

International Perspectives on Education and Society
Volume 18

The Impact of HIV/AIDS on Education Worldwide

Alexander W. Wiseman
Ryan N. Glover
Editors



THE IMPACT OF HIV/AIDS ON EDUCATION WORLDWIDE

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INTERNATIONAL PERSPECTIVES ON EDUCATION AND
SOCIETY VOLUME 18

THE IMPACT OF HIV/AIDS ON EDUCATION WORLDWIDE

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Emerald Group Publishing Limited
Howard House, Wagon Lane, Bingley BD16 1WA, UK

First edition 2012

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British Library Cataloguing in Publication Data

A catalogue record for this book is available from the British Library

ISBN: 978-1-78190-232-5

ISSN: 1479-3679 (Series)



Certificate Number 1985
ISO 9001
ISO 14001

ISOQAR certified
Management Systems,
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standards ISO 9001:2008
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PREFACE

Little is known about the impact of HIV/AIDS on education worldwide. Much of the mystery surrounding HIV/AIDS and education lies in the fact that their intersection is contextualized by many other factors. For example, many of the children who are at risk of not finishing school or have never had the chance to attend school live day-to-day in communities with high HIV/AIDS infection rates. To exacerbate the problem, in some countries the highest HIV/AIDS infection rates are in marginalized and extremely poor communities while in others it is among the most affluent communities. Girls, young women, orphaned and vulnerable children either living or working in disadvantaged communities have some of the highest risk for HIV/AIDS infection because of their frequent exposure to HIV/AIDS. But, those who are more mobile due to their occupations or wealth are also at high risk in countries worldwide.

A lack of specifically focused education about health and HIV/AIDS as well as more general health education not only diminishes their economic chances, but also increases their potential for high-risk sexual behavior and health-related decision-making. In addition, there is often a stigma associated with HIV/AIDS education and prevention, which inhibits teachers and other adults from talking candidly with primary school-age children about the disease and how to prevent it. Yet, in spite of the devastating impact of HIV/AIDS, the education of children and teachers is still perceived around the world as a great hope in the fight against it.

Through an examination of the disease's relationship with education, this volume uniquely explores how HIV/AIDS impacts education systems, while also examining how education has responded. Given the context and prevalence of HIV/AIDS worldwide, the chapters in this volume investigate the relationship between HIV/AIDS and education from international and comparative perspectives. The chapters focus largely on the relationship between HIV/AIDS and education in sub-Saharan African countries and national education systems. However, one chapter examines the HIV/AIDS phenomenon in the Caribbean, which is a unique approach given the proclivity of investigations to concentrate almost exclusively on African countries and systems.

This volume represents many voices from both inside and outside of communities and education systems impacted by HIV/AIDS, and as such provides the space for a dialogue across stakeholders and others with a vested interest in the development, treatment, and study of HIV/AIDS and education. The dialogue that is presented across the chapters in this volume addresses several common themes, such as the relevance of context and the management or minimization of risk or risky behavior.

The volume editors would like to especially thank the external reviewers who gave their time and expertise to make significant comments, suggestions for improvement, and recommendations regarding both content and contributions of the chapters published in this volume. These scholars and reviewers are:

Liesel Ebersöhn (University of Pretoria, South Africa)
Patricia L. Hardre (University of Oklahoma, USA)
Margaret Henning (Keene State College, USA)
Karin Hyde (Independent Consultant, UK)
Lynette Jackson (University of Victoria, Canada)
Colleen McLaughlin (Cambridge University, UK)
Sue Robson (Newcastle University, UK)
Mioko Saito (UNESCO, France)
Damien de Walque (World Bank, USA)
Lesley Wood (Nelson Mandela Metropolitan University, South Africa)

We would also like to thank two of this volume's chapter authors for the insightful comments and suggestions they made on colleagues' chapters in this volume. Thank you Grace M. Ntaote and Laban Ayiro for your contributions as both authors and peer reviewers.

Again, we extend a sincere and heartfelt thank you to the many supporters who made this volume possible, and who contributed to enhancing the quality and rigor of each chapter. The impact of HIV/AIDS on education worldwide (and vice versa) is still in need of much more investigation, but this volume provides an opportunity to explore, discuss, and learn from the experiences and unique voices in countries and communities worldwide.

Alexander W. Wiseman
Series Editor and Volume Co-Editor
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HIV/AIDS AND ITS IMPACT ON EDUCATION IN SUB-SAHARAN AFRICA: POLICY INITIATIVES AND CHALLENGES

Laban Ayiro

ABSTRACT

Impact mitigation strategies in sub-Saharan Africa on HIV/AIDS in the education sector involved initially the development of education sector policies. This study traces the policy development initiatives, level of implementation, progress made and existing challenges. The study is based on a close (textual) reading of authoritative literature from United Nations Programme on HIV/AIDS (UNAIDS), World Bank, UNESCO and UNICEF for the last decade on global monitoring of HIV/AIDS and statistical data. Studies on the impact of HIV/AIDS on the education sector in sub-Saharan Africa have been brought into focus and themes have been extracted and synthesised from a comparative perspective to guide the development of this chapter. Across the countries, the education sector HIV/AIDS policies had concurrence with the countries' national HIV and AIDS policy or guidelines, and conformed to international conventions, national laws, policies, guidelines and regulations. Most of the countries

in Sub-Saharan Africa showed a significant decline in HIV prevalence among young women or men and opportunities to improve HIV-prevention knowledge and behaviour still abound. Antiretroviral therapy and other types of treatment have expanded since the early 2000s, but the number of AIDS-related deaths remains high. This chapter fulfils an identified information/resources need and amplifies the progress achieved in the mitigation of the impact of HIV/AIDS on the education sector specifically and humanity in general.

INTRODUCTION

The importance of education is enshrined in various international declarations and conventions which underscore the critical importance of getting and keeping children of school-going age in school. As early as 1948, the Universal Declaration of Human Rights defined everyone's right to education. Further, Article 28 of the Convention on the Rights of the Child, adopted by the United Nations General Assembly in 1989, defines the right of a child to education. This right was endorsed in the World Declaration on Education for All (EFA), signed at the World Conference on Education for All in 1990; it was also reiterated by the Framework for Action for Education For All and the Millennium Development Goals, both signed in Dakar in 2000 (Hodgkin & Newell, 2002). Education is also seen as the foundation for 'lifelong learning and human development' (EFA Declaration, 1990), an essential ingredient in the fight against poverty and the promotion of individual and national development. The above Conventions and Declarations reaffirm the value of education and it must be taken to be one of the obligations of government to its people. Governments are therefore responsible for creating an education sector through formulating policies, establishing and staffing institutions with personnel, managing and funding the sector so as to allow for education and training of its people at all levels of education.

An educated population and work force are fundamental to national health and combined with sound macroeconomic policies, education is a key factor in promoting social well-being and poverty reduction. It directly influences national productivity, a factor that determines the standard of living and a country's competitiveness in the global knowledge-driven economies. Much of the macro- and microeconomic literature emphasises the role of education in economic growth (Krueger & Mikael, 2000). Accumulated research since the beginning of the 20th century provides robust evidence of a substantial social and private payoff to investment in

education. The evidence points to a positive association between economic growth and change in education: growth increases with more education, and declines with less education. Additionally, global poverty will only be reduced when all children across the globe have access to, and can complete, a primary education of adequate quality. It can be predicted that for those countries where HIV/AIDS has significantly reduced average years of schooling or enrolment rates, the impact on education alone will dramatically constrain economic growth.

Investment in education is seen as being vital, in the achievement of six of the eight Millennium Development Goals: reducing poverty, achieving universal primary education, improving gender equality, reducing infant and child mortality, improving maternal health, and lowering the prevalence of HIV/AIDS. Substantial evidence shows that education profoundly affects young people's reproductive lives. Better educated women are more likely, in comparison with their peers, to delay marriage and childbearing, have fewer children and healthier babies, enjoy better earning potential, and have stronger decision making and negotiation skills as well as higher self-esteem. Studies documenting the benefits of female education include reduced infant and maternal mortality, enhanced family health and welfare, and increased economic productivity (Odaga & Heneveld, 1995). An analysis of data from 100 countries also found that an additional year of female education reduces the total fertility rate by 0.23 births (World Bank, 2001a).

In case of the youth, education has been proven to provide protection against HIV infection (World Bank, 1999). A basic education has a general preventive impact: it informs the youth and enables them to make decisions concerning their own lives, bring about long-term behavioural change and give them the opportunity for economic independence – all fundamental to prevention. In addition, instruction focused on HIV/AIDS prevention is crucial to closing persistent fundamental gaps in knowledge, the latest report by the United Nations Programme on HIV/AIDS (UNAIDS) shows that 30 years into the epidemic, millions of young people, even in badly affected countries, are ignorant or have misconceptions about the disease (2000a).

HIV/AIDS STATISTICS AND THEIR IMPACT ON THE EDUCATION SECTOR

The scale of the AIDS epidemic is enormous and the statistics are still staggering. The number of annual AIDS-related deaths worldwide is steadily

decreasing from the peak of 2.1 million in 2004 to an estimated 1.8 million in 2009 (UNAIDS, 2010). The decline reflects the increased availability of anti-retroviral therapy, as well as care and support, to people living with HIV, particularly in middle- and low-income countries; it is also a result of decreasing incidence starting in the late 1990s. The effects of antiretroviral therapy are especially evident in sub-Saharan Africa, where an estimated 320,000 (or 20%) fewer people died of AIDS-related causes in 2009 than in 2004, when antiretroviral therapy began to be dramatically expanded. In 2009, there were an estimated 2.6 million people who became newly infected with HIV (UNAIDS, 2010). This is nearly one-fifth (19%) fewer than the 3.1 million people newly infected in 1999 and more than one-fifth (21%) fewer than the estimated 3.2 million in 1997, the year in which annual new infections peaked. In 33 countries, the HIV incidence has fallen by more than 25% between 2001 and 2009; 22 of these countries are in sub-Saharan Africa. In sub-Saharan Africa, where the majority of new HIV infections continue to occur, an estimated 1.8 million people became infected in 2009, considerably lower than the estimated 2.2 million predicted in 2001 (UNAIDS, 2010). This trend reflects a combination of factors, including the impact of HIV prevention efforts and the natural course of HIV epidemics. Several regions and countries do not fit the overall trend. In seven countries, the HIV incidence increased by more than 25% between 2001 and 2009. In Western, Central and Eastern Europe, Central Asia and North America, the rates of annual new HIV infections have been stable for the past 5 years. However, evidence is increasing of a resurgence of HIV in several high-income countries among men who have sex with men. In Eastern Europe and Central Asia, high rates of HIV transmission continue to occur in networks of people who inject drugs and their sexual partners. UNAIDS (2010) estimates that there were 33.3 million people living with HIV at the end of 2009 compared with 26.2 million in 1999 – a 27% increase. Although the annual number of new HIV infections has been steadily declining since the late 1990s, this decrease is offset by the reduction in AIDS-related deaths due to the significant scale up of antiretroviral therapy over the past few years.

HIV/AIDS has ravaged Africa in the 25 years since the ‘discovery’ of AIDS in 1982. UNAIDS (2001, p. 3) summarises it well:

It fractures and impoverishes families, weakens workforces, turns millions of children into orphans, and threatens the social and economic fabric of communities and the political stability of nations.

The epidemic’s grip on Africa has been by far the deadliest, but no part of the world is immune. Sub-Saharan Africa remains the epidemic’s

epicenter: average life expectancy is now 47 years, compared with an estimated 62 without AIDS (World Bank, 2000b), and prevalence rates are the world's highest – more than 10% in 16 countries, and as high as 44% among some groups, for example, pregnant women in urban Botswana. As well as the human tragedy, the epidemic has a profound impact on growth and poverty: UNAIDS (2006) estimates a loss of more than 20% of gross domestic product in the worst affected countries by 2020. Most devastating and far-reaching, perhaps, is the epidemic's impact on education systems. HIV/AIDS is draining the supply of education, eroding its quality, weakening demand and access, drying up countries' pools of skilled workers and increasing the sector's costs. Almost 90% of the 16.6 million children orphaned by AIDS live in sub-Saharan Africa. The full scope of the epidemic's impact on education becomes apparent when viewed in the context of the formidable challenges already confronting the sector. More than 113 million school-age children are out of school in developing countries, two-thirds of them girls. Of those who enter school, one out of four drops out before attaining literacy. At least 55 of the poorest countries seem unlikely to achieve EFA by 2015, and 31 of these countries are also among the 36 worst affected by HIV/AIDS.

EARLY POLICY CONSIDERATIONS AND INITIATIVES

Faced with the challenges discussed in the previous section, ministries of education in Sub-Saharan Africa took the cue from the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) which called upon Governments to develop and implement national strategies to reduce HIV infection among the 15 to 24 years old. It advocated for the vast expansion of access to information and education especially to youth. A similar call for the intensification of educational interventions for youth was made by the Education International First World Congress which asked countries worldwide to be active in promoting a comprehensive school health policy. This became the genesis for the formulation of national HIV/AIDS policy frameworks in sub-Saharan Africa and the subsequent sub-sector initiatives such the Education Sector HIV/AIDS policies by the ministries of education. The development of sector policies in education was anchored in the national HIV/AIDS policies for each of the countries and had the purpose of mainstreaming the mitigation efforts against HIV/AIDS into the policies, development plans and budgetary undertakings of the ministries of education.

Since 1984 when the first case of HIV/AIDS was reported in Kenya, the Government responded through various strategies based within the health and education sectors. The government prioritised policy development as the first step in the response to the HIV/ AIDS pandemic. The National AIDS Control Council (NACC) was established in 2000 under the Office of the President to steer the process of policymaking and coordinating a national multi-sectoral response to HIV/ AIDS. Under the guidance of NACC, the Ministry of Education Science and Technology (MoEST) developed the Education Sector Policy on HIV/AIDS in 2004. The ministry also put in place a sector-wide support programme referred to as the Kenya Education Sector Support Programme (KESSP) for resource mobilisation and partnership for all its educational programmes. HIV/AIDS was one of the investment programmes targeted for funding over the 5-year period under KESSP. The thrust for the education sectors in sub-Saharan Africa to develop these policies was driven by the impact of the epidemic on education (Kelly, 2000a) namely:

1. AIDS reduces the *supply* of education as teachers and education personnel become infected, fall sick and die. In addition, the AIDS epidemic impacts on educational planning and management processes. AIDS-related illness and funeral attendance as well as operating budgets diverted to support these additional costs diminish core education activities. These factors erode the quality and effectiveness of educational management at central, district and local levels.
2. AIDS reduces the *demand* for education in several ways. First of all, fewer children are born when large numbers of women of childbearing age contract the HIV virus. This reduces the number of children eligible to enter school. Secondly, AIDS strikes the parents of school children resulting in the loss of wage earners in the family, hence increased poverty.

Supporting the direct and indirect costs of education becomes increasingly difficult as medical and funeral expenses absorb family resources. Finally, when parents die, their children become orphans. Unless relatives take care of them, these 'AIDS orphans' are left without resources and the burden on grandparents is especially heavy. Many orphans drop out of school for economic reasons or fear of stigma and discrimination. By 2010, nearly 14.6 million children in sub-Saharan Africa had lost both parents. In about two out of three cases, the loss was due to AIDS.

THE COST-EFFECTIVENESS OF EDUCATION IN PREVENTION EFFORTS

The school system is cost-effective in its ability to bring together students, teachers, parents and the community, all of whom have to play a role in AIDS prevention. Countries need to invest in the education sector not only for the crucial benefits it yields — overall and in an AIDS context — but also because no other sector may be more fundamentally threatened by the epidemic. In the worst hit countries, teachers are dying faster than they can be replaced, absenteeism is eroding the quality of education and the problem of a rising orphan population — as high as 15% of all children — is demanding urgent national attention. The failure of education systems leads to a vicious cycle of deaths and decline in the sector, and the cycle is particularly vicious for girls. Already handicapped by less access to education than boys, girls may, as a result of the epidemic, be even less likely to attend school, either because they are themselves infected or because they are retained at home to care for patients. This pattern leaves them uneducated and unable to earn a living, protect them from infection or break out of the social traps (such as abuse and early marriage) that expose them to increased risk of HIV infection ([Kelly, 2000a](#)).

GUIDING PRINCIPLES FOR POLICY DEVELOPMENT

An education sector HIV and AIDS policy had to be guided by a set of principles that entrenched the rights and responsibilities of every interest group in the sector. In addition, these principles had to be in concurrence with the countries' national HIV and AIDS policy or guidelines, and be seen to conform to international conventions, national laws, policies, guidelines and regulations. In particular, the principles took into account gender issues, learners with special needs, and recognised the universality of human rights. To be effective, these principles addressed all of the key issues in the education sector including:

- access to education;
- access to information;
- equality;
- privacy and confidentiality;
- access to care, treatment and support;

- a safe workplace and learning institution;
- fair labour practices;
- gender sensitivity/responsiveness;
- greater involvement of people living with HIV;
- partnerships.

Excellent examples of the application of such principles may be found in the Education Sector Policies on HIV and AIDS for Kenya, Uganda and Zambia.

KEY ISSUES IN POLICY DEVELOPMENT

In developing the policy for each country, the following key issues were put into consideration.

The education sector HIV and AIDS policy was to guide a comprehensive and explicit education sector response within a national HIV and AIDS policy framework and within an international set of agreements, conventions and principles. In other words, an education sector policy had to acknowledge and be contextualised by national policy frameworks and guidelines, but at the same time deal with those issues of substance and detail that are specific to the education system and sector. That meant that the necessary generalities of a national HIV and AIDS policy (where these existed, and which often were underpinned by a health ministry approach) had to be supplemented by policies that specifically addressed the functions and structures of the education system, and were competent to guide regulation and legal frameworks within that system. The emphasis on international agreements and conventions was also important considering that an increasing number of these agreements inform every aspect of educational access, provisioning and quality, as well as workplace policy and other commitments to gender, human rights and in particular the rights of the child. In other words, any policy that did not take into account these issues would be judged inadequate and would therefore not be taken seriously by the international community.

Identification of Education Sector Interest Groups

Ministries of education had both the mandate and the responsibility to deliver quality teaching and learning in an accessible environment, but they had to recognize that there were many other interest groups in the sector in

terms of capacity, responsibility and power. These groups included teacher unions, private and independent basic education providers, representative parent bodies (at various levels), representative student bodies, including student teachers, higher education, independent or private colleges, non-governmental organisations (NGOs), community-based organisations (CBOs), faith-based organisations (FBOs), academics, researchers, funders and other development partners. If policy was to have sector-wide application and acceptance, it was necessary to identify and involve all the interest groups with a stake in its success. The greater the number of interest groups, the longer and more complex the process became. The key principle, therefore, was representativeness: in other words, ensuring limited but effective representation from as many groups as possible without unnecessary duplication. The interest groups involved had an obligation to engage with their areas of concern/expertise (and represent their constituencies) as well as the wider sector-policy context. This interest group involvement was also an opportunity to create and empower advocates from every sub-sector as 'champions' of the policy. While the situation may have varied from country to country, it is reasonable to believe that some or all of these interest groups contributed to a comprehensive policy development process and added value to the final outcome. Equally important, they became pivotal in implementing the education sector HIV and AIDS policy – or in contesting it if they were not seriously engaged or consulted.

Policy Development was Viewed as an Advocacy Intervention

The process of policy development, its adoption and dissemination had to be recognised as a national advocacy intervention of some magnitude, particularly if all the key interest groups had been involved and were supportive. The event of launching a policy on an issue as important as HIV and AIDS in education, and backing this with an achievable action plan for implementation, did send a national and international signal of great significance, one which eventually had the effect of mobilising both local and international support and funding.

Flexibility was Essential

In the AIDS era it was not viable to contemplate an education policy cast in stone – particularly one dealing expressly with the management and

mitigation of HIV and AIDS. The dynamics of HIV and AIDS impact in medium- and high-prevalence countries and the unpredictability this dynamic brought to planning suggested that it required at best a flexible policy framework capable of accommodating regular revision and change. For the education sector, where policy is traditionally an unquestioned edict from above, this approach represented a radical departure from tradition and one that took some time to accept. Certainly, experience with this policy development revealed considerable reservation among ministry of education officials about the concept of regular, possibly annual, review. In spite of this reservation, it was agreed that the policy be seen as a flexible, even responsive, guiding framework, within which implementation planning could be contextualised and decentralised delivery achieved.

This policy was intended to inform every function of the education system and sector management, including the development of regulations that gave legal effect to the policy. In particular, this education sector HIV and AIDS policy was intended to have the effect of making routine educational management sensitive to HIV and AIDS and of protecting the affected and infected. In other words, the policy laid down a number of achievable goals, objectives and guidelines that would make planning, budgeting, managing, monitoring and reporting at every level of the system sensitive to the direct and indirect impacts of HIV and AIDS. In practical terms, this meant providing guidance for the development of a regulatory framework that made such 'sensitivity' a routine function of every educational manager's job. The same framework would apply to managers and other professionals in the wider education sector, who were also bound by the provisions of the policy.

Every country then needed to agree to a comprehensive definition of its education sector for the purpose of policy development. This had to define levels, divisions and sub-sectors for inclusion and the following country examples serve to provide some insight into the issues that were involved:

Republic of Kenya Education Sector Policy on HIV and AIDS; scope of application: The Policy applies to learners, employees, managers, employers and other providers of education and training in all public and private, formal and non-formal learning institutions at all levels of the education system in the Republic of Kenya.

Republic of Namibia National Education Sector Policy on HIV and AIDS; scope of application: The Policy applies to the entire education cycle, from pre-primary to post-secondary and tertiary education, including both the private and public sectors.

Republic of Zambia National HIV and AIDS Policy for the Education Sector; scope of application: The Policy applies to all learners, employees, managers and providers of education and training in all public and private, formal and non-formal and traditional learning institutions at all levels of the education system in the Republic of Zambia.

Policy development has historically been the province of specialist working groups or commissions, usually established by governments, and characterized by political, legal and sectoral imperatives. The concept of consultation has long been entrenched, but more often than not the policy development process has been lengthy, with consultation taking place only in the period leading up to the final drafting of such a policy. In the AIDS era however, the circumstances changed quite profoundly. As the magnitude of the crisis was felt, more and more governments in general and ministries of education in particular recognised the need to develop sector-specific HIV and AIDS policy to guide response as a matter of urgency. As a consequence, the rules were open to change and the policy development process itself was subject to considerable pressure, often for the better. One outcome of this change was the development of a rapid policy development process pioneered by the Mobile Task Team (MTT) on the impact of HIV and AIDS on education from South Africa. Having been used in a number of African countries with considerable success, the approach involved bringing together a group of participants, representative of the wider education sector, to develop an initial draft policy in a matter of 5 days. This rapid policy development process reversed the traditional approach, in which a first draft may only emerge after a long period of consultation, review and often opaque deliberation. The rapid policy development process concentrated on getting 80% of the work done in the opening round in order to provide a tangible output for much wider review and more immediate public consultation. It should be stressed that this rapid policy development process was only one approach, and that other options exist. Whichever direction a given countries' education sector elected to take, the key issues remained the same.

POLICY IMPLEMENTATION THEMES

To be comprehensive, an education sector HIV and AIDS policy had to address four internationally recognised policy and implementation themes:

- prevention;
- treatment, care and support;

- workplace issues;
- management of the response.

By addressing all four of these themes, the danger of undue or one-dimensional focus on any one to the exclusion of others was avoided. The inclusion of all interest groups and directorates of the ministries meant that the importance of all these themes, and the issues within them, would be protected. It was anticipated that many of the interest groups involved would have a single-theme focus, but within the wider group (and plenary interrogation) those interests would merge to provide a comprehensive picture within which each element was adequately addressed.

A goal for each theme was set, which described the ‘desired outcome’ once the policy would be implemented. These four goals, taken together, attempted to describe an optimal situation in the education sector brought about by the successful implementation of the policy at every level and in every area. Theoretically at least, for each overarching theme goal, a set of objectives and activities was listed to address each key issue, focus attention and provide a checklist for implementation. For example, in the Kenyan Education Sector HIV and AIDS Policy, under the theme heading Care and Support, 21 separate objectives are contained under six sub-headings. These sub-headings include: scope; access to health services; psychosocial support; community mobilisation; orphans and vulnerable children (OVC); and financial support. Taken as a cluster of issues and objectives, these comprehensively addressed all the activities that would be required to achieve the theme goal, which reads (and had a 5-year focus):

An education sector in which care and support is available for all, particularly orphans and vulnerable children (OVC) and those with special needs.

For practical and legal purposes, it was the ministry of education that had to ultimately accept and adopt the draft education sector HIV and AIDS policy. It was, after all, the mandated ministry of government and had both the legal power and resources to give effect to the policy; it was also responsible for the parliamentary and other processes that would be required for the successful implementation of the policy. Most importantly, in the implementation phase of the policy development process, the ministry had the responsibility of establishing the legally binding regulations that would flow from this policy. These were central to the whole process as it was these regulations that would govern the management and administration of education and guided workplace policy and practice.

It was envisaged that once adopted, ministry would be committed to the legal process involved, and the policy would be shared with the sector and the nation. This posed a considerable logistical challenge but it was seen instantly as an opportunity for advocacy on a grand scale. Publication and release provide an opportunity for the minister of education to launch the policy with due fanfare and open a series of media engagements to interrogate and disseminate its contents. This in effect was intended to confirm the ministries commitment to transparency and access and hopefully be supported by the most extensive publication possible of the policy, in a format designed for easy reading and consumption. In the final analysis, the policy would be available throughout the sector up to the classroom and would constitute the basis for classroom-level codes of conduct, committing both the teacher and the learner to their collective responsibilities towards one another.

POLICY IMPLEMENTATION PLANNING OBJECTIVES

Implementation means achieving, carrying out and putting into action (in this case a policy). Its Latin roots confirm the character of the word and its intention; it means literally to satisfy and fulfil (needs and expectation). In other words, it appropriately signals that implementation is designed to meet the many expectations raised by an education sector HIV and AIDS policy.

The first objective was to demonstrate how national implementation of an education sector HIV and AIDS policy would be planned, costed, actioned, monitored, reported and used strategically to mobilise resources. The second objective was to develop an understanding of national implementation planning frameworks, sub-national (decentralised) activity planning, costing and monitoring. The third objective was to develop the skills to undertake such planning, co-ordinate its implementation and report its outcomes. The implementation process proceeded as per objectives and the dissemination of the policy and its implementation carried out throughout the provinces of the given countries.

WHERE ARE WE A DECADE LATER?

Current Responses

Many countries around the world have established national AIDS councils and secretariats, and HIV units in their ministries of education though they

are typically understaffed and lack executive power. There is extensive political commitment at the highest level in countries like Kenya, Uganda and Botswana, although others like South Africa for example, have fallen short in this regard. Many countries are now emphasising a multi-sectoral approach that deals with HIV/AIDS as a development issue that transcends health, and the importance of working together both multi-sectorally and with other stakeholders. Several countries have commissioned education sector impact assessments (Botswana, Kenya Mozambique, Namibia, South Africa, Swaziland, Zimbabwe) and have created HIV/AIDS and education policy and strategic plans. The implementation of such plans still reveals persistent management weakness. Most managers have not received professional preparation for their responsibilities and many hold posts by virtue of their seniority or experience gained as they rose through the ranks. HIV/AIDS is therefore wrecking havoc considering the fragile management systems that exist in these countries (Kelly, 2000a). Financial resources are reducing because of the pandemic's impact on availability of private and public funds for the sector, reducing total disposable assets, diverting resources away from education to other areas like health and social welfare, increasing costs and reducing taxable income from the private sector. Ministries have been deficient in planning how to make best use of international resources.

New HIV Infections Declining

The following countries – Kenya, Uganda, Botswana, South Africa, United Republic of Tanzania, Zambia, and Zimbabwe – showed a significant decline in HIV prevalence among young women or men in national surveys. Sexual behaviour changed in most of these countries. In eight countries with significant declines in HIV prevalence, the sexual behaviour of either men or women also changed significantly. The epidemics in East Africa have declined since 2000 but are stabilizing in many countries. The HIV incidence slowed in the United Republic of Tanzania to about 3.4 per 1,000 person-years between 2004 and 2008. The national HIV prevalence in Kenya fell from about 14% in the mid-1990s to 5% in 2006. The HIV prevalence in Uganda has stabilized at between 6.5% and 7.0% since 2001 (UNAIDS, 2009). The HIV prevalence in Rwanda has been about 3.0% since 2005. The HIV prevalence in West and Central Africa remains comparatively low, with the adult HIV prevalence estimated at 2% or under in 12 countries in 2009 (Benin, Burkina Faso, Democratic Republic of the Congo, Gambia, Ghana, Guinea, Liberia, Mali, Mauritania, Niger, Senegal, and Sierra Leone). The prevalence of HIV

Table 1. Sub-Saharan Africa HIV and AIDS Statistics, 2001 and 2009

	Adults and Children Living with HIV	Adults and Children Newly Infected with HIV	% Adult Prevalence (15–49 years)	AIDS-Related Deaths among Adults and Children
2009	22.5 million	1.8 million	5.0	1.3 million
2001	20.3 million	2.2 million	5.9	1.4 million

is highest in Cameroon at 5.3%, Central African Republic 4.7%, Côte d'Ivoire 3.4%, Gabon 5.2% and Nigeria 3.6%. In Botswana, where antiretroviral therapy coverage exceeds 90%, the estimated annual number of AIDS-related deaths declined by half (from 18,000 in 2002 to 9,100 in 2009), while the estimated number of children newly orphaned by AIDS fell by 40% (UNAIDS, 2010). The extensive provision of antiretroviral therapy has averted an estimated 50,000 adult deaths and, if this is sustained, Botswana could avert a further estimated 130,000 deaths through 2016. AIDS-related deaths in Kenya fell by 29% between 2002 and 2007. In rural Malawi, provision of antiretroviral therapy was linked to a 10% drop in the adult death rate between 2004 and 2008. Antiretroviral therapy and other types of treatment have expanded since the early 2000s, but the number of AIDS-related deaths remains high. Table 1 above gives a summary of the HIV/AIDS related statistics in sub-Saharan Africa on infection, prevalence and AIDS-related deaths over the period 2001–2009.

Opportunities to improve HIV-prevention knowledge and behaviour still abound. Less than half of young people living in 15 of the 25 countries with the highest HIV prevalence can correctly answer five basic questions about HIV and its transmission (these include Botswana, Burundi, Cameroon, Central African Republic, Chad, Congo, Cote d'Ivoire, Guinea-Bissau, Kenya, Malawi, Nigeria, South Africa, Togo, United Republic of Tanzania and Zambia). Young people ages 15–24 years old showed gradually improving knowledge about HIV in these 25 countries.

Human Rights and Gender Equality

In the context of HIV, protections comprise legal approaches that implement international human rights commitments as well as efforts to address harmful social and gender norms that put women, men and children at increased risk of HIV infection and increase its impact. A rights-based approach to HIV requires: realisation and protection of the rights people

need to avoid exposure to HIV; enabling and protecting people living with HIV so that they can live and thrive with dignity; attention to the most marginalised within societies; and empowerment of key populations through encouraging social participation, promoting inclusion and raising rights-awareness (UNESCO, 2004). Significant advances have been made in expanding HIV prevention, treatment, care, and support services in recent years but some key populations at higher risk such as sex workers, people who inject drugs and men who have sex with men, remain often underserved. Resources directed towards the needs of these populations, including support for them to claim and exercise their rights, are often not proportional to the degree to which they are affected by the epidemic.

In sub-Saharan Africa, women are more likely to become infected with HIV than are men. The most recent prevalence data show that in sub-Saharan Africa, 13 women become infected for every 10 men infected. One-half of people living with HIV globally are women and 76% of all HIV-positive women live in sub-Saharan Africa (UNICEF, 2004). Conversely, traditional roles and societal values related to masculinity encourage boys and men to adopt risky behaviours, including excessive alcohol use and concurrent sexual relationships, so increasing their risk of acquiring and transmitting HIV. Many harmful norms related to masculinity and femininity also stigmatise transgender people, men who have sex with men and other sexual minorities.

AIDS Is a Shared Responsibility

Investing for AIDS is a shared global responsibility that is paying clear dividends — it saves lives now, improves the quality of life of people living with HIV and will lessen future burdens of cost and disease. In 2009, international donors and governments together provided US\$ 15.9 billion for the global AIDS response, more than half of which came from domestic sources in low- and middle-income countries (World Bank, 2005). As a result of this unprecedented health investment, HIV prevalence is falling due to programmes that reduce risky behaviour, more than 5 million people are receiving life-saving antiretroviral therapy, millions of orphans have received basic education and health care, and more tolerant and enabling social environments have been established in many countries through campaigns to reduce HIV-related stigma and discrimination. None of this would have been possible without the strong mobilisation of the global community and the unprecedented levels of funding provided collectively by donors, governments, the private sector, philanthropic organisations and individuals to address HIV. However, the gap between investment needs and resource availability is widening at

a time of fiscal constraints. In 2009, there was a US\$ 10 billion gap as, for the first time, international assistance did not increase from 2008 levels. In most countries, the AIDS response is funded by a complex interplay of domestic public spending, multilateral and bilateral aid, private-sector and philanthropic support and individual out-of-pocket spending. In many low- and middle-income countries, the largest source of HIV funding – 52% – is domestic expenditure. Government donors provide an additional 42% and the international philanthropic sector 5%. International investment levels have largely reflected the epidemic distribution ([World Bank, 2005](#)). Donors' HIV-related spending is higher in countries with high HIV prevalence. The sharing of the responsibility has largely matched the financial capabilities of individual countries and the magnitude of national epidemics.

Middle-income countries contributed a far greater proportion of the resources to their national AIDS response. Low-income countries' share of investment for the national AIDS response was much smaller.

AIDS Response Must Be Predictable and Sustainable

As resource availability for HIV increased over the last decade, spending on HIV prevention, treatment, care and support have increased. Overall investments for the AIDS response grew by 82% between 2006 and 2008. Treatment and care programmes received 56% and HIV-prevention programmes received 20% of the total resources available. Nearly 71 countries depend on international sources for funding more than 50% of their prevention activities ([World Bank, 2005](#)). In contrast, the cost of treatment and care programmes on average appears to be shared equally between domestic sources and international sources. However, 26 countries reported that nearly 77% or more of their treatment and care expenditure relies on external sources. At a time when demand for universal access for prevention and treatment is growing, lack of additional resources is slowing down the pace of achieving results. As countries strive to increase their investments for the AIDS response, attention is needed to make long-term resource availability predictable.

THE CHALLENGES OF HIV/AIDS

HIV/AIDS lurks in communities and families, in the most intimate, private moments of human relationships. It is a creature of culture and circumstances,

local perceptions and behaviours, custom and religious belief. That means it is virtually impossible to generalise about good practice: what works to break the power of HIV/AIDS in one place may not work in another (Coombe, 2000b).

Policy Shortcomings

A study on Kenya's HIV/AIDS Education Sector Policy (GOK, 2004) on its implications for orphaned and vulnerable children and the teaching of HIV/AIDS education (Ruto, Fatuma, & Violet, 2009) came up with the following findings after a decade of implementation. These findings could also hold true for the other countries in Sub-Saharan Africa.

Ownership and Support

There was lack of ownership of the policy and adequate support among the key stakeholders. Prevention programmes are often under-funded, with inadequate attention to training teachers, sensitising managers, providing supportive health services and linking programmes with other community services. There is serious concern about the capacity or willingness of many teachers to engage with lifeskills programmes, or to provide complementary care and counselling support to affected learners or colleagues (Coombe, 2002). Many national strategies remain at pilot project level, although countries like Kenya are now making efforts to scale up to national level, especially in the areas of material development and distribution, and teacher training. The current challenge is to continue to expand and strengthen education-driven programmes aimed at AIDS-related behaviours (World Bank, 2000a, p 38). Education ministries and their non-government partners are struggling to deliver, considering that HIV/AIDS is only one of many problems faced by the education sector. Failure to deliver prevention messages effectively is compounded by the dire physical environment of many schools (lack of water, latrines, adequate classrooms and teachers' housing, decent hostels, furniture and books), by the teacher- and child-unfriendly ambiance in many learning institutions (where physical and sexual abuse are present along with corporal punishment and poverty or HIV/AIDS-related trauma), and by inadequate management support for teachers (overcrowded classes, low salaries, an inappropriate policy framework which may discriminate against HIV/AIDS-affected learners and educators, and comprehensive failure to make provision for educators affected by HIV/AIDS) (Coombe, 2000b). For example while

the policy provided guidance on how to treat teachers who had HIV infections, the issue of frequent sick leave seemed to contradict the laid down rules by the employer, the Teachers Service Commission.

Dissemination

Distribution and dissemination of the policy has been limited, fragmented and therefore not continuous. There is little evidence of a strategy for ensuring that all the stakeholders are adequately briefed on the content and use of the policy. Furthermore the policy has not been adequately popularised among the stakeholders at the various levels – national, provincial, district and zonal. Research has revealed that most teachers had heard and were aware of the policy's existence but were unfamiliar with its content. There is therefore an urgent need to make copies of the Education HIV/AIDS policy documents available to schools for familiarisation and utilisation.

Interpretation and Implementation

There is need for clear guidelines for the interpretation and implementation of the policy and an adequate framework for follow up and supervision. None of the schools represented in the study sample were fully implementing the policy.

Capacity Building

There is a general lack of capacity for the interpretation and implementation of the policy among the key stakeholders. Information, knowledge and skills for the interpretation, dissemination and implementation were inadequate. In addition institutions were not adequately empowered through training to be able to draw from the general sector policy to formulate their own institutional policies.

Resource Allocation

It is not evident from the policy document where and how the resources for the implementation will be drawn from. There is need for strategies for identification and allocation of adequate resources for the implementation of the HIV/AIDS policy at all levels – national, provincial, district and zonal.

Monitoring and Evaluation

The challenge for ministries of education is to strengthen the capacity of their staff and provide resources for monitoring and evaluating interventions

in the area of HIV/AIDS and the sector in general. Such monitoring is key to the dynamism of policy and steady improvement of interventions.

Provision of Quality Education

Despite efforts to place quality at the centre of strategies to achieve the EFA goals, special measures and partnerships are urgently required to confront HIV/AIDS, a threat that is undermining efforts to expand high-quality educational opportunity in Africa. There is need to systematise and categorize HIV/AIDS interventions to reflect their time perspective – short-, medium-, and long-term – in order to facilitate the process of implementation including the sequencing of activities ([Akoulouze, Khanye, & Rugalema, 2001](#)). This new thinking is essential in developing responses to HIV/AIDS in the education sector, where the epidemic is no longer only a medical issue but a menace to efforts to provide high-quality education to young Africans. It is only recently that HIV/AIDS has emerged as an educational quality issue. Much that has been written has focused on quantitative issues such as the impact of morbidity and mortality on the stock of teachers (e.g. IBRD/WB, 2002). To date, very little has been written explicitly about the relationship of HIV/AIDS and educational quality. Assessments of the impact of the HIV/AIDS epidemic on education have brought to light certain new factors that must be included in order to guide the formulation of policies that promote educational quality in Africa. Research is needed on the impact of HIV/AIDS on the different aspects of quality, supported by data from strengthened education information systems (EMIS).

HIV/AIDS Increases Education Sector Costs

HIV/AIDS is estimated to add between US\$450 million and US\$550 million per year to the cost of achieving EFA in the 33 African countries studied. This implies that HIV/AIDS increases the total EFA external financing gap for these countries by about one-third ([World Bank, 2007b](#)). On the supply side, budgets have to accommodate higher teacher hiring and training costs to replace teachers who have died of AIDS, as well as the payment of full salaries to sick teachers who are absent and additional salary costs for substitute teachers. Zambia has estimated the epidemic's financial burden on the supply of teachers to amount to some US\$25

million between 2000 and 2010, and Mozambique's estimate is about twice as much. These estimates do not include demand-side costs, yet efforts to reach orphans and other vulnerable children are a rapidly growing new expenditure, especially in the worst affected countries.

Knowledge Gaps Persist

Despite high levels of basic awareness about HIV/AIDS, knowledge gaps persist. Examples persist in Sub-Saharan Africa where infected men seek out uninitiated girls with the aim of curing themselves. In South Africa, a third of survey respondents believed that HIV-positive people would always show symptoms. In Kenya, AIDS orphans – often in denial – believed that their parents had died from witchcraft or a curse. Surveys of 15- to 19-year-olds showed varying levels of knowledge across 17 countries with greater knowledge in countries with a longer history of AIDS (UNAIDS, 2000a). Girls were generally more poorly informed than boys. Other gaps include African university students' belief that oral contraceptives prevent HIV infection and that the virus can pass through an undamaged condom. Only 45% of surveyed students considered themselves at risk, manifesting 'denial, fatalism, and an air of invulnerability' (Kelly, 2001).

Impact at Tertiary Level

Since the onset of the HIV/AIDS epidemic, African universities are operating in a worsening socio-economic environment. A recent study of seven African universities (in Benin, Ghana, Kenya, Namibia, South Africa and Zambia) found an overwhelming atmosphere of ignorance, secrecy, denial, and fear of stigmatisation and discrimination in relation to AIDS (World Bank, 2007b). Although information on staff and student mortality was vague and ambiguous, an increasing number of AIDS-related deaths have been reported. The University of Zambia reported an average of three deaths a month throughout the 1990s, while the University of Nairobi is currently experiencing four to six deaths a month. For university students, most of whom are in the age group most vulnerable to HIV infection, the real impact of infection will probably occur after graduation. The tragedy of HIV/AIDS is that primary, secondary and tertiary students now

affected are all potential valuable human resource of the future and therefore the impact of the disease will be felt by generations to come.

AIDS Orphans

An 'orphan' is defined by the United Nations as a child who has 'lost one or both parents'. Worldwide, it is estimated that more than 16 million children under 18 have been orphaned by AIDS. Around 14.8 million of these children live in sub-Saharan Africa (Bennel, 2005). In some countries which are badly affected by the epidemic a large percentage of all children, for example 16% of children in Zimbabwe and 12% in Botswana and Swaziland, are orphaned due to AIDS. Even with the expansion of antiretroviral treatment access, it is estimated that by 2015, the number of orphaned children will still be overwhelmingly high. The way forward is threefold: firstly new HIV infections must be prevented so that children do not lose their parents; secondly access to antiretroviral treatment needs to be stepped up; and finally care must be provided for those children who are already orphaned (Ayiro, 2009). The situation of AIDS orphans is ultimately generated by adult deaths; until this problem is addressed the orphan crisis will continue.

Support and Keeping Children in School

In the early days of the AIDS orphan crisis, there was a rush by well meaning non-governmental organisations to build orphanages. Given the scale of the problem, though, this response was unsustainable, as the cost of maintaining a child in such an institution is much greater than other forms of care. Most people now believe that orphans should be cared for in family units through extended family networks, foster families and adoption, and that siblings should not be separated. Studies in sub-Saharan Africa have repeatedly demonstrated that growing up in a family environment is more beneficial to a child than institutional care, which should be considered a temporary option or a last resort (Bennel, 2005). Ultimately, though, the extended family can only serve as part of the solution to mass orphanhood if adequately supported by the state and the community, as well as other sectors of society. The community needs to be supportive of children when they are orphaned, making sure that they are accepted and have access to essential services, such as health care and education. This means improving existing services and reducing the stigma surrounding children affected by AIDS so that they do not face

discrimination when trying to access these services. Schools can also play a crucial role in improving the prospects of AIDS orphans and securing their future. A good school education can give children a higher self-esteem, better job prospects and economic independence. As well as lifting children out of poverty, such an education can also give children a better understanding of HIV and AIDS, decreasing the risk that they will become infected. Schools can also offer benefits to AIDS orphans outside of education, such as emotional support and care.

