The first 25 years of HIV

Some key lessons for the education sector in responding to HIV and AIDS

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

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

The earliest HIV prevention interventions were civil society efforts among the infected and affected communities. Some of these were remarkably successful in raising awareness and changing behaviours, underscoring the importance of civil society activism in addressing the multi-faceted challenges presented by HIV and AIDS.

The education sector response to HIV has been a long time coming. Its emergence can be traced back to the International Conference on Education at its 40th session, held in 1986, which unanimously adopted a special recommendation entitled *Education in the fight against AIDS*, based on a proposal by the delegation of Venezuela (UNESCO, 1987a). UNESCO's *Draft Plan of Action in Education for the Prevention of AIDS* (UNESCO, 1987b) was presented as an integral part of the WHO Global Strategy for the Prevention and Control of AIDS.

Since the late 1980s, many countries have attempted to harness the education sector for HIV prevention, within the multi-sectoral national response. Ministries of Education have done this with varying degrees of commitment, intensity, programme coverage and effectiveness. Evidence from research on HIV in the sector presents a mixed picture. While the response has grown in scale in comprehensiveness, the pace of progress has generally been slow (World Bank, 2004). Moreover, it has recently been alleged, somewhat contentiously, that Ministries of Education have not succeeded in the HIV roles imposed on them (England, 2008). It is possible to take a more optimistic view, but it is abundantly clear

that the education sector response to HIV represents work in progress, and more long-term investment is required almost everywhere. More research is also needed to identify success factors. However, from the available evidence, it is possible to distil a number of key lessons. Seven of these are presented below.

1. Supportive leadership at all levels is critical to effective implementation of HIV education

Leadership on HIV from Ministers of Education and the most senior administrators such as Secretaries of Education is of critical importance in achieving a comprehensive response to HIV. This includes policy, strategic planning and strengthening institutional capacity to implement HIV education programmes. Numerous studies attest to the importance of support from education authorities at district level and school level and from community organisations (Kirby *et al*., 2006).

School leadership is an essential factor in school effectiveness (Leithwood *et al*., 2006). This includes the effectiveness of HIV education. School principals have a responsibility to ensure that teachers who are delivering HIV education are supported by their colleagues and school management (Visser, 2004). They need to create and sustain a safe, conducive and supportive environment for HIV education in schools (Wijngaarden, 2004), including addressing gender-based violence, sexual abuse (Leach *et al*., 2000, 2003 and 2007) and alcohol abuse (Kiragu, 2007) within the school setting (UNESCO, 2006a).

2. Appropriately designed and implemented education programmes are able to increase knowledge about HIV and AIDS and reduce reported risk-taking behaviours

Risk[1] reduction can be achieved through education programmes that specifically address those HIV-related risks that confront the target population (UNAIDS Inter Agency Task Team on Education, 2003). School-based programmes offer a very large target population and provide an opportunity for interventions to reach a very large number of young people before or around the time that they become sexually active and engage in high risk behaviour (World Bank, 2002). Good quality risk-reduction programmes encourage young people to delay the onset of sexual activity, to reduce the number of sexual partners and increase the use of condoms if they are already sexually active (UNAIDS, 2007c). They also address risk-taking behaviours related to alcohol consumption and injecting drug use.

A day care centre in Malawi for AIDS orphans and children

Numerous studies have demonstrated the effectiveness of school-based programmes in increasing knowledge about how to avoid HIV infection (Kirby *et al*., 2006). However, it is well recognised that although knowledge is not sufficient to affect behaviour change, it may be a necessary condition (Gallant and Matika-Tyndale, 2004). The research of Kirby *et al*. (2006) found a large majority of school-based sex education and HIV education interventions reduced reported sexual behaviours in developing countries.

The characteristics of effective school-based risk-reducing education programmes are now becoming better understood as a result of international research. Kirby *et al*. (2006) identify 17 characteristics of effective sex and HIV education programmes in developing countries. These are organised into four areas: developing the curriculum and content, curriculum goals and objectives, activities and teaching methods, and implementation. These can help Ministries of Education develop more effective curriculum-based programmes.

A review of HIV education programmes in Africa suggests that knowledge and attitudes are easiest to change, but behaviours are much more challenging (Gallant and Maticka-Tyndal, 2004). Programmes targeting younger, primary school children have had greater success in influencing sexual behaviours compared with those targeting older, secondary school children; likewise, there

appears to be a differential success among youth who were virgins at programme initiation compared to those already sexually active (Gallant and Maticka-Tyndal, 2004).

