughter, like reproductive issues. African families have extended families so we are not short of daughters and sons¹ in the classroom so it is difficult to teach. We will try to say it, but we cannot say it the way it should be said. We are constrained [when teaching HIV and AIDS] and cannot be explicit.”

Even within the anti-AIDS committee, two lecturers were siblings. One explained:

“Cultural norms make it even very difficult to speak now, in front of my sister.”

Despite significant societal changes, cultural norms in many places dictate that family members do not explicitly speak about sex (and HIV and AIDS by extension); this could constitute a major hindrance to the teaching of HIV and AIDS. Age differences constitute another barrier; within certain cultures, young people do not discuss sexual health matters openly with older people. This creates a communication barrier between tutors/lecturers and student trainees.

“If a younger person presents to the elders then the elders feel that the young person is insulting. This is also a barrier to teaching.”
(Anti-AIDS committee member)

The teaching of HIV and AIDS prevention was also inhibited by lack of materials.

“We need materials, and there are no materials. We need an artificial penis to demonstrate how to use a condom. We need people to show us how to use it. People just talk and tell us to use condoms and that we can get condoms from the clinic, but the clinic is always closed.

1. In many sub-Saharan African countries, daughters and sons also refer to extended family members, and ‘sister’ or ‘brother’ does not necessarily refer to biological siblings.

We need condoms and they should be in a convenient place.” (Male student, Zambia)

Within the FGD, it was observed that there was a need for relevant, interesting and adapted material, as times were changing. Teachers interviewed reported that parents disapproved of the teaching of HIV and AIDS when they learned that their children were being taught about sex.

Teacher trainees and tutors/teacher educators should be more ‘mature’ to teach and learn about the subject. Teacher trainees are older and teacher educators might benefit from an overall higher status and more schooling, which in principle would make them better placed to challenge existing social norms.

Integrating HIV and AIDS prevention into extra-curricular activities

Most TTCs had integrated HIV and AIDS education into non-curricular activities, such as sports or creative arts like drama and music subjects, plays and concerts, and debates. Awareness and sensitization activities had also been developed through clubs and societies. Creative arts such as drama, song/poetry and art and design are infused with HIV and AIDS messages. Dissemination of HIV and AIDS materials in the college is being done, although findings revealed that the colleges have very little of such materials.

TTCs are also inviting qualified external speakers or personnel, such as doctors from nearby hospitals or programme personnel from local NGOs, to give public lectures on selected days in the college calendar. In Kenya, some TTCs are inviting HIV-positive teachers from the Kenya Network of Positive Teachers (KENEPOTE) or other PLWHA to give these lectures. TTCs, in addition, are setting aside days for HIV and AIDS awareness and sensitization. College open days provide teacher trainees, staff, and local community members with an opportunity to discuss and share HIV and AIDS information. TTCs have also created internal resource centres where they keep HIV and AIDS materials and

videos for use by anti-AIDS clubs or interested students. Some TTCs have tried promoting HIV and AIDS education through the Internet.

Table 6.4 Summary of teaching and learning on HIV and AIDS

	Ethiopia			Kenya			Uganda		Zambia
	TTC 4	TTC 5	TTC 7	TTC 1	TTC 2	TTC 3	TTC 1	University	TTC
Teaching and learning on HIV and AIDS									
Is HIV and AIDS education taught in lectures?	P	P	P	P	P	P	P	P	P
Is it stand alone or integrated?	I	I	I	I	I	I	I	I	I
Is it examinable?	N	N	N	N	N	N	N	N	N
Have tutors received training in HIV and AIDS education?	S	S	S	S	S	S	S	S	P
Are there quality learning materials on the subject?	S	S	S	Y	Y	Y	Y	N	N

Key: Y=Yes; N=No; P=Partially; I= integrated; S = Some.

However, in virtually all the TTCs studied, the major constraint mentioned was lack of financial resources. In Kenya, the government tried to solve this problem by setting aside financial resources to enhance the capacities of TTCs to deal with HIV and AIDS. The Ministry of Education, through its ACU, started providing training for college HIV and AIDS co-ordinators, and funds for college HIV and AIDS activities. At present, the annual budget for each college is about Kshs.300,000 (US\$ 4,000). However, given that most colleges have high populations (800 to 1,200 trainees), the impact of these resources is extremely limited. A capacity-building training programme for both staff and students in TTCs is taking place in TTCs 4, 5, 6 and 7. This training programme is organized by the HAPCO Secretariat and covers topics such as leadership, gender and reproductive health, virginity initiative, gender violence, unsafe sex and associated issues including unwanted pregnancy, HIV and AIDS. The programme trains tutors who are patrons of anti-AIDS and gender clubs, as well as student officials.