Empowerment and Protection for the Legal and Human Rights of Orphans

If AIDS orphans are treated as active members of the community rather than just victims, their lives can be given purpose and dignity. Many children already function as heads of households and as caregivers. They are a vital part of the solution and should be supported in planning and carrying out efforts to lessen the impact of AIDS in their families and communities. Much can also be done to ensure the legal and human rights of AIDS orphans. Many communities are now writing wills to protect the inheritance rights of children and to prevent land and property grabbing, where adults attempt to rob orphans of their property once they have no parents to protect their rights. Children orphaned due to AIDS may face exploitation in other areas of their lives as well. For instance, evidence suggests that there is a relationship between AIDS orphans in sub-Saharan Africa and increased child-labour ([USAID, 2003](#)).

CONCLUSION

Two-thirds of all people infected with HIV live in sub-Saharan Africa, although this region contains little more than 12% of the world's population. AIDS has caused immense human suffering in Africa. The most obvious effect of this crisis has been illness and death, but the impact of the epidemic has certainly not been confined to the health sector; households, schools, workplaces and economies have also been badly affected. During 2010 only, an estimated 1.2 million adults and children died as a result of AIDS in sub-Saharan Africa. Since the beginning of the epidemic more than 15 million Africans have died from AIDS. Although access to antiretroviral treatment is starting to lessen the toll of AIDS, fewer than half of Africans who need treatment are receiving it. The impact of AIDS will remain severe for many years to come. The relationship between AIDS and

the education sector is circular – as the epidemic worsens, the education sector is damaged, which in turn is likely to increase the incidence of HIV transmission. There are numerous ways in which AIDS can affect education, but equally there are many ways in which education can help the fight against AIDS. The extent to which schools and other education institutions are able to continue functioning will influence how well societies eventually recover from the epidemic.

A decline in school enrolment is one of the most visible effects of the epidemic. This in itself will have an effect on HIV prevention, as a good basic education ranks among the most effective and cost-effective means of preventing HIV. There are numerous barriers to school attendance in Africa ([USAID, 2003](#)). Children may be removed from school to care for parents or family members, or they may themselves be living with HIV. Many are unable to afford school fees and other such expenses – this is particularly a problem among children who have lost their parents to AIDS, who often struggle to generate income. Studies have suggested that the chances that young people with little or no education contracting HIV are likely to be twice those who have completed primary education. In this context, the devastating effect that AIDS is having on school enrolment is a major concern. In Swaziland and the Central African Republic, it was reported that school enrolment fell by 25–30% due to AIDS at the beginning of the millennium. HIV and AIDS are having a devastating effect on the already inadequate supply of teachers in African countries; for example, a study in South Africa found that 21% of teachers aged 25–34 were living with HIV. Teachers who are affected by HIV and AIDS are likely to take 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 result from the psychological effects of the epidemic ([UNICEF, 2004](#)). 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. The impact of AIDS in Tanzania for example meant that in 2006 an estimated 45,000 additional teachers were needed to make up for those who had died or left work because of HIV and AIDS. The greatest proportion of staff that have been lost, according to the Tanzania Teacher's Union, were experienced staff between the ages of 41 and 50 ([Africa Renewal, 2004](#)).

Although both international and domestic efforts to overcome the crisis have been strengthened in recent years, the people of sub-Saharan Africa will continue to feel the effects of HIV and AIDS for many years to come. The impact of AIDS in Africa is linked to many other problems, such as

poverty and poor public infrastructures. Therefore, efforts to fight the epidemic must take these realities into account, and look at ways in which the general development of Africa can be achieved.

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HIV/AIDS EDUCATION PROGRAMS IN KENYA: CONTEXTS OF IMPLEMENTATION IN SECONDARY SCHOOLS IN KISII COUNTY

Kennedy Ongaga and Mary Ombonga

ABSTRACT

In the absence of a medical vaccine against HIV infection, research shows that educating individuals about actions they can take to protect themselves is the most effective means to control the epidemic. School-based HIV/AIDS education programs are premised on this assumption and are considered the best social vaccine to influence young people's attitudes, behaviors, and knowledge about HIV infection, prevention, and access to treatment and care. Drawing upon a larger ethnographic study, we use a tripartite analytic framework for understanding HIV/AIDS-related education to examine how schools in western Kenya implement HIV/AIDS education programs. Findings reveal that the implementation of these programs is context-driven and contested along

patterns of sociocultural beliefs, religious morals, economic challenge, and a wider crisis in education. We argue for de-localization of principals and teachers and that HIV/AIDS education programs should not only be informational, but also empowering and focused on the individual as well as the context within which the individual functions.

INTRODUCTION

It is almost three decades since Human Immunodeficiency Virus (HIV), which causes Acquired Immune Deficiency Syndrome (AIDS), was discovered. The disease still strikes human beings with staggering and frightening epidemiological figures of the infected, ill, and dead. The Joint United Nations Program on HIV/AIDS ([UNAIDS, 2010](#)) report on adults and children infected and living with HIV- and AIDS-related deaths (see [Table 1](#)) shows that there were an estimated 2.6 million people who became newly infected with HIV in 2009, including 1.8 million people in sub-Saharan Africa, which still bears an ordinate share of the global burden. The vast majority of the people newly infected with HIV in sub-Saharan Africa are infected during unprotected heterosexual intercourse.

The report further shows that in 2009, there were 22.5 million people, 68% of the global total, living with HIV in sub-Saharan Africa. During the same year, 1.3 million people who died of HIV related illness in sub-Saharan Africa comprised 72% of the global total of 1.8 million. Despite these dizzying numbers, the report states that the overall growth of the global AIDS epidemic appears to have stabilized in many countries.

According to [UNAIDS \(2010\)](#) “The incidence of HIV infection declined by 19% between 1999 and 2009 globally; the decline exceeded 25% in 33 countries, including 22 countries in sub-Saharan Africa” (p. 66). In Namibia, for instance:

Improvements across key knowledge and behavior indicators—including comprehensive knowledge, age of sexual debut, engagement in higher-risk sex, and condom use among both males and females aged 15–24 years—were associated with declines in HIV prevalence among young people, from slightly more than 10% in 2007 to about 5% in 2009. (p. 65)

In East Africa, HIV incidence slowed in Tanzania to about 3.4 per 1,000 persons between 2004 and 2008 ([Hallett, 2010](#)). According to Kenya’s [National AIDS Control Council \(2007\)](#), the national HIV prevalence in Kenya fell from about 14% in the mid-1990s to 5% in 2006 and

Table 1. Regional Figures on Adults and Children Infected and Living with HIV and AIDS-Related Deaths, 2001 and 2009.

		Adults and Children Living with HIV	Adults and Children Newly Infected with HIV	% Adult Prevalence (15–49 years)	AIDS-Related Deaths among Adults and Children
Sub-Saharan	2009	22.5 million	1.8 million	5.0	1.3 million
Africa	2001	20.3 million	2.2 million	5.9	1.4 million
Middle East	2009	460,000	75,000	0.2	24,000
& North	2001	180,000	36,000	0.1	8,300
Africa					
South and	2009	4.1 million	270,000	0.3	260,000
Southeast	2001	3.8 million	380,000	0.4	230,000
Asia					
East Asia	2009	770,000	82,000	0.1	36,000
	2001	350,000	64,000	< 0.1	15,000
Oceania	2009	57,000	4,500	0.3	1,400
	2001	29,000	4,700	0.2	< 1,000
Central &	2009	1.4 million	92,000	0.5	58,000
South	2001	1.1 million	99,000	0.5	53,000
America					
Caribbean	2009	240,000	17,000	1.0	12,000
	2001	240,000	20,000	1.1	19,000
Eastern	2009	1.4 million	130,000	0.8	76,000
Europe &	2001	760,000	240,000	0.4	18,000
Central					
Asia					
Western &	2009	820,000	31,000	0.2	8,500
Central	2001	630,000	31,000	0.2	73,000
Europe					
North	2009	1.5 million	70,000	0.5	26,000
America	2001	1.2 million	66,000	0.4	30,000
Total	2009	33.3 million	2.6	0.8	1.8 million
	2001	28.6 million	3.1	0.8	1.8 million

AIDS-related deaths fell by 29% between 2002 and 2007. In Uganda, HIV prevalence is said to have stabilized at between 6.5% and 7% since 2001. These declines are attributed to behavior change resulting from increased comprehensive correct knowledge about HIV infection, prevention, and access to treatment and care. This reflects goals and targets set at United Nations General Assembly Special Session on HIV/AIDS (UNGASS) in 2001, which stress increasing knowledge and behavior change in HIV prevention programs.

Recent studies (e.g., The International Group on Analysis of Trends in HIV Prevalence and Behaviors in Young People in Countries most Affected by HIV, 2010; UNAIDS & World Bank, 2010) show that among young people, the drop in HIV incidence is associated with a significant positive trend in behavior indicators, including increased condom use, delayed sexual debut, and reductions in multiple partnerships. [UNAIDS \(2010\)](#) augments these findings stating “Where key behavioral indicators related to the risk of HIV infection—condom use, sex before age 15 years (early sexual debut) and multiple partnerships—all have positive trends, the incidence of HIV infection is markedly reduced” (p. 64).

The decline in global HIV incidence confirms the need to increase the investment in education and echoes an early finding when the disease was discovered in the 1980s that, in the absence of a medical vaccine against HIV infection, “educating individuals about actions they can take to protect themselves from becoming infected is the most effective means available for controlling the epidemic” (Centers for Disease Control, 1988, p. 1). This assertion is premised on the assumption that since the virus is transmitted exclusively by behaviors that individuals can modify, “[HIV/AIDS] educational programs designed to influence relevant types of behavior can be effective in controlling the epidemic” (p. 5). Since then, several authors (e.g., [Coombe, 2000](#); [Vandemoortele & Delamonica, 2000](#); World Bank, 2002) regard education on HIV/AIDS as the *social vaccine* against HIV infection.

This chapter is based on a study we conducted in Kenya in 2007 that sought to understand experiences of secondary school principals and students regarding the implementation of HIV/AIDS education programs. We present findings on how schools conceptualize and respond to cases of HIV/AIDS and the challenges they experience. We use Section “Introduction” to examine the inextricable relationship between the impact of HIV/AIDS on education and how education about HIV can be used to mitigate the pandemic’s potential and actual impact on the system, learners, and educators. Section “Methodology” describes different theoretical perspectives upon which HIV/AIDS education is implemented, categorized, and contested. Based on the perspectives, we provide an overview of Kenya’s Education Sector Policy on HIV/AIDS and use it as a lens to examine how the schools we studied respond to cases of HIV and AIDS and the challenges they experience. Lastly, we present the findings of the study and underscore the influence of local contexts on individual behavior and HIV/AIDS education programs. The chapter concludes with implications for educational policy and practice not only informational, but also empowering to individuals and transformational to local contexts.

The Impact of HIV/AIDS on Education

According to World Bank and [UNAIDS \(2002\)](#), an educated population and work force are prerequisites to achieving national health and self-sustainable development. However, HIV/AIDS, which has eaten into every fiber and fabric of social life, threatens to overwhelm the very fabric and structure of the educational organizations, management, and provision of services as has traditionally been known ([Kelly, 2000](#)). During the World Education Forum, held in Dakar, Senegal in April 2000, UNAIDS Executive Director, Peter Piot, underscored the impact saying, “AIDS constitutes one of the biggest threats to the global education agenda. What HIV/AIDS does to the human body, it also does to institutions. It undermines those institutions that protect us” (UNESCO, 2000a, p. 22). The potential of education and the impact of HIV/AIDS traps 15-24-year olds, who hold the greatest promise, in the middle and provides an urgent call to use education as the best strategy to save them.

It is argued that before the year 2000, most countries in sub-Saharan Africa had few programs in place long enough to evaluate the impact of HIV/AIDS on the education sector (Gachuhi, 1999; [Kelly, 2000](#); Hunter, Williamson, Sussman, & Donahue, 1999; [USAID, 2002](#); [Valerio & Bundy, 2004](#)). Since then, a plethora of studies (e.g., World Bank, 2002; Kioko & Njeru, 2004; [Salmi et al., 2000](#); [Schenker, 2001](#)) have measured the impact of HIV/AIDS on education and conceptualized the disease to have the potential to negatively affect the education sector in terms of:

- The demand for and supply of education
- The quality and management of education
- Adjustments in response to the special needs of a rapidly increasing number of orphans and vulnerable children (OVC)
- Adaptation to new interactions both within and between schools and their communities

According to Tarantola and Gruskin (1998) the most devastating impact of HIV/AIDS on children is when their immediate family environment and support system is challenged by the sickness, disability, and premature death of one or both parents from AIDS. Other studies (UNAIDS, 2004; World Bank, 2002) show that more than 113 million school-age children are out of school in developing countries, two-thirds of them girls. Of those who enter school, one out of four drops out before attaining literacy. At least 55 of the poorest countries seem unlikely to achieve Education for All (EFA) by 2015.

By 2002, UNAIDS reported that as many as 1 million children and young people in sub-Saharan Africa had lost their teachers to AIDS. In Cote d’Ivoire alone, the report indicated, “teachers with HIV miss up to 6 months of classes before dying compared with 10 days missed by teachers dying of other causes, and 7 out of 10 deaths were as a result of confirmed AIDS cause” (p. 10). In 1999 alone, an estimated 860,000 children lost their teachers to AIDS in sub-Saharan Africa (UNAIDS/WHO, 2001). In the Central African Republic, 85% of the 300 teachers who died in the year 2000 was as a result of AIDS, whereas the toll had forced more than 100 educational establishments to close in the late 1990s (UNAIDS/WHO, 2001). In South African province of KwaZulu Natal, where HIV/AIDS prevalence is the highest in the country (Kelly, 2000), a random sample of 100 schools found that the mortality of teachers rose significantly from 406 in 1997 to 609 in 2001 (Badcock-Walters, Desmond, Wilson & Heard, 2003).

In the next section, we provide the impact of HIV/AIDS on the education sector in Kenya.

The Case of Kenya

While Kenya’s HIV prevalence seems to be stable (See Table 2), challenges in the education sector still abound. A World Bank (1999) on the ‘Impact of HIV/AIDS on Education in Kenya’ predicted that the impact was likely to be felt more in terms of reduced supply and demand of educational services, changing clientele for educational services and processes, and content of education and planning for the sector. The report further indicated that the annual attrition of teachers stood at 1,800, of which Teachers Service Commission (TSC) attributed to HIV/AIDS. Teacher deaths rose

Table 2. HIV and AIDS Estimates (2009) – Kenya.

Category	Number of People
Number of people living with HIV	1.5 million
Adults aged 15–49 prevalence rate	6.3%
Adults aged 15 and up living with HIV	1.3 million
Women aged 15 and up living with HIV	760,000
Children aged 0–14 living with HIV	180,000
Deaths due to AIDS	80,000
Orphans due to AIDS aged 0–17	1.2 million

from 450 in 1995 to 1,500 in 1999. In one of Kenya's eight provinces, 20–30 teachers died each month from AIDS-related complications (Gachuhi, 1999).

Teachers in rural schools in Kenya are in short supply because most of them have a tendency of wanting to work in urban areas, partly because of AIDS-affected teachers' desire to be close to medical services (Bennell, Hyde, & Swainson, 2002; Badcock-Walters, 2002). A comprehensive national study commissioned by the Government of Kenya and UNICEF on the impact of HIV/AIDS on education in Kenya and how education can be used in the prevention and control of HIV/AIDS (Ennew et al., 2002) found that teachers and head teachers were dying at a high rate due to AIDS. They also discovered that there was lack of basic needs to support OVC. The study's analysis of the form of assistance provided by various care structures showed that food, shelter, education, and clothing were the common forms of assistance. The least available forms of assistance included health, guidance and counseling, and moral support.

Studies (e.g., Elmore-Meegan, Conroy & Tomkins, 1999; Gachuhi, 1999) also found out that due to the high rates of adult mortality associated with HIV/AIDS especially in the rural areas, there was unprecedented pressure on children to drop out of school to take care of their ailing family members. Elmore-Meegan et al. (1999) discovered that 52% of orphans in four sample communities were not attending school compared with 2% of nonorphans. The nonattendance of school, the study concluded, was largely due to lack of money, uniform, and other school materials. In spite of the meager and overstretched family resources, caretakers of affected students still considered education to be very important in addressing the long-term needs of orphans and would go to great lengths to avoid withdrawing children from school. However, according to teachers in the surveyed areas, most of the students drop out of school 2 to 3 years later due to psychosocial, psychological, and social stress. They lead the life of orphanhood, which is frequently accompanied by prejudice and increased poverty, factors that can further jeopardize children's chances of completing school education and may lead to the adoption of survival strategies that increase vulnerability to HIV (2010). As James Wolfenson, the former World Bank president states, "...The schoolchildren of the world offer 'a window of hope' into a better future, and their schools and teachers can help them to grow up with the knowledge, values and skills to seize that opportunity." It depends on how we use education to reach them before HIV virus catches up with them. It is a race against an invisible enemy.

Education as a 'Social Vaccine' Against HIV/AIDS

Education is the most powerful weapon that can be used to change the world. It is also a weapon that the world cannot do without in the fight against HIV/AIDS. Education saves lives. And ignorance is lethal. (Nelson Mandela)

Given the absence of a vaccine and the inability of medical science today to contain the AIDS pandemic, education is said to be one of the most effective ways to prevent HIV infection. Literature (e.g., [Aggleton, Yankah & Crewe, 2011](#); [Vandemoortele & Delamonica, 2000](#); World Bank, 2002) show that 'education vaccine' against HIV is likely to be the only one available for the foreseeable future. In a World Bank report on HIV/AIDS prevention programs, Valerio and Bundy (2002) make a cogent argument why education is the best social vaccine for young people:

Children of school age have the lowest prevalence of infection, and even in the worst affected countries, the vast majority of schoolchildren are uninfected. For these children, there is a window of hope, a chance of a life free from AIDS if they can acquire the knowledge, skills, and values to help them protect themselves as they grow up. Providing young people with the "social vaccine" of education offers them a real chance of productive life. (p. 3)

The vitality of education in stemming the impact of HIV/AIDS was underscored in the Dakar Framework on HIV/AIDS and Education Systems in Africa. The Framework required governments to develop, by 2003 and implement by 2005, national strategies to provide their schools with vastly expanded access to information and education, including youth-specific HIV/AIDS education. The rationale was to help schools develop children life skills required to reduce risk and vulnerability to HIV infection and create a supportive environments for OVC.

In this context, education is regarded not only as a means of passing information, skills, and increasing youths' connectedness, but also as a means of changing attitudes and behavior concerning AIDS, both as a disease and as a social phenomenon ([Crewe, 2004](#); [UNAIDS, 2002](#)). According to [Aggleton, Yankah and Crewe, \(2011\)](#):

The best forms of education seek to help individuals and communities achieve their potential, recognizing that future circumstances may not be the same as in the past; that structural inequalities of poverty, gender/sexuality and race exist; and that individuals should be free to choose between options in ways that are informed by evidence and the values of freedom, democracy and rights. (p. 501)

Higher levels of education are often assumed to have significant influence on how young people make informed decisions about their

health – including very important areas such as sexual behavior and HIV/AIDS (UNAIDS, 2002). In Zambia, for instance, the decline in the prevalence rate for 15–19-year-old women in Lusaka was more marked for those with secondary and higher levels of education than for those who had not proceeded beyond the primary level (Fylkesnes, Musonda & Sichone, 1999). Further studies (e.g., Ainsworth, Filmer & Semali, 1998; Ainsworth & Semali, 1998; Hargreaves & Glynn, 2002) have documented the positive correlation not only between levels of education and the probability of engaging in high-risk sexual behavior, but also between the level of education and actual infection. In their work, *Systematic review exploring time trends in the association between educational attainment and risk of HIV infection in sub-Saharan Africa* (Hargreaves, Boler, Bonell, Boccia, Birdthistle, Fletcher et al., 2008) (as cited in Aggleton, Yahnkah & Crewe, 2011) differentiate between five mechanisms by which education can exert its effects. These include the influence of:

- School-based HIV and AIDS education itself
- The broader psychosocial benefits that derive from education
- The economic and lifestyle impacts of education
- Education's potential to influence power within sexual relationships
- Education's capacity to affect social and sexual networks

These authors' argument implies that higher levels of education are not only informational, but also empower individuals to move beyond focusing and changing individual behaviors to questioning and taking control of contextual factors that make them vulnerable. These may include interpersonal and sexual relationships, gender and power inequalities, stigma and discrimination, reproductive and sexual health, violence prevention, transmission and prevention pathways, and a variety of skills. They capture the potency of education by asking:

Why are more educated women more able to negotiate safer sex? It may be through more positive attitudes toward condoms being fostered in social networks in school, and/or more power and balance within relationships over how to have sex. Furthermore, if more highly educated women are changing their behavior because of HIV, then clearly HIV messages are also having an effect. (p. 42)

Based on a comprehensive literature review on school-based sexual health and HIV/AIDS education, UNAIDS (1997) recommended the following components for an effective school-based program:

- Responsible and safe behavior can be learned.
- Sexual education is more effective when it occurs before puberty.

- Effective programs encourage openness in communicating about sex.
- Programs need to be sensitive to the different requirements of boys and girls, but in all cases they should take account of the social context in which sexual behavior takes place and of the personal and social consequences of such behavior.
- Effective programs equip young people with skills to interpret the conflicting messages that come from adult role models, television, other media, and advertisements.

Schools can use the above components as tools to become learning organizations and radiating centers of change in the context of HIV/AIDS. This will allow them to extend their missions beyond the strictly academic realm, and attain a conscious continuum of actions that will allow them to recognize and understand what drives and characterizes the epidemic. Only then, will they know their response and assess the extent to which their existing responses are meeting the needs of those they serve.

Theoretical Perspectives

In this section we use [Miedema, Maxwell and Aggleton's \(2011\)](#) three theoretical approaches to the implementation of HIV/AIDS education programs in schools and communities. These include, scientific, human rights based, and moralistic approaches (See [Table 3](#)). Although education sectors around the world are scaling up their educational strategies, policies, and programs to address HIV/AIDS issues in and out-of formal education systems, complexities of the content and form of such programs abound. Research (e.g., UNAIDS, 2004; [Berne & Huberman, 1999](#)) shows that most HIV/AIDS education programs targeting young people in and out of school are designed to reduce misinformation, increase correct knowledge of HIV prevention, clarify and strengthen positive values and attitudes, and increase communication with parents or other trusted adults. The objective of these programs is to have young people to delay the debut of sexual relations, reduce the number of partners (for those who are sexually active), and embrace safer sexual behavior.

HIV and AIDS education programs that assume a scientific approach comprise those that are loosely situated within social-psychological and behavior change theory ([Ajzen, 1991](#); [Aaro et al., 2005](#); [Bandura, 2000](#); [Miedema et al., 2011](#)). The design of this approach assumes that young people need to be taught facts about HIV/AIDS – how the virus is

Table 3. Tripartite Analytic Framework for Understanding HIV- and AIDS-Related Education.

Approaches to HIV and AIDS-Related Education	Draws Upon
Scientifically informed HIV- and AIDS-related education	• Biomedical knowledge and understanding • Insights from experimental psychological studies • Evidence from epidemiological and behavioral studies
Rights informed HIV- and AIDS-related education	• Formal notions of rights • Loose definition of rights
Moralistic informed HIV- and AIDS-related education	• Explicit conservative (often faith-based) moral values • Implicit conservative moral values

Source: Miedema, Maxwell, & Aggleton (2011). Education about HIV/AIDS-theoretical underpinnings for a practical response. *Health Education Research*, 26(3), 381–392. doi: 10.1093/her/cyq088.

transmitted and its impact on the immune system. Most programs in this category are grounded in evidence-based studies and are more concerned with intervention effectiveness –‘what works’ (see Allen, 2005; Beasley, Valerio & Bundy, 2008). This is hoped to instill personal knowledge that lead to behavior change. Examples of this include Mema kwa Vijana in Tanzania and Kenya’s Primary School Action for Better Health (PSABH), an HIV/AIDS behavior change program that targets 12–16-year-old children in primary schools in Kenya.

The right’s based type of HIV/AIDS education programs are grounded in the International human rights standards, which recognize that young people have the right to access adequate information essential for their health and development and for their ability to participate in society. According to UNAIDS (2010), a vast majority of countries (89%) explicitly acknowledge or address human rights in their national AIDS strategies with programs that address stigma and discrimination. Hence,

A rights-based approach to HIV requires: realization and protection of the rights people need to avoid exposure to HIV; enabling and protecting people living with HIV so that they can live and thrive with dignity; attention to the most marginalized within societies; and empowerment of key populations through encouraging social participation, promoting inclusion and raising rights-awareness. (p. 124)

This approach uses terms like, participation, choice, and empowerment. A plethora of studies on rights-based education in the context of HIV/

AIDS (e.g., Cornwall & Nyamu-musembi, 2005; UNAIDS, 2004; Pettit & Wheeler, 2005; Gruskin & Tarantola, 2002) emphasize gender equality, advocate for legal approach to protect individual rights, universal access to formal education of good quality, responsibility, access to health care, especially reproductive services, sex education, including HIV prevention, treatment, and care and support services. Issues of respect, responsibility, privacy, choice, participatory, and a rights-based learning environment are also stressed. Another key feature of the rights-based approaches is the concept of empowerment, helping people to gain control over their lives and their health (Tones & Green, 2004; WHO, 1997).

Lastly, the moralistic approach to HIV/AIDS education touches on the faith-based organizations (FBOs) and raises contentious issues connected to HIV/AIDS prevention, such as morality, beliefs about the spiritual bases of disease, and rules of family life and sexual activity (Casale, Nixon, Flicker, Rubincam & Jenney, 2010). The most difficult and contentious dilemma of the programs based on the moralistic approach is how to address issues about sexual behavior, especially condom use and sex outside marriage – issues central to any HIV/AIDS prevention (Denis, 2003; Global Health Council, 2005; Kirby, Laris, Rolleri, 2007; Miedema et al., 2011; Pisani, 2008; Tiendrebeogo, Buyx & Van Beelen, 2004). HIV/AIDS education programs that espouse this approach believe in sexual chastity prior to marriage, sexual fidelity within marriage, and tend to condemn condom use or remain silent (see Casale et al., 2010; Denis, 2003).

These three approaches show the complexities, contradictions, and tensions that characterize implementation of most HIV/AIDS education programs. Coupled with structural issues, such as poverty, gender, and culture, it is imperative for school systems, as they respond to HIV/AIDS, to obtain broad community participation to ensure that HIV/AIDS education policies, strategies, and programs are locally determined and are consistent with community values. The central purpose of HIV/AIDS education, regardless of its orientation on these perspectives, is to prevent people from HIV infection. We argue that it is crucial for such education programs to work synergistically, and articulate to the target population and their constituencies what is most important to them, what will be most resistant to change, and what will be most necessary to change in order to establish a strong base of effective HIV/AIDS education programs. We now review Kenya's response to HIV/AIDS with special attention to the Education Sector Policy on HIV and AIDS.

Policy Response to HIV/AIDS in Kenya

Since the first case was discovered in Kenya in 1984, Kenya's response to the impact of HIV/AIDS can be described in three phases (Family Health international & AIDS Control and Prevention Project, 1996). The first phase (1984 through 1987) was characterized by political denial, fear, and dismissal of HIV as a disease of the Westerners. The high rate of deaths due to illness associated with HIV/AIDS moved the government to create the National AIDS Council (NAC), which worked with nongovernmental organizations to launch a formidable awareness campaign in a populace that was uninformed.

The second phase (1988–1991) saw an increase of HIV/AIDS awareness, but not the change of behavior that made people vulnerable to HIV infection. It was during this period when influential religious leaders strongly spoke against the use of condoms and the then president of Kenya, Daniel Arap Moi, publicly burned condoms arguing, "Condom use is a western solution diluting our way of life." Issues related to HIV/AIDS were solely left to the Ministry of Health and resources needed to increase awareness and prevention came from the international donor communities.

The third phase of Kenya's response (1992–1995) experienced significant changes including, release of surveillance data and a need for more policy direction led to the first Parliamentary Sessional Paper on HIV and AIDS, which led to increased donor funding to stem the tide of HIV/AIDS on different sectors of the economy. Close to two decades after the discovery of the first HIV case in Kenya, the president declared HIV/AIDS a national disaster in 1999, which led to the establishment of the National AIDS Control Council (NACC) to steer the process of policymaking and coordinate a national multisectoral response to HIV/AIDS. NACC created AIDS control units at ministerial, provincial, and county levels. It is under the guidance of NACC that Kenya's Ministry of Education, Science and Technology (MoEST) developed the Education Sector Policy on HIV and AIDS (2004).

The principles that guide Kenya's Education Sector Policy on HIV and AIDS (see [Table 4](#)) are in accordance with international conventions, national laws, policies, guidelines, and regulations. The policy is influenced by The Dakar Framework action for EFA, Millennium Development Goals (MGDs), and the UNGASS Declaration of Commitment on HIV/AIDS (July 2002). These organizations set the target of reducing HIV infection among 15-24 year-olds by 25% by 2010 and called for vastly expanded access to information and education, especially youth-specific HIV/AIDS education, necessary to develop the life skills required to

Table 4. Principles of Kenya's Education Sector Policy on HIV and AIDS.

Principle	Description
Access to education	• Every person has the right to education • No learner will be denied access to education on the basis of his or her actual or perceived HIV status • Access to education shall be facilitated for orphans and vulnerable learners
Access to information	• Every person has the right to relevant and factual HIV and AIDS information, knowledge and skills that are appropriate to their age, gender, culture, language, and context
Equality	• Every person has the same rights, opportunities, and responsibilities and shall be protected from all forms of discrimination, including discrimination based on actual, known or perceived HIV status
Privacy and confidentiality	• Every person has the right to privacy and confidentiality regarding their health, including information related to their HIV status • HIV testing should be voluntary • No person may disclose information relating to the HIV status of another person, without his or her consent • Every person has a moral responsibility to protect themselves and others from HIV infection. • Every person has the right to know their HIV status and openness and disclosure are encouraged within a safe, supportive, and accepting environment
Access to care, treatment, and support	• All infected and affected learners, educators and other personnel in the education sector have the right to access holistic care, treatment and support in line with available resources • The education sector will work in partnership with agencies offering support and care including institutions, communities and private and public health care systems
Safety in workplace and learning institutions	• There will be zero tolerance for sexual harassment, abuse, and exploitation • Every person, whether infected or affected, has the right to fair labor practices in terms of recruitment, appointment, and continued enjoyment of employment, promotion, training, and benefits. HIV testing as a requirement for any of the above is prohibited
Gender responsiveness	• HIV and AIDS affect and impact on women and men differently due to their biological, sociocultural, and economic circumstances. Application of all aspects of this policy should be responsive to the different needs of men and women, boys and girls

Table 4. (Continued)

Principle	Description
Involvement of people living with AIDS (PLWA)	• The involvement of PLWA to educate and inform shall be promoted at all levels of the education sector.
Partnerships	• While the education sector will be responsible and accountable for implementation of this policy it will at all times seek to develop effective partnerships to enhance the success of its implementation

reduce risk and vulnerability to HIV infection ([Government of Kenya, 2004](#)). According to the MoEST (2004), the policy acts as a guideline for effective HIV prevention and response. It:

Formalizes the rights and responsibilities of every person involved, directly or indirectly, in the education sector with regard to HIV and AIDS: the learners their parents and care givers, educators, managers, administrators, support staff and the whole of civil society. (p. 5)

The principles include, access to education of good quality; access to relevant information; equal rights, opportunities, and responsibilities; privacy and confidentiality; access to care treatment and support; safe workplace and learning institutions; and gender responsiveness ([Government of Kenya, 2004](#)). The policy also provided for the infusion of HIV/AIDS education in the national curriculum and stated that “curriculum should be sensitive to cultural and religious beliefs and appropriate to age, gender, language, special needs and context” (p. 16). Learning institutions are directed to assist OVC, identify and assess those with special needs, and develop an ongoing professional counseling process for the infected and affected, including referral to professional services.

It is on this policy that the curriculum and school-based HIV/AIDS education programs are implemented. The impact such programs had on learners and educators is manifested on contextual factors that influence their effectiveness. More often than not, the policy is implemented against the backdrop of other structural challenges including, poverty (World Bank, 2002), gender and power inequalities, ([Aikman, Unterhalter & Boler, 2008](#); [Banks & McGee Banks, 2010](#)), unsafe schools, sexual violence, selective teaching ([Boler, 2003](#); [UNESCO, 2002](#)), and FBOs’ influence, which are posited to be less effective in HIV prevention than their role in providing HIV-and-AIDS-related care ([Green, 2003](#); [Liebowitz, 2002](#); [Parry, 2003](#);

Pisani, 2008; UNICEF, 2003). Additionally, limited number of skilled educators to teach and manage education in the context of HIV exacerbates the epidemic. Clarke (2008) posits that there is paucity of research to understand this challenge.

There is very little published research on teacher education or teacher training for school-based HIV education. As a result, very little is known about the strategies Ministries of Education are adopting, the capacity that is being built in Teacher Training Colleges, the types of course that are being provided and, lastly, how effective these courses are in training teachers for the classroom delivery of the curriculum. (p. 66)

These challenges have the potential to be sources of tension between what the policy states and what happens in practice.

METHODOLOGY

Data for this chapter comes from a larger ethnographic study that sought to understand experiences of head teachers in implementing HIV and AIDS education programs in secondary schools in rural Kenya. This approach allowed us to explore the “why” and “how” questions, which conveyed the subjective reality of the participants’, lived experiences in their natural context. Data were collected for a period of 4 months through unstructured open-ended interviews, focus groups, field notes, and participant observation. We used unstructured open-ended, face-to-face interviews with the aim of getting participants to talk about their experiences, feelings, opinions, and knowledge (Patton, 2002) related to the implementation of HIV/AIDS programs in their schools.

The sample included nine secondary school head teachers (six males and three females), five teachers, who taught health-related subjects, and 22 students. We settled on head teachers as our primary source of data because they are information-rich in understanding and interpreting the contexts upon which implementation of HIV/AIDS education programs takes place. They are also respected leaders in the local community and are competent, have a repertoire of vocabulary, skills, and knowledge necessary to engage in substantive discussions concerning HIV/AIDS, a very emotive subject. From the head teachers, we wanted to understand their role, how their schools responded to HIV/AIDS cases, what impact HIV/AIDS education had on the students, and the challenges they experienced in the implementation process. Each head teacher was interviewed individually for a period of about 60 minutes.

We interviewed teachers and observed them teaching in their classrooms. The purpose of the observation was to capture how they teach HIV/AIDS

curriculum, the materials they use, and the role and participative nature of the students in the lesson. The interviews focused on their training and preparedness to respond to the impact of HIV/AIDS. The student sample consisted of 22 participants drawn from eight secondary schools that were part of the study. Their ages ranged between 16 and 21 years and were in grades 10, 11 and 12. We settled on these grade levels because we thought students at this level had reasonable exposure to and experience with HIV/AIDS education programs. We used focus group interviews with students to gain insights of their shared understanding and perceptions regarding the implementation of HIV/AIDS education programs.

Students were interviewed in four focus groups each comprising five students. Two student participants self-selected to be interviewed individually. Research shows that focus groups are particularly useful when there are power differences between the participants and decision makers or professionals, when the everyday use of language and culture of particular groups is of interest, and when one wants to explore the degree of consensus on a given topic (Morgan & Kreuger, 1993). In our view, focus groups offered students greater openness to voice their views on the influence of HIV/AIDS programs on them, a topic otherwise inaccessible in ordinary discourse between youth and adults in rural settings in Kenya. All focus groups lasted between 40 and 45 minutes.

We explained to all participants that their participation in the study was strictly voluntary and that they could withdraw from the study at any time without penalty. Rigorous protection of and respect for the participants' privacy were observed to the extent provided by law. The research was approved by the Committee for Human Research Protections at Michigan State University. With prior participant consent all interviews were audio-taped. To protect our participants' anonymity, we asked them to use pseudonyms or aliases and we also made a commitment to keep all data in a locked cabinet and/or in password-protected computers. Our data analysis involved the verbatim transcription of qualitative data from audio tape recordings, review of transcript data, coding, and categorizing emerging themes from whence our findings emerged.

FINDINGS

In this section, we present findings categorized into three contexts: school, religious, and cultural. These contexts wield huge influence on how schools in rural areas construct HIV/AIDS in terms of implementation, meaning, response, and communication.

School Context

Unsafe School Environments

Our study revealed that schools in rural Kisii County do little to protect students, especially girls from within and out of school environments that pose health risks to them including the risk of HIV infection. A girl captured the feelings of others when she candidly revealed that a teacher had sexually harassed her and “all the head teacher did was to transfer him to another school.” We garnered that two co-education schools, which were among three day-schools in our study, had the most gender-insensitive school environment, where sexual harassment and gender-based violence against girls, including lack of adequate toilet and sanitary facilities, were cited. It was common to find students walking for a kilometer out of the school going to look for water. Two girls had dropped out of school and got married in the local community because they became pregnant. In fact one girl said that she felt more insecure in school than at home. Boys also shared that teachers confiscated condoms whenever they did impromptu inspections, thereby taking away the only power they have to protect them of HIV infection and other STIs.

These cases point to unsafe school environments that condone abusive and inappropriate relationships that put girls at risk of infection. We gathered that the role of head teachers as the policy stated, creating conducive school environments that offer appropriate responses to all cases of violence including those related to HIV/AIDS, is severely constrained and constructed by a gender-insensitive cultural paradigm informed by a void in policy practice.

Research has shown that unsafe learning environments that perpetuate gender inequality and gender-based violence are among the reasons that girls drop out of school, get pregnant, or parents refuse to enroll and keep their daughters in school. In the context of HIV/AIDS, there is promise in HIV/AIDS education programs that are produced and implemented with a gender-based approach, those that take into account the ways in which gender norms influence HIV vulnerability, ability to adopt protective behavior, and the care and support of people living with HIV/AIDS.

Inadequate Teaching and Guidance and Counseling Personnel

One of the findings our study uncovered was lack of or limited guidance and counseling services in the county. Schools that had any form of guidance and counseling unit handled general cases of student discipline including drunkenness and substance abuse. Students and teachers who experienced

HIV/AIDS-related psychosocial stress did not receive any counseling or referral services. Schools did not have mechanisms of monitoring students who were either infected or affected by HIV/AIDS. One of the student participants whom we realized was HIV-positive received her antiretroviral medicine from a community-based organization, but due to lack of nutritious food in school, she usually sold some of her medicine to buy food.

From the data, we garnered that schools in Kisii County not only experience shortage of trained teachers but were also severely constrained by lack of trained teachers to teach HIV/AIDS curriculum. An overview of student population showed an average of 45 students for each teacher. This ratio was attributed to a high student transition rate from primary to secondary schools due to the implementation of free primary education policy. One head teacher observed, "The best accomplishment of this government was to let students come to school for free at primary level. But they forgot to factor the resources at secondary schools . . . teachers mostly. Now we have to do with what we have." We heard this message from most participants, but the main concern was that of limited trained teachers. The head teachers blamed the government's policy that had frozen the hiring of more teachers due to "budgetary constraints." We further learned that most teachers were leaving the profession either due to retirement, HIV/AIDS, or career change. Two of the schools had lost three teachers each in one semester. Caught in this crisis, most schools had been mandated by their respective board of governors (BOGs) to hire untrained teachers to fill the gap, and in most cases these were the teachers who taught HIV/AIDS components. While all participants thought that the infusion of HIV/AIDS component in the national curriculum was a good thing, the level of implementation was low due to a myriad of problems. First, not much had been done in training teachers to specifically teach HIV/AIDS education in schools. Teacher participants whom we observed in class had attended an average of one workshop related to teaching HIV/AIDS education in a year.

Our classroom observations revealed that the teaching of HIV/AIDS was teacher-centered, top-down, and rarely invited a discussion of the issues discussed. It was more informational, providing facts than discussing the manifestation of such facts in the context of students' lives. When we asked students to describe how their teachers taught HIV/AIDS education, the following phrases characterized their responses:

They teacher from their comfort zones

They lecture to us

Asking a question makes you look bad, especially if it is related to sex or something

They are selective; they avoid little details that are important to us
They are bad role models
They ask to revise exam subjects when we have AIDS lessons

The fact that HIV/AIDS education was not an examinable subject, both teachers and students did not take it seriously. Most students were disengaged during the lessons we observed because teachers gave them limited chances to actively participate. During a discussion touching on the ABC (Abstain, Be Faithful, Use a Condom) framework, we realized that most students knew a lot, but feigned ignorance to avoid being seen that they know too much about prevention methods beyond abstinence. It was apparent to us that a vast majority of students were aware of HIV/AIDS prevention, but they lacked the confidence or affirmation from the adults, especially teachers to integrate it in conversations and contexts that empowered them. This finding augments research, on teaching in most classrooms around the world, which tends to be didactic, nonparticipatory, inflexible, and assessment driven (DiClemente et al., 1989; Petosa and Wessinger, 1990; Ruder, Flam, Flatto, & Curran, 1990). Teaching about HIV/AIDS is recommended to be participatory and responsive, raising questions rather than providing clear-cut answers, and challenging young people and adults to find new ways of relating to one.

Outsider vs Insider Head Teachers

We found out that head teachers who were *insiders*¹ had personal and professional histories in their schools and community that left few chances for them to implement the HIV/AIDS education policy as envisioned. They are considered part of the social fabric of their communities and have an understanding of the norms and shared heritage. They subscribe to the mundane as well as the more vivid aspects of their community's socio-cultural aspects that impede the reality of implementing HIV/AIDS education programs in schools.

On the other hand, *Outsiders*² had more chances of success in implementing the HIV/AIDS education policy. This is because they lack the history, cultural nuances, and are generally free of the personal and cultural baggage that is attached to the *Insider* head teachers. Outsiders head teachers were generally motivated to confront and even change the existing understanding and patterns of their schools' HIV/AIDS education response. Two of them had allowed their schools to be used as centers of HIV testing, a thing that was not imagined by the schools' religious sponsors. Given that the MoEST encourages localization of head teachers and teachers, teaching and heading schools in one's own

backyard, such policy might need review in the context of HIV/AIDS education.

Religious Context

In this study, we garnered that the religious organizations play a pivotal role in school programs and leadership in rural Kisii County as is in much of Kenya. Since many schools are affiliated or sponsored by churches, head teachers expressed their fear of implementing or allowing HIV/AIDS education programs whose contents and method of delivery contravened religious beliefs. All participants indicated that the impact of religious organizations in school was manifested in messages of abstinence and provision of care for people living with HIV/AIDS.

ABC Framework

In prevention initiatives, most schools in Kenya understand HIV/AIDS education within the ABC framework: A: Abstain, B: Be faithful, and C: Use Condoms. According to UNAIDS (1998), ABC model of HIV/AIDS education includes information on:

- Abstinence or delaying first sex
- Being safer by being faithful to one partner or by reducing the number of sexual partners, and
- Correct and consistent use of condoms for sexually active young people, couples in which one partner is HIV-positive, sex workers, and their clients, and anyone engaging in sexual activity with partners who may have been at risk of HIV exposure.

However, we found out that from a religious standpoint school-based HIV/AIDS education was often wrapped up in questions of personal morality entrenched in teachings of abstinence and faithfulness. Both focus group participants and head teachers concurred that the churches' influence and role in disseminating HIV/AIDS awareness was shrouded in the message, "the wages of sin is death." The 'Condom' component, which is considered controversial, seldom finds its way in school-based HIV/AIDS education programs.

While the head teachers felt that they were obligated to respect their church policies, they were of the view that all three components of ABC approach, which form the bulky of HIV/AIDS prevention programs, should be fully implemented instead of emphasizing 'A' (*abstinence*). One

participant argued that abstinence might mean delaying having sex but that did not mean that they [students] would wait until marriage.