3. Education can help reduce HIV-related stigma and discrimination

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

The education sector can help prevent HIV-related stigma and discrimination through teacher training and curriculum-based teaching and learning. The rights of education staff and children living with HIV or affected by AIDS can be supported through workplace policies and anti-discrimination legislation. The results of a review of HIV education programmes in Africa show that

attitudes towards people living with HIV can be changed with school-based programmes (Gallant and Maticka-Tyndal, 2004). Similar findings were obtained in India (Catalyst Management Services, 2003; SWASTI, 2004).

UNAIDS (2007c) recommends that schools create awareness of stigma and discrimination, highlight the harm they cause, and outline the benefits of reducing them through participatory teaching and learning. Myths and misconceptions about HIV and AIDS need to be addressed. Contact strategies involving direct or indirect involvement between people living with HIV and schools help dispel myths and humanise the disease.

4. HIV education programmes need to be tailored to meet local needs

The examination of global and regional epidemiological trends by UNAIDS (2007b) suggests that there are broadly two patterns. First, epidemics are being sustained among the general population, chiefly in Sub-Saharan Africa, especially in the southern part of the continent. This is the region that is most seriously affected by HIV and where it is the leading cause of death. Second, epidemics elsewhere in the world tend to be concentrated among most at risk populations, such as sex workers and their clients or partners, men who have sex with men, and injecting drug users. These patterns imply that different response strategies are required. A more concentrated epidemic requires greater prioritisation and targeting of interventions towards those at higher risk (Wijngaarden, 2007).

Hence, the education sector response must position itself appropriately. HIV education programmes need to be based on evidence of vulnerability to and risk of HIV infection in the local context, rather than from a universal template of HIV-related knowledge and skills.

5. An enabling environment needs to be created for the education sector response to HIV

There are two critical areas for creating an enabling environment for the education sector response to HIV: (1) education policy framework, and (2) the education sector plan.

5.1 Education Sector Policy on HIV

Public policy consists of the issues that are identified for attention by government and the courses of action that are taken to address them, such as legislation, regulation and resource allocation. Policy-making is the process by which governments translate their political vision into programmes and actions to deliver outcomes that will achieve desired change.

Public policy on HIV may be enshrined in law, as in the case of the Philippines AIDS Prevention and Control Act of 1998 or the Cambodia Law on the Prevention and Control of HIV/AIDS. Policies may be framed at the national multi-sectoral level, as in the case of the National HIV/AIDS Policy of Zimbabwe (World Bank, 2007) or at the sectoral level, such as the Botswana Policy on HIV/AIDS Education and the Jamaica National Policy for HIV/AIDS Management in Schools. A range of policy instruments is likely in a multi-sectoral response. These need to be tailored to the existing legal and policy environment. It seems probable that a specific education sector policy framework for HIV will be most effective

in addressing the particular issues to be encountered in and by the sector.

A coherent, comprehensive and scaled-up response to HIV is considerably more problematic to achieve without a specific policy in place. Policy is required to define priorities, rights, entitlements and responsibilities with regard to the HIV response in the education sector. It should include a comprehensive workplace policy consistent with ILO and UNESCO guidance (2001, 2006a, 2006b). The policy should include appropriate positions on curriculum-based HIV prevention, school health, teacher education and HIV impact mitigation. It should also specify clearly responsibilities for implementation and monitoring/review. In summary, the policy needs to provide clarity about how HIV will be mainstreamed in the education sector.

An important aspect of having a policy in place is that it demonstrates ownership by the Ministry of Education of the issue and the response. It permits greater accountability by civil society, assuming of course that it is readily accessible to all through a national dissemination process. Policy-making may mean having to make hard choices and difficult decisions. HIV education in schools and how to address the needs of orphans have proved to be among the issues most difficult to resolve in policy-making processes in Africa (Stover and Johnston, 1999). Countries appear to be learning from regional experience and putting in place more comprehensive educational policies on HIV. Examples include, Botswana (1998), South Africa (1999), Jamaica (2001), Namibia (2003), Zambia (2004), Kenya (2004), Sierra Leone (2005) and Uganda (2006).

Policy dissemination is critically important. A study on Kenya's education policy for HIV revealed inadequate attention to dissemination (Ndambuki *et al*., 2006). The findings indicated that teachers, head teachers and other key stakeholders at the grassroots level:

- were generally not familiar with the policy.

- did not have access to copies of the policy document.

- were not sensitised and trained on the interpretation and implementation of the policy.

- and did not know their mandate, duties and responsibilities in the interpretation and implementation of the policy.