Respondents observed that the motivation for tutor participation in these training programmes was low because, for most of them, their efforts were not recognized and they were not financially compensated. There are also no formal criteria for evaluating who gets to know what. Lack of budget to support the clubs' programmes heightens frustration among staff and students. This implies a need for colleges to explore the possibility of diversifying their sources of funds for HIV and AIDS activities. Colleges thus need to build their capacities for accessing more funds, including learning how to develop proposals, and mobilizing resources from agencies other than the ministry of education.

Treatment, care and support for PLWHA

Colleges were making efforts to provide HIV and AIDS-related services. For example, college health facilities were trying to provide therapeutic services for managing opportunistic infections and STIs among trainees. However, the existing college dispensaries are constrained in two ways: First, the staff in these dispensaries are grossly unqualified. In one of the colleges visited, the health official managing the dispensary was a nursing assistant and, therefore, lacked the capacity to administer basic health services such as prescribing ART. Second, these dispensaries cannot stock the requisite supplies and equipment for managing basic HIV and AIDS-related illnesses, since most colleges have a limited operating budget.

TTCs might consider establishing close linkages with NGOs and government health facilities within the college's proximity to secure supportive services in dealing with HIV and AIDS-related illnesses. This would ensure that those diagnosed with HIV and AIDS can easily access ART and counselling services outside the TTCs, and in an anonymous environment. TTCs can also benefit from mobile VCT services provided by NGO and government medical services, as was found to be the case in TTC 1 in Kenya. Collaboration with NGOs and government health services existed in two out of the three colleges visited, but this linkage could be strengthened.

Nutrition programmes to support the infected are also in place but lack resources. The mobile VCT services in the colleges are irregular. ART is not available in the colleges for the trainees. However, colleges are trying to seek assistance from health institutions for providing ART to trainees and staff.

Provision of condoms

The majority of students and staff interviewed in this study reported being sexually active, but most did point out that condoms were not readily accessible in college. This was confirmed by the college administration, who indicated that it was not the policy of the college to supply students with condoms. In the NTC in Uganda, students who needed condoms had to travel far by public transport to go to the nearest town, and the fare would often be higher than the cost of the condoms themselves. Occasionally, there would be no stock. As a result, many students resorted to unprotected sex, with the consequences being a higher incidence of STDs, unwanted pregnancies and abortions.

“We are sensitized about HIV/AIDS but we are not given condoms. Imagine going to X town (town next to NTC) where the transport cost is one thousand shillings just to buy a pack of condoms for three hundred shillings.” (Second year male student, TTC, Uganda)

A second year female student remarked that:

“We do not understand why the college administration has refused to make condoms available within the college. They know too well that students here are sexually active.”

Limited access to condoms was reported as a major reason for unprotected sex among students.

In one college, in Kenya, a huge stock of condoms in the dispensary was about to expire because the principal had not given directions on how these condoms were to be distributed. This indecision by principals to provide directions on the distribution of condoms appeared to stem from a strong moral-religious discourse, pervasive in Kenya, that condemns condom use. The same applied in the colleges studied in

Zambia, Ethiopia and Uganda. Ironically, condom use was acceptable in universities but not in TTCs. In the universities, as was found to be the case in Uganda, the problem was a shortage of condoms. According to Katahoire and Kirumira (2007), limited access to condoms was reported as a major cause of the persistence of unprotected sex among students. Top administrators interviewed in the university, just as those in the NTC, were reluctant to avail condoms to students lest the administrators be perceived as condoning immoral behaviour. The administrators thought that by not making condoms available, the institutions would be discouraging sexual activity among students. On the contrary, this did not appear to deter students from engaging in sexual activity, but instead exposed them to greater risks of unwanted pregnancy and HIV/STI infection (Katahoire and Kirumira, 2007).

Box 6. Debate on condom use

Arguments in favour of condom use in TTCs

- College trainees are adults.
- Condom use is a right.
- It is better to use condoms than risk death.
- Condom use is the 'in thing' (fashionable) in the era of AIDS.
- Abstinence is not possible for young people.
- Condom use shows responsibility.