It is in the religious context that head teachers feared to irk or contradict the stand of their churches regarding sexual education and HIV/AIDS. Hence, they uphold and emphasize principles of abstinence and faithfulness after marriage, a stance they seemed to be aware was not reflective of the realities they experienced in their schools and communities.

According to one head teacher, the view of the church was that promotion of condom use was an invitation to promiscuous behavior and would lead to recreational sex. Another head teacher stated “students must wait until marriage to know about condoms. Talking about condoms does not allow us, as a school to provide the youth with necessary moral, social and spiritual preparation they need to navigate the social environment when they become of age.” Showing signs of a change of attitude and one male head teacher remarked, “I have gone to many funerals. We have borrowed resources to bury the dead. In a way we are selling our wealth and buying poverty. Times have changed. We have to tell them [kids] what works as science says.”

While a majority of student participants endorsed the abstinence message as espoused by religious organizations, they asserted that this method was hardly practiced by their fellow youth. We argue that the youth’s widely acknowledged best prevention method, abstinence, is the least utilized in their repertoire of HIV/AIDS prevention methods. This observation presents the inevitability of including condom-use knowledge when teaching HIV/AIDS education programs.

From the forgoing, it is discernible that the influence of religious organizations limits and constrains the role of head teachers from pushing comprehensive HIV/AIDS education programs objectively in a more frank, creative, interactive as well as experiential fashion. Hence, head teachers as HIV/AIDS educators accomplish the goal of teaching students in different forums about prevention messages that only harp on abstinence and fidelity after marriage. By so doing, prevention messages end up being informational and focused only on individuals rather than empowering and trained on the contexts upon which the individual operates.

Care and Support

While participants present the churches’ reactive influence in HIV/AIDS education strategies in schools in rural Kisii County, the churches’ proactive response to those who are infected and affected is remarkable. Besides reinforcing traditional moral teachings and values, especially with regard to

sexual behavior and marital relationships, participants said that churches assist OVC in the form of finance, pastoral counseling as well as care and prayer for those who are bereaved in the community. A student shared that the Catholic Church had set up a voluntary counseling and testing (VCT) center in a school around her home to serve both the school and immediate local community. There is no doubt that HIV testing and counseling services are a gateway to HIV prevention, care, and treatment since scaling up HIV testing and counseling services is a critical step for scaling up a range of interventions in HIV/AIDS prevention, care, treatment, and support.

It also emerged that head teachers were actively involved in caring and supporting children orphaned by HIV/AIDS. Illustrative of this observation was one head teacher's adoption of five children whom she lived with and another's support for his brother's three orphaned children. In the wake of these compassionate responses was a lack of systematic policies and strategies that build and strengthen the ability of schools, communities, and families to support orphans and children affected by HIV/AIDS. Such policies would mean providing counseling and referral services, adequate nutrition, access to education, protection from exploitation and discrimination, and addressing a host of other societal ills.

Cultural Context

In the context of HIV/AIDS, UNESCO and UNAIDS (2000) propose that culture be understood as ways of life, traditions and beliefs, representations of health and disease, perceptions of life and death, sexual norms and practices, power and gender relations, family structures, languages, and means of communication as well as arts and creativity. In view of this definition, culture can influence attitudes and behaviors related to the HIV/AIDS epidemic. These attitudes and behaviors may include taking or not taking risk of contracting HIV, accessing treatment and care, shaping gender relations and roles that put women and men at risk of infection as well as being supportive towards or discriminating against people living with HIV/AIDS and their families.

Our study showed that the difficulty of establishing effective school-based HIV/AIDS programs stems from a culture of silence regarding sexuality, male–female roles and relationships, illness and death, and other taboo subjects deeply rooted in the local culture. This study revealed that the influence of culture manifests itself in three interrelated ways.

First, culture influenced the contextual environment upon which HIV/AIDS education programs are implemented. This claim is supported by the way head teachers' cultural and religious dilemma seldom allowed them to sanction programs that deviated from "the cultural norms" of their community. We also gleaned that there was a culture of "passing the buck" with regard to the social institutions that ought to undertake sexuality education. The family passes the responsibility to the school, the churches to the family, and the school passes it back to the family. Societal and cultural attitudes have the potential and often prescribe what is considered appropriate behavior, and limit young women's power to negotiate safer sex or resist unwanted sex. These contexts make it hard for women to opt out of abusive or violent relationships, promote expectations of dependence on men, a dependence further exacerbated by poverty. Participants pointed to poverty as a major reason that enabled older men to prey on girls by offering them money and material goods in exchange for sexual liaisons. The "thick wall of silence" that the head teachers alluded to might mean reluctance to talk about HIV/AIDS prevention strategies between parents, teachers, and the young people.

Second, the content of the local culture such as its values, norms and practices, resources, and other dos and don'ts overly influenced what prevention measures are passed to students based on their gender and age group. For instance, an individual's concept and expression of sexuality is deeply entwined in the cultural and social norms of the community. This observation is manifested in instances where we observed head teachers' messages to students regarding HIV/AIDS prevention encapsulated in phrases such as "take care", "avoid boys", and "our culture is the best culture." Student participants shared their experiences where their parents and teachers talked to them in a convoluted language that least made sense to them. Male student participants interpreted confiscation of condoms by teachers as the height of betrayal.

Finally, the methods of who participates in HIV/AIDS prevention programs at the school level also influence the way HIV/AIDS education programs are implemented. Teachers, church elders, opinion leaders, and parents controlled the method of communicating on HIV/AIDS. Rarely were young people involved in HIV/AIDS implementation process at the school level. Erratic HIV/AIDS student groups, whose patrons were teachers, existed at boarding school. Student participants from boarding school reported feigning ignorance on HIV/AIDS issues in which they had knowledge just "to protect our reputation." While student participants encouraged the involvement of people living with HIV/AIDS as part of

HIV/AIDS education, they also suggested that young people of their age group who might be HIV positive be involved in HIV/AIDS education.

SIGNIFICANCE OF THE STUDY

The relevance of this chapter can be derived from the analysis of the impact of HIV/AIDS on education and how education can be used as a “social vaccine” to mitigate such impact. The findings of this study can provide educators, policymakers, planners, managers, and practitioners with an opportunity to share ideas on how programs may be re-contextualized to fit a variety of local circumstances. Meaningful response to HIV/AIDS epidemic requires total mobilization of entire societies, enabling a community-led transformation of norms, values, and practices that fuel the epidemic.

The study contributes in uncovering a wider crisis in schools that might need attention. It reveals an acute shortage of trained teachers and other key resources, which are critical to effective implementation of HIV/AIDS education programs. Teachers, when properly trained and provided with the appropriate materials, are able to conduct effective school-based HIV/AIDS education. Additionally, this study provides decision makers with insights and information on the needs of head teachers and their schools, which they can utilize to develop a systemic and accountable planning that tackles stigma and addresses the needs of OVC as well as infected and affected educators. The potential of FBOs’ seems to be underestimated and misunderstood. The fact that some of them had allowed setting up of HIV testing centers in their schools, in itself is an opportunity that need exploration.

CONCLUSION

In a world fraught with HIV/AIDS and with an enhanced risk of HIV infection especially for young people, schools can no longer deliver a strictly health-based message about AIDS in traditional ways. Kelley (1990) observes that HIV/AIDS programs and prevention messages should focus on the individual as well as the context upon which the individual functions. Such programs should be integrated in healthy children and healthy schools and should cover issues ranging from reproductive healthy, sexuality, gender, sex education as well as STIs and condoms use. Issues such as discrimination and human rights, respect for women, and the

information and life skills particularly needed by girls in the context of HIV/AIDS should also be part of the prevention strategies. These programs must be implemented by appropriate and trained teachers and by a greater variety of “teacher” role models, peers, traditional healers, priests and imams, politicians, families, schools, states, and the international world. All these must work synergistically.

As Jonathan Mann said in 1998, at the International AIDS Conference in Geneva, Switzerland, “Our responsibility is historic, for when the history of AIDS and the global response is written, our most precious contribution may well be that at the time of plague we did not flee, we did not hide, and we did not separate ourselves.” This is our signature today and our daily practice tomorrow.

NOTES

1. Those who headed schools in communities where they belong.
2. Those who headed schools away from their own communities.

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HIV EDUCATION IN UGANDAN SECONDARY SCHOOLS: ATTITUDES OF STUDENTS, TEACHERS, AND ADMINISTRATORS

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ABSTRACT

This study examines attitudes of students, teachers, and administrators about HIV education in Ugandan secondary schools. Results indicated significant differences between these groups regarding perspectives about sexuality, transmission of HIV, and AIDS stigma. Behavioral assessment indicated low prevalence of high-risk activities among students, which implies a need for continued education and behavioral reinforcement in the curriculum in the intervention programs for behavioral maintenance. This study provides important insights as to how a comprehensive HIV education program can be more effectively and efficiently integrated in the school system. An ongoing discussion within the public

and private sector of the country addresses the need for a comprehensive education curriculum, which includes teacher training, peer education, and strong involvement of governmental and nongovernmental organizations. Results from this study provide an important step in this process.

This study on HIV/AIDS education programs was conducted with the Uganda Ministry of Education and Sports (MOES) in a national sample of 76 secondary schools in Uganda and evaluates the national curriculum of education programs for the prevention and control of HIV/AIDS in secondary schools throughout the country. Where prior publications have focused on an introduction to this study and findings related to participants' knowledge and the hidden curriculum (see, for instance, [Jacob, Morisky, & Nsubuga, 2006](#); [Jacob, Mosman, Hite, Morisky, & Nsubuga, 2007](#); [Jacob, Shaw, Morisky, Hite, & Nsubuga, 2007](#)), and examines the attitudes of students, teachers, and administrators in Ugandan secondary schools. The results come from the first national evaluation of Ugandan secondary schools, which was conducted over a series of years (2002–2005).

Pre- and post-test assessments provide the basis for need analysis at individual, group, and community levels, targeted intervention to populations in need, and evaluation of the relative effects of the program on various psychosocial, environmental, and behavioral levels of outcome. Qualitative assessments were also conducted among study participants to provide additional insights into the analysis of quantitative surveys. Participating schools were given tuition and fee scholarships to assist orphaned students due to the AIDS epidemic in Uganda.

BACKGROUND AND HISTORICAL OVERVIEW

Uganda is positioned within the center of the original HIV epicenter – the Great Lakes region of East Africa. It was this geographic region that witnessed unprecedented HIV infection rate growth in the late 1980s and early 1990s, particularly in Uganda. The first two identified cases of AIDS in Uganda occurred in 1982. When the disease was first identified in Uganda in the early 1980s, it was given the name *slim* because symptoms included weight loss and diarrhea ([Serwadda et al., 1985](#); [Kagimu et al., 1996](#)). As early as 1986, the government of Uganda responded to the epidemic with

its first prevention campaigns (De Walque, 2004). Despite its initial drastic HIV infection rate among the adult population, Uganda has rebounded to curb the epidemic. This pandemic trend surprisingly began its decline throughout the mid- and late-1990s dropping to an estimated 11.3 percent in 2000 and an astounding 5.7 percent in 2003; as of December 2009, Uganda had an estimated prevalence rate of 6.5 percent among those aged 15–49. From the original two identified cases in 1982, the epidemic swelled to a gross 2 million HIV-infected persons by the end of the twentieth century (Okware, Opio, Musinguzi, & Waibale, 2001).

Several questions arise regarding this remarkable reversal trend. Why has Uganda been so successful? What indicators can be identified to use as a model for other sub-Saharan African nations? This study partially addresses these questions, by using a triangulation of data collection methods to examine the attitudes of students, teachers, and administrators at the secondary education level. Ugandan educators and policy makers are not entirely at ease with the realized success that their nation has achieved in the last decade. True, the trend has been curbed, but in recent years there have been resurgences of prevalence rates among various at-risk groups. Yet, government officials, educators, and parents are concerned that the rising generation may become lax toward past success. The awareness and promotion of sex education programs, contraception use, and changing familial structures have brought about new avenues for addressing the pandemic throughout Uganda. HIV is still as potentially rampant in the Great Lakes region of East Africa as it ever has been. The number of Uganda children orphaned by AIDS ranks among the highest of any nation on earth. Orphanhood is the primary reason that drives school-aged children away from formal education and often to the streets (Kasirye & Hisali, 2010). HIV/AIDS is the leading cause of orphanhood in sub-Saharan Africa generally and Uganda specifically. With over half of its population under the age of 16, the number of street children and orphaned children will continue to rise as adults currently infected with HIV will succumb to the full-blown impact of AIDS (Jacob, Troy, Steven, & Cheng, 2004). Over 2 million Ugandan children have lost one or more parents since the beginning of the epidemic. Before the orphanhood trend regresses, scholars project that over 3 million children will be orphaned by the epidemic. With a population that exceeded 35.8 million in July 2012, this number is staggering.

The concern over the AIDS epidemic in Uganda stems primarily from its unique features. First, it is one of the current epidemics whose principal route of transmission is through heterosexual contact. The World Health

Organization (WHO) and UNAIDS has identified heterosexual intercourse as the primary mode of HIV transmission for the sub-Saharan African region. Although heterosexual intercourse is the primary mode, other modes do exist, including mother-to-child transmission during birth or nursing; sharing of bladed materials such as circumcision knives, razors, or medical needles; gang rape from rebel and war-torn regions; and to a smaller degree than in other world regions, men who have sex with men. For additional information on modes of HIV transmission by global geographic regions, see the UNAIDS/WHO *Epidemic Update 2003*, and for sub-Saharan Africa in particular, see [Jacob and Curtis \(2003\)](#). The sexually active population is particularly vulnerable, starting at about ages 12–14. The overall mean age for adults with AIDS is 34.81 years. Stratified by sex, the mean ages are 36.9 and 33.4 for males and females, respectively. Females continue to be much more susceptible to acquiring HIV than males (see, for instance, [DiClemente, Crosby, & Wingood, 2002](#); [Kelly, 2000](#); [UNAIDS, 2004](#); [World Bank, 2000](#)). Sexual activity is the main defining risk factor for the variation of its incidence and prevalence according to sex, education level, geographical location, culture, and socio-economic status. Since social-cultural values and economic relations underlie sexual interaction between individuals, these have a strong bearing on the spread of HIV/AIDS. Between ages 12–14 and 25–29, females are at a higher risk of acquiring HIV (see, for instance, [Olowo-Freers & Barton, 1992](#); [Musisi, 2002](#)). It is therefore important that MOES makes effective intervention in HIV education and awareness building as soon as a child starts school, hopefully as early as Primary 1 (Grade 1 or approximately age 6). These efforts should be significantly strengthened at puberty and the onset of adolescent stage, which largely occurs at the secondary school stage for students attending formal education. Although the majority of students enter secondary schooling at age 12, it is not uncommon to find Primary 4, 5, and 6 students who are advanced in age. Several reasons can account for this age variance, including inability to attend school with the average age cohort because of lack of family finances, opportunities, or the need to work to help provide money for their families. In this regard, many sexually active students are actually enrolled in Ugandan primary schools. Thus, sex education begins as early as students enter primary schools, and continuously addressing HIV/AIDS prevention, control, and treatment issues throughout the education process is integral to ultimately curb and overcome the epidemic.

The age group most affected (15–30 years) also occupies a very critical position in families and communities as a whole: as students, teachers, and

administrators in schools; as parents or heads of households; and as active members of the nation's labor force. As a result, HIV/AIDS has affected virtually every aspect of Ugandan life and development including individual goals and aspirations of school children as well as the roles and functions of the family, tribes, and communities. In the absence of a cure or vaccine, change in sexual behavior through education and awareness building remains the most important approach toward preventing HIV/AIDS infection. Thousands of Ugandan teachers and students are leaving schools due to personal infection or to care for family members dying from AIDS. According to the World Bank, "the education sector has a key role in promoting and maintaining the critical behavior-change agenda and must take these factors into account when planning" (World Bank, 2000, p. 11). Educators must seek every opportunity to make HIV and AIDS prevention a part of the school curricula at all levels.

RATIONALE

Educational approaches for battling HIV and AIDS are context-dependent. The approaches and issues of AIDS prevention in developing countries cause key elements to surface such as the structures of national mandates, challenges of urgency and abundance, the importance of a language of "prevention" and "control," and issues of legitimate and tested decision-making processes. In this study, we raise some of the implications which affect the change based on the evaluation of current educational approaches and conclude with implications for educators and policy makers concerned with HIV/AIDS prevention and control strategies in education. The ongoing debate regarding the negative correlation between education and HIV infection continues to take precedence in the literature as prevention strategies are sought over treatment (De Walque, 2004; Fylkesnes et al., 1997; Hargreaves & Glynn, 2002).¹ Thus we assert that education does play a key role in battling the global AIDS epidemic; people must be informed about and understand the disease if they are ever able to prevent it from infecting themselves and others (Jacob et al., 2006). There is a tremendous need for the development of effective and sustainable education programs on the AIDS epidemic in sub-Saharan Africa and Uganda. In the traditional Ugandan context, parents rarely address sexual issues with their children, a responsibility generally left to relatives and friends of the children. With the disconnect between sex education and

home, school, often a home away from home, especially among the large percentage of boarding students, acts as a training ground for sex education. Unfortunately, cultural barriers regarding public sex education have often prevented many teachers from holding quality discussions in classrooms. Some feel uncomfortable discussing sex education issues. Other teachers feel that discussing prevention methods may trigger dissonance from students and parents, which could ultimately take away the teacher's job. Thus sex education discussions with students are generally left either to the senior female/male teacher or to the biology teacher. But if these teachers were never trained in sex education, largely because their teacher training was based on a pre-HIV/AIDS science orientation, then these teachers would often feel unqualified to address issues so pertinent to HIV and AIDS. Although schools provide a natural medium for sex education, it will be some time before it is incorporated into the national curriculum.

Yet there is not a large body of literature on the topic, as most HIV studies have been related to the traditional health rather than the education sector. This dearth is slowly being overcome by studies that have arisen on education (see [Jacob, 2009](#)). In recent years, several educational studies have also been conducted in Uganda (see, for instance, [De Walque, 2004](#); [Hyde, Ekatan, Kiage, & Barasa, 2002](#); [Kinsman et al., 2001](#)).

Heavily impacted by the AIDS epidemic in the 1980s and 1990s, Uganda has since become a leading nation in sub-Saharan Africa in reversing its overall infection rate. Along with Senegal and Thailand, Uganda is viewed as an early success story in curbing the global epidemic (UNAIDS, 2011). Uganda has focused on a number of innovative strategies based on traditional values and cultural norms that may prove to be an effective model for dealing with this educational health crisis in other nations. Some of these strategies include abstinence, collaborating educational efforts with local religious and nongovernmental organizations, literacy education programs to reach marginalized groups, targeting and educating youth, peer counseling, fidelity after marriage, and stressing condom use for citizens with high-risk behavior ([Leggett, 2001](#); [Shuey, Babishangire, Omiat, & Bagarukayo, 1999](#); [Stoneberger & Low-Beer, 2004](#)). Strategies with a heavy emphasis on education are generally the most effective and certainly the most sustainable.

While Hyde and her colleague's (2002) study spanned more than one Ugandan province, others have been single-province case studies of a portion of a village, town, region, or even a single school. This study is the first major national study of HIV/AIDS in secondary schools in Uganda. It is also the first time that the UNAIDS survey has been conducted in

Uganda, though in 2000, Kinsman and his colleagues (2001) included a very small portion of this survey in a Masaka Province study. In addition to the quantitative surveys, we conducted in-depth interviews with selected administrators, teachers, students, and parents of students, and this provided triangulation of our survey findings, backed by our qualitative interviews. This study adds to the literature as the first to provide a national sample of attitudes reflected from students, teachers, and administrators in private and government secondary schools, with recommendations on what needs to be done to improve the national curriculum. Our study also addresses what is known regarding AIDS transmission, prevention, and treatment; attitudes and beliefs; self-efficacy and self-esteem as identified by students, teachers, and administrators in Ugandan secondary schools. Existing Ugandan education programs clearly need further clarification and will form the basis for our area of investigation.

METHODS

School Selection Process

In this study on HIV/AIDS in 76 secondary schools in Uganda, students, teachers, and administrators were asked to complete a pre- and postquestionnaire on behavior, knowledge, skills, and beliefs. Schools were randomly selected from the official MOES List of Secondary Schools made available by the third author in this article.² School selection was stratified in three ways: first by geographic region, second according to urbanicity,³ and third by either a *government* or a *private* school.⁴

Uganda is divided into four geographic regions: Central, Eastern, Northern, and Western. The majority of the population resides in the Central Region, where the capital city Kampala is also located. In this study, we stratified the selection according to the geographic regions with an aggregate total of 76 schools nationally: Central ($N=26$), Eastern ($N=18$), Northern ($N=14$), and Western ($N=18$).

We further stratified our sample of schools by urbanicity insuring for an equal number of rural and urban schools where possible. As Kampala and Wakiso districts are substantially more urban than the other districts in the country, of the 13 schools selected in these 2 districts, 10 were urban schools and only 3 were rural. Government and private schools were evenly stratified at 38 schools apiece.

Once schools were selected, contact was made initially with the head teachers of the respective schools to introduce and explain the nature and purpose of the study.⁵ This initial meeting generally included the head teacher signing consent to participate and would then lead to the random selection of student, teacher, and administrator participants. Contact and a good rapport with the head teacher was an essential dynamic in the success of this study. Schools with greater administrative support tended to be more willing to participate in the study.

Study Participants

Participants in the questionnaires included students ($N=883$), teachers ($N=433$, 95.0 percent response rate), and administrators ($N=217$, 95.2 percent response rate) randomly selected from the master enrollment and teacher roster lists at the sample schools.⁶ Desiring to compare gender differences among students, we stratified our student selection by gender. We also wanted to compare between grade levels, so selection was further stratified so that two students were selected from each form or “grade level” (one boy and one girl from each form).⁷ Additionally, we conducted a series of in-depth, semistructured interviews from randomly selected students ($N=50$), parents of students ($N=10$), teachers ($N=38$), and administrators ($N=10$). This triangulation of data collection from various sources – including the focus group based interventions, pre- and postquestionnaires, and in-depth interviews – increases the trustworthiness of our research findings (Hammersley, 1992; Hanson, 1981; Maxwell, 1996). While this chapter primarily focuses on the attitudes of study participants of the pre-questionnaire from this study, several other publications include findings from other parts of the surveys, including comparing pre- and postquestionnaire results (see, for instance, Jacob et al., 2006,2007). This study received institutional review board approval and endorsement from the University of California, Los Angeles, and MOES.

Advisory Committee

We regularly met with the members of an advisory committee at the onset of this study and kept them informed as the study developed and progressed to completion. National and regional leaders from the Muslim, Protestant, and Catholic faiths joined our advisory committee and offered

helpful advice on how to proceed. Meeting regularly with students, parents of students, religious leaders, NGO administrators, MOES officials, and various community leaders gave this study a wider perspective on the environment within which we were working. One religious leader asked us to remove two questions in the skills section of our questionnaire because they were inappropriate in the Uganda context.

Instruments

The questionnaires and semistructured qualitative interview instruments drew from the Behavioral Changes for Interventions Model, Theory of Reasoned Action (Ajzen, 1985; Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975; Terry, Gallios, & McCamish, 1993), and the Information-Motivation-Behavioral Skills Model (Fisher & Fisher, 1992). The primary antecedents of this model include knowledge acquisition, attitude development, motivational support, and skills development. The questionnaires were administered and monitored by members of our research team. All questionnaires were administered confidentially, using unique identification numbers that linked participants between pre- and postquestionnaires and individuals participating in the study's intervention and in-depth qualitative interviews.

Constructs of the Questions

The Attitudes Scale was based on Albert Bandura's (1986, 1989) Social Learning Theory Model, comprising 25 items. When factor analysis was run on the 25 items, six distinct factors with eigenvalues greater than 1.0 emerged. These factors included attitudes regarding Peer Pressure, attitudes toward Abstinence, and attitudes toward Condoms, the Threat of Acquiring HIV, and Caring for Someone with HIV/AIDS (Table 1).

FINDINGS

Data collected from our national sample include attitudes and skills that can be shared with the comparative, international, and development education scholar community. These findings are of particular use to policy

Table 1. Attitudes Scale, Skills, & Intentions: Principal Components Factor Analysis.

Factor	Cronbach's α for		
	Students	Teachers	Administrators
<i>Attitudes Scale</i>	.76	.62	.58
It is alright to say "no" to friends when they want me to do things I do not want to do.			
A person does not have to feel bad about delaying or refusing sex.			
It is alright for young people to have sex without a condom if they know each other well.			
It is alright to have sex without a condom, because your chance of getting infected with HIV is very low?			
People who have AIDS should be forced to live far away from other people.			
I feel we should do more to help people who have AIDS.			
<i>Skills</i>	—	—	—
You like your boy/girlfriend very much. He/she wants to have sex with you, but you don't.			
How confident are you that you could refuse and still remain friends?			
You do not have money to buy a condom but you have heard that you can get them free at the local health center. If you wanted to use a condom, how confident would you be to go to the health center for condoms?			
<i>Intentions</i>	—	—	—
In the next six months, I intend to (a) not have sex, (b) have sex, (c) have sex with one person, or (d) have sex with two or more people?			

makers and educators striving to establish a curricular model for Uganda, and potentially other sub-Saharan African nations, in their attempts to overcome the AIDS epidemic through education.

Attitudes Scale

Constituting 25 questions with an internal consistency of 0.76 for students, 0.62 for teachers, and 0.58 for administrators, the Attitudes Index examined

six different constructs: attitudes toward Peer Pressure, Abstinence, Condoms, the Threat of Acquiring HIV, People Living with AIDS, and Caring for Someone with HIV/AIDS. Attitudes were measured on a three-point agreement scale. The Advisory Committee to this study agreed that we should not include a seventh section on the original UNAIDS questionnaire, which regarded attitudes toward using illegal drugs; it was not perceived to be a significant issue in the Ugandan context.

Peer Pressure

Attitudes about respondent peer pressure were assessed on issues of saying “no” to friends, respondent personal assertiveness, and support of other friends. Respondents expressed strong support of friends when they do something that is healthy (90.2 percent). While the majority of respondents considered themselves to be assertive (61.7 percent), 23.5 percent were not sure if they were assertive, and 14.8 percent considered themselves nonassertive. Most study participants (students, 85.2 percent; teachers, 95.2 percent; and administrators, 98.6 percent) did not enjoy friends leading them to participate in dangerous activities. Respondents also felt that they could say “no” to friends when friends wanted them to do things they did not want to do.

Abstinence

Even though an overwhelming majority of respondents agreed that abstinence before marriage and during school is a good idea (92.7 percent), still many respondents felt that it was okay for teenagers to have sex (41.7 percent of the combined groups); an opinion that varied significantly between groups ($\chi^2 = 807.03$, $p < .001$). Where 67.5 percent of the students felt that teenage sex was okay, most teachers (88.0 percent) and administrators (90.3 percent) felt otherwise. Student responses regarding premarital sex support the literature about the age of first sexual encounter falling well within the secondary school experience for students (Olowo-Freers & Barton, 1992; Shuey et al., 1999). Most participant groups (85.4 percent) responded positively toward abstinence, agreeing that a person does not have to feel bad about delaying or refusing sex prior to marriage. When faced with the scenario of potentially losing a girl/boyfriend by abstaining from sexual intercourse in their relationship, three-fourths of the students felt they could abstain. Most students (80.1 percent) felt that if they wanted they could abstain from sexual intercourse. A similar percentage of students also agreed sexual intercourse is not necessary to show affection in a relationship.

Condoms

Only 72.1 percent of the total respondents believed that it is alright for students to have sex without a condom. This number varied between groups (students, 60.8 percent; teachers, 86.6 percent; and administrators, 89.4 percent; $\chi^2=137.62$, $p<.001$), emphasizing the need to include additional condom prevention information dissemination among sexually active secondary students in Uganda. Most students agreed that they should carry a condom if they had intentions of having sex with a partner. The gap between stating the importance of using a condom and possessing an attitude that facilitates acquiring one was also tested. While roughly two-thirds of the students felt they would not be embarrassed to buy or use a condom, this still leaves a third of the student population too embarrassed to purchase or offer to use a condom during sexual intercourse.

Threat of HIV

Participant attitudes regarding the threat of acquiring HIV was apparent in their responses in the Attitudes Scale. Approximately 20.0 percent of students either believed or did not know that their chances of acquiring HIV via intercourse are so low that they do not need to use a condom. This number decreased significantly among teachers (6.2 percent) and administrators (6.0 percent), but this highlights an attitude of risk many students are willing to take in relationships. Virtually all respondents (97.5 percent) agreed that young people must protect themselves or they could become infected with HIV.

People living with HIV

Responses to people living with and affected by HIV varied tremendously between groups ($\chi^2=129.30$, $p<.001$). Only 62.4 percent of students agreed that it would be alright to have a peer with HIV or AIDS attend classes; the figure increases significantly among teachers (86.8 percent) and administrators (90.3 percent). A similar attitude polarizes the students again from the other two groups in this study regarding staying away from someone in their class who had someone in their family with AIDS. Only 85.5 percent of students said they would associate with a student whose family member had AIDS compared with over 95.0 percent of teachers and administrators. Perhaps most disturbing was regarding whether respondents felt that people living with HIV are getting what they deserve; many respondents, primarily among the student group, said that people living with HIV were getting what they deserved (students, 33.3 percent; teachers, 8.3 percent; and administrators, 3.7 percent).

Caring for Someone with AIDS

Almost all respondents agreed that we should do more to help people living with HIV. However, a significantly lower number of participants (students, 54.9 percent; teachers, 69.4 percent; and administrators, 65.7 percent) responded that they would feel comfortable caring for people living with HIV. Further, only 52.4 percent of all respondents agreed that they would feel comfortable hugging a close friend who has AIDS.

Student Skills

The skills and intentions section of the questionnaire was only administered to students. A total of four questions concerning skills measured refusal and condoms skills. These skills were measured on a three-point confidence scale. Over half of the UNAIDS original survey questions were rejected by this study's Advisory Committee, who felt the questions were not particularly relevant in the Ugandan context. Instead, they elected to rephrase three questions slightly and include a new question on girl/boy-friend sexual relationships.

Refusal Skills

Somewhat contradicting earlier findings in the attitudes scale portion of this study regarding students' expressing an ability to acquire and use condoms, only 56.5 percent of the students were very confident that they could refuse sex with a boy/girlfriend they liked very much. A similar majority felt very confident that they could refuse sex with someone they had been going out with and having sex without condoms with for some time. A final refusal question places the student alone in a private area with a girl/boy who the student thought was quite friendly. The friend begins saying things and touching the student in a way that makes the student feel very uncomfortable. Finally the friend begins to pressure the student to have sex with her/him. Based on this scenario, only 55.4 percent of the students felt very confident that they could refuse the friend and opt out of sexual intercourse. In all cases, approximately one-fourth of the students felt they were not at all confident that they could refuse sex in such a scenario.⁸

Condoms Skills

Condom skills were measured by a question that placed students in a circumstance where the student was not able to purchase a condom but

wanted to use one. Roughly three-fourths of the students felt very confident that they could acquire a condom from a local health clinic.

Behavioral Intentions of Students

Behavioral intentions make up the final factor asked only of student participants, which reads: "In the next six months, I intend to (a) not have sex, (b) have sex, (c) have sex with one person, or (d) have sex with two or more people?" If students responded by answering "b," "c," or "d," then they would answer a follow-up question: "In the next six months, (a) I will use condoms with my sexual partner(s), (b) it is unlikely that I will use condoms with my sexual partner(s), and (c) I will not have sex without a condom." While the majority of students responded to the initial question by answering that they do not intend to have sex in the next six months, 36.2 percent answered that they might. Of the students who responded that they intend to have sex in the next six months, 96.2 percent said that they would not have sex without a condom.

Comparisons between Groups

The Attitudes Scale table reflects student, teacher, and administrator attitudes regarding HIV/AIDS issues (see [Table 2](#)). Aggregate group scores posit the administrators at the top with over half (52.1 percent) receiving high scores, teachers in a close second with 48.7 percent with high scores, and students with only 26.8 percent receiving high scores ($\chi^2=183.75$, $p<.001$).

Attitudes Scale scores had less variance between male and female students ($\chi^2=1.44$, $p<.05$) than was portrayed in the Knowledge Index scores ([Jacob et al., 2006](#)). Yet attitudes between female and male teachers and administrators portrayed greater variance. No significance is noted regarding gender attitudes, nor is there significance realized in the entire teachers and administrators' Attitudes Scales groups. The student group has several areas of attitudinal significance, however. The large variance in age scores among students continued in the Attitudes Scale table, where 43.3 percent of the 21-year or older students scored a high mark compared with only 16.1 percent of the 12–13 year olds scoring a low mark ($\chi^2=48.47$, $p<.001$). Urban students were twice as likely to receive a high Attitudes Scales score compared with their rural peers ($\chi^2=36.83$,

Table 2. Scores on HIV Attitudes Scale.

	Students (%)			Teachers (%)			Administrators (%)		
	<i>N</i>	High	χ^2	<i>N</i>	High	χ^2	<i>N</i>	High	χ^2
Aggregate scores	883	26.8		433	48.7		217	52.1	
<i>Gender</i>									
Female	443	26.0	1.14	119	53.8	5.39	46	47.8	.43
Male	440	27.7		314	46.8		171	53.2	
<i>Age</i>									
12–14	112	16.1	48.47*						
15–17	409	22.7							
18–20	332	34.0							
21–26	30	43.3							
<i>Urbanicity</i>									
Urban	488	34.6	36.83*	239	51.5	1.82	119	58.0	.14
Rural	395	17.2		194	45.4		98	65.3	
<i>Geographic region</i>									
Central	299	37.8	31.40*	141	49.7	12.02	70	55.7	3.96
Eastern	212	21.2		107	48.6		54	57.4	
Northern	156	20.5		77	53.3		39	38.5	
Western	216	21.8		108	44.4		54	51.9	
<i>Governance Type</i>									
Government	466	31.3	14.08*	231	50.2	5.56	116	54.3	.67
Private	417	21.8		202	47.0		101	49.5	

* $p < .001$.

$p < .001$). Geographic region variance was greatest within the student group, though noticeable differences exist between the Northern Region receiving a scoring noticeably lower among administrators. An anomaly to the geographic region Attitudes Scale is where a larger percent of Northern Region teachers than the other three regions received high scores. Government school participants outperformed private school participants.

Based on the Skills Scale that was created to measure condoms and refusal skills among students in real-life case scenarios, female students showed less Refusal and Condoms Skills on average than did male students in our sample ($\chi^2 = 21.12$, $p < .001$). This trend held true with all student Skill scores (see Table 3).

Fifty-six percent of the 21-year or older students scored a high, compared with only 24.1 percent of the 12- to 13-year olds ($\chi^2 = 15.72$, $p < .05$). Similarly, 40.4 percent of the urban students received high scores compared with only 25.1 percent of the rural students did ($\chi^2 = 24.68$,

Table 3. Student Scores on HIV Skills Scale.

	<i>N</i>	Skills Scale Level (%)	
		High	χ^2
<i>Gender</i>			
Female	443	32.1	21.12***
Male	440	35.0	
<i>Age</i>			
12–14	112	24.1	15.72*
15–17	409	31.8	
18–20	332	36.7	
21–26	30	56.7	
<i>Urbanicity</i>			
Urban	488	40.4	24.68***
Rural	395	25.1	
<i>Geographic region</i>			
Central	299	39.1	20.41**
Eastern	212	29.2	
Northern	156	26.9	
Western	216	34.7	
<i>Governance Type</i>			
Government	466	33.7	2.72
Private	417	33.3	

p* < .05; *p* < .01; ****p* < .001.

p < .001). Northern Region students struggled most with condom and refusal skills; the Central and Western Regions scored highest at 39.1 percent and 34.7 percent, respectively. When combining the high and medium student skill scores, government school students (81.6 percent) were outperformed by private school students (85.4 percent).

DISCUSSION AND CONCLUSION

This study highlights the differences that exist between students, teachers, and administrators regarding their attitudes about HIV. It is important to understand the attitudes of each participant group when considering curriculum development and teaching strategies and methods. It is particularly important to understand the various perspectives that exist between each group and subgroup, especially as the MOES continues to focus its

HIV education initiatives at the secondary education level on integrating instruction into several key subjects.

This study helped inform several key policy initiatives in Uganda, including the Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY), which serves as the key HIV education program at the primary and secondary school levels. In addition, the study helped inform researchers and administrators at Uganda's primary teacher training institution – Kyambogo University – in the selection of key subject areas to focus the formal instruction of HIV.

This is the first time the UNAIDS survey has been conducted on a national level among secondary students in sub-Saharan Africa. While many of the questions remained unchanged, many others required slight alteration in wording. Our Advisory Committee also found some questions inappropriate for a Ugandan context. This study relies on the validity of student self-reports on questionnaires. Unique codes were used to link students to their responses, to minimize the problem of students purposefully concealing information based on issues of possible exposure. All questionnaires were administered and proctored by at least two members of our research team; participants were carefully seated far enough apart that they could not copy answers from neighboring student participants. Students were encouraged and able to ask members of the research team if they did not understand the meaning of a question being asked. Efforts to minimize this problem were made by careful review of the questionnaires by members of the Advisory Committee who were aware of cultural sensitivities and language appropriate for secondary-age students in Uganda.

Gender attitudes did not differ among the various groups, but age was a significant factor among students. This highlights the age range of students who are enrolled in Ugandan secondary schools, with many students who were aged 18 or older (40.9 percent). Many of these older students had been dropped out for one reason or another during their earlier years and were returning to school to complete their secondary education. This creates an age imbalance between a significantly higher sexually active age group of students – those who are 18 or older – and those who fall within the normal age cohort and were considered adolescents. Teaching strategies differ significantly between what is or should be taught to adults and what is and should be taught to children and youth. There is no single answer for when to introduce HIV education at the secondary level, but surely the age of students should be considered for future policy decisions on curriculum.

Attitudes are an increasingly important topic to consider in HIV education. Whether it is how to deal with peer pressure or deciding what is the best approach for HIV prevention, individual perspectives are essential in overcoming the epidemic in Uganda and throughout the world (Bandura, 1986). Student skills and behavioral intentions are also essential discussion points to have at the secondary education level, especially as they relate to Bandura's Social Learning Theory Model, including self-efficacy beliefs and the theory of planned behavior (Bandura, 1986, 1989; Jacob et al., 2004). An understanding of and ability to adapt to life's challenges is a fundamental part of becoming an adult and succeeding in life. HIV education is a crucial part of life skills education in Uganda. Teachers and administrator attitudes about HIV education will help make this transformation process a positive one for their students. Teachers need positive attitudes to be able to serve as role models. A positive attitude about HIV education may not change the world, but HIV education can have a sustained and lasting influence on influencing students' learning, attitudes, and life skills – essential ingredients in overcoming the AIDS epidemic.

ACKNOWLEDGEMENT

This research was supported by multiple grants from the Pfizer Foundation, ProLiteracy Worldwide, Brigham Young University, and the University of California, Los Angeles. Others who were involved and provided substantial contributions to this study included Dr. Steven J. Hite, Lynn R. Curtis, and Christopher B. Mugimu. Research team members who helped with the data collection included Natalie K. Jacob, Ryan F. Brown, Brenda Heaton, Stacey Shaw, Heddie Richards, and Troy D. Smith, Kasujja Asuman, Sumaiah Fauziah, Nyanja Lawrence, Peter Owomugisha, and Rose Naisumba.

NOTES

1. Only 1 out of 27 studies reviewed by Hargreaves and Glynn identified a significant negative association between education and HIV infection. De Walque argues that education gains precedence as the epidemic matures in a given country. His study on the impact of education on Uganda's rural region of Masaka District portrays how education reduces the probability of HIV infection. In an urban study in Zambia, Fylkesnes and his colleagues discuss findings of a negative relationship between education and HIV infection.

2. As of 2002, there existed 748 government secondary schools and 1,200 registered private schools nationwide.

3. Recognizing that it is difficult to come to a consensus on exact meanings for the terms *urban* and *rural*, the following definitions have been agreed upon by the researchers and the MOES for this study. Urban schools refer to any school located within a 15-km radius of the district capital city with a population greater than or equal to 300,000. The definition also encompasses any school located within a 10-km radius of a district capital city or town with a population less than 300,000. A rural school is defined as any school located beyond a 15-km radius of the district capital city with a population greater than or equal to 300,000. Likewise, any school located beyond a 10-km radius of a district capital city/town with a population less than 300,000 qualifies as a rural school.

4. For the purposes of this chapter, the term *private* refers to any nongovernment supported school in Uganda. This chapter identified four types of private schools in our sample: (1) religion-operated schools, (2) dismissed teacher schools, (3) for-profit, and (4) progressive. The term *public* refers to a government-aided school; we use the terms public and government interchangeably in this chapter. For more information on the terms public and private, see Val D. Rust (2000).

5. Only one government school declined our invitation to participate in this study, stating that “we have already participated in a number of studies of the MOES and do not have time for another study cutting into our already tight schedule.” Thus this school was replaced by the random selection of another government school to maintain the balance between an equal number of both private and government schools.

6. Response rates for pre- and post-questionnaires were 96.5 and 91.1 percent for students, 95.0 and 79.2 percent for teachers, and 95.2 and 89.9 percent for administrators, respectively.

7. Of the 76 schools in our sample, 5 were all-girls schools and 3 were all-boys schools. In these instances, 12 students of the same gender were included from each single-sex school.

8. One of the schools in our sample was pillaged while participating in this study by Joseph Kony’s Lord’s Resistance Army in the Northern Region of Uganda. Many of the girls at this school were abducted and gang raped by the rebels. Thus even in recent years Uganda has struggled with the aftereffects of conflict and post-conflict circumstances (Jacob & Ouattara 2009).

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MULTIPLE EFFECTS OF EDUCATION ON DISEASE: THE INTRIGUING CASE OF HIV/AIDS IN SUB-SAHARAN AFRICA

William Smith, Daniel Salinas and David P. Baker

ABSTRACT

Understanding of the effects of formal education on HIV/AIDS infection in South Saharan Africa (SSA) has been a complex task because consecutive waves of research offer different, seemingly contradictory results and explanations of what exactly are the schooling effects on HIV/AIDS and the causal mechanisms driving those effects. This chapter concentrates on the narrative and implications of the key substantive findings from a multidisciplinary scientific team that was formed to explore the precise nature of the relationship between population education and the HIV/AIDS pandemic in SSA and to determine the main causal mechanisms behind the association. As members of this team, this chapter reviews and synthesizes our technical demographic, epidemiological, and health research. This, and other relevant research, suggests that, like in other cases of education and health risk, because of

The Impact of HIV/AIDS on Education Worldwide
International Perspectives on Education and Society, Volume 18, 79–104
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ISSN: 1479-3679/doi:10.1108/S1479-3679(2012)0000018007

a historical change in the public health and information environment during the pandemic there was a shift in which outcomes of education dominated individual's sexual and disease prevention behavior. The SSA HIV/AIDS case is thoroughly examined, and then used to bridge to a general discussion of the effects of educational development on population health.

INTRODUCTION

Achieving a clear understanding of the effects of formal education on HIV/AIDS infection in South Saharan Africa (SSA) has been a complex task for the international scientific community. Consecutive waves of research offer different, seemingly contradictory results and explanations of what exactly are the schooling effects on HIV/AIDS and the causal mechanisms driving those effects. In particular, while early findings unexpectedly identified formal education as a risk factor (with the more educated individuals being most likely to be infected), recent research identifies a historical shift in the effects of education back to its widely known and more common role as a *social vaccine* (more educated are less likely to be infected). Numerous explanations have been put forward to explain these trends, including hypotheses on the ways schooling may increase the availability of information, create attitudinal changes, or enhance cognitive abilities of individuals leading to safer health decision making.