It follows that there need to be clear guidelines on the access and utilisation of resources for the distribution, dissemination, interpretation and implementation of the HIV education policy. There should be well-co-ordinated approaches for the interpretation of the policy, and a monitoring and evaluation system for the implementation of the policy.

5.2 HIV and the Education Sector Plan

The education sector should develop its own specific costed strategic plan to respond to HIV, integrated within the education sector plan. This can be considered as the touchstone of success in mainstreaming HIV. The education sector response should in turn be a key component of the multi-sectoral National AIDS Strategic Plan.

Integrating costed HIV activities into the Education Sector Plan remains one of the greatest challenges. Ministries of Education

have generally been slow to develop an evidence-based comprehensive and costed strategy for HIV (Bakilana *et al.*, 2005). A study of the initial 12 Education For All Fast Track Initiative (EFA-FTI)-endorsed plans found that they did not adequately address HIV (Clarke and Bundy, 2004). A follow-up review of the next eight plans endorsed the FTI, found that five of these had included an HIV and AIDS response, but only three countries provided details of the costings of their HIV-related activities (Clarke and Bundy, 2008).

6. Effective teachers are fundamentally important for teaching and learning about HIV

If a programme is to be faithfully implemented, teachers must be properly trained for and committed to the task (Gallant and Maticka-Tyndal, 2004). Competent and skilled HIV educators need to be developed through pre-service and in-service training to teach a skills-based approach to HIV prevention. This requires the adoption of participatory teaching methods and classroom management skills, a major challenge in education systems that retain didactic teacher-centred pedagogy and where class sizes are large. Enhancing teachers' content knowledge of HIV is an important facet of teacher training, as is developing confidence to handle sensitive and taboo topics in the classroom. Teacher motivation and commitment to the programme are critically important factors in programme success (Kirby *et al.*, 2005; Kirby *et al.*, 2006).

In-service training tends to be the vehicle for introducing knowledge and skills to serving teachers for HIV education, sometimes using a cascade approach. Coverage, duration and quality of training tend to be recurrent issues. HIV education, relevant to the national epidemic, needs to be given appropriately high priority in initial teacher education as an integral component in the curriculum for the professional preparation of all new teachers. Some countries with significant HIV epidemics do not yet include HIV education in regular pre-service training, e.g., Guyana, Malawi and Tanzania (Education International, 2007). On a more positive note, some countries provide HIV training to all trainees, e.g., Burkina Faso, Guinea, Kenya, Uganda (Education International, 2007). However, in some contexts, even where HIV is included in pre-service training, activities tend to be ad hoc and with no budget for HIV training (Nzokia and Ramos, 2008).

Developing the capacity of teacher training colleges generally (Lewin and Stuart, 2003) and specifically for HIV education (Ramos, 2007) should be a high priority for the education sector plan.

7. The importance of assessing and addressing the impact of HIV on education service delivery in high HIV prevalence contexts

In generalised epidemics, over time, HIV can impact on the supply of education staff reducing the number of qualified and experienced staff available to the sector. The increased attrition rate of teachers as a consequence of HIV epidemics threatens also to impact on the quality of education service delivery, which can also potentially reduce demand for education.

Assessments of the impact of HIV and AIDS on education have been undertaken in Botswana (Bennell *et al.*, 2002), Malawi (Bennell *et al.*, 2002), Mozambique (Verde Azul Consult, 2001), Nigeria, (Ssengonzi *et al.*, 2003), Rwanda (Kinghorn, 2003), South

Africa (Shisana *et al.*, 2005), Tanzania (Kauzerni and Kihinga, 2004), Uganda (Bennell *et al.*, 2002), Zambia (Grassley *et al.*, 2003) and Zimbabwe (HEAT, 2003).

These studies employed a range of methodologies, including epidemiological modelling, quantitative and qualitative research, and anonymous HIV testing. They reveal the difficulty of disentangling AIDS impacts from other sector challenges, but significant impacts on the teaching stock in some contexts, e.g., South Africa, Tanzania and Zimbabwe. The findings indicate the importance of implementing the following steps.

- Understanding the gendered vulnerability of teachers to HIV infection.

- Addressing the needs of teachers living with HIV to treatment, care and support.

- Taking preventive action involving teachers' unions with teacher trainees and serving teachers.

- Expanding the supply of teacher trainees in high impact scenarios.

- Monitoring attrition of the teaching stock at decentralised levels of the system.

- Addressing HIV-related stigma.

- Addressing teacher absenteeism from all causes.

- Putting in place HIV workplace policies and means of implementing them.

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Endnote

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

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