Arguments against condom use

- Condom use encourages sexual promiscuity.
- Condom use promotes immorality.
- Condoms are for prostitutes.
- TTC produce teachers who should be role models, hence it should not promote condom use.
- Condoms sometimes have holes and are not effective.

Source: FGDs with student trainees.

This inertia is undesirable because it exposes trainees to risks of HIV infection when this could be avoided. This is also inconsistent with the HIV prevention messages trainees receive in class. Studies also seem to demonstrate consistently that availability of condoms *per se* does not,

in itself, encourage or promote sexual activity among students. Rather, making condoms available in academic institutions enables students easier access to condoms, but does not increase condom use. It does not address the real barriers to condom use (Brener, Kirkby, Brown and Moore, 1998).

Table 6.5 Summary of services and awareness campaigns

	Ethiopia			Kenya			Uganda		Zambia
	TTC 4	TTC 5	TTC 7	TTC 1	TTC 2	TTC 3	NTC 1	University	TTC
Services									
Are explicit policies/ statements on condom distribution available?	N	N	N	N	N	N	N	N	N
Are condoms readily available?	N	N	N	N	N	N	N	P	N
Are there any VCT services on college?	N	N	N	N	N	N	N	Y	P
Is there on campus guidance and counseling service for students?				Y	Y	Y	Y	Y	R
HIV and AIDS awareness									
Are posters and other behaviour change communication messages displayed around campus?	Y	S	S	Y	Y	Y	Y	Y	N

Key: Y=Yes; N=No; P=Partially; I= integrated; S = Some; R = Referral.

Given that most college trainees are adults by age, and some are married and actually have families, it may be necessary for the MoE to issue a more direct and explicit policy on condoms rather than leave it to the discretion of the principals. Such a policy directive should specify modalities of distributing condoms, such as where in the college these condoms should be placed, by whom, how and when. Thus condoms could be made easily accessible, leading to a significant uptake in condom use and, eventually, to a reduction in HIV infections in TTCs.

Community outreach, partnerships and networks

This study noted that community outreach, partnerships and networks between TTCs did exist in varying degrees and forms. In most colleges, there is no testing or guidance and counselling services, so students and staff seek these services from NGOs and other organizations in the vicinity of the college. Staff and students tend to utilize the services of partner organizations because they provide privacy and anonymity often not possible within the TTC.

A female student in a college in Zambia confirmed this when she said:

“If I am positive then I can talk to a social co-ordinator, but it is not a good idea to have lecturers as social co-ordinator. An office with an external counsellor not related to the college would be better.”

The same college in Zambia was also working in partnership with Student Partnership Worldwide, an NGO for training peer educators (Ramos, forthcoming). In the university in Uganda, Youth Alive is an NGO running a peer education programme known as Prime Time, together with the St. Augustine Community and University Community Church. This programme addresses HIV and AIDS issues and is referred to as the Behaviour Change Programme. The peer educators meet every Monday, at the beginning of the semester, and work out a programme for that semester. Resource persons are invited to come and speak to the peer educators on topical issues, and sometimes debates are organized. The programme introduces students to how HIV is contracted and prevention methods, and discusses the challenges of being at university and the risk factors involved (Katahoire and Kirumira, 2007).

“These meetings have greatly raised our awareness about HIV and AIDS and they have enabled us to go out and spread the same information to our peers. Sometimes inter-denominational meetings are held, which draws together student leaders of different religious denominations.” (Youth Alive member)

“The leaders are taken through a course on HIV and AIDS prevention and control methods and they are trained as trainers and are tasked with the responsibility of going and carrying out peer education.” (Youth Alive co-ordinator)

According to the Prime Time co-ordinator:

“Prime Time is an AIDS prevention programme that provides education and entertainment meetings at the university as an alternative to sexualized entertainment like discos and nightclubs ... it promotes abstinence and discourages the use of condoms.”

A male student who also attended Prime Time regularly explained:

“Prime Time focuses on specific themes for example, on how to resist demand for sex or how to deal with pornography or promiscuity. So, a drama scene is acted where a student in a hall of residence or hostel deals with pornography, or a scene is shown portraying how to say no to a boyfriend who is demanding for sex and so on.”