In light of this, a multidisciplinary scientific team was formed to explore the precise nature of the relationship between population education and the HIV/AIDS pandemic in SSA and to determine the main causal mechanisms behind the association.¹ This chapter concentrates on the narrative and implications of the key substantive findings from our original research; publications are referenced as to detailed methodological information and complete statistical analyses. Along with other relevant research, this chapter reviews and synthesizes the team's technical demographic, epidemiological, and health research in two subsequent sections.

The first section considers the social mechanisms and contexts driving the shifting relationship between education and HIV/AIDS over the course of the pandemic in SSA. Our initial contribution to this topic employed statistical analysis of the Demographic and Health Surveys (hereafter DHS) database combined with a historical study of the

sociopolitical contexts in which the pandemic emerged and developed. These studies advance the hypothesis that formal education has a range of effects on the individual that can influence health outcomes in various ways, sometimes in concert and sometimes in contrast. Because our demographical and epidemiological research illustrates how education can have contrasting effects on health, it begs the question of which causal factors are in play and what is their relative impact. Much prior research on the cause of the education–health association has assumed that the main, and even only, effect of education on health is through its influence on material and status attainment: more wealth and status lead to better health. Until recently this has been such a widely held assumption that it has drowned out discussion of other effects of education. Building off of the SSA HIV/AIDS case, our psychological-cognitive research demonstrates that a less considered major mechanism through which education improves individual health is the significant enhancement of general cognitive skills (such as problem solving and risk assessing) that in turn lead to preventive, risk-avoidance individual behavior. Juxtaposing all the results suggests that the education effects of socioeconomic and health outcomes are long-term effects. The impact of enhanced cognitive skill, a more immediate effect of education, then, depends on an interaction with the nature of a disease and the social, political, and public health environment in which it is occurring. This offers both a parsimonious explanation of contrasting risk factor and social vaccine effects of education over the course of the SSA's HIV/AIDS pandemic and a new way to think about education and disease in general.

The second section bridges our technical analyses to the larger research agenda on the effects of education on health and society, as they occur in the context of a global society in which schooling has become a social institution of pervasive importance for individual and social life. The intriguing case of education's shifting influence on HIV/AIDS in SSA is considered in the context of a general theory about the relationship between population education and health and social outcomes. Additionally, a fuller understanding of the education effect has both immediate implications for educational policy in SSA, which has at times suffered from the early epidemiological findings of education as a risk factor, and for a scientific perspective on the general education and health link.

The main policy message of this research is that national and international agencies should not be misled in terms of whether education is

currently having a positive or negative effect on HIV/AIDS. Our evidence shows that under the present community and social conditions that exist in SSA, education is consistently working as a social vaccine and therefore should be considered fundamental to a comprehensive strategy to combat the pandemic in the region. Among other things, this means that substantially more investment is necessary to guarantee that public schooling is available for all, and also to improve the quality of education by increasing the availability of different kinds of resources in schools, especially those who attend the most vulnerable populations. Education is arguably one of the best investments that exists to improve population health, and certainly more effective than mere information-transfer campaigns that do not, as education does, build in individuals the capacity to effectively process and understand the complex risks they face in order to produce long-term preventive changes in their health behavior.

EXPLAINING THE SHIFTING ROLE OF EDUCATION IN THE HIV/AIDS PANDEMIC IN SSA

From Risk Factor to Social Vaccine in Selected SSA Countries

A social vaccine is derived from an institution or personal trait that provides an individual with a layer of protection against an undesirable health outcome. The origin of the social vaccine concept is unclear. In the literature, social vaccine is first referenced in 1967, when Taylor and Sekora apply the term to African American higher education; however, they fail to provide a definition. The concept did not catch on until the late 1980s when Chew and Monteiro (1989) recognized the role of education as a necessary social vaccine in the global HIV/AIDS pandemic. The first definition of social vaccine is found in reference to self-esteem. In describing a 1990 report from the California Task Force to Promote Self-esteem and Personal and Social Responsibility, Walz (1991) concluded that self-esteem could play the role of social vaccine for youth, a trait that “empowers people and inoculates them against a wide spectrum of self-defeating and socially undesirable behavior” (p. 2).

Over the past 20 years research in education has illustrated its power as a social vaccine. In our review of this emerging relationship, we find “extensive demographic and epidemiological literatures report that education lessens engagement in risky behavior and facilitates healthier lifestyles

to the point where one could effectively argue that the spread of schooling is a leading cause of the underlying improvements in global health” (Baker, Collins, & Leon, 2009, p. 468). For example, an increase in the national school attendance rate is associated with longer life expectancy and a reduced fertility rate (de Walque, Nikiyingi-Mirro, Busingye, & Whitworth, 2005). Furthermore, individuals with higher levels of educational attainment have better health outcomes than their less educated peers (Mirowsky & Ross, 2003), including better-perceived health and increased physical functioning (Ross & Mirowsky, 1999).

The effect of education as a social vaccine can be seen in an array of health outcomes. In a meta-analysis of 55 studies from 1995 to 2005, we concluded that education, controlling for preeducation effects such as income and childhood illness, had a significant effect on the age of mortality (Baker et al., 2011). In Kenya, for example, the education of mothers plays a protective role, decreasing the likelihood that their children will die before the age of five, while children of uneducated mothers saw their risk of premature death rise by 45% between 1988 and 1998 (Vandemoortele & Delamonica, 2002). A recent study on education, maternal use of health care, and child disease in Ghana found similar results (Smith Greenaway, Leon, Baker, 2012).

Among specific health problems, epidemiological research finds sensitive to the social vaccine effect of education are alcohol consumption, drug use, obesity, and tobacco use. Droomers, Schrijvers, and Mackenbach (2004), using the longitudinal GLOBE survey, found that those with more education were three times less likely to engage in excessive alcohol drinking, a result that remained significant after controlling for the increased stressors and vulnerability affecting those with less education. Among African Americans those who dropped out of high school or received their GED are two times more likely to inject drugs (Obot, Hubbard, & Anthony, 1999). Tobacco intake is now also negatively linked to educational attainment (de Walque, 2007). Additionally, lower education is associated with fewer quit attempts and a decreased likelihood of cessation (Gilman et al., 2008). Studying the effects of education on obesity, Nayga (2001) tested the role of health knowledge as a moderating factor and concluded that the negative relationship between high levels of schooling and the likelihood of becoming obese remained significant after taking into account an individual’s level of health knowledge.

Based on so many prior empirical accounts of education as a social vaccine, researchers approached the HIV/AIDS pandemic in SSA expecting to see a negative association between education and the disease. As illustrated

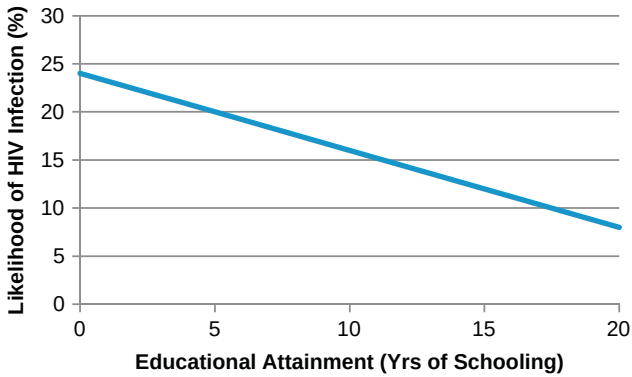


Fig. 1. Education as a Social Vaccine for HIV. Source: Leon, Baker, Salinas, and Henck (2012).

in the hypothetical relationship in Fig. 1, the presence of education as a social vaccine would result in a falling HIV infection rate as the level of educational attainment increases.

But, as noted above, interesting epidemiological results from early in the SSA pandemic sharply contrasted with the notion of education as a social vaccine. Instead these findings indicated that education was a risk factor associated with HIV; those with higher levels of education were more likely to be infected (Ainsworth & Semali, 1998; Cogneau & Grimm, 2006; Gregson, Waddell, & Chandiwana, 2001; Smith et al., 1999). Also the risks of many of these individuals were compounded by the presence of formal wealth as a risk factor (Mishra et al., 2007), as generally the wealthier are also the more educated. Then 20 years into the pandemic, by the mid-1990s, some reports from the region started to reveal a shift to educational attainment acting in its more common role as a social vaccine (Konde-Lule et al., 1997; Mnyika, Klepp, Kvale, & Ole-King'ori, 1996). Complicating the picture further, a recent thorough analysis, published in the journal *Demography*, found that, of five countries in SSA investigated, education remained a risk factor in three countries and had no significant relationship in the other two, concluding that in these countries education, at best, provides a social vaccine only for those that completed the highest levels of education (Fortson, 2008).

The key to reconciling the seemingly contradictory evidence about the role education has played over the course of the HIV/AIDS pandemic in SSA is to appreciate the interplay between the social environment and

contrasting education effects on the likelihood of infection. Upon further analysis, our team recently found that this conclusion is probably incorrect by showing that different political information environments can shape the relative balance between contrasting outcomes of formal education (Leon, Baker, Salinas, & Henck, 2012; see also Baker et al., 2009). Early on the low-quality political–informational environment in SSA, including weak public health responses and inaccurate and misinformation about the disease and its cause, suppressed cognitive benefits and enhanced material and status benefits from educational attainment leading to more participation in risky sex among educated males (often in the commercial sex trade, e.g., Swidler & Watkins, 2007). Then a marked improvement in the information and public health response later on enhanced cognitive benefits from schooling leading to better risk assessment and prevention enactment and suppressed the use of material benefits to engage in risky sex.

To do this, we nationally analyzed representative household data from the DHS data from 2003 and 2004 in four of the five nations included in Fortson's study (Ghana, Kenya, Tanzania, and Cameroon). These four were the first SSA nations to include information based on a HIV/AIDS biomarker test in DHS. Any man or woman who consented to HIV/AIDS testing was administered a dried blood spot test using a filter paper card (ORC Macro, 2005). First we replicated Fortson's model, and then added the regional responsiveness and available quality of the information across three, 10-year periods following the initial disease outbreak. From 1975 to 1984, SSA experienced a period void of accurate information. This was primarily due to delayed awareness and denial at the national level. Furthermore, the vulnerable population was incorrectly limited to only homosexual males and the disease was either mislabeled as the "slim disease" or misappropriated to an aggressive form of tuberculosis (Baker et al., 2009). From 1985 to 1994, only partial information about HIV/AIDS was available in the region. This mixed accuracy was coupled with weak or nonexistent responses. A good example of government action during this period is illustrated by the government of President Moi of Kenya. In his attempts to deny the severity of the pandemic, Moi's administration deliberately underreported the disease and developed a response that confused who was at risk and how the disease can be transmitted (Grmek, 1990). From 1995 to 2005, there is evidence of more accurate information in the region. In addition to better information, governments increased the scale and intensity of their response and there is increasing participation by NGOs and international

organizations. The importance of the mid 1990s as a time of transition is also identified by [Coombe and Kelly \(2001\)](#). They split the pandemic's history in SSA into two informational phases. Prior to 1995, programs were implemented sporadically, teacher knowledge was limited, and prevention programs were not responsive to local needs, hampering the ability of education to act as a social vaccine.

As summarized in [Fig. 2](#) for four SSA nations, after statistically controlling for wealth and numerous other demographic factors, taking these information periods into account in our new analyses of the relationship between education and HIV/AIDS, we reach significantly different conclusions. During the initial period of information void, a time where the highest HIV infection rates are found, years of education is positively associated with HIV infection and is therefore a risk factor. In this period, males with greater levels of education and material wealth, and thus elevated social status, continually engaged in high-risk sexual behavior both within and outside the active sex trade relative to their poorer, less educated peers. The poor information available masks the potential health risks and under-motivates individuals to closely analyze their behavioral choices ([Leon et al., 2012](#)).

During the most recent period from the mid-1990s on, when individuals were exposed to accurate information, education became a social vaccine, represented by a clear negative linear relationship between years of education and HIV infection rate. In this environment, education functions as a social vaccine. As cognitive skills are engaged, individuals integrate the more accurate information and motivation is heightened leading to increased problem solving and more preventative behavior.

During the partial information period of 1985–1994, the relationship between education and HIV infection is curvilinear, represented by an inverted U curve. As years of education increase, the role of education changes from a risk factor to a social vaccine. [Fylkesnes et al. \(1997\)](#) find a similar effect in Zambia during the early and mid-1990s. In this mixed environment, individuals with higher levels of education are motivated to employ their advanced decision-making ability to disentangle accurate information from misconceptions. Their evaluation of the emerging accurate information leads to a change in risk taking behavior. During this period, individuals who completed only primary schooling continue to use their relatively higher status to continue to engage in high-stakes behavior. It is not until accurate political information is widely disseminated throughout the environment that education acts as a social vaccine at all levels ([Leon et al., 2012](#)).

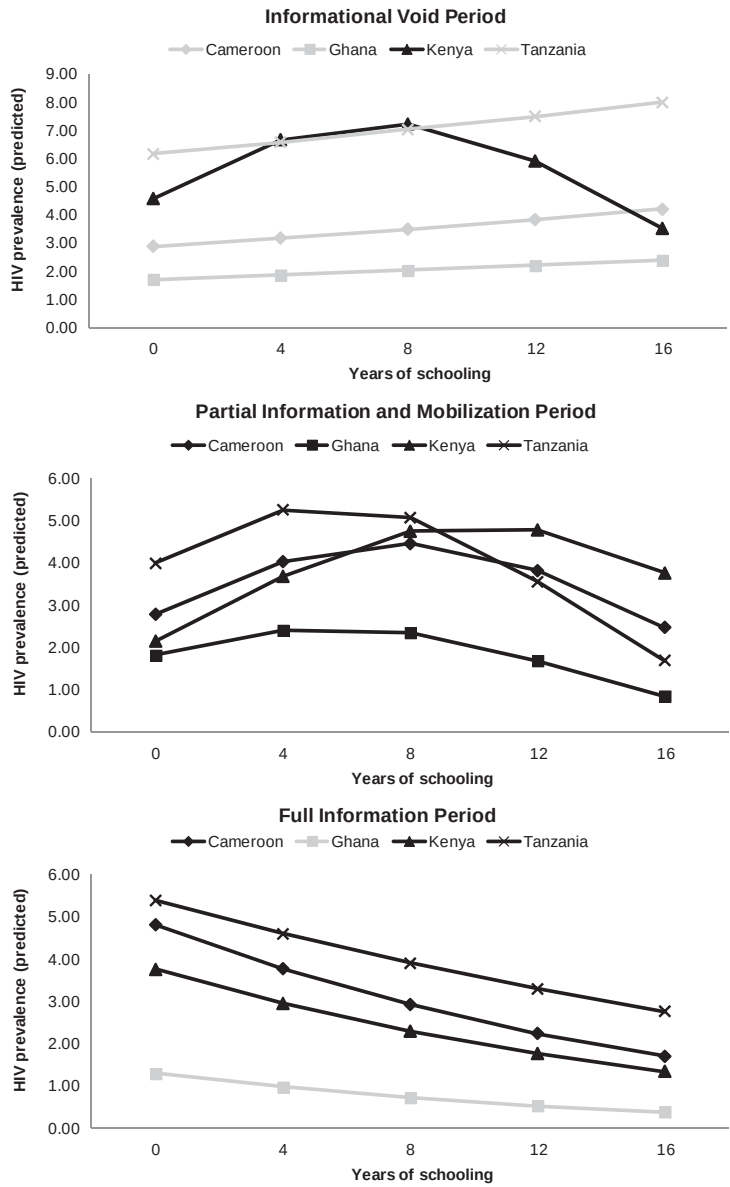


Fig. 2. Impact of Historical Change in the Political-Informational Environment on the Relationship Between Educational Attainment and HIV Prevalence in Four SSA Nations⁵.

What Is the Current Role of Education in the HIV/AIDS Pandemic in SSA?

The final period of improved public health and information has been the focus of most research aimed at analyzing the period effects of education on HIV throughout SSA. For example, the effects of education change from a nonassociation with HIV prevalence and risky sexual behavior in Uganda and South Africa in the early to mid-1990s to a social vaccine in the early 21st century (Michelo, Sandoy, & Fylkesnes, 2006; de Walque et al., 2005). A meta-analysis of epidemiological studies conducted by Hargreaves et al. (2008) confirmed this shifting dynamic. Through their review of 36 articles on 72 distinct populations over 11 countries, Hargreaves et al. concluded that prior to 1996 there was no or negative associations between educational attainment and HIV infection rates; however, from 1996 onward education had a negative gradation with HIV infection. In an earlier study, our team also found supporting results for a shift in education effect over the life span of the pandemic in 11 SSA countries. Using DHS survey data², Baker et al. (2009) report that in the youngest cohort, those who were educated during the accurate information phase, education played the role of social vaccine in six of the countries and was unrelated in the other five countries. This reflected a shift in the role of education from the oldest cohort, in which education played no significant role in HIV infection.

Lastly, in another study by our team, a detailed analysis of education, sexual and preventative behavior among adults in SSA in the 2000s demonstrated how the dynamic between material and status outcomes and cognitive outcomes shift. Baker, Leon, and Collins (2010)³ find that while on average SSA individuals with greater education (controlling for other demographic factors) continue to have more sexual opportunity and sexual partners than the less educated, with each year of education the likelihood of proper use of preventative strategies (condom use, accurate awareness of risks, more negotiations with partners about safe sex, etc.) increases. Education offers greater access to some types of risky behavior as well as an understanding of strategies to manage risk more effectively.

Similar Patterns of Shifting Education Effects on Smoking

The changing nature of the education effect from a risk factor, to an inverted U indicating mixed effect, to a social vaccine as a probable function of shifting political (public health) and information environments has

been recorded for other health risks. The clearest example is [de Walque's \(2004\)](#) analysis of U.S. tobacco consumption patterns. Using information from the U.S. National Health Interview Survey between 1978 and 2000, [de Walque \(2004\)](#) constructed a smoking history of 373,738 adults age 25 or older. In 1940, when there was no medical consensus about the risks associated with smoking, individuals with less than a high school degree were least likely to smoke (35.8%), while individuals who had attended college (40.8%) or completed college (40.4%) were most likely to smoke, indicating education was an early risk factor for smoking. From 1950 to 1970, more accurate information about smoking was diffused through society, and in 1950 four reports from medical journals indicated a consensus in the medical field. In 1964, the first Surgeon General Report was published and in 1970 a health warning was placed on cigarette packages. During this time of partial or changing medical information, de Walque reports the same inverted U pattern that we find during the partial political informational period in the SSA HIV/AIDS case. The initial decline in population smoking rates in 1954 occur among those with a college degree, indicating that they perhaps had access to better-quality information or had the ability to more efficiently separate the accurate information from spurious rumors, relative to the less educated comparison groups (see discussion of causal hypotheses below). By 2000, education was clearly playing the role of social vaccine against health problems from tobacco use. Over a 60-year span smoking rates between education groups in the United States had reversed, in 2000 those with a college degree were less likely to smoke (14.2%) and those with less than a high school diploma were most likely to smoke (29.2%). Also among smokers, individuals with a college degree smoked 50% less pack-years than those with less than a high school degree.

Why Did the Shift in Education Effects on HIV/AIDS in SSA Occur?

The significant changes in the relationship between education and HIV documented above reflect a shifting prominence in the varying effects of education. When the political information environment was poor, the immediate effects of educational attainment, such as cognitive functioning and changes in attitude, were overshadowed by long-term effects, such as increased economic affluence. Early in the pandemic, the correlation between education and wealth, led to the identification of both characteristics as risk factors. Education provided individuals with greater

economic flexibility, allowing them to be more mobile, providing them with additional disposable income, and increasing the likelihood they would interact with sex workers (Berkley et al., 1989; Dallabetta et al., 1993; Filmer & Pritchett, 1998; Grosskurth et al., 1995; Hargreaves & Glynn, 2002; Kirunga & Ntozi, 1997; Michelo et al., 2006; Quigley et al., 1997). Additionally, those with more education were more likely to engage in sex with multiple partners (Caraël, 1995). Thus, during the period of inadequate information more educated males, who have resources for more travel and engagement in risky sexual behavior, returned home and spread the disease to those with fewer resources. The mischaracterization of HIV/AIDS as a homosexual disease allowed better-resourced and higher status heterosexuals that participated in risky behavior to continue their behavior and not consider risks of infection. Although some research still points to wealth as a risk factor (Mishra et al., 2007), most, as illustrated in the special supplemental volume of *AIDS* in 2007, believe the relationship is a mixed effect of education and material wealth (Gillespie, Kadiyala, & Greener, 2007). The emerging concern, especially in relationship to the nature of education as a social vaccine, is the fear that HIV/AIDS is becoming as disease of the uneducated and poor (Lopman et al., 2007).

As the quality of information improves, more immediate effects of education should be seen (Baker et al., 2009). In the late 1980s and early 1990s, the introduction of partially accurate information in SSA led to a decline in HIV rates among more educated, suggesting they may have the greater cognitive skill required to sift through the various levels of accuracy and mount a more effective response (Gregson et al., 2001). The latest time period, then, provided sufficient, accurate information as well as the motivation needed to analyze the personal risks of behavioral choices, bringing to prominence the cognitive effect of education (Leon et al., 2012).

More on the Cognitive Hypothesis

Examining what an individual learns does not shed light on how he or she learns. To explain this process and separate it from the other effects of education, we have put forward the “cognitive hypothesis” of education. In an early iteration, in part motivated by the SSA HIV/AIDS case, the “mass schooling-decision making hypothesis” (Baker et al., 2009) specified that “over the course of teaching academic material such as mathematics

and reading, even in small amounts, schooling enhances fundamental skills associated with reasoning and solving novel problems” (p. 13). These skills are then applied to more accurately comprehend the available information and make choices consistent with proper reasoning. The desired effect does not require elaborate amounts of education. Minimal levels of formal schooling, perhaps as little as two or three years, is sufficient to result in observable differences in healthy choices (Becker, Agopian, & Yeh, 1992; de Walque et al., 2005; Kenkel, 1991).

The “cognitive hypothesis” builds on the work of Coombe and Kelly (2001) and advances in the field of cognitive neuroscience. Investigating the role of education in Zambia, Coombe and Kelly (2001) conclude that education itself is more important than increased information. Instead, it was the mastering of basic literacy and numeracy skills that helped “people develop the ability to analyze and evaluate information” (p. 441). There immediate effects of education were, therefore, found at all levels of education. However, greater effects were found for increased schooling (Coombe & Kelly, 2001; Jukes, Simmons, & Bundy, 2008). From the field of cognitive neuroscience, there has been increased emphasis on education’s ability to teach individuals how to think. Formal schooling improves an individual’s cognitive and decision-making abilities making them more receptive and responsible for their own health (Lleras-Muney, 2005). Additionally, evidence suggests that education may increase cognitive processes and intelligence (Ceci, 1991; Nisbett, 2009). Increased numeracy and literacy have resulted in greater decision-making ability (Peters et al., 2006; Stanovich & West, 2000).

In our study of nine SSA nations,⁴ we use DHS data from 2003 to 2005 to test education’s effect on condom usage (Baker et al., 2010). Using structural equation models, we found that information transfer and attitude change were positively related to condom use. However, once health reasoning was included as an independent variable, the cognitive effects of health reasoning are significantly associated with increased condom use ($\beta = 0.54$, $p < .05$) and completely mediate early effects of information transfer and attitude change. Using a naturally occurring experiment of 181 individuals in Ghana (Peters, Baker, Dieckmann, Leon, & Collins, 2010), we found that once cognitive and decision-making ability are included in the model, level of education and knowledge was not significantly related to protective behavior. Additionally, an increase in cognitive and decision-making abilities ($\beta = 0.34$, $p = .02$) significantly increased the likelihood an individual would partake in protective behavior.

Taking this path further, we have recently analyzed unnoticed relationships between social science research on education and cognitive neuroscience studies observing brain activity during performance of academic tasks and learning (Baker, Salinas, & Eslinger, 2012). The combined understanding of both clusters of literature is a promising new venue of scientific support to the notion that schooling is working as a neurocognitive developmental social environment, that is, “what happens in classrooms around the world enhances ... the very nature of cognitive processing and especially the individual’s executive functioning and high order cognitive capacities” (Baker et al., 2012, p. 10).

Alternative Explanations

We offer the above account of the shifting education effect in the HIV/AIDS pandemic in SSA as the most accurate account of what has occurred. There are, however, some popular alternative explanations. The first two below generally ignore the overwhelming evidence that *ceteris paribus* formal education is a social vaccine, and these have been criticized for such elsewhere (Baker, Leon, Smith-Greenway, Collins, & Movit, 2011). The third is a popular, but ultimately limited explanation. These alternatives often see education as spurious to the outcome, solely synonymous to SES, or they simplify the process of information, pushing more complex cognitive tasks to the periphery (Baker et al., 2009).

Economists have questioned the validity of the schooling-health relationship, stating that the correlation “may result from the action of some underlying difference among individuals who effect both schooling and health behaviors” (Farrel & Fuchs, 1982, p. 218). The appearance of a third or instrumental variable would render the schooling–health relationship spurious. Both Fuchs (1982) and Grossman (2006) point to time preference as a likely instrumental variable. Individuals who choose to forgo present benefits for greater future returns are said to have a future oriented time preference. Those with this orientation would choose to continue their education as well as ensure their long-term health.

Human capital theorists posit another possible explanation. From this perspective, individuals weigh the costs and benefits of engaging in risky behavior and choose to avoid dangerous behavior that may diminish their financial and social return on their educational investment (Feinstein, 1993). As the political information environment evolves, this cost–benefit analysis may change, encouraging more to refrain from risky sexual

behavior. Grossman (1972) suggests that these individuals are not simply prompted by avoidance but by investment in health capital. Health capital is defined as “a durable stock that produces the output of healthy time” (Grossman, 1972, p. 246). Given that those who are more educated are more efficient producers of health and those with higher wage rates will receive a higher return on their healthy time, upper class individuals are expected to invest more in health capital.

A third, more common explanation found in the literature involves education's role in enhancing psychological states by changing individual attitudes. The stigma associated with those who have HIV/AIDS in SSA paralyzes some from getting tested. As formal education changes attitudes toward those with HIV/AIDS, it reduces the stigma of those infected and creates a more open atmosphere where prevention can be emphasized (Baker, Leon, & Collins, 2010). These changes in attitudes and beliefs may also increase self-efficacy. This transformation can be especially powerful for women, providing them with the confidence and voice they need to change submissive family dynamics and slowly alter discriminatory community norms (Vandemoortele & Delamonica, 2002). Information transfer, the final and most simplistic explanation, is often emphasized in prevention practices in SSA. It assumes that as the quality of information improves, the basic facts of the disease can be more efficiently transmitted and this increase in HIV/AIDS knowledge will lead to more preventative behavior.

Increased knowledge is important but not wholly sufficient. To have an impact on behavior one needs not only to access and absorb the information but also to process and implement it. This praxis is not taken into account by programs that focus on solely on the prior notion of access (information transfer) or the later notion of action (behavior modification). The challenge for researchers involves specifying this process and separating it from other effects of education.

Changing behavioral practices, like condom usage and number of sexual partners, proves more difficult than altering attitudes or information (Jukes et al., 2008). In a review of 23 studies, Paul-Ebhohimhen, Poobalan, and Teijlingen (2008) confirmed that attitudes and knowledge were the most commonly found significant change related to school-based sexual health interventions, but behavior change was more difficult to find and often related to an individual's preintervention sexual history. In their investigation on education and vulnerability of young women in South Africa, Jukes et al. (2008) found that neither attitudes nor knowledge provided an efficient mechanism for behavioral change.

The ineffectiveness of information-transfer programs can also be seen in the Drug Abuse Resistance Education (D.A.R.E.) program implemented by the United States during the Reagan presidency. The \$750 million program used law enforcement officers to provide information to students about the dangers of drug use. The program resulted in well documented failure as adolescents with the knowledge of the dangers of drug use did little to change their behavior (Birkeland, Murphy-Graham, & Weiss, 2005).

WHAT DOES THE SSA HIV/AIDS CASE TELL US ABOUT HOW EDUCATION INFLUENCES POPULATION HEALTH?

The cognitive effect, as described above, is a constant, immediate effect of formal schooling, how the effect is manifested, however, is dependent on the community and national environment in which schooling is situated and interacts with other education effects such as increased material and social resources. This whole process determines the distinctive long-term effects of education on health. For example, in the early stages of the HIV/AIDS epidemic public information was nonexistent and government response was lethargic at best (Leon et al., 2012). Although this environment may have resulted in the overshadowing of cognitive effects by contextually more prominent income or wealth effects, this does suggest that cognitive functioning as a result of formal schooling was absent. Instead, based on the constraints present in the community and national environment, individuals were making rational decisions in the light of misleading information. Type-casted as a homosexual disease during its emergence, many heterosexual males did not feel they were engaging in risky sexual behavior and, in line with the information available, continued their previous patterns. As the community and national environment changed, individuals were able to recalculate the risks of their behavior and adjust accordingly. Initially this decrease in prevalence was seen by those with the greatest ability to decipher between murky mixed messages, those individuals with higher amounts of education. Finally, as the information increased in accuracy and the government response became more robust, individuals used the reasoning they gained through the cognitive effect to increase their protective behaviors, resulting in better health outcomes – a long-term effect of formal schooling.

Much research demonstrates that formal education has considerable effects on individuals and populations. These range from significant cognitive enhancement to the near full domination of occupational and social status attainment in most national societies. Prior thoughts about education's influence on health has tended to focus on either a limited view of cognitive effects of schooling (e.g., gaining more information, reading) or by conflating the education with material effects. The story of HIV/AIDS in SSA reveals why both of these positions are problematic and underestimate the full effect of education. Educational effects interact with one another and can produce powerful outcomes. Sometimes these interactions work in the same direction in terms of health outcomes and other times, as early in the cases of HIV/AIDS pandemic and the rise of mass manufacturing of tobacco products, they can work at odds with each other. But once there is distribution of reasonably accurate information, the cognitive effects, related to decision making, prevention strategies, and behavior dominant material and social effects, tend to result in education working as a social vaccine. This conclusion also suggests that the quality of schooling is a central component in the education as social vaccine model.

The effects of education are unique to the individual community and depend on the quality of school available and the community and national environment. As illustrated by the case in SSA, this exogenous environment includes both political and informational factors, in addition to social and economic influences. [Fig. 3](#) is a conceptual map of how formal schooling traverses through these two filters to make prominent the long-term effects of education. The immediate effects of formal schooling are mediated through the quality of schooling provided. To initiate some of these immediate effects, such as cognitive functioning, the quantity of schooling may be minimal.

This does not mean, however, that school quality does not matter. Since [Heyneman's \(1976\)](#) study on school effects in Uganda, there has been a significant body of literature that has studied the importance of school quality in low-income nations. If we think of school quality forming a spectrum from low to high, the presence of immediate effects, such as enhanced cognitive functioning, in the early years illustrates the vast range in school quality and the minuscule likelihood that we have encountered schools that are truly worthless. We, however, have not yet tested this school quality hypothesis. The cumulative effect of educational attainment which recognizes that additional years of education enhances cognitive processes, suggests that higher quality schooling at a single level would

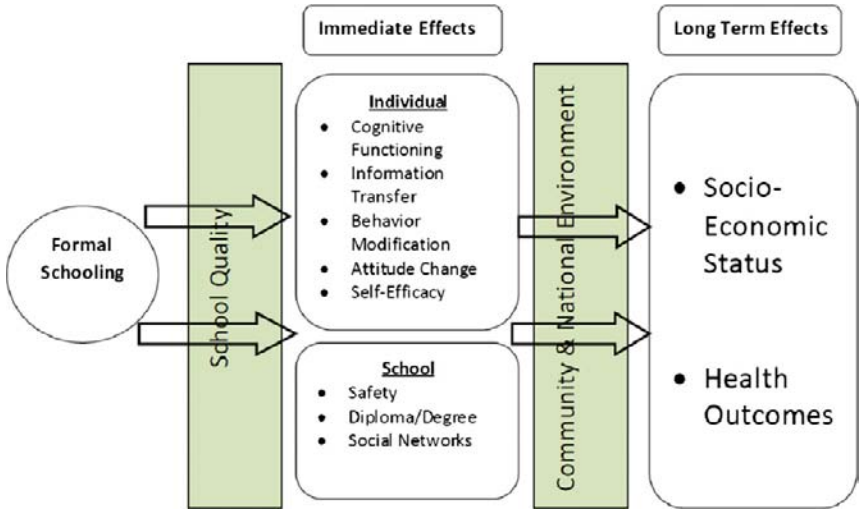


Fig. 3. The Multiple Effects of Education on Health.

result in increased literacy and numeracy skills and a more prevalent cognitive effect (Coombe & Kelly, 2001; Jukes et al., 2008). Future research should test the sensitivity of the basic cognitive effect of schooling to variation in the quality instruction and curriculum of literacy and numeracy.

Immediate effects of formal schooling can be seen at the individual level – independent alterations that are inherent to a single individual and a school level – changes that transpire due to the structure and associations present in the school. Assumed pathways in previous literature involve formal schooling increasing individual knowledge (immediate effect), with individuals using that knowledge to improve their health outcomes (long-term effect) (Adih & Alexander, 1999; Caldwell, Caldwell, & Quiggin, 1989; Glick & Sahn, 2008; Merson et al., 2008; Mirowsky & Ross, 2003; Snelling et al., 2007), as well as changes in individual attitudes (immediate effect) leading to modified community norms (long-term effect) (Kane, 1995; Mirowsky & Ross, 2003). Additional individual immediate effects of formal education include, but are not limited to, increased self-efficacy (Jukes et al., 2008; Strecher et al., 1986) and behavior change, such as discipline and self-control (Coombe & Kelly, 2001).

School-level effects are not unique to the individual, do not require individual effects, such as cognitive functioning, to be attained, and are dependent on the structure and associations present in the school. Schools have

the ability to create a safe environment for individuals and expose them to other perspectives through increasing their social networks. [Hargreaves et al. \(2008\)](#) found that the protective social network provided by schooling can lead to less risky sexual behavior by decreasing the available sexual network. Furthermore, these institutional measures may be more significant for girls' attendance in school than boys' ([Jukes et al., 2008](#)).

To this point we have focused on health outcomes as the long-term effect; however, there are numerous other long-term effects of education. The most widely reported effect of education is income ([Altonji & Dunn, 1996](#); [Ashenfelter & Rouse, 1997](#); [Blundell, Dearden, & Sianesi, 2005](#); [Card, 1999](#); [Jukes et al., 2008](#); [Kuepie, Nordman, & Roubaud, 2009](#); [Oreopoulos, 2003](#); [Rouse, 2007](#)). The economic returns on education vary in relation to school quality ([Card, 1999](#); [Card & Krueger, 1992, 1996](#)) and the economic sector – public versus private versus informal private – one retains occupation in ([Kuepie et al., 2009](#)). These results indicate that the observable economic return on education is dependent on both school quality and economic environment filters. The theoretical framework in which economic return is calculated, human capital theory, provides additional insight in how the economic effects of education may differ by community and national environment. Human capital theory is based on neoliberal economic assumptions; the supply and demand present in the environment may therefore alter the economic returns on education. This may be seen in increased returns in high demand, low supply educational fields or changes that result from the saturation of one educational level – if the degree an individual holds is rare they are able to provide a unique service and are thusly compensated.

An additional and related example, of how the environment impacts the long-term effects of education involve educational credentialing. Although formal schooling institutions confer diplomas or degrees, the larger society determines their value. [Meyer \(1977\)](#) initially observed the degree to which the value of an individual's education is largely linked to the societal preference to mark certain levels of education as part of an organized practice that has reinforced and intensified labor market credentialing through formal educational degrees (see also [Hogan, 1996](#)). Those with the given level of education are deemed competent and assumed to have mastered certain associated skills ([Bills, 2003](#)). As education as an institution takes on ever-more robust meaning in postindustrial society and educational practices become more isomorphic internationally, credentialing gains legitimacy as more occupations require standard levels of educational completion ([Baker, 2011](#)).

In addition to health outcomes and socioeconomic status, other long-term effects can be seen as the immediate effects of education is molded by the community and national environment. Other long-term effects of education include: nonmarket outcomes such as consumption and savings patterns (Grossman, 2006), community crime rates (Lochner & Moretti, 2004; Machin, Marie, & Vujic, 2010; Moretti, 2007), levels of social networking (Jukes et al., 2008), and engagement in civic participation (Dee, 2004; Milligan, Moretti, & Oreopoulos, 2004; Sondheim & Green, 2010).

CONCLUSION

We have advanced the hypothesis that the changing effects of schooling on HIV/AIDS in SSA – from being a risk factor early in the pandemic to a social vaccine more recently – were the result of the interaction among the immediate effect of education on individual cognitive abilities, the more long-term effect of greater material and social status derived from education attainment, and the changing political–informational environment available in SSA countries. In the 1980s, weak health policies fostered an environment of incomplete and often biased information that prevented more educated individuals to perform their usual risk-avoidance behavior, and the greater material and status afforded to more educated males led to more sexual partners and risky sexual practices. Starting in the 1990s, after stronger international and national policies were implemented, the cognitive benefits of education resumed its usual role as a social vaccine and led educated individuals to safer sexual practices, helping to lower infection rates of the population (although significant infection rates continue for uneducated portions of population in SSA).

Like other known histories of risk and disease, the case of education effects on HIV/AIDS in SSA illustrates that education, through its cognitive skill enhancement and its empowerment of people to think for themselves, has powerful influences on health that most cases produces a positive social vaccine. Although other powerful effects of education on material and status can mask these effects in certain political and informational contexts, policy-makers should be aware of this conclusion and let it be the main one guiding policy about education for population health.

NOTES

1. Current team members include David Baker, Daniel Salinas, Paul Eslinger, Emily Smith Greenaway, Saamira Halabi, Adrienne Henck, Haram Jeon, Hyung-Kee Kim, William Smith Penn State University; Martin Benavides, Juan Leon GRADE Peru; Nathan Dieckmann Decision Research Oregon; Ellen Peters Ohio State University.

2. Nations included and year of DHS collection: Burkina Faso, 2003; Cameroon, 2004; Ethiopia, 2005; Ghana, 2003; Guinea, 2005; Kenya, 2003; Lesotho, 2004; Malawi, 2004; Rwanda, 2005; Senegal, 2005; Tanzania, 2003.

3. DHS data collected from 2003 to 2005. Nations included Cameroon, Ghana, Guinea, Kenya, Lesotho, Malawi, Rwanda, Senegal, and Tanzania.

4. Nations included Cameroon, Ghana, Guinea, Kenya, Lesotho, Malawi, Rwanda, Senegal, and Tanzania.

5. The figure comes from [Leon, Baker, Salinas, and Henck \(2012\)](#) and shows the predicted probabilities from the complete model. Informational Void Period (1975–1984); Partial Information Period (1985–1994); Full Information Period (1995–2005).

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TAKING A HOLISTIC APPROACH TO HIV/AIDS EDUCATION IN ZAMBIAN SCHOOLS

Rosah Moonga Malambo

‘Teach them while they are young, they will live to remember’ (Malambo, 2000)

ABSTRACT

The purpose of the study was to analyse approaches to HIV/AIDS education adopted by the Zambian Ministry of Education (MoE), using a holistic approach and focusing on the Zambian culture. This chapter reports on an explorative qualitative study involving focus group discussions and in-depth interviews with Ministry of Education and Health officials, pupils, students, and members of the community. Qualitative analysis was applied and themes from ecological theory were used to organise and discuss data. At the macro level, there was inadequate implementation of HIV/AIDS education in schools, very few handbooks, textbooks and learners’ reading materials, and no discussion of the Zambian cultural (sexual) practices in relation to HIV/AIDS education. Inadequate laws and policies on HIV/AIDS prevention, poverty, unemployment, lack of job creation, and lack of social security were blamed for the lack of positive sexual behaviour changes. Communities had

The Impact of HIV/AIDS on Education Worldwide
International Perspectives on Education and Society, Volume 18, 105–140
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ISSN: 1479-3679/doi:10.1108/S1479-3679(2012)0000018008

strong theological and metaphysical beliefs including witchcraft and sex with a widow, a menstruating woman or a woman who had an abortion as possible causes of HIV and incurable diseases being a curse from God. At the individual level, the knowledge of HIV/AIDS was high with radio and television being sources of information. Respondents viewed sexual cultures in communities not to have significantly changed. A majority of respondents did not use condoms; most adults continued having multiple sexual partners and women were submissive in marriages. This chapter is useful to policy makers, teachers, pupils/students, and the community, and in understanding interactions and influences of cultures on HIV/AIDS education and government's role in creating an enabling environment to sustain desirable changes.

INTRODUCTION

The Ministry of Health (MoH) in Zambia reports that HIV/AIDS became a visible public health problem when the first AIDS case was reported in 1984 (MoH, 1999). The national surveillance results indicate that HIV prevalence has been largely stable, reported around 19–20% between 1994 and 1998 among the ages between 15 and 49 years, and currently estimated at 16% by the Central Statistical Office in Zambia (CSoZ, 2012). The prevalence is estimated to be twice as high in urban areas compared with rural areas. The disease is mainly transmitted heterosexually and through mother to child transmission in sub-Saharan Africa. HIV transmissions through homosexuality are not discussed as the whole concept of homosexuality, even if it exists, is taboo, illegal, unacceptable and hence not a subject of discussion. It can be argued that homosexual relationships in relation to HIV/AIDS need to be addressed in Zambia because they exist.

HIV/AIDS IN A ZAMBIAN CULTURAL CONTEXT

The spread of HIV in Zambia is largely associated with cultural practices, especially those associated with sex. Merson, Black, and Mills (2012) and O'Connor et al. (1997) argue that cultures become causal determinants of feelings, attitudes, habits, values and even the overt behaviour of individuals in a particular society. In Zambia, cultures that facilitate HIV

transmission include polygamous marriages, practising dry sex, multiple sexual partners and sexual cleansing (a sexual act with a member of the opposite sex from the bereaved family) after death of a spouse. Another cultural practice is the use of HIV contaminated razor blades or knives during circumcision and tattoos in traditional medicine (MoH, 1999).

Polygamous marriages are common in rural areas and farms in Southern, Eastern and parts of Northern Provinces. Marrying several women and producing several children is considered to be a way of ensuring cheap labour on the farm. It is argued that Zambian culture allows for a man to have several sexual partners as men cannot be sexually satisfied by one woman. In some tribes like the Ngoni (Eastern Province) and Bemba (Northern Province), younger sisters or cousins are sent to look after their in-laws (men), when their pregnant wives deliver. This is because it is traditionally considered taboo to have sex within 3 months of giving birth. There has also been a breakdown in the extended family systems. The extended family provided information on appropriate sexual behaviour, advocated abstinence and mutual faithfulness and offered a social safety net in times of need. Traditional ceremonies and rites (initiation and marriage) could also be channels of information that stress respect, faithfulness, mutual responsibility and support within the family context (MoH, 1999). Cultural aspects of sexuality are very important in the fight against HIV/AIDS if educational campaigns also target sexual behaviour changes.

The National AIDS Council (NAC), which falls under the National AIDS/STD/TB, spearheads HIV/AIDS prevention activities. NAC operates as a non-governmental organisation (NGOs), although it is answerable to the MoH. The MoH (1999) lists factors affecting the HIV/AIDS epidemic in Zambia as follows:

- High prevalence of other sexually transmitted diseases.
- Multiple sexual relationships.
- Traditionally low use of condoms, even in high-risk sexual encounters.
- Low levels of male circumcision, argued as an advantage in HIV transmission due to the hardening of the skin making it not easily bruised or cut during intercourse.
- Poverty and the low health status of much of the population.
- Low social and economic status of women making them more vulnerable to prostitution.
- Settlement patterns with 43% of the population living in urban areas. Compared with other sub-Saharan African countries, Zambia is highly urbanised.

- Early sexual activity with the average age of first sex at 16.3 years for girls and 16.4 years for boys.
- Cultural practices such as polygamy, engaging in dry sex where a woman is bruised and bleeds during a sexual act and sexual cleansing of widows or widowers.

There have been tendencies in developing specific preventive programs for risk groups in communities, for example, prostitutes, truck drivers, drug users, homosexuals, cross border traders, commercial sex workers, fishermen and fish traders, military personnel, prisoners and refugees. Categorising and directing education towards a group of people makes others, who do not fall into these categories, believe that they are not at risk. The approach should be AIDS education of the total population.

MoH (1999) reported behavioural changes in some parts of Zambia. There was a decline in the prevalent rates in the age groups 15 and 19 years (adolescents), attributed to increased use of condoms. One can argue that using the age groups between 15 and 19 years as an indicator for behaviour change misses the point as they could delay sexual activities (Siamwiza & Chiwela, 1999) and most Zambians marry after the age of 19 years. Age groups above 19 years would give a better picture on behaviour changes, as they are more sexually active and would not normally use condoms within marriage.

Zambia has about 470 centres administering free Anti-Retroviral Therapy (ART) to about 51,764 HIV positive people countrywide (NAC, 2012). Shortages of drugs have been reported because the drug companies supplying cheaper drugs are unable to supply on demand. This creates a new problem of drug resistance and emergence of new HIV strains.

THE EFFECTS OF HIV/AIDS ON DEVELOPMENT

About 33 million people in the world live with HIV/AIDS, 22.5 million of these live in sub-Saharan Africa and 30 million people have since died due to the disease (UNAIDS, 2012). There is still no cure for HIV/AIDS making disease prevention the most effective way of dealing with the spread of the disease. Piot (1999) simply stated: 'HIV is now the single greatest threat to future economic development in Africa' (Piot, 1999, p. 26).

Piot (*ibid.*) a Public Service Reform Programme (2000), also state that long illnesses of those affected lead to absenteeism from work and low work output affecting country economies. There is destruction of families, an increase in orphans due to loss of spouses and increase in child-headed

households. Heavy funeral costs and loss of work hours due to attending funerals of work mates and family members are not uncommon. Although the bereaved family would get help from the community in terms of feeding and emotional support, the sole responsibility of financing the funeral remains with the host families. The agriculture sector, which employs about 71.6 % of the labour force in the country (CSoZ, 2012), is also affected where most of its productive age group capable of growing crops is too weak or ill due to HIV/AIDS. Lack of food further complicates the disease pattern because people living with the disease need adequate nutrition to improve their immunity and quality of life.

THE RELATIONSHIP BETWEEN HEALTH AND EDUCATION

A two-way relationship exists between health and education. Teaching and learning are affected by the personal health of a school community, while school activities and what is learned could be influential factors in promoting the health and well-being of pupils (MoE, 1996). A World Health Organisation (WHO) official simply said that health and education are inseparable (MoE, WHO, & CBoH, 2001, 2002). The relationship between education and health is of great importance in Zambia where poverty-related malnutrition, environmentally related malaria, lifestyle-related sexually transmitted diseases (including HIV/AIDS) and other health problems are widespread but preventable. Schools in Zambia can contribute greatly to the prevention of HIV/AIDS because the school age groups constitute the largest population (54% of total population) of persons living without HIV/AIDS, although they engage in sexual activities as early as the age of 13 years (CSoZ, 2012; Salmi, 2000).

An essential prerequisite for effective learning is that a child comes to school healthy and ready to learn (Fullan, 1993). Good school facilities, abundant materials, and high-quality teaching cannot result in the intended learning if children are too sick or too weak to learn. Increasing death of the teachers reduces the potential for extending educational provision to all eligible children. This gives the education sector an obligation to foster HIV/AIDS education, providing knowledge, fostering awareness and promoting life-asserting attitudes. Realising the contribution schools can make towards the prevention and control of HIV/AIDS, the WHO established a Global School Health Initiative in 1995, which is guided by

its expert committee on Comprehensive School Health Education and Promotion (WHO, 2012).

The WHO views a health-promoting school as a good concept that can help concerted local, national and international efforts to provide a safe and health-enhancing social and physical environment (*ibid.*). Schools can integrate and complement health promotion strategies addressing issues such as active living, life skills, tobacco use prevention and HIV/AIDS or sexually transmitted diseases (MoE, 1996). Schools are also custodians of culture. Starting teaching early could result in healthier choices and attitudes especially in the fight against the spread of HIV, whose cure is largely prevention. Schools are equally affected by the HIV/AIDS epidemic.

The MoH (1999) summarises the impact of HIV/AIDS on education as follows:

- Reduction in number of trained teachers.
- Increased teacher absenteeism.
- Reduction in number of education officers.
- Reduced public finance for schools.
- Reduced family resources for schooling.
- Fewer children able to afford or attend school, especially girls who leave school to look after the sick members of the family.
- Fewer children able to complete school.
- More orphans with less access to education.

Above reasons mandates the MoE to strengthen its involvement in the fight against HIV/AIDS.

THE ZAMBIAN EDUCATIONAL SYSTEM

The government adopted the Basic Education for All concepts with basic education running from Grades 1 to 9; Grades 1 to 4 is the Lower Basic, Grades 5 to 7 is Middle Basic and Grades 8 to 9 is Upper Basic. It caters for the age groups of between 6 and 16 years. The structure of the education system continues with high school, Grades 10 to 12, covering a 3 years period. After high school, pupils continue in tertiary education in colleges and universities (MoE, 1996). The 1996 MoE policy document has not been reviewed as of 2012.

The MoE in Zambia views the quality and effectiveness of an education system to be dependent on the quality of its teachers. They also add that

the educational and personal well-being of children in schools hinges crucially on the competence, commitment and resourcefulness of teachers (MoE, 1996).

The mandate to include HIV/AIDS education in Zambia has added to the many societal pressures teachers face including overcrowded curriculum, poor conditions of service and being role models for the children under their care. The training of teachers is a requirement for effective HIV/AIDS education. Since HIV/AIDS education includes sex discussions, it has to be mentioned that it is generally taboo for adults to discuss sex with young people in the Zambian culture (Bajaj, 2008), unless during marriages and initiation ceremonies. Teachers, who form part of the adult population, have however an obligation to discuss these issues with children, making adequate training a necessity to effective discussions. Chiwela and Siamwiza (1999) found that a third of teachers in their study responded that exposing young people to sexual information and related images stimulated them to practise what they saw and heard. This is a typical reaction one expects of an adult in the Zambian community. According to the CSOZ (1998), a study on systematic HIV/AIDS intervention for youths indicated, however, that good AIDS education among adolescents did not lead to increased sexual activity, but delayed the age of first sexual intercourse and encouraged avoidance of risky sexual behaviours.

Studies by Malambo (2000) and Chiwela and Mwape (1999) concluded that HIV/AIDS prevention and psychosocial life skills received very little attention in Zambian schools and colleges. Some of the teaching on HIV/AIDS prevention occurred in science, geography, spiritual and moral education, social studies, biology, home economics and civics. The teaching of psychosocial life skills on the other hand occurred mostly in spiritual and moral education and mathematics. At college level, it occurred in education and psychology.

The Main Research Question

How can we educate school children on HIV/AIDS in a Zambian culture?

Objectives of the Study Relevant to This Chapter

1. Analyse the approaches to HIV/AIDS education adopted by the MoE.
2. Assess pupils'/students' knowledge and understanding of HIV/AIDS prevention using an ecological approach.

- 3. Evaluate whether HIV/AIDS prevention messages include the Zambian cultural practices.

Theoretical Framework

The fact that cultural practices contribute greatly to the spread of HIV and given the factors contributing to HIV/AIDS listed above, the main interest was investigating whether what children learn at school and messages given reflect their immediate environment and cultures. Evaluating health-related behaviours is complex and that is why a health promotion planning model known as the PRECEDE–PROCEED model by Green and Kreuter (1991), which has adopted an ecological approach to educating for health was applied (see Fig. 1). For the purpose of this chapter, the ecological theory by Brenfonbrenner (1979) will be the main theoretical framework

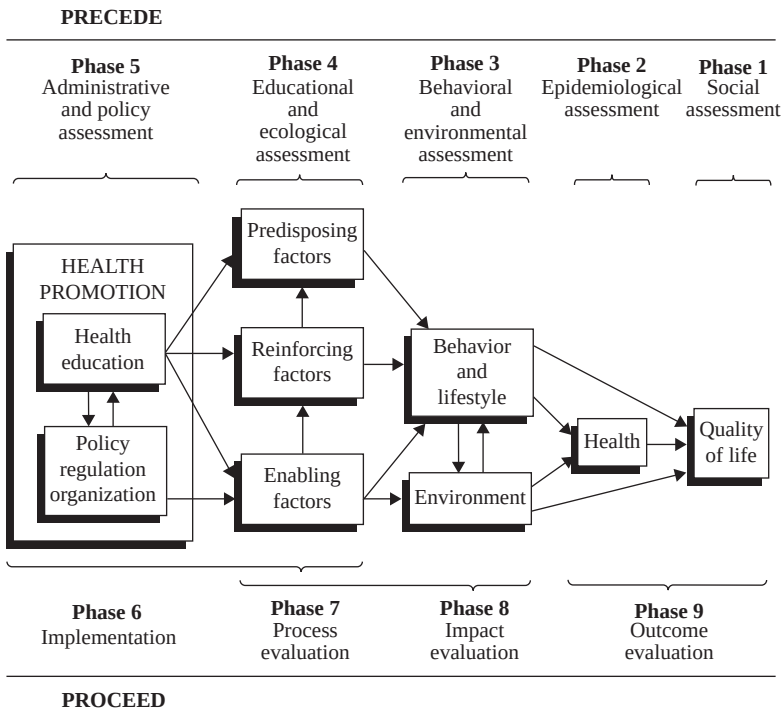


Fig. 1. An Illustration of the PRECEDE–PROCEED Model. Source: Green and Kreuter (1999, p. 35).

discussed in order to highlight how cultural practices and the social economic issues affect HIV/AIDS education.

UNDERSTANDING THE ECOLOGICAL
(HOLISTIC) THEORY

Pupils and students receiving HIV/AIDS education are part of society and interact with environments and cultures around them. Educational messages should therefore reflect the socio-cultural practices and environmental factors related to the spread of HIV/AIDS. [Bajaj \(2008\)](#) supports the assertion that pupils and students’ knowledge and beliefs on HIV/AIDS are shaped both in schools and their communities. The concept of holism is important when investigating health and disease as it includes the broader context of any phenomenon that would be influenced by diverse factors, for example, the HIV/AIDS pandemic ([Merson et al., 2012](#)).

Below is an illustration of the theory ([Fig. 2](#)).

[Bronfenbrenner \(1979\)](#) defines the ecology of human development as the scientific study of the progressive, mutual accommodation between an active growing human being and the changing properties of the immediate

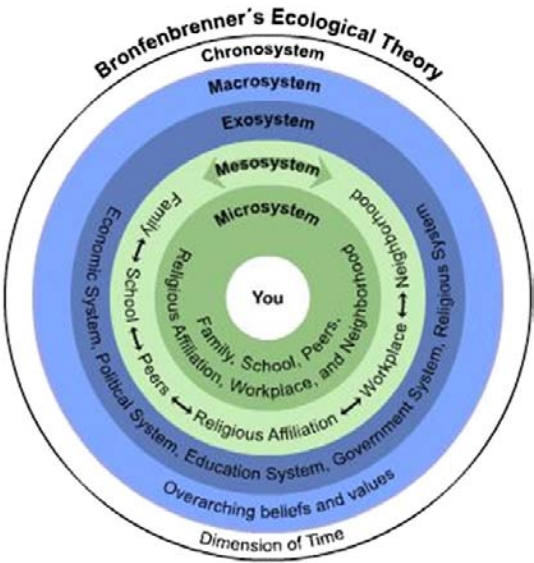


Fig 2. Social Ecological Framework (or Model).

settings in which the developing person lives. This process is affected by relationships between these settings and contexts in which these settings are embedded. The author further illustrates this theory in four systems:

- A micro system denotes patterns of activities, roles and interpersonal relations experienced by a developing person in a given setting. It includes physical and material characteristics. These are powerful in shaping a person's psychological growth and how he/she perceives situations. It forms the inner person and includes the home, classroom, play-ground, day care and face-to-face interactions.
- A meso system comprises interrelations between two or more settings in which the developing person actively participates.
- An exo system involves one or more settings that do not involve the developing person as an active participant, but occur in those events that affect or are affected by what happens in the settings.
- The macro system refers to consistencies in the form and content of the micro, meso and exo systems that exist or could exist at the level of sub-culture or the culture as a whole, along with any beliefs or ideologies underlying such consistencies and government policies.

Respondents were asked questions related to the prevention and spread of HIV/AIDS in each of the above systems, for example, messages from school, at home, between friends, families, communities, cultural practices, churches, government policies and poverty. The UNAIDS and WHO also recognise that structural factors such as the socio-economic (poverty) and social cultural inequalities (gender inequalities) have to be taken into consideration in the fight against HIV/AIDS in Southern Africa for effective responses to take place (UNAIDS, 2012). This makes the ecological or holistic approach to any intervention important in achieving positive results.

Methodology

A qualitative exploratory research study was conducted. Multiple informants were selected due to the different subsettings embedded in HIV/AIDS education, behaviour change and school health. The Precede–Proceed model and the ecological theory helped define and delimit the sample (Bryman, 2008). Snowballing was employed where the MoE officers recommended the Copperbelt provincial educational offices leading the researcher to the private boarding primary and secondary

schools. An official from MoE recommended few schools in Lusaka, Central and Southern Provinces. The MoH officials led researchers to the provincial and district officials in the health sector.

Officials from the MoH and MoE were included in the study by virtue of their positions and responsibilities in HIV/AIDS education and government policies. Community members were conveniently selected as long as they were above 18 years of age and willing to participate in the study. School pupils were chosen from Grades 5, 7, 9 and 12 because these are the last grades between lower primary, upper primary, lower secondary and upper secondary schooling in Zambia respectively. Pupils who participated in either interviews or focus group discussions were purposefully selected with the help of teachers for their ability to provide information on HIV/AIDS education.

College students who were in their first and last years of training were included by convenience sampling to provide information on their views and experiences on HIV/AIDS education. Below is a list of the sources of information:

From the MoE,

- 1 Provincial focal point person in MoE.
- 1 Work-based distributor in the provincial offices of MoE.
- 2 school headmasters from some of the schools visited.
- 128 Pupils provided information on knowledge about HIV/AIDS, sexual cultural practices and discussions around HIV/AIDS among themselves and others.
- 17 College students provided information on HIV/AIDS, cultural practices and the best strategies for HIV/AIDS prevention.

From the MoH, informants provided information on policies and their involvement in HIV/AIDS education and School Health and Nutrition (SHN). These included

- 1 Health promotion officer at the MoH.
- 1 School health program officer working with local health centres at Lusaka urban.
- District health management team.
- 2 Nurses from health centres in Lusaka and Southern Provinces.
- 6 Peer educators from a compound in Lusaka.

Members of the community provided views on HIV/AIDS education, the sexual culture and its effects on HIV/AIDS education and issues of behaviour change observed in their communities. These included

- 6 Administrators from different organisations.
- 31 Community members from the markets, shoe repairers, women and men from communities surrounding the schools.
- 2 Female commercial sex workers from Ndola (Copperbelt Province), who provided their experiences as sex workers in an HIV/AIDS era.

Document analysis: Policy documents from the Ministries of Education and Health, Curriculum Development Centre and schools were analysed for contents addressing HIV/AIDS education and the extent to which they reflected the Zambian culture.

Data Collection

Data was collected over a period of 8 months spread over 3 years. Document analyses were conducted throughout the study period. The theoretical sampling guided the data collection exercise where data collection from different categories ended due to data saturation and non-emergence of new information.

A 21 years old male, who worked as a peer educator in reproductive health and HIV/AIDS for the United Nations Development Planning (UNDP), was involved as a research assistant. He was trained over a period of 2 weeks and was involved in collecting data from pupils, students and members of the community together with the researcher. A tape recorder was used to record all conversations during the study period and a notebook was kept.

INTERVIEWS

In-depth interviews were conducted using separate non-standardised, open-ended interview guides for MoH and MoE officials, few students, pupils and community members. Objectives of the study guided the themes for the questions (Bryman, 2008; Kvale, 2001).

Both English and vernacular were used during interviews. Unlike school children in government schools who used both vernacular and English during discussions, children from a private boarding school preferred using English only. They were surprisingly fluent in the language even at 5th Grade. Other languages used included Bemba and Nyanja in Lusaka, Copperbelt and Central Provinces and Tonga in the Southern Province. This

made it easy to translate few questions into vernacular where the respondents were not clear. Interviews were held in empty classrooms or offices to ensure confidentiality and privacy, except for market places, sex workers and shoe repairers. Interviewing in a location ended when there was no new information emerging.

FOCUS GROUP DISCUSSIONS

Focus group discussion guides were used to collect most of the data from most of the pupils, few students and few members of the community. It covered similar themes from the interviews. Both English and vernacular were used during discussions. The different groups consisted of 5–12 respondents attending the same grades and of similar sexes. This type of separation allowed for free discussions since discussions on sex are considered sensitive in this culture. None of the respondents participated in both focus group discussions and interviews. Only one tool was administered as was found convenient.

QUESTIONNAIRE

A self-administered questionnaire with open-ended questions was administered to the MoE HIV/AIDS co-ordinator. This allowed for giving responses in the respondent's own time.

Study Sites

Budget constraints limited the study to only Lusaka, Copperbelt and Southern Provinces. The MoH and MoE officials recommended the study sites because most of the NGOs have projects on HIV/AIDS concentrated in these sites and as such became interesting cases for the study. The National [HIV/AIDS/STDTB Strategic Framework of 2001–2003](#) (National HIV/AIDS/STD/TB Council, 2000) also mentions the city of Lusaka, Copperbelt and Southern Provinces as high-risk areas and hence priority areas for HIV/AIDS prevention. From Lusaka Province, 3 colleges from the city of Lusaka were chosen, the MoE and MoH headquarters and provincial offices, the District Health Management Team

including one local Health Centre and members of the General public from two compounds, a rural boys' secondary school and community members. From the Southern Province, a primary school, its surrounding communities and the nearest Health Centre were selected in the study. From the Copperbelt Province, Ndola the second largest city in Zambia after Lusaka was chosen and included MoE provincial headquarters, the headmaster and pupils at a high school and a hotel. Focus group discussions were held with shoe repairers and sellers at markets in the city centre.

Ethical Considerations

Permission to conduct the study was sought from the University of Oslo in Norway, MoH and MoE in Zambia and from school headmasters/mistress of individual schools. Individual permission was sought from all other respondents. Inclusion in the study was voluntary after explaining the purpose and significance of study. Permission to interview children below 14 years was sought from teachers who arguably acted as guardians during school periods. All respondents were assured of confidentiality.

Data Analysis

Qualitative data analysis methods were employed. Data collected was recorded on a tape recorder and a field notebook. Tape recorded data was transcribed into written texts with the aid of a computer (Bryman, 2008; Kvale, 2001). Direct quotes or citations from the data texts were used in the analysis where appropriate, adding respondents' voices to the study.

Both inductive and deductive analysis of the data was conducted (Patton, 2002). The analysis started with a deductive approach where texts were organised according to informants or data sources categories. Inductive analysis was thereafter undertaken where, after reading through the transcripts, line by line analysis of the data called microanalysis and data coding also called open coding were conducted (Strauss, 1990). Data was organised according to categories and themes derived from the ecological theory. Although the Grounded Theory (Strauss, 1990) was to some extent applied in the analysis, there was no intention for theory building, as it was not the purpose of this study. In few cases, simple quantification were used for categorical data.

Presentation and Discussion of Findings

‘It may seem hopeless, but we will not give up’ (Vold, Jan Erik in [Christie, 1994](#)).

From the findings, HIV/AIDS education seems hopeless, but educating pupils and communities should continue as [Kelly \(1991, 2000\)](#) stated that education generates hope. Data is presented and discussed according to the systems in the ecological (Holistic) theory.

HIV/AIDS in Relation to the Pupils/Students’ Immediate Environment

Findings at individual level, the micro and meso systems in the ecological theory will be discussed under this subheading. Data is discussed thematically and sources of data are mentioned where ever appropriate. Data was collected from informants of both sexes ranging from those with university level of education to informants with no education at all. The age range was also quite wide from as young as 10 years up to as old as 60 years. The wide range of views or data triangulation enriched the data on understanding the spread of HIV/AIDS, its prevention, HIV/AIDS education and school health, behavior change, beliefs and attitudes, lifestyles as related to HIV/AIDS and proposals for possible solutions.

KNOWLEDGE ON HIV/AIDS

As observed by most studies done on knowledge levels in Zambia, most respondents had high knowledge on HIV/AIDS and most of them had actually seen a person suffering from AIDS. This observation could be attributed to the large number of NGOs involved in HIV/AIDS prevention campaigns in the country.

Even if knowledge on HIV/AIDS was high, one Grade 5 pupil in a rural school in Southern Province asked, ‘... What do the letters HIV and AIDS stand for ...?’ The acronym was explained. It was the same group of pupils in Grade 5 that also responded that HIV was a disease and AIDS as a disease when asked what HIV/AIDS was ([Malambo, 2000](#)). Pupils however competently answered the rest of the questions during focus group discussions. Questions were also asked around HIV transmission through kissing. The pupils and few adults had inaccurate information due to conflicting messages discussed in the media where several articles

highlighted that HIV could not be transmitted through kissing unless both partners had cuts in the mouth and one partner had bleeding gums. Responses from secondary and primary school pupils and college students are summarised in a [Table 1](#).

On the sources of information, all respondents mentioned radio and television except in a rural school where only 17 out of 49 pupils had heard prevention messages from the radio, 16 from the television while the rest heard from anti-AIDS clubs and the classroom lessons. There are many debates on the influence of watching television on individuals. According to [Howe \(1985\)](#), television is seen as a member of the family. Being a member of the family, it could have the same influence on individual behaviours as any other member of the family. Howe goes on to say:

Television influences viewers' behaviour, new habits and skills maybe gained.

Knowledge and interests maybe influenced and it can lead to fear and anxiety ([Howe, 1985](#), p. 51).

It can be argued that television could have both positive and negative influence on individual viewers. It is more important to assess the effect of television on younger children (especially those below 12 years), who could sometimes believe that everything they see on television is an accurate reflection of reality because they cannot make rational moral judgements ([Howe, 1985](#)).

Pupils from a Southern Province Basic school, a Copperbelt High school and a primary school in Lusaka Province included in the study, were taught by the HIV/AIDS school focal point persons in Grade 4. Pupils in fourth grade are about 10 years old and this is arguably the best time to start teaching them about sex and safe sex. Details on or about sex and HIV/AIDS education should be adjusted according to the ages of the audience.

Anti-AIDS clubs supported by Family Health Trust (FHT) were the third most cited source of HIV/AIDS information by most of the pupils. There appears to be no guidelines on how extra-curricular activities through anti-AIDS Clubs and others, can supplement, support and reinforce classroom lessons. According to the [World Bank \(2003\)](#), the Copperbelt Health Education Project reported that anti-AIDS Clubs in Zambia did not reach the vulnerable youths. On the other hand, a few people benefit from these clubs as was reported in one of the *Zambian newspapers* that few anti-AIDS clubs spent weekends performing drama, songs and dances to community members on the prevention and dangers of HIV/AIDS (*Daily Mail*)¹.

Table 1. Responses on Knowledge About HIV/AIDS Ranked from Most Recited to the Least Recited.

Question Category	Common Responses Given by All Respondents
What HIV/AIDS was	• Human immune deficiency syndrome and acquired immune deficiency syndrome. • A disease/a deadly disease. • A disease causing long illness where people become thin, the skin colour changes, they have body rashes, they suffer from diarrhoea, they cough and the hair starts thinning.
Sources of information	• Television except for 8.2% of respondents from Southern Province Basic School. • Radio except for 8.7% of respondents from Southern Province Basic School. • Anti-AIDS clubs mostly from pupils from a Southern Province Basic and a Lusaka rural boys' school. • Grade 4 class lessons from a Southern Province Basic, a Copperbelt high school and Lusaka Province primary schools. • Health Centre workers from a Southern P. Basic and a Copperbelt high. • NGOs and Planned Parenthood Association of Zambia and FHT from Lusaka rural boys' school and colleges. • Public talks and friends from a Lusaka boys' school and a Copperbelt High school. • Vehicles giving HIV/AIDS on the streets using loud speakers from Lusaka. • Magazines like lover boy and trendsetters. Churches from a Lusaka rural boys' school. • Zambia Integrated Health Programme workshop for 2 weeks (ZIHP) from a woman working in Lusaka.
Prevention of HIV/AIDS	• Using condoms (although not 100% safe). • Abstinence. • Be faithful to one sexual partner. • Do not sleep around. • Do not share needles or reuse sharp utensils. • Create jobs for the unemployed to keep people busy. • Find medicines to alleviate suffering for the infected people. • More health education especially with the youth. • Discourage alcohol drinking especially among youths.
Areas of uncertainty about HIV/AIDS	• Can one transmit HIV/AIDS through kissing? • What and how is mother to child transmission of HIV? • The actual words on the acronym HIV/AIDS from a Southern Province Basic school.

PEER EDUCATORS OR CHILD TO CHILD PROGRAMMES

Anti-AIDS clubs were well accepted by students and pupils although participation is voluntary. Members however spread HIV/AIDS education messages through role-plays, drama and educational talks to schools and communities. These clubs have been evaluated as a successful means of peer education to pupils who are non-members and communities on HIV/AIDS prevention (Malambo, 2000).

The health centre visited in Lusaka urban had 9 peer educators; these were young women between 16 and 25 years of age working under a Zimbabwean Non-Governmental Organisation only known as HRT (none of the nurses in the health centre knew what the letters stood for). There were about 21 peer educators under HRT in Zambia's Lusaka and Southern Provinces. They received monthly wages from the same NGO and health centres in the districts they worked in.

HIV/AIDS DISCUSSIONS WITH PARENTS AND FRIENDS

The attitudes and roles of parents are critical in shaping sexual behaviours and reproductive health for their children. In an earlier study (Malambo, 2000) more than half of the pupils discussed HIV/AIDS with parents (females with mothers and males with fathers) and friends. Pupils, who did not discuss, mentioned embarrassment and a lack of respect, as reasons why they did not discuss sex with parents at a young age. Parents however should be aware that children are exposed to movies and television programmes and magazines involving sex (*ibid.*). They could just be naïve that their children were too young when in fact they knew more than what parents could have imagined. Traditionally, older women are supposed to talk to girls about growing up and issues of sex the elderly men would talk to the boys. One boy from a private school in Ndola said that his mother did not have problems discussing HIV/AIDS because she was an HIV/AIDS voluntary counsellor at a local Health Centre.

One pupil said that the parents could be infected themselves and would find it difficult to advise children on how to avoid infection (*ibid.*). Due to the stigma associating HIV/AIDS with promiscuity or unfaithfulness, parents who are infected might be thought to be more effective in teaching

their children to avoid infection. These findings agree with Siamwiza (1999) who indicated that far too many people, including teachers, find themselves in a situation where they are embarrassed to teach about HIV/AIDS because of their own HIV status or vulnerable situation. However, few orphaned children are believed to have made positive decisions about their sex lives, due to experiences they have had with their parents before they died (Malambo, 2000).

In some focus group discussions, few pupils responded that discussions on HIV/AIDS were more open in urban compared with rural areas, where people were still very conservative. One adult during an informal discussion alluded that the Zambian culture teaches young people to respect elders, similarly girls are asked to respect older women and men. How then can young girls be expected to decline sexual advances from older men including teachers (*ibid.*)?

This study however revealed that there was an improvement on parents or guardians when it came to discussing HIV/AIDS with children in their homes. All the adults who had children or dependants above the age of 15 talked to them about the dangers of HIV/AIDS. Parents could be in denial thinking that their children were still young to be told about sex and HIV/AIDS when they actually knew a lot from friends, school, television, radio, magazines and all the posters in public places. Family members often discussed HIV/AIDS when they were talking about other people affected by it. One respondent observed that churches were more open about HIV/AIDS.

HIV/AIDS in the Exo and Macro Systems of the Ecological Theory HIV/AIDS Education Policies

School health programmes that existed in the early years ceased to exist in the late 1970s. Since then, efforts have been made to revive these school health programmes but with very little success. There is a question of ownership of the programme. Should the MoH or the Education own it? The MoE was of the opinion that it had the overall ownership since school health activities would be carried out in schools. Teachers are mandated to carry out any activities that are performed within the school premises. Health workers on the other hand believed that they should carry out school health activities since they mainly involved prevention of diseases. It is still not clear how this problem would be resolved. In Norway, it is the health personnel like public health nurses and medical students that

carry out school health programmes in schools (Christie, 1994). This approach has been said to be successful since health workers had better training in health issues.

From the data, the concept of school health in the MoE falls under the HIV/AIDS co-ordinators and SHN. The MoH officials were of the opinion that the MoE was not ready to take up this challenge due to inadequate training in health promotion. Although the MoE has clear policies on school health including HIV/AIDS education, the implementation process has been very difficult due to logistical problems. The MoE has therefore been termed as a sleeping partner especially in HIV/AIDS education. NGOs carry out most of the education in schools and support teachers by training them on HIV/AIDS through short seminars. Schools and colleges still lack teachers' handbooks and learners reading materials. Implementation of programs is not only unique to Zambia, Masatu, Kvale, and Klepp (2003) and Klepp et al. (1999) found that although AIDS education programmes in Tanzanian schools were available, they were not implemented consistently and persistently throughout the public school system where the majority of the adolescents can be reached.

ORGANISATION AND ADMINISTRATIVE CHANGES IN HIV/AIDS EDUCATION

According to the MoE official, the HIV/AIDS unit at the Ministry worked with appointed focal point persons from the provincial headquarters, districts and schools. These positions did not appear in the Ministry's organisational structure and as such existing structures were being used. For example, the provincial and district focal point persons would normally be school inspectors or ordinary teachers, while school focal point persons were teachers in those respective schools. She gave information that the existing fourteen-teacher resource centres at provincial levels and the sixty-two centres at district levels would be used to train teachers in HIV/AIDS education.

Regarding the point of duplication of work between the HIV/AIDS focal person, SHN focal point person (HIV/AIDS component) and child to child co-ordinator in the MoE, the MoH official pointed out that HIV/AIDS needed all prominence and attention to be addressed effectively. He also said, '... HIV/AIDS falls under nutrition and others call it a nutrition deficiency syndrome....' Many people working with HIV/AIDS prevention

agree that the disease is also worsened with nutrition deficiency. An Employer-Based Distributor (EBD) from the Copperbelt said;

... poverty and hunger contribute to HIV/AIDS. Someone infected with HIV need a proper diet to maintain the energy and strength. These people's immunity is already weak, it becomes worse with hunger, and they die quickly ...

The provincial co-ordinator under the MoE in Lusaka was also an education inspector. She was however not directly involved with HIV/AIDS in schools but added that the district, zonal and school focal point persons met to discuss HIV/AIDS education. They only submitted their reports to the provincial office, so that they could be aware of activities in schools.

At the school level, the co-ordinator mentioned that an integrated approach was being used to teach HIV/AIDS. It could be told as a story during an English lesson, as a problem needing some calculations in a mathematics class and it could also be taught as a topic under viruses in biology and home economics. She also observed:

... There is no room for teaching HIV/AIDS as a subject due to the loaded curriculum. Some schools discuss the disease every day during assembly ...

The co-ordinator also pointed out that the HIV/AIDS education team worked together with communities to provide simple snacks for pupils who went to schools without any food.

TEACHING AND LEARNING MATERIALS

At the time of the study, the HIV/AIDS co-ordinator pointed out that there was no account of teaching and learning materials at all levels, that is, provincial, district and school levels. This was because schools used whatever materials were available from either NGOs or local health centres. There were plans to provide teachers' guides produced by the UNAIDS, WHO and UNESCO. A magazine meant for pupils called 'Soul City, Choose Life' had been sponsored by DFID to be piloted in 3 schools in each district in three provinces. The pilot would determine what pages or contents needed to be adjusted to create the Zambian version. The MoE officer also mentioned that they would use whatever materials were available.

During the study, a resource book which was a teachers' guide from the [WHO and UNESCO \(1999\)](#) was available in one school. The guide includes information similar to the World Bank handbook mentioned

above but it includes details on teaching methods, questions and answers, as well as student activities under each lesson. It is a practical and easy resource book for teachers but the problem was that it was not readily available for use by all schools.

In 2001, the MoE published manuals for workshop trainers called listening and action skills and beginning counselling skills and interpersonal relations (Syamujiye, 2001a, 2001b). These were distributed to all schools for teachers to use as resource books in workshops. The first edition in Psychosocial Life Skills series was also published and distributed to all schools in the same year of 2001. The first series is called, *Stress, What It Is and How to Manage It* (Byers & Kayungwa, 2001). It was also meant as a resource book in teachers' workshops on HIV/AIDS education. Although these books were not in the schools visited at the time of the study, there were deliveries taking place to two out of the nine provinces during a study visit to the MoE headquarters in Lusaka in 2002.

Another handbook found was that from the FHT in Zambia (1998). It is a comprehensive resource book mainly designed for both teachers and pupils in anti-AIDS projects. This manual was basically written by Zambians and covered more detailed youth to youth learning activities on growing up, relationships, sexual health and adolescence. It also had a quite comprehensive coverage on methods used under each lesson and it covered issues of behaviour change (Life Skills) to a minimal extent as compared with the two resource books mentioned earlier. The handbook however had a title (Happy, Healthy and Safe), which could arguably add on to the already existing stigma on people living with HIV/AIDS. Does it mean that people living with HIV/AIDS are not happy? Much as they are ill, they could still live for several years while feeling healthy and would be safe to themselves and others.

In the year 2000, the MoE published pamphlets for the youths and the public to read. These are referenced as MoE (July 2000c, 2000d, 2000e, 2000f) in the reference list. They were distributed to all schools, colleges and interested organisations country wide. The pamphlets meant for youths were entitled 'Ten Reasons to wait before having Sexual Intercourse' and 'When No Means No; Key Points about HIV/AIDS; Talking to our Children about Sex and Growing up and Get the Facts about HIV/AIDS and Protect Yourself'. These pamphlets are single paged making them easy to read even for busy people. This effort by the Ministry needs to be acknowledged as a step forward in reaching their goals on HIV/AIDS education.

Although a magazine called *Soul City, Choose Life* and a manual titled *Happy, Healthy and Safe* were available during the study, the schools visited did not have any of these books. Sixty-two per cent of teachers held

the opinion that, the teaching of HIV/AIDS would improve if they were given more teaching and learning materials including videotapes, charts and magazines (Malambo, 2000). More learning materials were however a matter of urgency for use in both schools and colleges. The HIV/AIDS co-ordinator also pointed out that a draft to provide guidelines for the teachers and a school HIV/AIDS guidance training manual had been produced. It was waiting for printing and distribution at the time of the study.

From the textbooks and all resource books on HIV/AIDS reviewed during this study, it is clear that children were taught about HIV/AIDS without taking into consideration the realities of community sexual behaviours. Community sexual behaviours are culturally oriented and commonly accepted by members as will be discussed later in this chapter and as such need to be addressed seriously in all educational materials if any behaviour change is to be anticipated. Kaaya et al. (2002) agree that placing information firmly within the social cultural contexts in which young people are raised would be an effective intervention to delay sexual intercourse and would adopt risk reduction strategies. These children leave school at the end of each day and become part of these communities whose sexual practices are contrary to what they learn at school. This brings about confusion and like one male respondent in this study said, '... I will follow what my grandfather tells me ...' It is easier to follow what children are told by members of the communities because much of what they learn in schools is divorced from their daily lives and it remains at school. Divorcing what is learned in schools could explain the reason why a knowledge, attitude, skills and habits study in Zambia revealed that most young people had a disconnection between their beliefs, thoughts and actions (The World Bank, 2003).

THE CURRICULUM

According to the MoE official, the curriculum framework was available and had been approved (Ministry of Education, March, 2000a, December, 2000g), printed and distributed to provinces, districts and schools. Plans were under way to procure HIV/AIDS videos for the provincial, district and college resource centres. HIV/AIDS was treated as an integrated subject. The new teacher education course was using the integration concept. She added that the teachers were having problems with integrating issues of national concern in their lessons such as HIV/AIDS, gender, environmental issues, human rights and drug abuse.

The challenge of the integrated approach was the ability to retrain all teachers on cross cutting issues with the already inadequate resources at the Ministry. It has to be mentioned that any added responsibility for government workers would mean added remuneration to civil servants. A lot of them expect added allowances and without them, there could be no motivation for teachers to take up added responsibilities. These curricula were not available in the schools visited during the study. HIV/AIDS is not an examinable subject and as such is given less time and emphasis in school curricula that is exam driven (Malambo, 2000).

TEACHER TRAINING

Since the focal point persons were appointed, the MoE had not carried out any training. Plans were however in place to train as many teachers as possible in

- a. Programme management.
- b. Impact model presentation.
- c. Peer education.
- d. HIV/AIDS counselling.
- e. Parent—elder training.
- f. HIV/AIDS teaching methodologies (Ministry of Education, 2001–2005).

The above report from the officer conformed to the findings on an earlier study (Malambo, 2000). In this study, the teachers stated that they did not have any training on HIV/AIDS education or just had 2 weeks of in-service training. They complained that the 2 weeks-training courses they had received were inadequate to make them competent in teaching the subject. It had to be mentioned that few NGOs also got involved in teacher training through workshops and seminars.

THE SCHOOL HEALTH AND NUTRITION (SHN) PROGRAMME

The MoE had a unit for SHN co-ordinated by a focal point person who was independent of the HIV/AIDS unit. According to the focal point person, SHN was one of the seven components under BESSIP. Other components included infrastructure; teacher development, deployment and

compensation; education materials; equity and gender; curriculum development and capacity building and decentralisation. At the time of the study, a policy draft on SHN had been developed (Ministry of Education, May, 2000b) and was awaiting confirmation from stakeholders. These included the Curriculum Development Centre, UNICEF, FAO, Ministry and District Education offices, District Boards of Education and the MoH especially the District Health Management Teams. All these stakeholders signed a memorandum of understanding to ensure their commitment to SHN. The problem is at the level of implementation of these programmes because schools visited during the study did not have any SHN activities.

HIV/AIDS Prevention in Zambian Communities

About 98% of respondents admitted that a lot of people had knowledge about HIV/AIDS and how it could be prevented. They mentioned that prevention messages would be more effective if poverty was addressed critically. They were many NGOs in the communities teaching about the spread of HIV/AIDS and trying to reinforce the efforts made by government. The only problem was that the organisations were concentrated in urban areas leaving most of the rural areas neglected. Even if the knowledge was high, it had been said that knowledge does not equate to behaviour change. One can argue that the problem with changing behaviour is that deaths related to HIV/AIDS are a remote reality for most people. One male respondent added, ‘... the staunch traditionalists and others with strong beliefs in customs and cultures, HIV/AIDS messages do not have any meaning to some people’.

Most of the respondents gave Condom use, Abstinence and Being faithful to one partner, the ‘A,B,C’ of HIV/AIDS education being promoted in all campaign programmes, as the best way of preventing HIV/AIDS. From the results, alternatives to penetrative sex, like non-penetrative sex were not mentioned by any of the respondents. In one focus group discussion with shoe repairers in Ndola, one man mentioned masturbation as a method of prevention (non-penetrative sex), but the group members argued saying; ‘... Masturbation is taboo in an African society’.

The man who talked about masturbation was aware of the taboos around it because he talked about going to do it alone in the bush and not at home. It is believed that masturbation brings about impotence and barrenness in men. From the results, non-sexual HIV/AIDS preventive measures such as screening all blood for HIV before transfusion were less

cited. Sharing used needles and not re-using used sharp objects like razor blades were however cited by half of the respondents. None of the respondents mentioned preventive measures like wearing protective clothing such as gloves and protective eye glasses when handling blood or body secretions, even of deceased relatives or preventing HIV transmission from the mother to a child either in pregnancy or during breast-feeding.

Members of the community explained that parents or close relatives who wore gloves did not love and care for the sick or dead persons. The use of gloves in this sense would signify non-intimacy in the relationship and to some extent disrespect to the sick or deceased.

Most churches had started discussing HIV/AIDS prevention after the sermons. A respondent from a compound in Lusaka attended a Catholic Church, which had a committee responsible for HIV/AIDS discussions. He also said that youths between 10 and 17 years of age held these discussions after Church services and sometimes, a health worker or any guest speaker conversant with HIV/AIDS was invited to speak to members of the church. This was done as a moral obligation for the churches and mosques. Few communities in Lusaka also benefited from HIV/AIDS prevention activities such as drama, songs and role plays performed by peer educators based at the local health centres.

The Zambia-Integrated Health Programme (ZIHP) at the MoH trained EBD for most institutions in the country. These peer educators were meant to teach fellow colleagues or workers on HIV/AIDS prevention and they also distributed condoms and contraceptives.

All the respondents were asked on whether women or men should be targeted for HIV/AIDS prevention. About 80% of the respondents were of the opinion that both men and women should be targeted because they were equally responsible for a sexual act. Twenty per cent of respondents were however of the opinion that men should be mostly targeted because they initiated sexual acts in the Zambian culture, excluding female commercial sex workers. Respondents also pointed out that even if the men initiated the sexual advances, women had the right to say no and hence both should be targeted for education. A girl in Grade 9 from Southern Province proposed compulsory testing for HIV in the country. HIV test results would then be made public at local health centres so that everyone was made aware of the HIV status of all adult members of the community and as such avoid infection. This is however a violation of the human rights of people living with HIV/AIDS.

Although people are responsible for adopting sexual behaviours that prevent HIV infections, the social economic environment in Zambia does

not facilitate the adoption of behavioural changes that might have been the result of all the knowledge gained from the Health Ministry, NGOs and all other actors involved in HIV/AIDS education. Environmental factors include the existing sexual cultures, policies, poverty and inequitable distribution of health services.

POVERTY

The main problems identified under poverty were unemployment even among university and college graduates, lack of job creation and unfavourable agriculture policies. There was also lack of social security amongst the poverty stricken citizens and orphans in the country.

Poverty leads to commercial selling of sex, multiple sexual partners especially for unemployed men and women searching for financial support, lack of money for buying condoms for those without access to free ones, street children and lack of proper nutrition.

URBANISATION

Zambia is said to be a highly urbanised country compared with few countries in sub-Southern Africa, with 43% of the population living in urban areas (CSoZ, 2012). Most of the people from rural areas move into cities and towns in search of jobs and to buy and sell some merchandise. This creates overcrowding in most compounds in the peripheral areas of the capital city, Lusaka. Urbanisation could be said to be positive but it carries its own problems. Most of the people living in these areas are unemployed increasing the risk of crime, prostitution, street adults and children and the risk for HIV/AIDS infection. The risk for HIV/AIDS infection could be related to a high turnover in both horizontal and vertical sexual relationships. These problems increase the risk of HIV/AIDS infections of most Zambians living under such conditions.

CULTURAL PRACTICES

Several predisposing factors were identified under cultural practices. These increase the risk for HIV/AIDS infections for the people involved in such behaviour.

Multiple sexual partners were reported as the main problem in this study. Most married men had multiple sexual partners. Most of the college students included in the study had a steady boyfriend and an older man financing their studies, agreeing with discussions in Bajaj's study on sugar daddies (Bajaj, 2009). Intergenerational sex where older men and women are having sexual relationships with younger girls and boys increases the risk of HIV infections. The infected young boys and girls later seek marriage within their age groups further increasing the risk of more infections.