Prime Time also produces a newsletter, which is free for students. The newsletter discusses different challenges faced by university students, and provides solutions to some of them. During the FGDs, students mentioned Prime Time as one of the HIV and AIDS prevention programmes that draws large numbers of students (Katahoire and Kirumira, 2007).

Other programmes run by external organizations, though very innovative, seem to attract less interest. The institution of higher learning could, however, take advantage of some of these programmes and expand them to include more students and staff. The peer education programmes and life skills training were considered by students to be effective in communicating the message of HIV and AIDS.

In **Ethiopia**, most of the colleges organize educational trips to the local communities and other educational institutions focusing on education issues, but not necessarily exclusively for HIV and AIDS education. Equally, during teaching practice, students are expected to discuss HIV and AIDS with pupils in the schools where they do their

practical training. However, in many cases, the teacher trainees feel constrained by the sheer lack of adequate knowledge and technical competence to address HIV-related issues.

In Ethiopia, another major constraint cited by trainees as an obstacle to their involvement in HIV and AIDS activities with local communities was government restrictions. According to some students interviewed, college students may not deal directly with communities without obtaining the approval of the relevant college authorities, and similarly, without the college obtaining approval from the regional state authorities. Despite these restrictions, some anti-AIDS clubs did report reaching out to communities to create HIV and AIDS awareness. TTC 4 in Ethiopia had also played host to teachers from neighbouring schools to participate in workshops organized by the health department of the college. In TTC 7, both students and staff had organized plays on HIV and AIDS and had invited local people to watch.

However, TTC 6 in Ethiopia did report having established a strong partnership with the Family Guidance Association of Ethiopia (FGAE). FAGAE was thus assisting TTC 6 with financial and material contribution for the college's HIV and AIDS activities. In TTC 4 in Ethiopia, the Dean of Students was a member of the HAPCO Regional HIV Secretariat. Respondents in this study saw partnerships and networks as vital for TTCs to access funds, expertise, best practices and resources. Partnerships and networks were perceived as useful vehicles for safeguarding the long-term interest of the TTCs and promoting good relations with local people and communities.

VII. RECOMMENDATIONS

Education has been termed as the best social vaccine to HIV and AIDS. Educational institutions play, therefore, a critical role in the fight against HIV and AIDS. TTCs have a wide reach, influence and capacity to mobilize their trainees and communities to respond to this disease. TTCs train teachers who in turn train young people and members of local communities. Yet, the responses of most TTCs in this study have been lukewarm and their leadership has been slow in fully responding to the epidemic. This stems from the cloud of silence still shrouding HIV and AIDS, even in tertiary education institutions.

TTCs should be encouraged to mainstream HIV and AIDS through the development of appropriate institutional policies, creating institutional structures and setting aside budgets for HIV and AIDS activities. Mainstreaming HIV and AIDS education also requires adjusting policies, programmes and daily practices, and incorporating new insights and developments into the TTCs' activities and programmes. TTCs need to recognize their susceptibility to the impact of HIV and AIDS and reduce their vulnerability by educating their members on modes of HIV transmission and on prevention education, treatment, care and support.

Teachers are the largest cadre of civil servants in most countries, and are found in every corner of each country studied. By virtue of their profession, teachers are in touch with local communities on a daily basis and have access to the widest segment of young people, most of which are in their formative years. TTCs need to recognize the important role teachers can play in reversing the tide of HIV and AIDS. For teacher trainees to become effective advocates of HIV and AIDS messages, there needs to be recognition of the fact that HIV and AIDS touch on the sensitive subject of sex and sexuality, and generate stigma and discrimination because of the negative symbolic meanings associated with them. Consequently, teacher trainees must be well-trained communicators. They need to know how to communicate and convey

sensitive messages in ways that are congruent to local cultures and personal sensitivities. For example, data from this study show that some TTC authorities hold judgmental attitudes towards condom use and distribution, yet there is a need to distinguish private morality and public responsibility (Ashebir *et al.*, 2007). The teaching of HIV and AIDS education in the TTCs also appears to be cursory and rather fragmented. Perhaps it is time TTCs considered making HIV and AIDS education a stand-alone subject. The impact of HIV and AIDS can also not be meaningfully understood without adequate and clearly worked out statistical data. Plans and strategies cannot, however, be developed without data. TTCs need to try to develop HIV and AIDS-sensitive information-gathering systems, because lack of accurate data makes interventions less effective and daunting. Moreover, structured data is extremely useful in guiding policy-making, setting priorities, monitoring and evaluating interventions, and the rational allocation of limited resources.