Polygamous marriages were also mentioned as one contributing factor although permanent or long-term mistresses were slowly replacing them. Polygamous marriages are in themselves not a risk to HIV transmission as long as all partners remain HIV negative and are faithful in the relationship. Almost 98% of all respondents were of the opinion that sexual behaviours had not changed even in the advent of HIV/AIDS, especially those of men. During an interview with the EBD in Lusaka, a similar opinion was expressed stating, '... People have the knowledge on HIV/AIDS but they still indulge ... they have 4 sexual partners ... or 4 wives, there are so many factors to consider like poverty and high levels of unemployment. It is more important to find means of surviving than think of HIV/AIDS ...' These views were held by almost all the respondents. The issue of poverty and survival was brought up in each interview or discussion held.

Low condom acceptance especially in marriages and long term relationships was another common cited factor. Most respondents reported that few people did not use condoms because the sexual partner did not look like they could be infected with HIV or because the partners trusted each other. Most youths and young men noted that the high number of sexual bouts they would have in one night or each time made condom use costly and impractical. Some forgot or would deliberately stop using them. Most respondents added that condoms were not safe hence using them gives people a false sense of security. A leader of the Catholic Church, the late Pope John Paul II also advocated for abstinence and non-use of condoms. The Pope's stand on condom use would have had a negative influence on the large number of Catholics in Zambia. More than half of the men in this study pointed out that they would not be men enough if they had no children making the issue of condom use very problematic. Proving manhood through childbearing adds to the pressure of unprotected sexual activities. The National HIV/AIDS/STD/TB also observed that (Daily Mail);²

... Although the levels of sexual behaviour change was difficult to quantify, the assumptions based on the levels of HIV infections indicate that there was a high level of condom use but new HIV infections stood at 1000 per year ...

The article further states that condoms use could be at 30% to 40% in the adult population due to the high levels of Sexually Transmitted Diseases, which facilitates transmission of the HIV. A lot of male respondents in the study were not very positive to the use of condoms. A Grade 12 pupil from a Copperbelt High School even said:

... sex with a condom is like eating a sweet with its cover ...

Responses were given that people did not enjoy and get sexual satisfaction when they used condoms. The solution to this problem could be to start teaching children on how to use condoms at an early age so that they do not experience unprotected sex until marriage with an HIV negative partner. Most of the respondents questioned how using a condom properly would be possible under the influence of alcohol.

Marriage between widows or widowers and family members of the deceased were reported. This is to a larger extent sexual cleansing. It gives a risk to HIV infection when one partner is infected bringing in the issue of HIV testing before marriage and unprotected sex.

Most elderly men in the study advocated for dry sex (sex performed before a woman is ready). One man added that he could buy the wife herbs or medicines to dry secretions if it were possible

Different beliefs were held strongly by few respondents such as witchcraft bringing about HIV/AIDS, incurable diseases being a curse from God, having sex with a woman who has just had an abortion or menstruation or a widow as a cause of HIV/AIDS. One respondent also reported that some tribes offered male visitors women to have sex with for the period of their visit, commonly practised in rural areas as an appreciation for the visit.

ALCOHOL CONSUMPTION

Almost all respondents strongly condemned irresponsible sexual behaviour after alcohol consumption. More unlicensed alcohol outlets were operating illegally in most market places in the country. These outlets did not consider age limits when buying alcohol. This has exposed many youths to excessive alcohol consumption leading to irresponsible sexual behaviours.

Most of the respondents were of the opinion that there should be laws to guide alcohol consumption or to totally ban it to prevent the spread of HIV/AIDS. Banning alcohol is however unrealistic, an applicable solution would be to try to control consumption for the underage.

THE PLIGHT OF WOMEN IN AN HIV/AIDS ERA

Several factors, which made women more vulnerable to HIV infection, were identified. Most female respondents reported that they continued having unprotected sexual relationships even with full knowledge of their husbands' other sexual partners. Reasons given for this trend were financial support, for the sake of their children and that all men had similar behaviours. One woman added '... for all I care I could already be infected ...' One man added that women would rather stay in marriages because unmarried women were not respected and were sometimes labelled as prostitutes. On the contrary, unmarried men are not labelled as such.

High unemployment levels among women forced them into unfaithful relationships and commercial sex work. The two commercial sex workers sold sex to fend for their families. They earned more money when they did not demand condom use putting them at risk of HIV infections. The culture and economic situations makes women more vulnerable hence the need to empower them. It was observed that Zambia also lacks serious laws protecting women, that is, in cases of marriage interference by mistresses or infidelity, polygamy and wife battering. One respondent was of the view that men and women lacked the moral responsibility to protect their families against HIV/AIDS.

It has to be added that the female anatomy of the reproductive organs adds to the risk of infection. The surface area of exposure to HIV infected seminal fluid is wider in women due to the position of the vagina, the uterus and fallopian tubes. Women become more vulnerable during dry sex as bruises are not easily seen from the surface of the perineum except for external ones.

STIGMA AND DENIAL

It was observed from the data that most people who were HIV positive would rather be silent about their disease. This was due to negative

attitudes attributed to diseases caused by sex. The denial and silence encourages spread of the disease since most of them would not tell their sexual partners and hence continue spreading the disease. There was also some discrimination at work places and abroad reported. HIV positive people are normally retrenched from work and cannot undertake further studies in some countries abroad (Sontag, 1991).

The silence and denial would be addressed by accepting HIV/AIDS as one of the sexually transmitted diseases. Once this is accepted, preventive measures and all the campaigns against its spread should be provided together with other communicable diseases like cholera, tuberculosis, malaria, which equally kills hundreds of people in Zambia. Campaigns should then be followed by treatment strategies for all these communicable and preventable diseases. The billions of kwachas that are spent on HIV/AIDS prevention campaigns could also be spent on improving treatment coverage for all people living with HIV/AIDS. This is in view of most Zambians currently having high knowledge about the disease as discussed in earlier chapters.

LACK OF LAWS AND POLICIES ON HIV/AIDS PREVENTION AND EDUCATION

Many respondents suggested that government should pass strict laws on people infecting others knowingly. This also goes for people infecting younger girls, including issues of incest and child abuse. There was an urgent need for the revision of customary or traditional laws, which gave men leverage over most infidelity crimes. The laws should be amended to support women and allow for fair hearing.

CONCLUSION

Discussions above emphasise the need for inclusion of all factors associated with the spread and prevention of HIV in HIV/AIDS education. A holistic approach would be the most appropriate as seen in the diagram (Fig. 3).

Individual behaviours are affected by all systems making behaviour change complex. Factors directly or indirectly related to the spread and

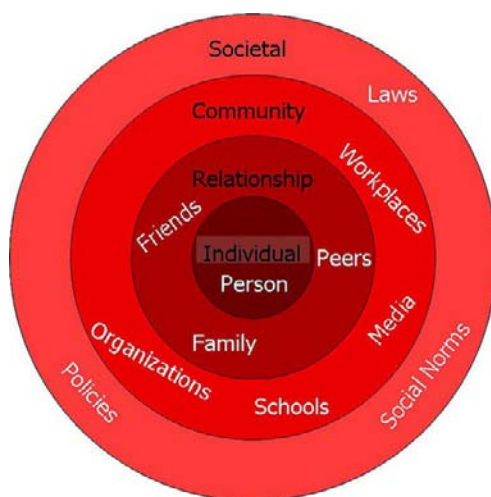


Fig. 3. Adaptation of [Bronfenbrenner's \(1979\)](#) environmental ecological theory.
Reference for figure: [Nielsen \(2011\)](#).

prevention of HIV/AIDS at individual level, in the community, the culture, laws and government systems need to be included in HIV/AIDS education for desirable results to be achieved.

In the education sector, the implementation of HIV/AIDS education and school health programmes has been largely left to the NGOs. Most of the schools have HIV/AIDS as a co-curriculum under anti-AIDS clubs. The schools that conduct classroom lessons on HIV/AIDS do it out of their own initiative with limited resources. There was also an urgent need for the co-ordination of activities performed by NGOs in schools and HIV/AIDS prevention in general. The study revealed that most of the HIV/AIDS messages in the schools visited were directed to the individual, that is, saying no to sex, using condoms, being faithful to one sexual partner and abstinence. It is naivety to assume that community, cultural, economic and national factors do not affect the choices pupils/students make as regards to the prevention of HIV/AIDS.

Adequate school and community based educational programmes are needed. These programmes should seriously address cultural practices (especially existing sexual cultures) and their influence on HIV/AIDS education. Community involvement is important as it forms part of the school children and student's immediate environment. It also calls for tailored

education programmes for parents, pupils/students and community members. This suggestion stressed the active involvement of men. A comprehensive HIV/AIDS education training for teachers was seen as a requirement. The use of multiple methods of teaching was a necessity. These would include lectures, drama, role-plays, songs, use of peer educators, school clubs (such as the anti-AIDS clubs, debate clubs, drama clubs) combined with the use of health workers and NGOs to reinforce the efforts of the teachers. Psychosocial Life Skills and behaviour change training should be intensified to encourage most individuals especially youths to be more assertive and take responsibility for their own lives. People can improve the skills and knowledge through attending courses and accessing literature that addresses necessary steps for HIV/AIDS prevention.

ACKNOWLEDGEMENTS

Acknowledgements to Professor Brock Utne at the University of Oslo and Professor Godfrey Lungwangwa then at UNZA.

NOTES

1. <http://www.daily-mail.co.zm/news-i/feat01.htm> (29 November 2003).
2. <http://www.daily-mail.co.zm/news-i/feat01.htm> (29 November 2003).

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HIV/AIDS AND EDUCATION IN BOTSWANA

Gaelebale Nnunu Tsheko

ABSTRACT

HIV and AIDS have had a significant impact on education and society in Botswana. By giving a background of HIV and AIDS in the country and outlining the main response activities in Botswana's education sector, the author provides a detailed foundation for understanding the phenomenon of HIV/AIDS in Botswana as well as the conditions and activities used to respond to this epidemic. The methodology primarily consisted of document analysis of government policies and other documentation as well as research reports of studies conducted on education and HIV and AIDS or related topics.

BACKGROUND OF HIV AND AIDS IN BOTSWANA

Country Profile

In order to understand the impact of HIV/AIDS in Botswana, it is necessary to understand the context in which the epidemic has developed and

continues to thrive. Several components are relevant to the development and spread of HIV/AIDS in Botswana. For example, as is explained below, Botswana was a relatively new independent country when HIV/AIDS began to develop worldwide in the 1980s. The Republic of Botswana gained independence from the British in 1966. This political context may help explain why some of the policies and government responses to the epidemic are developed, implemented, and regulated the way they are.

At the time of independence, Botswana was one of the poorest countries in Africa. Since the country is two-thirds a desert, there was nothing much the colonial government was gaining from it. The situation turned around when diamonds were discovered and, therefore, the country today is classified as a middle-income economy to a point where it no longer qualified for external funding for projects like other African countries. The financial situation of Botswana may also contribute to the environmental conditions that both exacerbate and contextualize HIV/AIDS and its impact on education. Botswana as a poor country with a recently developed financial infrastructure and a natural resource industry creates a class of wealthy citizens and deepening economic divisions among the citizens (where one group becomes increasingly wealthy and others remain in poverty).

Botswana has for a long time enjoyed a fast growing economy. The current nominal GDP per capita is reported as \$7,343 with a real growth rate of 3.5%. The main economic activities are mining (mainly diamonds, copper, nickel and coal), agriculture (sorghum, maize, millet, beans), raising livestock (cattle, sheep, goats), and other services including tourism and beef processing ([CIA World Factbook, 2012](#)).

Geography also plays a role in the impact that HIV/AIDS has on education and society in Botswana. The Republic of Botswana is a landlocked country in Southern Africa, bordered on the west by Namibia, on the south and east by South Africa and on the north by Zimbabwe. Botswana covers an area of 582,000 km². The population of Botswana is estimated at 2 million from the 2011 census with an annual growth rate of 1.4% ([CIA World Factbook, 2012](#)). The population density of Botswana is not high on average, but concentrations of workers in diamond-producing regions and the living conditions in those regions may contribute to the spread of HIV/AIDS nationwide.

These conditions of political, economic and geographic context provide an environment rich for the development of HIV/AIDS and which may also not be the most conducive to rapid, innovative, or effective responses to HIV/AIDS within Botswana. As a result of these and other factors, the

prevalence of HIV/AIDS has grown rapidly and consistently since the first reported cases in Botswana.

HIV Prevalence

Botswana's first AIDS case was reported in 1985 and since then HIV and AIDS have come to be of paramount concern in Botswana (Central Statistics Office, 2005; Republic of Botswana, 2003). As the HIV and AIDS epidemic continues to amplify in Southern Africa, Botswana is reported to have one of the highest HIV prevalence rates in the world. The Botswana AIDS Impact Survey (BAIS), a national survey, provides better estimates of HIV prevalence rates and the latest of these population surveys was the third survey, BAIS III that was conducted in 2008. This latest survey shows an increase in the national prevalence rate from 17.1% (2005) to 17.6% (20.4% for females and 14.2% for males) (Central Statistics Office, 2009). The gender distribution reflects that in general females have the highest prevalence compared with their male counterparts and this has been the pattern even in the past two surveys. Prevalence in urban areas (17.9%) continues to be higher than for rural areas (17.6%) (Central Statistics Office, 2009).

A close analysis of the HIV and AIDS situation in Botswana shows that young women and girls are more vulnerable to HIV infection. Trends show that girls aged 15–19 are 12 times more likely to be infected than boys in the same age category (Central Statistics Office, 2009). Furthermore, young women aged 20–24 are 3.5 times more likely to be infected than their male counterparts. The major determining factors for these disparities are biological and physiological, intergenerational sex, sociocultural factors and gender inequality and discriminatory practices that put women at a social and economic disadvantage.

The evidence clearly suggests that HIV and AIDS in Botswana have become a serious developmental and social problem impacting all sectors of the economy and society. It continues to be a threat to the survival of individuals, families and communities at large. HIV and AIDS constitute a major obstacle in attaining the Education for All (EFA) goals and the Millennium Development Goals (MDGs). Despite the attention that has been given to the epidemic, much remains to be done in education to address the problem. While the role of education in prevention efforts has been recognized as a key factor in the fight against the pandemic, less attention has been paid to mitigating the impact on the education sector itself.

NATIONAL RESPONSE TO HIV AND AIDS

Botswana has responded to the epidemic by putting in place several policies and intervention programs to prevent HIV transmission and mitigate its impact. A multisector and coordinated approach has been adopted as AIDS has been declared a national emergency. The multisector approach required coordination as more sectors were involved, and this led to the establishment of the National AIDS Council (NAC) in 1995, which was mandated to monitor and coordinate the implementation of the national AIDS policy and programs developed within its framework. Additionally, this council was to advocate for the active involvement of all ministries and sectors in HIV and AIDS prevention and care ensuring the implementation of programs in their own ministries and organizations. The National AIDS Coordinating Agency (NACA) was established under the NAC in 1999 and serves as NAC secretariat. NACA guides the national response to HIV and AIDS through a National Strategic Framework (NSF) for HIV/AIDS. This strategic framework provides guidance for ministries, districts, NGOs, and the private sector to enable them to work in a collaborative manner to “to eliminate the incidence of HIV and reduce the impact of AIDS in Botswana” ([Republic of Botswana, 2003](#)). With prevention as the first priority of the Botswana National Response ([Republic of Botswana, 2003](#)), the framework has several key goals including prevention, care and support, management of the national response, and provision of a strengthened legal and ethical environment for those who are HIV positive.

Currently, there are many intervention programs in Botswana to cover areas of prevention, treatment, care, and support. These programs need to be continually evaluated and monitored to map out their impact. Two of the most successful programs are the Prevention of Mother-to-Child Transmission (PMTCT) of HIV and the Anti-Retroviral Therapy (ART) program, MASA. The PMTCT program was rolled out nationally in 2000 and all public health facilities offer the program. PMTCT services are integrated into routine sexual and reproductive health services in all public health facilities in Botswana. All women reporting at antenatal clinics are offered services in this program including HIV pre- and post-counseling and testing and ART where necessary.

Botswana was the first country in Africa to provide free ART to all citizens who need it. This was accompanied by a nationwide Information, Education, and Communication (IEC) program to provide Botswana with

the necessary information on HIV and AIDS and ART. This treatment package is available throughout the country and the team working on this is involved in various activities including community mobilization. Though this program is one of Botswana's success stories, it has not been without challenges. The program started in one site (Gaborone) and within the same year had expanded to three more sites (Francistown, Serowe, and Maun) to ensure that there was a site in all four corners of the country for access by rural and urban dwellers. Given the size of Botswana, this meant that some people travelled long distances and endured long queues to access treatment. With assistance from African Comprehensive HIV and AIDS Partnerships (ACHAP), the number of sites has increased and the situation has been alleviated. A further challenge with treatment is the low adherence to treatment by patients as reported often by health practitioners, but this is expected to be under control once planned intervention strategies are fully implemented.

It is from the National Framework that the public sector through its various ministries has developed sector-specific strategic frameworks. The Ministry of Education and Skills Development (MoESD) is guided by its ministerial HIV and AIDS strategic response framework.

EDUCATION IN BOTSWANA

The impact of HIV/AIDS on education in Botswana results from a confluence of several conditions and institutionalized characteristics of the Botswana education system. One significant condition is that while education is centrally administered from a national ministry, the implementation of education has been decentralized. Decentralization of educational implementation may contribute to less consistent responses to or education about HIV/AIDS in schools.

The management of education is mainly through the MoESD. This ministry operates a central office in the capital of Gaborone, but has decentralized the running of education to five educational regions throughout the country. The MoESD derives its mandate from the Education Act CAP 58:01 Section 3 (1) which states that this ministry should "promote primary, post-primary education, education research and the progressive development of school" ([Republic of Botswana, 2008](#)). The core functions of the ministry include provision of policies, strategies and leadership, teaching manpower, as well as education at various levels.

Structure of the Education System

The education system in Botswana is currently 7-3-2 that is seven years of primary school, three years of junior secondary, and two years of senior secondary education. Pre-primary education was for a long time not considered as part of the mandate for the government despite the 1993 Revised National Policy on Education (RNPE) recommendation. The MoESD is currently working on how to incorporate this part of education into the main education system. The provision of pre-primary education was left in the hands of private practitioners and accessible to only a few who could afford the usually exorbitant fees. The 7-3-2 system has been in place since 1995 as part of the implementation of the recommendations of the 1993 National Education Commission. In Botswana, education has always been free but not compulsory. School fees were abolished in 1988 and reintroduced in 2006.

The education at primary and secondary levels is driven by the MoESD. The first 10 years of schooling (seven years of primary and three years of junior secondary) is called basic education. These 10 years were meant to be accessible to all children but this has not been possible as some children still have problems of distance between their homes and nearest school(s), which are further compounded by the introduction of school fees. The introduction of school fees was in no way to leave any child of school-going age at home as it was thought the fee was a small amount and those assessed not able to pay were to be exempted from paying. However, there are parents and guardians who are not able to pay these fees, and given the delays in assessing families for exemption, some children do drop out of school for nonpayment of school fees.

Access to senior secondary school has been increased tremendously over the years and has selective accessibility as entrance is based on performance on national examinations at the end of junior secondary. The selection is more rigorous from secondary to tertiary education as places are limited. Scholarships for tertiary education are mainly obtained from the government. An undergraduate university degree takes four years. There has been one public university and a second one is open and will be enrolling students starting in the fall of 2012. There are however a number of private tertiary institutions that also rely on government sponsorship for potential students.

The educational structure outlined above suggests that there are multiple opportunities for education about HIV/AIDS to be introduced into the educational curriculum, teacher professional development, and special programs within the Botswana education system. However, it also suggests that there are severe limitations to access and opportunity to learn in the

Botswana system because of fees and performance-based mobility within the system itself. These sorts of limitations are not unique to Botswana, but are shared with other recently independent and developing countries, particularly in sub-Saharan Africa. Yet, these limitations are not the only reasons why education is impacted by HIV/AIDS nor why the Botswana education system has responded to HIV/AIDS to the degree and in the manner than it has.

EDUCATION AND HIV/AIDS

The responsibility of the MoESD as outlined under the national policy is to reduce the spread of HIV infection by addressing HIV and AIDS in all its programs. The major task for this ministry is to integrate and infuse HIV and AIDS issues in the school curriculum and in the training of teachers.

The MoESD's role as outlined in the national HIV and AIDS policy is the

- Integration of AIDS and STD education into all levels and institutions of education, starting at primary school level and extending to tertiary, teacher training, and nonformal institutions.
- Involvement of parents, through parent–teacher associations and other appropriate mechanisms, in discussion of school-based HIV and AIDS education.
- Ensuring that other services related to HIV and STD control and care are accessible to students and teachers in need.

The ministry developed its HIV and AIDS Education Policy and Strategic Framework as part of the national response to the epidemic. The major task for this ministry is to integrate and infuse HIV and AIDS issues in the school curriculum and in the training of teachers. This, it was thought, would equip both learners and teachers with skills and development of right attitudes and practices to curb the spread of HIV and to manage it.

HIV AND AIDS RESPONSE IN EDUCATION

HIV Policy

The HIV and AIDS Education Policy was developed in 1998 as part of the national response to the epidemic. The responsibility of the MoESD as

outlined under the national policy is to reduce the spread of HIV infection by addressing HIV and AIDS in all its programs. The major task for this ministry is to integrate and infuse HIV and AIDS issues in the school curriculum and in the training of teachers. The guidelines in this policy are therefore to

- Make the integration HIV and AIDS into the curriculum at all levels of education compulsory;
- Adapt age-specific content, methodology, and strategies in imparting HIV and AIDS education;
- Make it the responsibility of all education practitioners to participate in HIV and AIDS education;
- Develop in-service courses on HIV and AIDS education and strategies;
- Develop in-service curriculum and plan for implementation in consultation with Ministry of Health;
- Make counseling a component of training programs for guidance and counseling teachers;
- Involve community through PTA in AIDS education;
- Run HIV and AIDS awareness programs for all ministry employees;
- Support learner, teachers, and other education practitioners and guard them against discrimination.

Ministry of Education HIV/AIDS Strategic Response Framework

The MoESD response to HIV and AIDS is guided by the ministry's strategic framework of 2001–2003. This framework was developed using the Botswana NSF for HIV/AIDS as a guide and thus uses the role of this ministry as outlined in the NSF to focus. This ministerial framework has not been revised as of 2012. The ministry set to use its trained staff as resource persons in building capacity in others in the implementation of the framework. In the framework document, the ministry conducted a SWOT analysis as a way of informing its strategic response. The strategic response for this ministry therefore focused on

- Mainstreaming HIV and AIDS into the education sector;
- Developing an effective management structures;
- Developing functions and responsibilities at both central and regional levels;
- Developing reporting structures.

HIV AND AIDS COORDINATION IN EDUCATION

As a response to the HIV/AIDS epidemic in Botswana since 1985, the ministry has established an HIV/AIDS Committee made up of all heads of department. An HIV/AIDS coordinator has been appointed reporting directly to the Permanent Secretary. A Technical Working Group composed of focal point persons from all departments has been established to plan and coordinate the ministry's response. HIV and AIDS work in the ministry is therefore coordinated in this unit. The main responsibilities of this unit are to

- Ensure that HIV is mainstreamed into all ministry departments;
- Mobilize resources, both financial and human, for HIV interventions;
- Implement the part of NSF that is relevant to the ministry;
- Inform policy and program development relating to HIV and AIDS.

This unit liaises with the departments of the ministry to develop appropriate programs at ministerial level and these programs are to be developed at institutional level. At the institutional level, these programs are non-existent as this is hampered by lack of capacity and often efforts at that level target mostly the learners. This unit does not deal directly with welfare matters of teachers but works with other departments of the ministry such as Teaching Service Management (TSM) on matters relating to teachers.

Curriculum Changes

Schools are mainly focused on the traditional syllabus content. *HIV and AIDS* are not a core learning area and this is made worse by it and other related areas, such as life skills education, not currently being examined. However, there has been an effort to include HIV and AIDS in the curriculum either by integrating it into the content of some subjects or by infusing it in some. For example, with subjects such as biology, it has been easier to integrate issues related to HIV/AIDS while in other subjects such as mathematics, infusion of the topic has been less viable. For subjects such as moral education and guidance and counseling, HIV and AIDS are covered as a main content area. Though infusion was planned to happen at all levels of formal schooling, the degree to which HIV/AIDS education is infused varies across levels with most of it done in the middle levels of schooling. There is less attention to this at senior secondary and in tertiary education. Furthermore, since teacher training does not formally include

HIV and AIDS education, this integration and infusion have proven to be difficult for most teachers, as it is often left to the discretion and ability of individual teachers.

The ministry makes other efforts on HIV and AIDS education through some of its departments such as Educational Broadcasting. Additionally, important components of HIV prevention among youth have been provided through NGOs and voluntary organizations. Examples of these include the Peer Approach to Counseling by Teens (PACT), which has been in the schools promoting peer-based education and training since the 1980s. This is partially inactive in the 2010s due to limited funding. There are other outreach peer education programs offered by some of these NGOs, which are popular with youth because they are youth friendly. An example of these is the Botswana Family Welfare Association (BOFWA) that offers youth friendly reproductive health service. This service is however not enjoyed by most youth as the centers are few.

This lack of capacity to handle HIV and AIDS is experienced mostly at the school level where most teachers have not had any HIV and AIDS training. The guidance and counseling teacher gets overburdened with HIV and AIDS issues when in some cases even such a teacher is not trained. The guidance and counseling teacher post came with a higher salary and some teachers got promoted to such a post with no training. Though the guidance teacher should be able to handle HIV and AIDS issues, other teachers also need to be trained as they also need to address such issues in their teaching. This has not yet been successful. Many teachers responsible for implementing the infusion program are unwilling or lack confidence to teach sexuality and life skills subjects. Interviews conducted as part of recent studies indicated that many teachers are conservative or lack the aptitude to facilitate effective discussion of these issues. Inadequate teaching materials and approaches also present a challenge to teaching about HIV and AIDS.

HIV/AIDS EDUCATION AND MANAGEMENT OF TEACHERS

The supply and demand for teachers has an interesting history in the context of HIV and AIDS. The attrition of teachers due to deaths has been drastically reduced as a result of better healthcare service, especially the free provision of treatment. The supply of teachers is mainly from the six

colleges of education that award qualifications only up to diploma level. Four of these colleges train mainly primary school teachers and the other two train teachers geared mainly for junior secondary teaching. The University of Botswana continues to train teachers at the bachelor level who are geared mostly for senior secondary school teaching and for primary school. Enrolment of preservice teachers in the colleges is slightly lower than expected due to welfare matters, such as a shortage of accommodation. Of these graduates, about 10% are in-service teachers who had teaching certificates, but have been upgrading. Department of TSM reports indicate that all diploma teachers from the colleges are recruited by TSM, while the market for the secondary school teachers, especially the degree holders, seems saturated as most are not employed after graduation (Kinghorn, Coombe, McKay, & Johnson, 2002). There is no accurate information on the number and characteristics of teachers recruited to both primary and secondary schools (Benell & Molwane, 2008) due to a lack of capacity and compounded by the use of an electronic human resource management system, which requires proper management.

The recruitment, deployment, promotions, conditions of service, welfare, training, and development of teachers lie with TSM. For primary teachers, this is done in collaboration with the Department of Pre and Primary Education, while for secondary teachers it is done in collaboration with the Department of Secondary Education. It should be noted that pre-primary education is a new addition, though it was long recommended for inclusion as part of formal education in the RNPE (Republic of Botswana, 1994). The Pre and Primary Department is responsible for the supervision and inspection of all primary school teachers and schools. Likewise, the Secondary Department does the same for secondary school teachers and schools.

Teachers in primary and secondary schools leave for reasons of retirement, resignation, dismissal, death, further studies, secondments, and other reasons. Retirement from public service is compulsory at age 65, but after 25 years of service one can take early retirement. Most teachers work until compulsory retirement as at that point benefits are better. Resignation rates are not high given the limited employment opportunities elsewhere especially for primary school teachers. Every year about 20 teachers are dismissed for misconduct. Though acts of misconduct are not clearly stated in the Teaching Service Act (Republic of Botswana, 1976), the Code of Regulations give a list of duties and conduct issues that if not done accordingly can be an act of misconduct, for example, disclosure of public information, political involvement, accepting presents related to performance of duty.

In an earlier study, Benell et al. (2001) had projected (based on the situation that prevailed at the time) that teacher mortality rates would rise due to HIV/AIDS, but this has not happened as the rates have declined over the years especially with the availability of ARTs that are offered at no cost to those who need them (see Benell & Molwane, 2008). Teachers who are members of the Botswana Public Officers Medical Aid Scheme (BPOMAS) and those accessing the government program, MASA, receive treatment, and thus are still in the workforce. BPOMAS is a contributory scheme established through a presidential directive in 1990 and is a scheme that covers public servants and their dependants. This scheme allows those covered to receive healthcare services both inside and outside the country. The standard coverage under this scheme includes emergency and medical evacuation and funeral cover for the principal members and their dependants. Additionally, there is a managed care program that focuses on chronic illnesses. Under this program, beneficiaries manage their chronic illnesses through a health provider of their choice. Member contribution depends on their salary and is deducted monthly from their salaries. Enrolment is voluntary. MASA, the national ART program, originally was offered to HIV positives with a CD4 count of 200 or less, but this figure has been revised to 350.

Regarding teacher movement around Botswana, there is a small number of teachers going on study leave on a full-time basis, but most would rather take part-time studies. Therefore, part-time teachers still make up a majority of the teaching force. Secondment to other departments takes place on a small scale. This is significant because teacher mobility has been linked to the spread of HIV/AIDS in sub-Saharan African countries like Botswana.

Teacher Demand

There are many reasons contributing to the demand for teachers, which include having to replace teachers who have been lost through the many attrition routes (study leave, retirement, resignation, dismissal, localization, and death). Additionally, untrained teachers need to be replaced by qualified teachers, thus adding to the demand for teachers. There is no increased demand for relief teachers as teachers even in ill-health force themselves to perform their duties to avoid loss of salary and also being stigmatized (Benell & Molwane, 2008). This can be a compromise on the quality of education as an unhealthy teacher is bound to not fully carry

out his or her duties. Early retirement comes with lower pension pay so teachers opt to stay on to maximize their pension especially that the new contributory pension scheme offers them a chance to increase their pension pay. The implication is that infected teachers may stay on long past when they should (and potentially infect other teachers or students) because they want to receive as much pension as possible.

Teacher Absenteeism

In the 1976 Code of Regulations (COR 903(1)) governing the conditions of service of teachers, with the exception of illness, a teacher may not be absent from their duties unless they are given leave of absence by the school head, a supervisory officer or the director. Applying for leave is not a guarantee that the leave will be granted and therefore a teacher needs to wait for approval before taking such leave. Even when leave has been approved, the supervisor has the right to recall a teacher from leave except when the leave is prior to retirement, resignation, or dismissal.

A teacher who is not able to attend their duties due to illness is to report as soon as possible to their supervisors. Absence from leave for 48 hours should be accompanied by a medical report stating the nature of the illness and a period for sick leave recommended. The medical certificate must be signed by a government or private medical officer. If a teacher is considered to be incapable of carrying out their duties because of physical or mental illness, they may undergo a medical examination conducted by either a medical practitioner or a medical board nominated by the director. The teacher can also request for such an examination on their own. Results of such an examination will be used with other information from the teacher to decide whether the teacher should be retired on medical grounds.

BENEFITS FOR HIV INFECTED AND AFFECTED TEACHERS

No special benefits for HIV infected or affected teachers exist. Teachers infected or affected by HIV are entitled to the same benefits as other teachers. In the event that a teacher is compelled on urgent and compassionate grounds such as death in the family or to nurse a sick family member,

the teacher may apply for compassionate leave that is granted based on head teacher's discretion. This leave is for a period of no more than five days and is with pay. The head teacher's application for such leave is decided by their supervisors. If a longer period is needed for such leave, an extension of leave, again based on supervisor discretion, may be granted provided total leave days do not exceed thirty days.

Teacher Replacement

There is a need to replace teachers lost due to various attrition routes. There is a general feeling among teachers that replacement of teachers takes too long. When a teacher is absent, other teachers take on the load. The common practice is for the other teachers to divide the class of the absent teacher among themselves. Teachers are replaced only when they have been granted leave such as long sick leave, further studies, maternity leave, and retirement.

Teacher Transfers

There is a great deal of movement of teachers though detailed analysis is unavailable. Transfers are facilitated by the various transfer boards that are in place such as regional transfer board, inter-regional transfer board and senior management transfer board. Many teachers are applying for transfers at any given time. Reasons for requesting transfers are many but ill health is often cited by the majority. Other reasons include transfers to other schools and request to be near study institutions.

Though HIV treatment is available to most Batswana who need it, it is not yet available in some rural and remote areas. Treatment is often offered in semiurban areas, towns, and cities. Disclosure of status is voluntary. Teachers do disclose when they want to strengthen their transfer application. Sometimes reasons are given such as "want to be closer to my family as that will reduce chances of being infected with HIV" or "My spouse is sick and needs my attention" (Tsheko, 2010). On companionate grounds, depending on the availability of teachers, sometimes such transfers are granted.

It must be noted that this movement is mostly toward the cities, especially the capital city, Gaborone. This has earned the city the name, "Sick Bay." A result of this internal migration has been a negative impact on the

quality of teachers left in the remote or rural areas, as most qualified teachers move to urban areas, especially the cities (Tsheko, 2010).

There is no clear evidence that urban schools have surplus teachers, though, with rural schools the compromised quality of teachers is evidenced by poor performance in primary and secondary school leaving examinations. Surplus teachers are reported to regional offices and are then transferred according to demands for the subjects they teach. To curb this, it would be ideal to provide full health facilities and service across the country, but this is an expensive exercise. The government is committed to this and benefits should be realized in the near future.

However, given that disclosure of HIV status is not required, some teachers do give false reasons for transferring (such as to be near sick family member), and this cannot be verified. Administrators and evaluators do make school visits and observations tend to indicate an unhealthy workforce, but since HIV status cannot be deduced from just looking at a person, it is difficult to relate the situation to HIV and AIDS.

Stigma still plays a significant role in the schools. It has been observed that sometimes school management uses one's HIV status to recommend them for transfer. There are instances where school heads recommend teachers for transfer when suspected to be HIV infected. Stigma is sometimes also shown by parents when they hear that a teacher who is HIV positive has come to the school, and they will either remove their children or ask that their children be moved from such a teacher's class. Issues of stigma date as far back as the pandemic, though major progress has been made to address these. Unfortunately, education is the best strategy to address stigma and this takes time. Given the often lower levels of education of parents in rural and remote areas, rigorous steps need to be taken to expedite this. At the moment one time efforts are being made, but this cannot be enough if the much needed change is to be realized.

CONFOUNDING FACTORS IN HIV AND AIDS EDUCATION

Sex education is culturally not an open topic and this comes as a challenge to teachers in teaching about HIV and AIDS. The training of teachers on HIV and AIDS is also not strong enough and as a result imparting the right knowledge and skills is hampered. Drivers of the epidemic that include intergenerational sex and multiple concurrent partners become intertwined with culture to provide a breeding ground for HIV infection.

Culture plays a complex role in relation to risk of HIV infection in Botswana. Botswana youth are at risk because of certain cultural norms that dispose them to HIV infection. Culturally marriages are between young women and older men and with HIV these interage sexual relationships have driven the epidemic. It must be noted that there is also a new trend of older women and younger men. These interage partners are commonly referred to as “Sugar-daddy” and “Sugar mommy,” respectively (Kinghorn et al., 2002). These relationships are popularized by many factors including myths of cleansing HIV with virgins (Bajaj, 2009). The older partners belief that sleeping with the young can cleanse one of any virus they might be carrying including HIV (Chilisa, Dube-Shomanah, Tsheko, & Mazile, 2005). Poverty and love for material are also some of the reasons given for engaging in such risky relationships. Closely related to this is sexual abuse of children, which traditionally was a private affair. Some older relatives or neighbors would coerce the younger generation into having sex, and families would not report these to protect their family name (Chilisa et al., 2005). These practices turn out to create high risk environments for children.

Additionally, Botswana is over 90% Christian and religion is important in teaching about HIV and AIDS. For example, the use of condoms in the prevention of HIV infections was met with so much resistance in religious circles that it has had implications in the teaching of HIV and AIDS in schools.

ORPHANED AND VULNERABLE CHILDREN

The advent of HIV and AIDS has not only increased the problem of orphans but also compounded the vulnerable children phenomenon (Kinghorn et al., 2002; Robson & Sylvester, 2007; Ruto, Chege, & Wawire, 2009). The long-term sickness and eventual death of a parent or both to HIV and AIDS exposes children to all kinds of abuse. For instance, it is frequently mentioned that many vulnerable children end up leaving their homes to join the ranks of “street children,” while some remain in poverty in their homes (Kinghorn et al., 2002). The number of orphans in Botswana has increased tremendously in recent years, and HIV and AIDS are a contributing factor. Botswana’s registered orphans are taken care of under the orphan care program, and they are supplied with a food basket that contains the main basic food and toiletry items on a monthly basis. The

program also provides school uniforms, clothes, and blankets as a way of keeping orphans in school. As more children become either orphaned or left to care for sick parents as a result of HIV and AIDS, Botswana's home-based care system was strengthened to relieve children of caring for sick adults or siblings. Extended families became an integral part of the support system; however, with the introduction of the government grants many subjected orphans to abuse. These members would take in orphans just to benefit from the provided grant with little going toward the orphan. In the school, though mostly uncoordinated, there has been a wide range of support given to OVC such as recognition and referral of OVC to grants and other support.

ALCOHOL AND DRUG ABUSE

Alcohol and drug abuse is growing at an alarming rate in schools. The correlation between these and risky behavior such as unprotected sex is perceived to be high (Caillods, Kelly, & Tournier, 2008). Though not much evidence has been reported, discussions about the use of alcohol and drug among school children are a consistent concern.

EXAMPLES OF BEST PRACTICE PROGRAMS

Botswana generally boasts of several successful programs in addressing HIV/AIDS, such as PMTCT and ART, but in Botswana's education sector the real success story is the television show TalkBack, which is a Teacher Capacity Building Project (TCB). This program is a partnership between ACHAP, MoESD, Botswana Television, and the United Nations Development Program (UNDP). The curriculum includes topics on basic HIV and AIDS knowledge, prevention, care and support, HIV testing, culture, attitudes, and the role of the community.

Other than coverage of the topic in subjects like science and guidance and counseling, there is the TCB, Botswana's success story in the education sector. There are programs that have been put in place such as the TalkBack program, but there are many issues surrounding such a program. TalkBack is an interactive television teacher education program that targets Botswana teachers with information about HIV and AIDS in an

effort to build teacher capacity to effectively address HIV and AIDS issues in the classroom ([Republic of Botswana, 2004](#)). This TCB is a partnership between ACHAP, MoESD, Botswana Television, and UNDP. The curriculum for the program has been prepared and produced by the Department of Teacher Training & Development (TT&D) with technical support provided by the UNDP. The curriculum includes topics on basic HIV and AIDS knowledge, prevention, care and support, HIV testing, culture, attitudes, and community role. Though this is another Botswana success story, it has not been without challenges. Some schools do not have electricity and therefore are not able to participate, while in some schools facilities are not always functional. The timing for the program is every Tuesday at noon and sometimes schools are not able to stop regular teaching and have all viewing at such a time. Teachers have to call in and telephone service is reported to be a challenge in some areas.

Beyond this, there have been other projects such as the Ringing the Bell project that has not done so well, but in 2010s the project was being resuscitated ([Tsheko, 2010](#)). In this project, HIV-positive persons were attached to schools to promote positive living. There are yet more programs such as the Circles of Support project in which basically all stakeholders are capacitated on general issues including HIV. There are efforts to engage both teachers and students on HIV, AIDS, and health issues though mostly isolated.

CONCLUSION

HIV and AIDS have had a significant impact on education and society in Botswana. By giving a background of HIV and AIDS in the country and outlining the main response activities in Botswana's education sector, this chapter provides a detailed foundation for understanding the phenomenon of HIV/AIDS in Botswana as well as the conditions and activities used to respond to this epidemic. The methodology primarily consisted of document analysis of government policies and other documentation as well as research reports of studies conducted on education and HIV and AIDS or related topics. While there are several ways to think about HIV/AIDS and education worldwide, this chapter provides a focus on one particular country that is dealing with high rates of infection. This prevalence rate impacts education, but there are several methods for education to also impact or respond to the epidemic in Botswana.

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THE IMPACT OF HIV AND AIDS ON LESOTHO PRIMARY SCHOOL CHILDREN

Grace Makeletso Ntaote

ABSTRACT

Fifty-one orphans from five primary schools in the Maseru District, whose parents died of HIV- and AIDS-related illnesses, were interviewed for their experiences of HIV and AIDS. They were interviewed with regard to their psychosocial problems, their attendance at school, stigma and discrimination, nutrition and career aspirations. The interview schedule comprised of 37 items developed and validated by the researcher. Sixty-four per cent of the orphans lived with maternal grandmothers, 8% with maternal aunts, 8% with the elder sisters, 12% with elder brothers and 8% lived on their own, including looking after younger siblings. The orphans do not only have unmet basic or material needs but also have markedly increased psychosocial problems, exacerbated by their inability to access essential services such as healthcare due to poverty. Thus, their long-term psychological health, resilience, self-worth and self-esteem are in jeopardy. There is an urgent need to enhance and expand all current community and school intervention programmes not only to meet the basic needs of orphans but also to include psychosocial

support (PSS), improved counselling services and training of caregivers and teachers in critical areas of care and support for the orphans.

Lesotho is a small country completely surrounded by South Africa. The country is just over 30,000 km² in size. All the land is over 1500 m above sea level, the only country in the world with this distinction, earning it the name of 'the kingdom in the sky'. Its population is just over two million. It has a fragile environmental base and, except for water and some diamonds, it has few natural resources (Silase, Morrison & Letsoela, 2004; Vilakati, 2001).

Historically, its main export was labour. It provided South Africa with semi-skilled labour for the mines. However, the number of semi-skilled labourers joining the mines from Lesotho has declined over the past 14 years. Despite the relatively few natural resources, the fragile environmental base and the poverty affecting a majority of households, most people are reached by a variety of social services such as portable water, education infrastructure, roads and health services (Silasi, Morrison, & Letsoela, 2004; Vilakati, 2001).

According to UNAIDS (2007) and the Ministry of Health and Social Welfare (2004) Lesotho suffers from one of the highest HIV infection rates in the world. It is one of the six countries in Southern Africa suffering a humanitarian crisis driven by poverty, unemployment and HIV and AIDS. For example, there are 270,000 people living with HIV and AIDS of which 260,000 are adults and 12,000 are children. Eighteen thousand people died of AIDS in 2007, and today it is estimated that 23% of the population is infected with HIV and AIDS, although the estimated population is over two million (UNAIDS, 2007). Young women are especially susceptible to HIV infection with an estimated 58% of women in the 15–24 years age group HIV positive, compared with 42% of men (UNAIDS, 2007). Currently, the HIV and AIDS prevalence rate in Lesotho is estimated to be 29% among the adult population, making the country the third in the world most hit by the pandemic (UNICEF, 2007).

The major risk behaviours, which contribute towards rapid and rampant HIV infection in Lesotho, include low levels of knowledge, inadequate access to HIV and AIDS information and services, multiple and concurrent sexual relationships, high levels of unprotected sexual practices exposing individuals to the risk of STIs and HIV, early sexual debut, alcohol and drug abuse, coercive sex, intergenerational sex and contact with contaminated blood. Socio-cultural factors include income inequality, high levels of poverty, which create situations of risk, high unemployment rate,

mobility, gender inequalities and gender based violence, cultural and traditional beliefs together with dramatic social, attitudinal and cultural changes (Kimaryo et al., 2004; [UNAIDS, 2006](#))

According to the Joint United Nations Programme on HIV and AIDS, 36.1 million adults and children had become infected with HIV worldwide by the end of 2000, and about 70% of them were in sub-Saharan Africa.¹ It is estimated that so far, the pandemic has caused 21.8 million deaths worldwide with 75% of these in Africa.² Up to seven countries in sub-Saharan Africa have adult HIV prevalence rates of more than 20%.³ This high level of HIV/AIDS infection has resulted in huge numbers of orphaned children in the region. By the end of 1999, 13.2 million children had been orphaned worldwide and 90% of them were in Africa. Eighty per cent of all the world's children orphaned by HIV/AIDS reside in sub-Saharan Africa. Overall, about half of all orphans in the region are between 10 and 14 years old, 35% are 5–9 years old and about 15% are 0–4 years.⁴ The percentage of the region's orphans whose parents died from HIV/AIDS has grown from 3.5% in 1990 to 32% in 2001. In Lesotho, for instance, with a population of about two million about 73,000 children had been orphaned by AIDS at the end of 2003.⁵ It is estimated that the proportion of children orphaned by AIDS will continue to increase, reaching a global total of about 44 million by 2010.⁶ Recent statistics reveal escalating numbers of children being orphaned by HIV and AIDS pandemic in Lesotho.

There have been relatively few studies of children orphaned by AIDS. The most comprehensive studies have generally come from Uganda and Zimbabwe.⁷ From these studies and others, it is evident that the soaring numbers of orphans overwhelm the extended families, the care system that, under normal circumstances, would assume responsibility for the orphans. Extreme poverty and hunger are already widespread in worst affected countries such as Lesotho and the added burden of having to look after the orphaned children causes great economic hardship. Orphans often lack adequate food, shelter, clothing, schooling and access to health services.⁸

According to a number of studies conducted in some African countries, most approaches to helping orphans have justifiably focused on basic needs ([Richter, Manegold, & Pather, 2004](#); [REPSSI, 2007](#)). These studies noted that many orphans did not perform as well as could be expected in school even when their material needs were adequately met. They suggest that psychological problems may be responsible for their inability to perform well, at school. This study investigated the impact of HIV and AIDS on primary school children in Lesotho.

THE PROBLEM STATEMENT

Because of the HIV and AIDS pandemic, the number of orphans and vulnerable children (OVC) has increased globally. It is estimated that there will be about 20 million AIDS orphans in sub-Saharan Africa by 2010 (UNAIDS, 2007).

Since the first case of HIV and AIDS was reported in Lesotho in 1986, the pandemic has been escalating at an alarming rate, reaching crisis proportions. The HIV and AIDS pandemic has a devastating impact on individuals, families, communities and the society as a whole. The incidences of ill health, the number of funerals being attended every week (with most of the deceased being younger people) bear testimony to this. One of the most disturbing features of the pandemic in Lesotho is the disproportionate effect it has on children. As one or both parents become sick or die as a result of HIV and AIDS-related illnesses, children increasingly have to become caregivers to the sick parent/parents, younger siblings and/or other relatives.⁹ Today Lesotho is experiencing a phenomenon that is totally new to the nation; children head households and families. Their prospect to attaining quality education is seriously jeopardised because of frequent absenteeism from school and/or school dropout. Their long-term prospect of employment and self-reliance is threatened.

It is estimated that about 180,000 Basotho children under the age of 15 years have either lost one or both parents due to the HIV and AIDS pandemic.¹⁰ Most of these children are in primary school. These children suffer profoundly as their parents fall sick and finally die. They experience psychosocial distress from their parents' illness and/or death that is exacerbated by the stigma and shame that is associated with HIV and AIDS. The psychosocial impact of caring for ill and dying parents cannot be overestimated. It affects schoolwork and the ability to keep up in class. Withdrawal from school is also characteristic of these children even before their parents die. They are compelled to abandon school when their parents ultimately die. Malnutrition and illness are also associated with children who are left alone after the death of their parents.

Relatives of some of these children take the property that was left to them by their parents. This traumatises these children as they are left in abject poverty and food insecurity resulting in their not continuing with their education. There is evidence that the girl child endures the worst suffering since girls are forced to take up employment at a tender age even in

hazardous work such as commercial sex and domestic labour (Kimaryo et al., 2004).

This study investigated the impact of the HIV and AIDS pandemic on primary school children in Lesotho. For the purposes of this study, five primary schools in Maseru District were involved. The study also assessed the extent to which primary school teachers are equipped with skills for providing PSS to the infected and the affected children that they teach.

LIMITATIONS TO THE STUDY

The time in which the study was to be completed was short. This made it difficult to follow up on the pupils after responding to the interview in order to solicit accurate information regarding their understanding of the HIV and AIDS pandemic vis-à-vis their parents' death. The financial resources were also a serious limitation that restricted the number of trips that had to be made to each school.

RESEARCH METHODOLOGY AND DESIGN

This study used qualitative research methodology. The aim was to gain insight into qualitatively different ways in which children who are affected by HIV and AIDS perceive, understand and experience the world around them (Leedy & Ormrod, 2001). It also sought to gain insight into mechanisms that teachers adopt in coping with the apparent problems these children exhibit at school and in class. Qualitative research methodology allows these kinds of investigation, since qualitative research implies '... a direct concern with experience as it is *'lived'* or *'felt'* or *'undergone'*'.¹¹

In the study, the lives of 51 children orphaned by the HIV and AIDS pandemic¹² were explored from the perspective of the children themselves and from the perspective of their teachers. Semi-structured interviews were used as a method of data collection. Interviews were conducted in Sesotho and then translated into English for purposes of analysis.

The first stage in the research process involved the selection of participants. A form of purposive sampling was employed. It was decided to select primary school children with both parents deceased at each school. The researcher also interviewed five teachers of these children. *Ten complete or*

double orphans and five teachers were interviewed from each school. Thirty-two girls and nineteen boys from across all primary school classes were interviewed. [Table 1](#) shows the number of children who were interviewed per class. The study was conducted in five primary schools in the Maseru District: Hoohlo Primary School, Mohlaka-oa-Tuka Primary School, Roma Primary School, St Philomena Primary School and Thabana-Tšooana Primary School. The researcher requested the schools to select both the children and the teachers who participated in the study.

RESULTS OF THE STUDY

Children’s Understanding of HIV and AIDS and HIV Testing and Counselling (HTC)

Eighty per cent of the orphans who participated in this study reported that they knew what HIV and AIDS pandemic is, while 20% did not know what it was. The latter were younger respondents who were mainly in the lower infant classes, classes 1 and 2.

Participants reported that HIV and AIDS is incurable and that it is a killer disease. Looking after the person who is infected must be treated with a lot of care and caution, and one must use protective material such as rubber gloves. They had more accurate knowledge about the transmission of HIV and AIDS. They reported that one gets infected with HIV through engaging in unprotected sexual intercourse; through contact with blood and other body fluids of the infected person; sharing needles and razor blades with infected persons; and not using gloves in caring for people living with HIV and AIDS.

Table 1. Class of Respondent (Primary School Children).

Class	Frequency	Per Cent	Cumulative Per Cent
Std 1	4	7.8	7.8
Std 2	2	3.9	11.8
Std 3	3	5.9	17.6
Std 4	3	5.9	23.5
Std 5	10	19.6	43.1
Std 6	7	13.7	56.9
Std 7	22	43.1	100.0
Total	51	100.0	

Asked about HCT, it was found out that of the children who were interviewed, 61% reported that they have heard about the 'know your status' campaign and therefore knew what HCT was. Thirty-nine per cent did not know anything in this regard. Again the younger participants did not know about HCT. Out of a total of 51 participants, only 1 had undergone HCT and knew her status. Asked why she took the test she stated that it was accidental but she was happy it happened since she then knows that she is HIV negative. Six out of the fifty participants who have not tested for HIV reported that they were afraid of testing in case they got 'bad news'. All the participants agreed that it is important for one to know more about HCT and their HIV status. Table 2 shows the frequency of the reasons they put forward for the importance of knowing one's HIV status.

The participants' sources of information regarding their knowledge about HIV and AIDS and HCT ranged from their teachers at school, to public rallies by health workers and media such as radio, newspapers and magazines.

One of the questions that were asked attempted to find out the reaction of participants if they were to test and find out that they were HIV positive. Tables 3 and 4 summarise the participants' responses to this item.

Table 2. Importance of Knowing One's HIV Status.

	Frequency	Per Cent	Cumulative Per Cent
Know how to live well	12	23.5	23.5
Get help from doctors	26	51.0	74.5
Not to infect others	9	17.6	92.2
Don't know	4	7.8	100.0
Total	51	100.0	

Table 3. Respondents' HIV Testing (Have You Ever Tested for HIV?).

	Frequency	Per Cent	Cumulative Per Cent
Yes	2	3.9	3.9
No	43	84.3	88.2
I'm scared to test	6	11.8	100.0
Total	51	100.0	

Table 4. Reaction If Positive.

	Frequency	Per Cent	Cumulative Per Cent
Anger	7	13.7	13.7
Frustration	4	7.8	21.6
Will be sad but accept	21	41.2	62.7
Hurt but accept	11	21.6	84.3
Will accept but will not disclose	6	11.8	96.1
Will cry	2	3.9	100.0
Total	51	100.0	

Table 5. Cause of Death of Respondents' Parents.

Cause of Death	Father		Mother	
	Frequency	Per Cent	Frequency	Per Cent
TB	23	45	17	33
Pneumonia	2	4	9	17
Herpes sores	9	17	8	16
AIDS	1	2	1	2
Swollen feet	1	2	2	4
Chest pains	3	6	4	8
Long-term illness	4	8	1	2
Don't know	6	12	6	12
Accident	1	2	1	2
Flu	1	2	1	2
Bewitched	0	0	1	2
Total	51	100	51	100

Cause of Death of Parents

All the children who were interviewed were complete or double orphans, meaning that they each had lost both parents (Table 5). Teachers selected the children on the basis of their being complete orphans and to a limited extent on the basis of the cause of death of the parents. Table 5 summarises the children's response:

With the exception of one participant, none of the children reported that the parents might have died from AIDS and/or an AIDS-related illness. However, it is observable that the majority of parents died of AIDS-related illnesses with tuberculosis (TB), pneumonia and herpes sores topping the list. The younger participants did not know the cause of death of parents.

Table 6. Common Illness.

	Frequency	Per Cent	Cumulative Per Cent
Headache	12	23.5	23.5
Common cold	14	27.5	51.0
Rashes	8	15.7	66.7
Boils	4	7.8	74.5
Stomachache	5	9.8	84.3
Flu	5	9.8	94.1
Fatigue	1	2.0	96.1
Nausea	2	3.9	100.0
Total	51	100.0	

Table 7. When Ill.

	Frequency	Per Cent	Cumulative Per Cent
Go to the doctor	16	31.4	31.4
Never goes to doctor	1	2.0	33.3
Take traditional herbs	8	15.7	49.0
Get patent medicine	16	31.4	80.4
Do nothing until ok	7	13.7	94.1
Never get seriously ill to go doctor	3	5.9	100.0
Total	51	100.0	

Children's Common Illnesses

Table 6 shows that children reported their common illnesses as common cold, headaches and rash. However, most of them were unable to say what the possible cause for these could be.

The majority of the children reported that they were not able to go to the doctor whenever they fall sick (Table 7). This is because there is often no money to pay for the medical services to be rendered to them. Many children stated that this was the case even before they lost their parents.

Life at School: Teachers' Attitudes

Table 8 shows that participants' feelings about teachers' attitudes towards them were overwhelmingly positive. 74.5% of respondents indicated that teachers like them. This suggests a strong association between teachers and students in the sample.

Table 8. Life at School – Teachers’ Attitudes Towards Respondent.

	Frequency	Per Cent	Valid Per Cent	Cumulative Per Cent
Teachers like me	38	74.5	74.5	74.5
Teachers overly protective	5	9.8	9.8	84.3
Teacher show sympathy	8	15.7	15.7	100.0
Total	51	100.0	100.0	

Table 9. Life at School – Pupils’ Attitudes Towards Respondent.

	Frequency	Per Cent	Valid Per Cent	Cumulative Per Cent
Sympathetic	13	25.5	25.5	25.5
Discriminate against me	2	3.9	3.9	29.4
Don’t play with me	1	2.0	2.0	31.4
Don’t like me	1	2.0	2.0	33.3
Like me	27	52.9	52.9	86.3
Always want to play with me	5	9.8	9.8	96.1
Tease me	2	3.9	3.9	100.0
Total	51	100.0	100.0	

Life at School: Schoolmates Attitudes

Participants did not display any feelings of being discriminated against and stigmatised as a result of their parents having died of the HIV and AIDS pandemic. In fact since none but one of them reported that the parents died from AIDS, they could not observe signs of discrimination due to stigma (Table 9).

Accessing Post-Primary School (Secondary) Education

Children were asked to say something about whether in their opinion they thought they would be able to proceed to secondary schools upon completion of their primary education. Table 10 gives the result of their responses.

From the results displayed in Table 10, it would appear that the majority of the children interviewed aspire to further their education despite their deplorable situation. Pictorially as shown in Fig. 1, the picture is more vivid.

Table 10. Respondents’ Perception About Accessing Post-Primary School Education (Secondary School Education).

	Frequency	Per Cent	Cumulative Per Cent
Will go to secondary school	27	52.9	52.9
Will not go to sec school	3	5.9	58.8
Will seek financial assistance for secondary school education	21	41.2	100.0
Total	51	100.0	

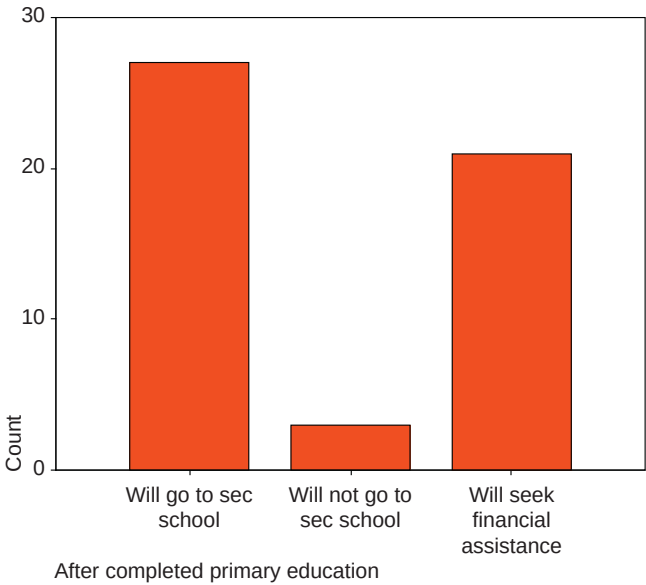


Fig. 1. Perception About Accessing Post-Primary Education.

From the results displayed in Table 11 it would appear the majority of respondents aspire to become nurses after completing tertiary education (Fig. 2). The other preferred professions in order of preference are teaching, armed forces and medicine as in being a medical doctor. Almost all the respondents chose what they chose because they felt that these are the professions that permitted people to help those that are marginalised to overcome their disabling situations. The obvious effect of experiencing debilitating illnesses of parents and other guardians could be a major

Table 11. Career Aspirations of Respondents.

	Frequency	Per Cent	Cumulative Per Cent
Lawyer	5	9.8	9.8
Soldier	8	15.7	25.5
Police	6	11.8	37.3
Nurse	13	25.5	62.7
Teacher	11	21.6	84.3
Doctor	7	13.7	98.0
Engineer	1	2.0	100.0
Total	51	100.0	

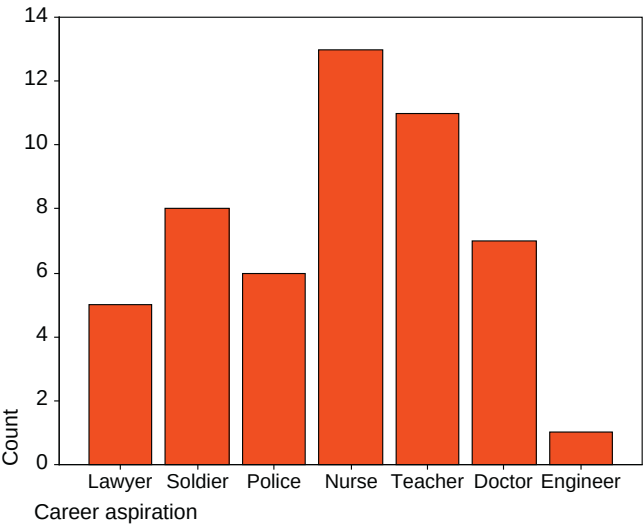


Fig. 2. Career Aspirations of Respondents.

source of the selection of the medical field for those who did. With teaching, respondents explained that teachers are very kind people and they are able to help them through their pain of loss of loved ones. One child said:

My teacher is very kind to me. When I get to school each day, she will ask me if we had anything to eat before coming to school. When I tell her nothing she will reach for something from her lunch box and offer me. What touches me most is that she will do all this strictly when there is only her and me. When I grow up I will be a teacher and extend the same help and compassion to other children with similar circumstances as mine.

Those who chose law as a career advanced reasons such as ... *to help those children whose inheritance rights are violated; their parents' houses, money, furniture, clothes and fields are taken away from them when their parents die* reported one of the interviewees.

Nutrition

Tables 12 and 13 show the children's responses for what they ate for breakfast and dinner in the week before they were interviewed.

Nutrition

In terms of nutrition the participants' responses revealed that there are children who live virtually on and/or just maize meal and cabbage or spinach (*papa and moroho*) for both breakfast and dinner. Their only balanced meal comes from school lunch which is available five days a week.

Table 12. Respondents' Breakfast (Assessed by Researcher as Reported by Respondent).^a

	Frequency	Per Cent	Cumulative Per Cent
Balanced nutritious meal	3	5.9	5.9
Unbalanced meal	23	45.1	51.0
Sometimes balanced meal	25	49.0	100.0
Total	51	100.0	

^a“Papa & vegetables” or “papa & nothing” means ‘unbalanced meal’; ‘sometimes balanced meal’ means including protein occasionally; ‘balanced nutritious meal’ means a meal with protein, vitamin and other nutrients.

Table 13. Respondents' Dinner (Assessed by Researcher as Reported by Respondent).

	Frequency	Per Cent	Cumulative Per Cent
Balanced nutritious meal	3	5.9	5.9
Unbalanced meal	19	37.3	43.1
Sometimes balanced meal	29	56.9	100.0
Total	51	100.0	

Primary School Teachers' Experiences with OVC in Their Care

Only 15 primary school teachers were interviewed on a number of issues regarding the teaching of OVC in their specific classes. They were all female teachers. These teachers reported that they were overwhelmed by the increasing number of children who have lost their parents to the HIV and AIDS pandemic and/or HIV/AIDS-related illnesses. In fact, in one or two cases, there were one or two parents in a mortuary awaiting burial. Teachers further reported that it is still difficult for the communities and families to report that death has occurred due to the HIV and AIDS pandemic. Children are never told the truth about their parents' illness and cause of death because of the stigma associated with the pandemic. Teachers then draw conclusions from what they observe when a parent is sick. Where they have not been able to visit the home they rely on information that they are given by the caregivers.

Common Problems of the Children Orphaned by the HIV and AIDS Pandemic as Reported by Teachers

Teachers reported that the most common problems that children who have lost parents experience are as follows:

- School absenteeism and/or dropping out of school because of increased poverty and lack of money to cover additional school requirements such as uniforms and extra books that are not covered under free primary education (FPE) which has been introduced by the government of Lesotho (GoL).
- Malnutrition since in most cases these children have the school lunch as their only meal of the day. They have no income to assist them cultivate nutritious vegetables for consumption and to purchase food.
- Psychological problems as a result of parental loss, compounded, more often than not by the second loss of the guardian/caregiver (grandmother, grandfather, elder brother or sister, aunt or uncle), thereby relocating to go and live with a new person.
- Homelessness and exposure to the worst forms of child labour (WFCL), including domestic work, herding and commercial sex work are the obvious risks that face these children according to teachers. Teachers reported that despite FPE, many children drop out of school after their parents' death due to poverty.

- Inability to access healthcare services and medicines. These children are not able to go to the doctor, the clinic or the hospital. There is nobody to pay the necessary fees.
- More generally these children lack basic necessities such as food, clothing and shelter.
- In this study, teachers reported that social stigmatisation of HIV and AIDS; discrimination and peer rejection did not seem to be a problem. And this was confirmed by the children in their responses to questions about the treatment at home and in school.

Provision of PSS to the OVC

PSS is an ongoing process of meeting the physical, emotional, social, mental and spiritual needs of children affected by HIV and AIDS, poverty and conflict.¹³ Teachers who were interviewed in this study reported that their schools provided some kind of counselling to the children whose cases were extremely serious. None of the five teachers had had training on the job or otherwise in HIV counselling and in PSS. They reported that they would like to have some kind of training in these critical areas because their work is made difficult by the fact that there are certain aspects of developing the child that increasingly prove difficult. To deal with the child who does not even understand or accept that the parent's death was due to HIV and AIDS is distressing. The situation is made worse by the fact that almost every week they (teachers) have to deal with at least one death of a parent — let alone their own family members' deaths. In fact teachers too are affected by the HIV and AIDS pandemic at both personal and professional levels.

Special Needs of Orphans as Reported by Primary School Teachers

Teachers identified the most pressing needs of orphans in their classes as follows:

- Psychologically, children need to be prepared to come to terms with their circumstances. They need to have control over their lives in which case they need to look forward to building a bright future like everyone else.
- Orphans require continued access to basic healthcare and good nutrition. They need to be protected from abuse and exploitation.

- The educational needs of these orphans need to be addressed in a special way. Orphans need to continue going to school not only to learn but also to maintain a daily routine and a stable social environment. Other school paraphernalia such as uniform, school shoes and socks, additional pens, pencils, exercise books etc. need to be provided for.
- The need for food, clothing, healthcare and education also implies that orphans have substantial financial needs.

CONCLUSION AND RECOMMENDATIONS

The findings from data gathered in this study provided information on 51 children with both parents lost to HIV and AIDS and/or AIDS-related illnesses from their own perspective and from the perspective of their teachers. The results highlight the various aspects of the impact of the HIV and AIDS pandemic on the lives of some affected and infected orphaned primary school pupils.

Almost all the orphans interviewed have had to deal with their grief on their own or with minimal support from others. Teachers on the other hand are not equipped to provide the direly needed PSS to these children. The psychosocial needs of children cannot be overlooked as the HIV and AIDS pandemic takes its toll among all the communities in Lesotho, leaving soaring numbers of orphans in deplorable circumstances. The problem of orphans in this country is grave. Despite FPE, these children are still denied their right to education in that additional materials needed for school are not accessible to them. Access to property of the late parents is often denied, and this perpetuates poverty leading to exposure to street life, substance abuse, sexual abuse and exploitation and the worst forms of child labour.

The findings of this study have important implications for HIV and AIDS programming with particular emphasis on provision of care and support to OVC. The Ministry of Education and Training, the Department of Social Welfare, Development Partners and civil society organisations working on OVC issues such as Lesotho Save the Children (LSC) need to form a strong visible partnership to address the service needs of children affected by the pandemic and of their families. Some of these needs are community-based support networks to give these children and their families, social and psychological support. Educational provision for these children, particularly FPE, needs revisiting by the Ministry of Education

and Training. Support for these children within the health and welfare systems including information about available services is crucial.

This study is significant in that it provides information critical to the conceptualisation of the framework priorities for primary school children orphaned and made vulnerable by the HIV and AIDS pandemic. Professionals, politicians and policy makers often assume that their interventions such as FPE are appropriate and adequate to meet the basic needs of children affected by the pandemic. They believe they know what the priorities of these children and of their families are. It is critical that the interventions take as starting point information on how these children and their families are experiencing their lives in their particular contexts.

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APPENDIX A: INTERVIEW SCHEDULE 1: PRIMARY SCHOOL PUPILS

1. Name of the School:										
2. Name of the child:										
3. Gender								F	M	
4. How many sisters and brothers do you have?								S	B	
5. How old are they? (List the ages in a descending order starting with the oldest and ending with the youngest in space provided below)										
6. Date of Birth/Age (Respondent)								D	M	Y
7. Class			1	2	3	4	5	6	7	
8. Where are your parents?	Both alive	Both ill	Mother ill	Father ill	Mother deceased	Father deceased	Both deceased			
9. If parent is ill, what is he/she suffering from?										
10. If both parents are ill, state what each is suffering from?								Mother:		
								Father:		
11. Who looks after your sick parent/parents?										
12. What do you think was the cause of death of:										
▪ Your mother?										
▪ Your Father?										
13. Who do you live with?										
14. If not your parent, how did you come to live with this individual?										
15. Do you know anything about HIV/AIDS?								Yes	No	

16. Please tell us more about how you came to know about HIV/AIDS and what it is that you know about it.		
17. How do you think people get infected with HIV/AIDS? (<i>Probe</i>)		
18. Do you remember days when your parents were still alive?	Yes	No
19. Can you describe how life for you and your siblings was like when they were still alive? (<i>Please find out as much as possible through probing</i>).		
20. What has changed now – at home and at school? (<i>Probe please</i>)		
21. Since your parents' death, how do you think other children perceive you – at home and in school? (<i>Probe</i>)		
22. Please tell us about the most disturbing encounter that you experienced in the village with the other children and the adults. Briefly describe to us your feelings and your reaction then. (<i>A sensitive but important issue, please be careful while probing</i>)		
23. Please tell us about the most disturbing encounter that you experienced at school with other children and teachers. Briefly describe your feelings and your reaction then. (<i>Again exercise a lot of care</i>)		

24. Please tell us what you do when you are not feeling well.			
25. What are the most common ailments that you experience?			
26. If you have to visit the doctor who pays for your consultation fee and prescribed medication?			
27. Please try to remember what you ate for the last seven days for breakfast, lunch and dinner?			
	Breakfast	Lunch	Dinner
Day 1			
Day 2			
Day 3			
Day 4			
Day 5			
Day 6			
Day 7			
28. Do you know anything about HIV counselling and testing/voluntary counselling and testing (HCT)/VCT?			Yes
			No
29. If "Yes", how and where did you come to know about it? Briefly explain.			
30. Have you undergone the HIV counselling and testing (HCT/VCT) yourself?			Yes
			No
31. If "Yes", please tell us why you found it necessary to undergo this?			

32. If "No" would you like information on HCT/VCT and its importance?		Yes	No	
33. Do you think it is important to know your HIV status? Please explain your answer.				
34. In your opinion, why is it important for everyone to know his or her HIV/AIDS status?				
35. Suppose you went for HCT/VCT and you were told you are HIV positive, what will be your reaction? Briefly describe your answer?				
36. What do you think will happen to you after you successfully complete Class 7/PSLE?				
Will go to secondary education	Will not be able to go to secondary education	Will seek financial assistance for my secondary education from sources like DSW, NMDS, Red Cross, MOET Bursary Scheme, etc and proceed to secondary education	Will seek any type of employment to assist my siblings	Will wait for a good Samaritan to come and offer help that will make it possible for me to proceed with my secondary education
37. What do you want to be when you are grown up? Explain why.				

APPENDIX B: TEACHERS' INTERVIEW SCHEDULE: INTERVIEW SCHEDULE 1: PRIMARY SCHOOL TEACHERS

1. Name of the School:						
2. Gender:					F	M
3. Age next birthday (No of years):						
4. Teaching experience (No of years):						
5. No of years at current school:						
6. State your position at current school:						
7. Class/Classes you teach:						
8. Tell us if there are orphans in your class, and say how many they are by gender and status.	Double orphan		Maternal orphan		Paternal orphan	
	F	M	F	M	F	M
9. Do you share a classroom with any other teacher? Please explain.					Yes	No
10. Does your school provide children whose parents are deceased with some form of counselling?			No idea	Yes	No	
11. Are you able to offer any form of counselling in your own class to those children that are affected by death of parents, particularly those whose death is HIV/AIDS related? (<i>Probe</i>).				Yes	No	
12. Explain your answer, briefly.						

13. Have you ever had any training in psychosocial support?	Yes	No
14. Do you know what psychosocial support is all about?	Yes	No
15. What are the problems facing orphans at your school?		
16. As a teacher/principal, what do you think schools should do to address the psychosocial needs of children affected by HIV/AIDS and poverty? Please explain your answer.		
17. In your observation, how do other children in your class perceive children who are orphaned by HIV/AIDS? Please explain.		
18. In your opinion, what is the most pressing need – social, psychological, emotional or otherwise – for the children in your class that are affected by HIV/AIDS? Please explain your answer.		

19. What in your opinion should be done to improve and enhance the emotional health of the orphans in your school?

20. How would you rate the academic performance of the children affected by HIV and AIDS in your class compared to the other children. Please give details.

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ACTING STUBBORN: UNDERSTANDING “VULNERABILITY” AND SECONDARY SCHOOL PARTICIPATION IN LESOTHO

Anne Smiley

ABSTRACT

In recent years, access to schooling for children orphaned and made vulnerable by AIDS has emerged as a major humanitarian concern, particularly in sub-Saharan Africa. International discourse largely fails to define what “vulnerability” means, while also depicting “orphans and vulnerable children” as passive victims of complex social processes. This ethnographic study of a “typical” secondary school in semirural Lesotho investigates the research question: At the secondary level, how does “vulnerability” shape the educational participation and home life of young Basotho? Through extended observation, in-depth interviews, and student diaries, the study reveals that “vulnerable” children in Lesotho, who are locally defined as those without strong adult caregivers, actually exercise

a high degree of autonomy that is often manifested through “stubbornness.” “Stubborn” students resist adult control and are closely associated with early sexual debut and high-risk behaviors. As a result of their resistance, they are often singled out by teachers for corporal punishment, increasing the likelihood that they will drop out of school. This chapter adds to the literature on youth agency by demonstrating that “acting stubborn” is one way in which “vulnerable” children can exercise control over their own lives and resist the status quo. In addition, the findings point to the failure of the school model, which is highly authoritarian, to retain “vulnerable” students and teach them valuable life skills, including HIV/AIDS prevention. Finally, this study demonstrates that local and culturally inflected definitions of “vulnerability” may not always align with international definitions and policy prescriptions.

INTRODUCTION

Lesotho, a small “mountain kingdom” situated inside the borders of South Africa, has one of the highest rates of HIV/AIDS prevalence in the world, with an estimated 23.5 adult infection rate and over a third of all school-aged children having lost one or both parents due to death (UNAIDS, 2008; IRIN, 2007; Smiley, Omoeva, Sylla, & Chaluda, 2012). However, it has become evident that a singular focus on orphans does not adequately account for the multiple forms of vulnerability faced by young people as a result of the HIV/AIDS epidemic, and the more inclusive term “orphans and vulnerable children,” or OVC, is now commonly used in the development literature (UNICEF, 2006). Meanwhile, recent studies demonstrate that, while orphans are less likely to go to school than non-orphans, the differences all but disappear after controlling for socioeconomic status – a finding that supports the expanded definition of vulnerability (Campbell, Handa, & Moroni, 2010).

In Lesotho, education is free at the primary level, and a government-run scholarship program provides access to secondary school for “orphans and vulnerable children.” So what does “vulnerability” actually mean for schoolchildren? Are children orphaned or otherwise affected by the disease experiencing school in the same way as children whose lives are less directly impacted? How do communities understand and interpret orphanhood, vulnerability, and childhood, and how does this shape educational participation? And how does educational participation shape the

life chances and HIV exposure of "vulnerable" students? In this chapter, I use an ethnographic lens to investigate these questions in the context of Lesotho.

This study is conceptually grounded in critical policy studies. Over the past several decades, critical scholars of educational policy have consistently pointed to the role of global discourse, dominated by rich countries, in shaping the national educational policies of developing countries in ways that are often inappropriate to the local context, creating a gap between policy development and implementation and doing little to incorporate indigenous ideas (Abdi & Cleghorn, 2005). The policy "truths" that inform the development and humanitarian literature are rarely critically examined with an eye for power dynamics and indigenous dispossession. My ultimate goal is to put the "local" in conversation with the "global," analyzing the lived experiences of so-called "OVC" and attempting to understand how "local" and "global" concepts are simultaneously interwoven and disconnected.

I begin the chapter by presenting the ethnographic research methodology. I then go on to briefly discuss the country context and review the literature on "orphans and vulnerable children," the "OVC" crisis in Lesotho, the Southern African educational environment, and youth agency in Africa. I then present the major research findings, followed by a discussion and overall conclusions.

METHODS

This ethnographic study took place over a nine-month period, from August 2009 through April 2010, in a rural village in Lesotho. Ethnographic methods allow a researcher to gain an emic (insider's) perspective into the phenomenon under study, with the understanding that the researcher's own identity and inherent biases will never allow true objectivity (O'Reilly, 2005). Through participant observation, in-depth interviews, home visits, and student diary writing, the study aimed to answer the following research question: *At the secondary level, how does vulnerability shape the educational participation and home life of young Basotho?*

To answer this question, I purposefully selected one "typical" secondary school in rural Lesotho to serve as a case study. Merriam (1998) defines a case as a bounded system, characterizing the case study as *particularistic*, focusing on a particular situation, event, program, or phenomenon;

descriptive, providing rich, “thick” description; and *heuristic*, illuminating the reader’s understanding of the phenomenon under study. In collaboration with Basotho colleagues, a “typical” school was defined as church-owned, of medium size, in a semirural area, with average student performance. St. Ignatius High School¹ was a Catholic institution located in a small village that lacked electricity relatively near a paved road. During data collection, I lived in the home of a Basotho family and also volunteered as a substitute teacher and administrative assistant at the school site.

At the school, I took the role of observer-as-participant: the researcher’s observational activities are known to the group so that the level of information revealed is controlled by the members of the group being investigated, and the researcher’s participation in the group is secondary to the role of information gatherer (Merriam, 1998). My observations on a variety of themes and activities were carefully recorded in hundreds of pages of field notes. As I began to build relationships with adults in the school community, several teachers and administrators emerged as key informants on the topic of “vulnerability.” Informal interviews were held with approximately 20 teachers and administrators, while two teachers and the deputy principal were formally interviewed multiple times at length.

A group of Form B (9th grade) students was at the heart of the study. I purposefully selected a cross section of 18 children to participate in the group, representing double orphans, single orphans, nonorphans facing other significant challenges such as extreme poverty or ill parents, and children who had no outward signs of such challenges. The students represented a variety of household structures, including families headed by mothers, fathers, grandparents, aunts/uncles, and those living alone or with younger siblings. Twice a week they were asked to write diary entries on themes related to their lives. All in all, I collected 113 diary entries on 10 topics from 18 students. Additionally, most of the students took me to visit their homes and families. As I got to know the students, I engaged 14 of them in in-depth interviews. At first, the interviews were semistructured in order to ensure a level of comparability and seek answers to the specific research questions. Over time, they became more open-ended.

This study dealt with a population that was, by definition, “vulnerable.” However, the children whom I worked with were functional members of society in a context where orphanhood and “vulnerability” have been largely normalized by the sheer scale of the AIDS crisis. In Lesotho, there does not appear to be much stigma associated specifically with orphanhood, though mention of HIV and AIDS is practically taboo. While nearly all Basotho are familiar with HIV and AIDS, almost no one is willing to

admit a personal association with it. The research subjects were never asked to discuss anything that would be dangerous, harmful, or traumatizing to them, and I never directly asked about sex, HIV/AIDS, or parental death, though students often raised these topics on their own. All participants gave informed consent to participate in the study.

In qualitative research, trustworthiness is established through frameworks that ensure methodological rigor and establish credibility (Guba, 1981; Shenton, 2004). Throughout the study, I kept a reflexivity journal, constantly focusing on my role in the community, my biases and preconceived notions, and the potential effects of my presence on the collection of data. Close collaboration with participants, which is similar to “member checking” (Stake, 1995), allowed me to verify and investigate emerging trends in the data: as issues came to the surface, I discussed them with members of the community. Rich description and extended time in the field allowed me to gain in-depth understanding of the lives of “vulnerable” children. Finally, I ensured credibility through regular peer debriefing, including discussions with my faculty advisors, lecturers at the National University of Lesotho, and regular study meetings with a group of Basotho doctoral students.

During fieldwork, I engaged in as much data management and preliminary interpretation as possible, which led me to the overarching theory that eventually emerged. My goal was to discover and learn, and ultimately generate insight into the research questions, based on the hypothesis that there is a difference between policy and practice relating to the lived experiences of “orphans and vulnerable children.” Using the computer program Atlas.ti, I thematically coded the data and developed a theory based on relationships between local conceptions of childhood, “vulnerability,” and the emergent theme of “stubbornness” that is discussed in depth in the findings section.

COUNTRY CONTEXT

Lesotho has a population of just under two million, is highly rural, and is fairly homogeneous, with 99.7% of the population made up of ethnic Basotho (U.S. Department of State, 2008). Its history is inextricably intertwined with its powerful neighbor, South Africa, with an economy that, for decades, has been almost entirely dependent on male labor migration to the South African mines. The correlation between labor migration and HIV infection is well demonstrated (Jochelson, Mothibeli, & Leger, 1991),

and Lesotho's soaring rate of HIV is generally traced to that phenomenon (IOM, 2007). In high prevalence countries such as Lesotho, the group most heavily affected by HIV and AIDS tends to be adults from 30–50 years old – the core of the economically active and child-raising population. The resulting “youth bulge” is often associated with unemployment, political instability, and a high level of violence (Ignatowski, 2007). In 2009, Demographic and Health Survey data revealed that 34% of Lesotho's primary-aged children had lost one or both parents due to death (Smiley et al., 2012).

LITERATURE REVIEW

At the turn of the 21st century, development reports reflected a growing consensus that a singular focus on providing assistance to AIDS-orphaned children was an inadequate and stigma-laden response to the complex social, economic, and political changes that were profoundly affecting AIDS-afflicted states all over the world, particularly in southern and eastern Africa (USAID, 2000). Children who were living with HIV, at home caring for sick family members, living on the street, in abusive homes, living with disabilities, or living in extreme poverty, were consistently being left behind by policies that were specifically designed to assist “AIDS orphans.” Development agencies and organizations began to use a new term that was meant to be more inclusive: “orphans and vulnerable children,” or related variants such as “children rendered vulnerable by HIV and AIDS.” Though “orphan” was relatively straightforward, the term “vulnerable” has been consistently difficult to define, with most new documents and publications providing new interpretations and categorizations of the term. Definitions were further complicated by the fact that some donor funding, such as the Global Fund to fight AIDS, Tuberculosis, and Malaria, was tied to the HIV and AIDS aspect of vulnerability, while other funding was more flexible.

In December 2005, Lesotho's Ministry of Health and Social Welfare (MOHSW) published a *National OVC Strategic Plan for 2005–2010*, detailing the national commitment to “have a society within which all orphans and other vulnerable children are free from discrimination, live in dignity and to their full potential, and have their rights and aspirations fulfilled” (p. 10). The *Plan* defines an orphan as “any person who is below the age of 18, who lost one or both parents due to death.” Vulnerable children

are then defined as “any child below 18 years, who has one or both parents neglecting or deserting him to the extent that he has no means of survival and is exposed to dangers of abuse, exploitation, and criminalization and is therefore in need of protection.” This definition of vulnerability, which emphasizes the absence of parents above other factors, proves to be salient to this study. As I will describe in the next section, the local definition of vulnerability in Lesotho also emphasized the quality of adult care.

In 2010, Lesotho had a strong educational infrastructure, with a high literacy rate for the region, estimated at 90% among adults (UNICEF, 2012). The education system, which is largely church-owned but government supported, is based on the authoritarian British colonial model. Authoritarian educational structures, pedagogies, and conceptions of knowledge are a global phenomenon; in much of Africa, colonial policies led to the development of educational systems informed by missionary zeal and European political ideas. Harber (1997) describes how the spread of mass schooling emanated from Europe in the 19th century and reflected the bureaucratic nature of commercial and industrial organization that was dominant at the time, inculcating values of obedience, loyalty, punctuality, and respect for rules. Children were viewed through a deficit lens, innately depraved and in need of moral guidance, leading to a condescending style of education in which learners are controlled and directed by teachers (Tabulawa, 1997). In Africa, many countries have made significant educational reforms, including policies to prohibit corporal punishment and promote learner-centered pedagogy, but in many countries there is little capacity for enforcement or training. Many African educational systems, including Lesotho, continue to reflect the authoritarian aspects of the original colonial model.

Harber (1997) examined child-rearing practices in Botswana, where the Batswana people have a very similar cultural background to the Basotho, including a mutually intelligible language. He found that, among the Batswana, the domination of adults and the subordination of children is an important cultural pattern rooted in conceptions of age. Aging is a movement toward death, and therefore toward the ancestors, meaning that proximity to the ancestors is synonymous with accumulated experience. Children must therefore always learn from those who are older, and because children have little accumulated experience, those who are older can rarely learn from young people. The education system of Botswana embraces this cultural pattern, entrusting teachers with total authority over children. In Lesotho, the situation is similar: teachers are expected to have complete control over learners, and students who misbehave in any way are physically punished (Setlolela, 2009; Ngakane, 2010).

Whatever the education system looks like, children are not passive, and a great deal of research has been done on the agency of children and youth in Africa (Abbink, 2005; Bajaj, 2008a; 2008b; Comaroff & Comaroff, 1999; de Boeck & Honwana, 2005; Diouf, 2003). This realm of research stems from the so-called “problem” of youth and the contrasting conceptualizations of African children and youth as “makers” – innovators, the leaders of the future, innocent victims of social upheaval – and “breakers” – perpetrators of violence, harbingers of social collapse, blind consumers of globalized cultures (de Boeck & Honwana, 2005).

In the context of “OVC” in southern Africa, Henderson (2005) describes the experience of a group of orphaned and vulnerable youth in KwaZulu-Natal performing in a play, in which they talk freely about AIDS and act out roles as orphans, while in their everyday lives they find it too painful to refer to the deaths of the parents and other family members. She argues that orphaned and vulnerable children and youth in KwaZulu-Natal actively draw on kinship networks to create new bonds and reconfigure a sense of place for themselves in a society ravaged by AIDS. Similarly, Ansell and van Blerk (2004) focus on the migration of children in Lesotho and Malawi, examining the “coping strategies” employed by families in the context of the AIDS pandemic. Children, they argue, actively participate in household decisions and income-generation activities, regularly shifting from one household to another as circumstances change.

If there is additional work to be undertaken or additional money that must be earned, children may take on roles normally reserved for adults. Children are thus able to contribute to the coping strategies of a household or family in response to HIV/AIDS, migrating in order for their needs to be met or to make use of their abilities. Clearly, children’s needs and capacities are not undifferentiated, but relate to (socially constructed) age and gender. Hence, it might be expected that children undertake different forms of migration in response to HIV/AIDS, depending on their age and sex, and may undertake a series of distinct migrations as they grow older (p. 675).

Thus, OVC are shown to be active participants in determining their own futures, rather than apolitical victims of larger social processes.

FINDINGS

The goal of this research was to investigate the gap between policy and practice, using ethnographic methods to answer the research question: At the secondary level, how does “vulnerability” shape the educational

participation and home life of young Basotho? In this section, I describe the research findings in terms of local meanings of childhood, vulnerability, risky behaviors, and an emerging theory of stubbornness as a form of youth agency.

Defining Childhood

Both adult and child research participants willingly shared their understanding of what it means to be a child in Lesotho, and there was wide consensus on the basics. Although the sex, age, and birth order of the individual are all determinants of expected behavior, there appears to be a common definition of a "good child" in Lesotho – one who treats all others with respect; who obeys his or her elders without asking questions; and who does not protest any punishment, whether or not it is "fair." Being respectful, especially of adults, is the most critical attribute of a "good child." Mrs. Maneo, the deputy principal of St. Ignatius, explained:

A good child is one who can talk to adults in a respectful manner. Who can do whatever an adult is asking him to do. Who respects everybody no matter whether it is a parent or somebody else, as long as he's an adult or is older than him or her. Respect. Such a child is considered to be well behaved. A bad child ... can shout to his adults, and deny to do some of the things when they are asked to do that. Whether the child is angry or not, always when talking to an adult, he has to be calm, and the voice has to be soft ... no shouting, *eh*. Once the child can do that, that is considered subversive behavior, and we punish ... we Basotho people, yes Basotho adults, we do punish, we beat. Once a child can behave like that, you have to do something. (Interview with Mrs. Maneo, Deputy Principal, St. Ignatius)

Following the orders or advice of elders without question or argument, in a calm tone, is vital to the concept of proper respect, and failure to do so warrants physical punishment. Importantly, the identity of the adult is not important – anyone who is older than the child is considered superior to him or her in terms of accumulated experience.