The following are recommendations derived from the findings:

1. Developing national responses

Ministries of education should explore ways of developing strong relationships with the national AIDS councils or national AIDS commissions to secure funding and technical support to develop national education sector policies on HIV and AIDS (if none exist) and to support related activities in the entire sector.

2. Impact assessment

TTCs should be encouraged to conduct internal HIV and AIDS impact assessments on themselves. This would enable them to ascertain the level to which HIV and AIDS are adversely affecting their functions, activities and resources.

Since there are currently no established indicators for monitoring and evaluating HIV and AIDS programmes in TTCs, ministries of education should assist in developing such indicators, and encourage

TTCs to use these indicators for monitoring and evaluating HIV and AIDS programmes.

Ministries of education should also conduct external evaluations of each TTC's HIV and AIDS programmes with a view to teasing out 'good lessons' and practices that could be shared among other TTCs.

Data collection systems in TTCs need to be improved by use of reliable and valid indicators. A regular, consistent, and effective EMIS needs to be put in place as a basis for the design of effective responses to the impact of HIV and AIDS.

3. Institutional policies and structures

Ministries of education should give TTCs technical and financial support to develop their own policies, while TTCs with an HIV and AIDS policy should be given support to implement their policies. As the findings indicate, human resource capacity to plan, design and implement policies is lacking. Therefore, policy development should be participatory and inclusive. MoEs should avoid entirely driving policy from the central level.

Ministries of education should allocate more resources to support HIV and AIDS initiatives in TTCs, while also encouraging them to mobilize resources from other sources through proposal development and fundraising activities. For example, the MoE could organize an annual bidding from TTCs. This would encourage the sector's involvement in HIV and AIDS responses and be a tangible way for funds to be channelled into the teacher education departments.

HIV and AIDS focal points in TTCs need appropriate management training skills to manage their HIV and AIDS programmes and projects more effectively. For example, refresher courses need to be built into programmes. Focal points can also be encouraged to explore the possibility of exchange visits with other colleges

TTC HIV and AIDS response structures should adopt a representative and participatory approach to ensure optimal involvement of both staff and trainees in HIV and AIDS-related activities and programmes.

4. Leadership in HIV and AIDS

TTCs' authorities should seek to provide more staff with the appropriate skills to deal with HIV and AIDS, both at individual and institutional level.

TTCs need to provide appropriate training on HIV and AIDS to the leadership of relevant institutional bodies such as anti-AIDS clubs, media, drama, music and debate clubs, and provide budget support.

TTCs should tap into the leadership of both the infected and affected, and encourage teachers as well as male and female students to participate in anti-AIDS activities.

College principals should discuss with tutors and staff the importance of positive living, and encourage the involvement of PLWHA in activities. Positive teacher networks should be encouraged to visit TTCs and share their experiences and challenges of living with HIV and AIDS with TTC staff and students, and also promote HIV and AIDS prevention education in the college community.

Leadership in TTCs should also be exposed to gender issues to be in a better position to understand the way it impacts on social relations and differential positions for men and women in society. This understanding is necessary because the spread of HIV is largely driven by gender power relationships.

5. HIV and AIDS prevention education

HIV and AIDS prevention needs to be integrated into curricula, and teachers must be trained in how to do this properly.

HIV and AIDS subject matter content should be tested in internal and external TTC examinations.

TTCs need to explore interactive ways of teaching HIV and AIDS education to trainees, such as the use of creative arts and the Internet.

TTCs need to be supplied with adequate IEC materials on HIV and AIDS and be encouraged to be innovative and develop their own.

TTCs could also be encouraged to develop relevant creative arts activities on HIV and AIDS, such as skits, plays, games, art and songs, education and communication materials. Manuals and explicit guidelines on curriculum integration ought to be developed, and customized trainings provided to teachers.

Teaching materials and resources such as instructional videos, manuals and inspirational talks should be made more accessible to TTCs.

TTCs should institute formal mechanisms to reward individual teachers engaged in HIV and AIDS activities, including relieving them from other official duties. For example, the most motivated lecturers should be acknowledged. Additionally, duties related to HIV and AIDS activities could be reflected in their job description.

Peer counselling and information sharing should be encouraged as a strategic way of promoting HIV and AIDS prevention education in TTCs.

Leadership training for anti-AIDS clubs should be provided to all teacher trainees. This will ensure that when they become teachers, they will know how to run an anti-AIDS club. The most motivated teachers will then do so.

Life skills education, such as how to resist peer pressure, how to handle sexual harassment or how to use a condom, must be provided repeatedly.

Anti-AIDS club members need training in HIV education so that they can train other students. For example, in Zambia, worldwide student partnerships trained peer educators in the college.

6. Prevention, care, treatment and support

The high cost of tuition fees, books and accommodation is pushing a number of poor students to transactional sex. Ministries of education need to explore ways of extending financial assistance in the form of scholarships and student loans to cushion these poor students from

possibly getting involved in unsafe sexual activities. TTCs could also explore possibilities of providing students from poor families with part-time on-campus employment or securing for them private primary school tutoring employment in the neighbourhood surrounding the TTC. These strategies could assist poor students financially, helping them desist from partaking in unsafe sexual activities.

TTCs need to be much more vigilant in enforcing a professional code of ethics to minimize the occurrence of tutor-trainee sexual relationships. Appropriate action needs to be taken against those who breach these ethics. The ACUs should also establish a workplace committee that reviews and enforces sanctions.

The restrictions to condom distribution should be lifted in all teacher education colleges. The excuse that it is against college rules and regulations is unacceptable, because the situation obviously hampers the institutional response to HIV and AIDS. Condoms could be made available to teachers and trainees at convenient locations on campus. In addition, MoE should attempt to harmonize the rules and regulations of TTCs in a manner that does not jeopardize any efforts to mitigate the spread of HIV (see Ashebir *et al.*, 2007).

Health clinics in TTCs should be equipped with qualified staff and be encouraged to establish linkages with other health referral systems in the neighbourhood to enable the TTC community easy access to VCT services. For example, the MoE and MoH should discuss concrete ways to co-operate in this exercise.

7. Partnerships and networks

Linkages with clinics and NGOs operating within the vicinity of TTCs should be fostered to allow staff and students access to such benefits as free ART, counselling and other services. In the case of Uganda, two NGOs, namely the AIDS Support Organization (TASO) and the Uganda AIDS Information Centre, could assist Uganda TTCs with VCT, ART services and support for PLWHA. In Kenya, TTCs could approach organizations such as KENEPOTE and the Kenya Association

of Professional Counsellors (KAPC) for assistance in developing counselling skills.

Partner with NGOs and other civil society organizations in strengthening the capacities of anti-AIDS clubs.

Strengthen linkages with appropriate bodies for information and experience sharing and capacity building.

8. Regional co-operation

There is need to build reliable and efficient data banks and information systems on best and promising practices across the region to permit a smooth and efficient exchange between ministries of education and TTCs in the region.

Teacher education directorates across the region should consider implementing the recommendations laid out in this study and take active steps to improve teacher preparation courses and institutions.

Ministries of education in the four countries should consider the creation of a regional inter-country information network for sharing information on best practices and effective responses to HIV and AIDS in TTCs. This would facilitate better synergy and cross-fertilization of ideas within and across TTCs in all the countries.

9. Development partners and UN agencies

Development partners and UN agencies should, as much as possible, influence national education policies on teacher education in HIV and AIDS.

Development partners and UN agencies should try, through such initiatives as UNESCO's EDUCAIDS and the Teacher Training Initiative for Sub-Saharan Africa (TTISSA), to provide financial and technical support (skills and training) to both staff and student teachers to deal with HIV and AIDS, thereby improving the overall quality of education.

Development partners and UN agencies should also create inter-country networks of TTCs that can facilitate the exchange of ideas

and information on best practices for enhancing the capacities of TTCs to deal more effectively with HIV and AIDS.

10. Recommendations for further research

A tracer study needs to be conducted to document the experiences of teacher trainees in teaching HIV and AIDS upon graduation. This could cover issues of how the trainees feel they have been prepared in the teaching of HIV and AIDS education, the pedagogical and institutional challenges they face in the teaching the subject, as well as the strategies they utilize in circumventing these challenges. Such a study could also tap into inter-country experiences with a selected sample of graduate teachers from certain TTCs across the four target countries.

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