According to this cultural framework, children need to be "guided" and "shaped" in order to become responsible adults. In a diary entry, 15-year-old Lineo expressed this sentiment using a Sesotho proverb, translated into English: "My mother used to sometimes be angry with me, and now I can see that a stick is best straightened when wet" (Diary entry). When I asked her what she meant, Lineo explained that children need to be set on the right path in order to grow into responsible adults, which requires regular discipline and punishment. As a wet stick (a young person), she was still

capable of being straightened, or molded, into a good adult by her elders. Failure to provide this straightening, which requires strict discipline, would likely lead the child to grow into a bad adult and would be an indication of the failure of the parents, family members, and other adults who were responsible for that child.

Defining Vulnerability

In Lesotho, the term “vulnerability” was almost never used by participants, except by adults as part of the policy phrase “orphans and vulnerable children.” When asked to describe a “vulnerable” child, most participants – of all ages – used the term “needy” in conjunction with the absence of a responsible and loving caregiver. The term “needy” is even used in local policies: the government-funded OVC scholarship, for example, uses “needy” rather than “vulnerable” to refer to eligible children, including orphans, abandoned children, and children with ill parents.

Among study participants, “needy” implied poverty, and was usually described in terms of the child’s physical characteristics – the child is in “need” of certain obvious things, such as food, clothes, soap, and body lotion. Mrs. Mathato explained what a needy child looks like:

Yes, you can see just by looking at them, that this one must be an orphan. Hunger, and sometimes just that he is not active in class daily, he is sleeping or weak. These are some of the signs Sometimes she will see that this one . . . has no Vaseline or any lotion, body lotion, so that’s how we see that this one must be needy, or an orphan. (Interview with Mrs. Mathato, Geography Teacher, St. Ignatius)

Visibly needy students are often assumed to be orphans because of an assumption that a very poor child must be without proper adult supervision and care. Thus, the critical factors in determining neediness appear to be physical: tattered clothing, hunger (or weakness emanating from hunger), low standard of cleanliness, and lack of grooming, all of which are associated with lack of adult care. These characteristics are relatively easy to observe.

Despite the connection between neediness and a poor appearance, the term is not directly equated with poverty. Instead, according to most participants, neediness indicates lack of proper care from a responsible adult. Poor children are not necessarily needy, as long as they are being properly cared for, but children without a strong caregiver are almost always needy. Mrs. Mathato went on to explain how orphans (meaning

children without responsible adult caregivers) are different from other children, pointing to the important role of strong adult caregivers in children’s lives:

The non-orphans are in a better situation because for any problem they meet on the way, they know they can consult the parent. These [orphans], they just stay and don’t know what to do sometimes. She might or she might not be able to communicate with the guardians or the grandparents. Non-orphans are better in the way that they communicate with the parents. They know they are loved by the parents, they know they can consult their parents whenever they have problems. The [orphans] feel alone, and that is not good, especially for young children.

Importantly, it is usually assumed that a visibly needy child does not have a proper caregiver, or is an orphan, because a responsible adult should ensure that basic needs are met, even in a context of poverty. Thus, the term “vulnerable” was generally assumed to mean a child without a strong adult caregiver (therefore, “needy”). This finding is supported by Nyabanyaba (2009) who notes that lack of adult care is the driving factor behind child vulnerability in Lesotho: “Many of these children do not have anyone to look after them and guide them. Also related to poverty and orphanhood was the growing incidence of leaving children on their own, with no supervision” (p. 49). It is easy to see why visibly needy children are often assumed to be orphans, although it is actually lack of adult care, not orphanhood per se, that is the driving factor in the local definition of vulnerability.

Vulnerability and Exploitation

According to research participants, children without strong adult caregivers face a variety of challenges in Lesotho. Property grabbing and forced labor are common, and “vulnerable” children may be considered easy targets for physical and sexual abuse because they lack adult protection, leading many, especially girls, to become victims of rape, unwanted pregnancy, HIV infection, and related trauma. Such abuses often occur within the family context and are rarely reported. Additionally, students were quick to point to the involvement of “vulnerable” children in crime, cross-generational relationships, and prostitution. While students had a negative view of these activities, they clearly pointed to poverty, and lack of education, as the underlying cause. As 13-year-old Selloane explained in a diary entry, “Poor people wish to have what rich people have, so they rob into rich people’s homes.”

In a diary entry explaining what her life would be like if she had never been to school, 14-year-old Karabo wrote:

I would be committing crimes by entering at other people's houses while they are away in order to steal the money or their clothes. I would be abusing alcohol to take away stress or depression. I would be going up and down the streets. I would be committing adultery by having sexual intercourse with every guy or fathers for me to get money to live, or buy something I want to buy.

Among students, cross-generational relationships and prostitution were regularly identified as a means of income generation for poor girls, and were associated with the lack of strong adult caregivers. As 15-year-old Meletsatsi explained, "Young people do the prostitution because they do not have parents, so they do the thing that brings the change to their situation. Prostitutes become prostitutes because children have freedom from their parents."

Vulnerability and "Acting Stubborn"

In Lesotho, young people who resist conformation to the expected behavior of children are often labeled as *manganga*, or "stubborn." The term is used for all young people that question authority, refuse to receive punishments, and/or engage in "rebellious" behaviors such as drug use or premarital sex. According to Mrs. Manaledi, an education researcher at the National University of Lesotho, the Sesotho term *manganga*, like the English word stubborn, literally refers to a person who will not easily change his or her mind after making a decision. However, it also has a very specific cultural meaning among the Basotho people: the fact that a person will not easily change his mind also means he will not take advice, even from adults, and in that context, it means that the person has no respect for an adult's opinion. A typical example: a young person has been advised to do something in a certain way, but decides not to follow the advice, and then confronts a problem. At that point, the person who offered advice will immediately say "O manganga — o hannekemoeletsa, bona ntho e mohlalhelangoale," meaning "He is stubborn — I advised him, look at what has happened now."

Stubbornness is thus equated with a young person being out of the control of his or her elders. Stubborn children do not want to be told what to do and do not want to conform to expected standards of obedience. Fifteen-year-old Maletsatsi explained:

Here in Lesotho, young people don't have the parents, and they are getting more problems than other people by drinking the beers and all those, they are stubborn. It's because they are out of control. No one can make them get in control.

Stubbornness is thus resistance against adult control, or more generally, engagement in independent behavior. This includes children who ask too many questions or make their opinions known too often, or who otherwise fail to meet adult expectations of respect and obedience. On one occasion, I was visiting 17-year-old Moeketsi at home when his mother referred to him as "stubborn." I was surprised, and when I asked her what she meant, she replied, "He talks too much," indicating that he was unwilling to follow the expected norm of silent obedience.

Stubborn behavior is generally associated with two social groups: boys and "vulnerable" children who do not have someone to answer to at home. According to participants, boys are stubborn because they do not like being told what to do by anyone and they are not afraid of being punished, while girls are more often socialized into obedient roles. Boys are, to some extent, expected to be stubborn. While a gendered analysis of "stubbornness" was beyond the scope of this study, it does appear to be an important pattern revealed by the data. Unlike boys, "vulnerable" children are often stubborn because, lacking strong adult caregivers, they become used to acting of their own free will and no longer want to obey the authority of adults.

Most participants, adults and students alike, linked the stubborn behavior of "vulnerable" children to "deep thinking." Orphans are at particular risk for this because they used to have parents and now must face life without them, leading them to dwell on what life would be like if their parents were still alive. Sixteen-year-old Karabo described the phenomenon of thinking deeply. "It's because ... sometimes [orphans] are staying with people who ... who are not wanting to listen to them. So ... that kind of person would be ... always ... thinking about his parents, yes madam. If they were here, I would be doing this and this and this. And that thinking ends up destroying him." "Vulnerable" children compare themselves to other children at school as well as their own lives before parental loss, and often become frustrated by the perceived injustice of their situation, which may lead them into "stubborn" behavior.

Manganga, Sex, and HIV

Among "vulnerable" children, stubborn behavior is associated with early sexual debut and, therefore, increased risk of HIV transmission. In the absence of a strong adult caregiver, and with the need to survive, children are raped, exploited by teachers or other authority figures, and forced to sell their bodies to support themselves and their families, all of which were

cited by student research participants. The sexual exploitation of poor and “vulnerable” children has been extensively cited in the literature in the African context (Human Rights Watch, 2002; Bajaj, 2009). Seventeen-year-old Lindiwe saw rape as a particular concern for orphans and other children without strong adult caregivers.

Some ... get raped. Yes madam. The girls, and even the boys! The next-door neighbors may rape them ... Even the boys who know that ... no one takes care of those children. No one will take responsibility for that ... problem. No, no one will take that situation seriously. Even their relatives may affect them, actually that is most of the time!

Of course, there are obvious risks associated with this kind of exploitation: in addition to emotional trauma, children may contract HIV, become pregnant, or suffer from other health challenges.

Though both adult and student research participants seemed to understand that HIV is sexually transmitted, there was strong denial about its prevalence, and a great deal of stigma and fear around issues of sexuality. The research findings demonstrated that children are not being taught about HIV/AIDS, or sexuality, in any meaningful way at school. At St. Ignatius, I observed a biology lesson about sexually transmitted diseases, consisting of a chart that included some very basic information about HIV. In the column for prevention was simply the word “abstain,” and the teacher did not offer further explanation.

As a general rule, teachers appeared to be unable, or unwilling, to speak to children about issues related to either sex or HIV/AIDS. According to Mrs. Maneo, the Deputy Principal of St. Ignatius:

Somehow ... when it comes to the use of the condoms ... it's ... highly questionable, really. We cannot talk of sex issues very openly to our children. Just because of our culture ... according to our culture, sex-related issues you are not supposed to discuss with children. And sometimes, if you discuss them with children, they don't give you that respect. 'How can she say this?' (Interview with Mrs. Maneo, Deputy Principal, St. Ignatius)

In my own experience, students and teachers almost always maintained silence about HIV except in private conversation, and then only as an abstract concept.

Premarital sex is culturally taboo among children, and engaging in it is another way that “vulnerable” exercise *manganga*. In Lesotho, there are contradictory conceptions about sex and pregnancy for unmarried girls. On the one hand, sex before marriage is culturally prohibited, but on the other hand “everyone is doing it,” and pregnancy can bring an unmarried

girl respect as a new mother and as a sign of fertility. Fifteen-year-old Refiloe explained the cultural contradiction:

Sometimes, I have my own boyfriend. So, when I go to [a school sporting event] with him, when we have spare time, we can go, sometimes we say we are going out to be out for a few minutes, so we will have sex. And the girl ... sometimes she will come back pregnant, sometimes she will not. But many times the girl becomes pregnant. They don't use condoms ... I think it's because they know that what they are doing is not correct, so they did that so their parents cannot see and their teachers cannot know that they have been having sex. But if the teachers know that you are pregnant, you are going to be out of school. No one is allowed to have sex before being married, but most of them are doing it. Most. As for Form C, most do it. But ... Form C and Form B and Form As, they do it, but not like in Form D and Form E. But even the young ones are also doing it. That's ... they broke a law of the country. Because the law says that no one is allowed to do sex before marriage.

As Refiloe described, sex before marriage is culturally "illegal" – she went so far as to say it is against the law – and therefore incompatible with schooling. But since "most" young people are doing it, it does have some level of cultural acceptability.

Though HIV prevention was not explicitly taught at St. Ignatius, students were clearly developing their own ideas about it. According to 17-year-old Lindiwe,

When we are going to the hospitals, clinics, we are given these condoms, we are told, 'If you feel like you are old enough to have sex, please, please, in order to avoid yourself from teenage pregnancy or being affected from HIV or AIDS, please use these things.' But they don't use them. Girls and boys say that condoms destroy their body. When they have sex, they don't want to ... they say that they don't want to use condoms because their bodies are going to have such a terrible shine ... like when you smeared yourself with too much Vaseline. So they feel like if that happens, then everyone will know.

Lindiwe also spoke about the fear associated with a positive diagnosis for HIV. When I asked her if students know how to get treated for the disease, she replied:

They know, but they are scared to go there to get tested, because they don't want to know. Because they think if people know that I have HIV, everybody's going to laugh at me, everybody's going to be scared of me, so I think that's why they don't go for tests. It's because we don't know more about information about HIV and AIDS.

She went on to cite sexual and physical abuse of girls by their own boy-friends, and the girls' unwillingness to leave such relationships, as a widespread problem leading girls to contract HIV.

You can get [condoms]. But ... but the problem is that ... some boys force girls to have sex with them, and before having sex, when the girls ask for the protection, the

boys just tells us no, I'll do withdrawal. So that's why ... I just don't know ... sometimes you might find that the situation is too difficult. If the boy told you do this and you don't do it, he will just promise you that he will beat you. We don't know why these girls stay with these boys. Cause if you, as a friend, you give your friend advice, 'No, drop this boy' because you see the situation, she doesn't, she will just tell you 'No, I love him so much,' so there is nothing you can do because you have tried your best to advise her and she doesn't want to take the advice. And most of the boys are cheating, most of them. So, the girls take that thing, the AIDS, from the boys.

Because they spend their time without strict adult supervision, which forbids sexual relationships before marriage, young women without caregivers are more likely to become sexually active or choose to engage in transactional sex to earn money. According to participants, the lack of adult guardianship also means that "vulnerable" children are more likely to be exploited in the course of these relationships because the exploiters view them as easy targets.

Manganga and Corporal Punishment

In Lesotho, on the school grounds, age is not really important. Instead, power is concentrated in those who do not wear uniforms – the teachers and administrators – and exercised over those who do wear uniforms, the students. In some cases, students may be the same age as their teachers, as was the case with the 23-year-old Form B student, Mohau, and his 23-year-old physics teacher, Mr. Thabang, but the roles were clear – Mr. Thabang had complete authority over Mohau. In his home life, Mohau was a double orphan who had been taken in by his aunt in order to finish his schooling. He was old enough to drink beer with the men at the tavern, was already a father, and had been working to support himself for years, but at school, none of that mattered – he was a child, and Mr. Thabang could, and did, beat and berate him at will. Any resistance on Mohau's part could lead him to suspension or even expulsion.

Through six months of observation at St. Ignatius Secondary School, the authoritarian nature of the school was made clear to me. Children were required to follow the rules or be punished. This school culture was well illustrated by an excerpt from my field notes from my first week at the school, describing the actions of the agriculture teacher, Mr. Letela, who was about to give me a tour of the school plots:

Just as we were leaving for our tour, [Mr. Letela] whipped out a full-on slingshot and fired a rock at a girl who was walking in an area where she wasn't supposed to. 'How

many times do I have to tell you not to walk there?” he shouted, and then turned back to me and acted as though nothing had happened. The girl ran away whimpering, clutching her backside where the rock had struck.

Each day at the morning assembly, students were reminded to maintain good behavior and threatened with beatings or expulsion if they did not. During my six months at St. Ignatius, I witnessed many instances of corporal punishment, usually in the form of caning. Student participants related that they expected to receive some form of physical punishment every day, or at least several times a week.

At school, stubbornness often took the form of “subversive” behavior – conscious opposition to school rules and adult authority often leading to punishment or even expulsion. These behaviors ranged from the mundane to the extreme. Thabo, an orphaned 18-year-old research participant, was regularly caned for wearing a hat that did not match the school uniform. Once, a boy came into the teacher’s room to deliver copybooks, and the principal noticed that his hair had grown too long – he was beaten and warned to cut it immediately. Speaking Sesotho rather than English; talking during the morning assembly; being late to school; causing damage to school property; being “silly” to teachers; failing to do what was asked by an adult – all of these were daily examples of school-based “stubborn” behaviors cited by students. More extreme forms of *manganga* included smoking *dagga* (marijuana), drinking alcohol, or sniffing glue; engaging in premarital sex including inter-generational relationships, often leading to pregnancy; beating up teachers or other adults; bullying each other, including “hazing” rituals for new students; or engaging in criminal behavior such as theft, vandalism and rape.

According to research participants, these “stubborn” behaviors were associated with “vulnerable” children, but were not exclusive to them; as previously mentioned, boys in general were associated with such behaviors. However, some forms of *manganga* were considered to be unique to “vulnerable” children. Teachers noted that children without strong caregivers at home tended to have a disrespectful and antisocial attitude at school, including a tendency to be ungrateful:

The other big difference that you can notice, I don’t know whether I’m using the right word ... but most of them [“vulnerable” children] are selfish. You remember I said they always prefer their own company. You ask them to share or to work together in class, and you are going to identify them isolating themselves. You talk to that child, you know, ‘I can offer this and this and this at my place’ ... not many of them will appreciate it. Many of them ... I don’t know whether they consider it, or they take it in that manner, that they are being exposed. Especially because you are not going to

mention it in class, you talk to the child alone somewhere. But ... such a child, or most of them, cannot do that, cannot appreciate the offer.

Adults regularly pointed to “vulnerable” children’s pride, including lack of appreciation for any form of assistance, as part of their stubborn attitude. As described above, children are expected to be passive and obedient, following the instructions of adults without question. A refusal to do so — even to accept a gift or donation — can lead to the assumption that the child is “selfish” or “stubborn.” The child is operating outside the norms of childhood in which he should be dependent upon adults and grateful, not proud.

At home, corporal punishment is intended to shape the behavior of children and help mold them into responsible adults. Those who lack this kind of “care” are considered to be “vulnerable.” Mrs. Mathatho, the Geography teacher, observed this clearly: “The behavior of needy kids is different. They tend to be victims of disasters like pregnancy, and abuse ... because there is no one at home who is beating them.” Students themselves agreed with this assessment. Sixteen-year-old Maletsatsi, herself a double orphan, referred to orphans as “silly,” making the point that, without anyone at home to punish them, “vulnerable” children have a tendency to get out of control and behave badly at school:

Orphans are telling the people ... hey, I don’t know how to express it but ... they are insulting others because they know that no one can punish them. Orphans are more silly than you can think. I don’t think they could have done that if they had parents ... *hey*. If you take care of someone or guide someone I don’t think he or she could get out of control because you will always be with him or her.

According to participants, the lack of adult guidance meant that “vulnerable” children were more likely to resist adult control on the school grounds, be targeted for punishment, potentially resist that punishment, and ultimately face suspension, expulsion, or voluntary dropout from school.

While the teachers saw corporal punishment as a natural and necessary feature of school life, students had a more nuanced view. Students did not like being on the receiving end of the stick, but they also did not see any other method of disciplining students who failed to meet strict standards of obedience. However, all students regularly pointed to the possibility of unfair use of corporal punishment and recognized it could lead students into worse, rather than better, behavior. Student research participants were clear that corporal punishment, and resistance against it from “stubborn”

students, is a major reason for secondary school dropout. Fourteen-year-old Karabo made the point:

In Lesotho, students drop out of school because of corporal punishment. Sometimes someone will be late at school. Then ... she will go at home because of fearing the stick. Boys and girls both. And boys are even refusing when teachers are beating them. If they refuse, they are just expelled. Sometimes corporal punishment is working, because it is helping us to obtain some good things, madam. Sometimes I will be hurting myself, dodging the classes, when the teacher find me, beat me, and then ... *eh* ... and then told me that I should not do it again and I will leave it because I have been beaten. But sometimes I will be ... late here at school, by some reasons. When I'm trying to tell the teacher, he refuse to understand me, and he beat me. And that way ... it's not good.

Karabo highlighted the wish of many students that adults would listen to them and allow them to explain the reasons for their actions before beating them. However, at school, teachers and administrators expect to have complete authority over their students, and the justification of decisions is not important. Naturally, under this kind of system, there is ample opportunity for authority figures to abuse the system.

Beyond Corporal Punishment: *Manganga* and School-Based Abuse

According to participants, students were regularly abused at the hands of teachers and administrators, leaving pupils little recourse but to leave the school or deal with the consequences of the situation in other ways. Fifteen-year-old Lineo considered dropout after a damaging interaction with a particular teacher as part of a "mass punishment" at school:

Last year, the teachers found the toilets written on. They ... someone had written, "someone is in love with someone" ... and the teachers found that. And ... we were beaten at the buttocks. They beat all the Form A and the Form B classes, because most of the names that appeared in the toilets were for the Form Bs and the Form As. Some refused ... but they beat all of us. So, when they beat us, we as the students we used to put the jerseys in here [on our buttocks under our skirts] so that we cannot feel it to be painful. And [when they were beating me] my jersey fell out. When it fell, the teacher took me like this, and she wanted me to get back in line and get beaten again, though they had already beaten me here, under the buttocks. And I didn't go [back in line], and now she hates me. The same day, she said that I passed where she lived and insulted her, although I didn't, and she beat me again. And she said that if I don't want her to beat me, I will be expelled from school. So she always beats me. And after that, the teachers, most times when I pass, they normally say 'This girl is silly,' they discriminate [against] me. And I felt like I could leave St. Ignatius.

Lineo resisted the unfair mass punishment by putting her sweater under her skirt, and was “stubborn” again when she refused to get back in line for a second beating. As a result, she faced serious ongoing discrimination at school from her teachers, which may have had important ramifications for Lineo’s future success at the school.

Abuse of the authoritative school environment can also be sexual, a phenomenon commonly noted by policymakers and scholars ([Human Rights Watch, 2001](#); Humphreys, 2008; Leach, Fiscian, Kadzamira, Lemani, & Machakanja, 2003). Exploitative relationships between male teachers and female students were a fairly regular feature of life at St. Ignatius, as 18-year-old Lerato explained:

And the other thing that I always see here at school, is just that the other students drop out of school because of the teachers. The teachers, always ... sometimes the student is in love with the teacher. It happens here at school, and after that when [the principal] realizes this, he is going to expel these girls ... but only the girls, not the teacher. And when [the principal] finds them, he is going to expel ... only the children. We, as students, when we find that that girl is in love with the teacher, we always tell [the principal] that that girl is in love with the teacher. And [the principal] expels the student. The girl sometimes does it because the teacher can give those girls better marks or if they do that.

Importantly, such relationships were not condoned by the school, but only the student was punished, not the teacher. When 15-year-old Refiloe told to me about this, she explained that the issue of students having sex with teachers was sometimes about love, and other times it was similar to prostitution:

Sometimes they love, and sometimes they want to get something. Sometimes a teacher sees her like ... a prostitute. You know that prostitutes are bought there in town, and even here in the village, some boys pay girls to have sex without being a girlfriend or a boyfriend ... just like that.

Clearly, in a context where teachers have absolute authority over students, there are many opportunities for abuse, and students may have few options other than to leave the school altogether.

Relatively autonomous in their home lives, it can be difficult for “vulnerable” children to participate in an educational system in which they are constantly subjugated and belittled by adults to whom they are not even related. They act out, resisting adult control and engaging in “illegal behaviors” — drug use, alcohol abuse, premarital sex — in order to demonstrate their independence and prove that they can determine their own destinies. Often, these children end up dropping out or being expelled from school because they simply cannot stand the authoritarian school environment.

DISCUSSION AND CONCLUSIONS

Acting stubborn is one way in which “vulnerable” children can exercise control over their own lives and resist the status quo, even as they often end up maintaining it by engaging in behaviors that are self-destructive, perpetuating their own cycle of poverty. Children are not immune to their cultural, economic, and political contexts, and even their agency is mediated by factors outside of their own control. A leading scholar of agency, [Giddens \(1976\)](#) argues: “The realm of human agency is bounded. Men produce society, but they do so as historically located actors, and not under conditions of their own choosing” (p. 160). In other words, no one is truly autonomous and truly free — we may exercise agency, but we are all bound to our particular contexts. Agency is not equal to resistance — oppositional agency is just one of its many forms, and scholars of agency must account for the multiplicity of motivations behind all human actions. Building on this, [Ahearn \(2001\)](#) provides a concise definition of agency as the “socio-culturally mediated capacity to act” (p. 112). Agency is not the same as free will: “The main weakness in treating agency as a synonym for free will is that such an approach ignores or only gives lip service to the social nature of agency and the pervasive influence of culture on human intentions, beliefs, and actions” (p. 114). In the African framework, where the worldview is inextricably tied to community and family relations, this distinction is especially critical ([Nsamenang, 2002](#)).

In conceptualizing *manganga* as a form of agency, I have taken Giddens’ concept to heart. The “vulnerable” children who participated in this study are not free agents, but they do have the capacity to act, even as they are deeply influenced by their environment — by the expectations of the adults in their lives, their responsibilities to others, the label *manganga*, peer pressures, exploitation in its various forms, their own “deep thinking,” and sense of social injustice. Ultimately, “vulnerable” children, like all agents, make choices for themselves, but they operate within a complex sociocultural context that constantly mediates and governs their behavior, including their stubbornness.

All children, particularly those who lack consistent adult care, need skills and tools in order to protect themselves and their families from harm. Though it is not possible to generalize about the state of HIV education across Lesotho based on ethnographic research at one school, it was clear that the teachers at St. Ignatius were completely failing to teach students about safe sex and HIV prevention. My observations are corroborated by

2007 data from the Southern and Eastern African Consortium for Educational Quality (SACMEQ): "... Major alarm bells should be ringing in Lesotho because in 2007 a majority of Grade 6 pupils (81%) lacked the minimal knowledge about HIV and AIDS that is required for protecting and promoting health. In all other SACMEQ countries the situation was also very serious" (Jopo, Maema, & Ramokoena, 2011). Indeed, across sub-Saharan Africa, even in education systems with official HIV prevention programs, students are failing to learn about safe sex and effective HIV prevention (Dolata & Ross, 2010). In such circumstances, it becomes difficult for children, particularly those without caregivers, to mitigate the AIDS crisis in their own lives.

At the same time, Lesotho's authoritarian school environment is not welcoming for "vulnerable" students and creates a strong possibility for school dropout, even while government policies aim to increase secondary school access for the same group of children. In my view, this problem goes back to the debate between access and quality, between enrollment and retention. There is little benefit to enrolling children in school if they do not stay there. The school environment is an issue of educational quality and one that Lesotho needs to address if the educational participation of vulnerable children really is a priority.

There are numerous models for inclusive education, "child-friendly" schools where all students are made to feel welcome, physical punishment is not allowed, services are provided to children who lack basic necessities at home, and teachers are trained in counseling. However, these reforms are expensive, and have largely been emphasized at the primary level. There are other challenges, too – most Basotho adults, particularly parents, appear to view more physical punishment and authority, not less, as the solution for "stubborn" students. There are few resources to retrain teachers, provide extra services, develop alternatives to corporal punishment, or enforce laws designed to make schools more inclusive. And finally, the biggest challenge of all is that these kinds of educational reforms are, like so many others, imposed from outside, rather than developed from within.

However, with the onset of the AIDS pandemic, Lesotho's social landscape has changed so rapidly that new spaces for political and social transformation may be opening up. When I spoke with teachers, most told me that corporal punishment "doesn't work," although they don't know what else to do and are afraid to relinquish control. Students feel the same way – in a discussion of the pros and cons of corporal punishment, they argued that caning makes them "stubborn" and "not stubborn" at the

same time, and one of their main justifications for corporal punishment was related to culture and tradition. The time is ripe for new and creative approaches that can benefit all of Lesotho’s children. Local institutions, as well as international agencies and researchers, can work in concert to delve into the lived experiences of “vulnerable” children and pilot and implement new policies that improve their life chances.

Based on the research findings, it is possible to make a number of recommendations related to educational quality for “vulnerable” children in Africa. First, “vulnerable” children are not powerless victims, but active agents who make choices related to survival and self-transformation. In order to effectively improve the life chances of all young people, policy-makers must recognize the diverse ways in which educational policies shape their lives, seeking to understand their perspectives, and incorporating their views into policy development and implementation processes. Second, at all levels, schools need to be reconceptualized and recreated as safe, violence-free spaces where ALL children not only feel welcome and comfortable but also receive needed HIV prevention skills and psychosocial support from adults.

Globally, this study demonstrates that local and culturally inflected definitions of “vulnerability” may not always align with international definitions and policy prescriptions. Certainly, there are lessons that may transcend borders – for example, this study points to the importance of teaching young people about safe sex and HIV prevention, and also about making schools into places where children want to be, and where they feel welcome. The quality of education is just as important, if not more important, than access to schooling. Above all, using an emic perspective to engage with specific cultures and communities provides a needed insight into the lived experiences of people, including children, whose lives are constantly being shaped by global forces.

ACKNOWLEDGMENTS

This paper derives from the author’s doctoral dissertation research at Teachers College, Columbia University. The author is indebted to Drs. Monisha Bajaj, Lesley Bartlett, and Gita Steiner-Khamisi for their tireless guidance, and to the Fulbright U.S. Student Program, the Teachers College Office of Policy and Research, and the Teachers College President’s Grant for Student Research in Diversity, for funding the study.

NOTE

1. All personal and place names have been changed to protect the identity of participants.

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GENDER, SEXUALITY AND HIV AND AIDS EDUCATION IN SOUTH AFRICA

Deevia Bhana and Shakila Singh

ABSTRACT

The HIV epidemic in South Africa affects young people in their teenage years, the majority of whom are young women located in schools. Sexual violence and gender inequalities create vulnerabilities for young women increasing their risk of HIV. Promoting their sexual health as well as preventing the disease amongst young people remains a substantial educational and health priority. South African education has well-developed policies related to HIV and AIDS education in schools. Despite this the disproportionate burden that young women bear in relation to HIV remains acute. What remains missing is the development of an integrated HIV and AIDS education approach that takes children, gender and sexuality seriously. Given the urgency of the disease in the country, there is need for renewed efforts to integrate gender and sexuality within HIV and AIDS education. This is the central focus of this chapter.

INTRODUCTION

A Limpopo school principal has been arrested for allegedly raping a former primary school pupil. The principal allegedly had sex with the 13 year old girl on the back seat of his car on the road between Vuwani and Ha Masia villages . . . The girl told her aunt that she had been having sex with the principal since last year when she was in Grade 7 at the school . . . (Daily News, 21 February 2012, p. 5).

This chapter begins with a newspaper report of sexual violence involving a South African school principal and a 13-year-old learner. Sexual violence against children in South Africa is a major health problem and is implicated in HIV infection (Jewkes, Dunkle, Nduna & Shai, 2010). The allegation of rape perpetrated by a school principal is part of the pathology of South African schools. Young women at school remain in fear and unsafe with male learners and male teachers complicit in sexual violations (Bhana, 2012; Dunne, Humphreys, & Leach, 2006; Human Rights Watch, 2001; Leach, Fiscian, Kadzamira, Lemani, & Machakanja, 2003). Gender power and age inequalities and social and cultural norms which reproduce women's subordination together with poverty have been identified as important in understanding sexual abuse of young women at school. To be effective, HIV and AIDS education and prevention must address widespread forms of structural and gender inequalities and the persistence of sexual violence.

In South Africa, sexual violence and gender inequalities are important determinants in young women's HIV risk. The development of an effective HIV and AIDS education that takes consideration of sexual violence, risk and the differential ways in which men and women are affected remains important. Whilst South Africa has now well-developed policies related to HIV and AIDS education in schools, debate continues about the form and shape of HIV and AIDS education. Gender and sexuality do feature in education policies but, as research indicates, progress in the development of an integrated approach to HIV and AIDS education that takes children, gender and sexuality seriously remains limited (Morrell, Epstein, Unterhalter, Bhana, & Moletsane, 2009). Given the urgency of the disease in South Africa, its impact on young people and the disproportionate effect on young women, there is need for renewed efforts to integrate gender, sexuality and violence within the HIV and AIDS education framework.

Sexual violence and enduring forms of gender inequalities increase risk to HIV infection. In South Africa, over 5.6 million people are infected and there are great gender disparities in rates of infection. Amongst teenage women aged between 15 and 19, the HIV prevalence is 6.7% increasing to 21.5% of those 20–24. 2.5% of teen men are infected and 5.3% by the

ages 20 to 24 (Shisana et al. 2009). Whilst biological susceptibilities to HIV have been identified as a driver in understanding women's vulnerability, gender differences in sexual socialisation account for the wide gender disparity in rates of infection (Jewkes & Morrell, 2010).

The escalating levels of HIV amongst young teenage women point to the critical value of HIV education prevention programmes in schools. The South African education department has implemented Life Orientation. Life skills education was expected to increase knowledge, develop skills and enhance positive relations. Life skills education amongst other goals expects learners to demonstrate a clear and accurate understanding of sex, sexuality and gender, to respond assertively to pressures for sexual intercourse and unprotected sex and critically evaluate reasons for delaying sexual intercourse or practicing abstinence (Department of Education, 2002). There remains much debate about the ability of HIV and AIDS education to address gender and sexuality (Bhana, 2007; Morrell, Epstein, D., Unterhalter, E., Bhana, and Moletsane, R 2009; Pattman & Chege, 2003). How can schools, principals, teachers and learners expect to work against gender inequalities and address gender sensitivity when the social values and the social context reflects widespread forms of gender and sexual violence and male power?

The effectiveness of HIV and AIDS education in the context of sexual violence is undermined impacting on young women's ability to negotiate safe sex. Some success, however, that has been noted is the use of condoms. Shisana et al. (2009) and Moyo, Levandowski, MacPhail, Rees, and Pettifor (2008) note that amongst women condom use is highest in their teenage years, although condom use is irregular. However, young people still do not regularly practice safe sex as the statistics point to the failure of interventions to secure behaviour change. Acquisition of knowledge cannot automatically lead to behaviour change (Allen, 2007). In South Africa, knowledge about gender and sexuality is not featured prominently in teaching and learning about HIV and AIDS (Morrell et al., 2009) with sex considered as taboo (Morrell, 2003). Teaching and learning about HIV and AIDS education necessarily involves teaching and learning about sex. A dominant presumption of childhood is sexual innocence and this discourse inhibits the potential to address sexuality more comprehensively (Bhana, 2008). There remains a dearth of information, research and interventions that deal with young people, schools, gender, sexuality and HIV and AIDS education in the country. As Bhana and Pattman (2009, p. 69) state:

Currently we know very little about the world inhabited by young adults, how they see themselves, what they wish for, their desires and passions, their fears and the ways in

which the performance of masculinities and femininities are constructed, how it is advantageous and how it can inhibit other potential experiences and how it is vulnerable to disease. Given this, greater understanding of these gender identity processes would appear vital to successful strategies in the protection against HIV/AIDS in South Africa and such work lies at the heart of improving sexual and reproductive well-being of young adults (Cornwall & Welbourn, 2002). There are great benefits in addressing gender and sexuality within the context of HIV and AIDS not simply by eliciting responses based on risk but by addressing young adults as people who have interests, passions and desires

Much more information is required from teachers and learners about the negotiation of gender and sexuality in order to develop appropriate responses to the disease so that HIV and AIDS can be better formulated and transmitted in the classroom. It is important to understand what young people consider to be appropriate and work from young person-centred approach in the delivery of HIV and AIDS education. Thus far the policy perspective in Life Orientation has done little to alter the grim realities of gender and sexuality in South Africa. The context within which gender and sexuality play out is important to consider for education. This is the main argument in this paper. The context of sexual silencing and gender and sexual violence undermines effective HIV and AIDS education in the country. Despite vast recognition that gender and sexuality are important pillars of the AIDS education response, comprehensive approaches that address gender and sexuality have yet to become fully inserted into South African schooling. The lack of attention to gender and sexuality, the context of sexual of gender and sexual violence and the notion of sexual innocence in understanding children remain part of the challenge in the delivery of effective HIV and AIDS education in the country.

CHILDHOOD INNOCENCE AND THE REGULATION OF GENDER AND SEXUALITY IN HIV AND AIDS EDUCATION

To understand how gender and sexuality in HIV and AIDS education are regulated, it is necessary to see how childhood innocence is mired in assumptions that make sex a taboo subject. Whilst the AIDS pandemic in South Africa has focused attention on children's knowledge of sex and sexuality, research has illustrated the ways in which knowledge about sexuality is regulated drawing from Christian moral principles derived from the legacies of colonialism and apartheid. Such understandings of childhood

innocence have resonance with the research in the west where the ideal child is one that is desexualised (James, Jenks, & Prout, 1998; Kincaid, 1998; Renold, 2005). Following this view, children should be protected from sexuality. Any association that children have with sex and sexuality will mean that children are contaminated and made to be immoral and subordinate to the status of ideal. The discourse of childhood innocence reinforces adult power over children and assumes that children need adult protection from sexuality.

Like the west, childhood innocence has been identified as a means through which adult teachers distance from sex and sexuality in HIV and AIDS education and are afraid to mention the word sex (Bhana, 2007). In South Africa, Deluis and Glaser (2002) note that the way in which childhood sexuality has been interpreted is not static and has changed over time. Drawing from historically rooted analysis, Delius and Glaser show that there was a relative openness towards sex including during childhood. Such continuities can be seen in reed dancing ceremonies where teenage virgins are presented in highly sexualised ways at Zulu cultural festivals. But such openness which is restricted to certain cultural festivals sits in tension with dominant notions of childhood innocence and Christian morality.

In much educational research a dominant theme is innocence. Saying the word 'sex' in the classroom is avoided and missing (Bhana, 2007). Pattman and Chege (2003) note that in many sub-Saharan countries the efficacy of HIV and AIDS education is inhibited by restricting comprehensive knowledge of sex and sexuality – key to HIV transmission. Teachers and learners express discomfort about sex in HIV and AIDS education. Sex causes embarrassment and children and sexuality are dangerous connections which must be avoided to protect the innocence of children. Teachers whilst strategically positioned to mediate knowledge about the disease also wield a great deal of power in restricting and shaping messages about sex within the dominant moral framings which restrict and regulate children's knowledge of sexuality.

GENDER AND HIV AND AIDS EDUCATION IN SOUTH AFRICA

Much faith has been placed in developing educational initiatives in schools to provide young people with relevant knowledge and life skills to help them avoid HIV and AIDS (Mathews, Boon, Flisher, & Schaalma, 2006).

Effective HIV and AIDS education requires engagement with gender and sexuality. Dunkle and Jewkes (2007) argue that programmes that promote gender equality and address gender violence are needed to combat HIV. The UNAIDS Action Framework states that gender inequality and unequal power relationships between men and women continue to be major drivers of HIV transmission. Addressing gender inequalities and changing sexual behaviour remains the lynchpin of HIV prevention. As reported by [UNICEF \(2002\)](#):

Global success in combating HIV/AIDS must be measured by its impact on our children and young people. Are they getting the information they need to protect themselves from HIV? Are young women being empowered to take charge of their sexuality? ... These are the hard questions we need to be asking.

Learners and teachers are expected to develop enhanced capacities for rethinking gender and cultural norms through which male sexual entitlement and women subordinated position are entrenched. HIV and AIDS education in South Africa is expected to encourage young people to stop and prevent the spread of the disease, change behaviour and encourage the development of appropriate patterns of conduct that are likely to be less risky. The ideals of masculinity, the perpetration of violence and sexual risk taking are interlinked. The successful way to be a man is often understood to be associated with multiple sexual partners and sexual prowess. Effective HIV education requires protection of both men and women's health. HIV education must attend to sexual violence and sexual risk and work towards active transformation of gender norms that make men and young men feel entitled to sexual power and control and sexual risk taking. Reviews of school-based intervention have noted that school-based HIV educational programmes can reduce sexual risk; however, many of these programmes have not been duplicated and their effectiveness cannot be proven ([Mathews et al., 2006](#)).

Outside school, the awareness of gender differences in HIV infection and the ways in which sexuality is tied into women's vulnerability have led to some interventions that attempt to address the gender norms which give rise to the disparity in rates of infection ([Jewkes, Wood, & Duvvury, 2010](#)). The only programme that has shown to have impact on sexual risk is the Stepping Stones programme ([Jewkes et al., 2010](#)). The Stepping Stones intervention uses critical drama and learning approaches to help address safer gender equitable relationships. Situating HIV within the broader context of sexuality and gender relations, the intervention builds on the development of appropriate gender skills. The intervention shows

that whilst not ending patriarchy, there was evidence that women developed more assertive skills and men were less inclined to take on hegemonic forms of masculinity.

Such intervention programmes are yet to be implemented in South African schools. In education, there has been relatively little research and analysis of behaviour change interventions that address gender and sexuality (see [Morrell et al., 2009](#)). [Pattman \(2005\)](#) stated that HIV and AIDS education, as it is being taught in schools, may yet be another vehicle through which gender inequalities may be produced in relation to sexuality particularly in the context of sexual violence. School-based intervention faces a number of challenges. UNAIDS (2010) in their review of school-based interventions in Tanzania found that interventions are likely to suffer in the context of school-based cultures of violence and sexual coercion as well as age disparities between learners and teachers which enable a context of rape, sexual harassment and widespread forms of gender inequalities which undermine the positive messages of intervention programmes. A further challenge to addressing gender and sexuality in HIV and AIDS education is that schools often fail to consider the wider context through which HIV is situated focusing on ABC and abstinence messages without understanding that young people themselves are sexual and as agents express a keen interest in matters of sex and sexual relationships ([Bhana & Pattman, 2011](#)). Effective HIV and AIDS education must put sex at the centre of discussion, and yet emerging evidence shows that both teachers and learners are often silent on sexuality and reproduce it as a taboo subject making it difficult to address sex in HIV and AIDS education ([Bhana, 2007](#)). [Bhana and Pattman \(2011\)](#) argue that in the context of massive structural inequalities, and the context of death and disease surrounding HIV, the focus on sexuality has been one-sided with sex considered as death, danger and disease. Amidst the elaboration of danger around HIV and AIDS, young love has become more audible in research in South Africa ([Hunter, 2010](#)). [Pattman and Chege \(2003\)](#) assert that part of the reason is that teachers still do not focus on gender and sexuality as key to the spread of the disease neither do teachers teach the subject in ways that encourage conversation and dialogue that empower the voices of young adults. Clearly young people need to be taught about AIDS and its modes of transmission, but this does not mean that they should become the passive recipients of HIV and AIDS and sex education. To what extent however can schools address gender and sexuality in HIV and AIDS education under circumstances of widespread sexual violence? Ross argue that the school environment is critical for the success of HIV prevention. How is

it possible to conceptualise effective HIV and AIDS education and prevention in a context of massive gender power inequalities which provides ripe opportunity for the sexual abuse of young women? An inadequate understanding of the context that produces the fertile environment for gender and sexual violence can often lead well-intentioned HIV and AIDS education programmes to fail (Jewkes, 2010). HIV and AIDS education cannot expect to provide knowledge alone. The context through which teachers and learners engage with HIV and AIDS education is vital and could undermine the extent to which gender equitable relationships are addressed.

GENDER AND SEXUAL VIOLENCE: THE CHALLENGE FOR HIV AND AIDS EDUCATION IN SCHOOLS

Since the epidemic affects young men and women in their teenage years, the majority of whom are located in schools, promoting their sexual health as well as preventing the disease amongst young people more generally remains a substantial educational and health priority. Against the backdrop of high rates of infection amongst young South Africans and the gendering of AIDS, the significance of education as a preventative measure remains critical (Coombe & Kelly, 2000). HIV and AIDS education in South Africa is situated within the crucible of pervasive forms of sexual and gender violence both in and out of the school (Bhana, 2012). To what extent can both teachers and learners in engage with HIV and AIDS education in ways that transform gender relations, address gender inequalities and produce a gendered climate conducive for ending the scourge of the disease which affects young women in particular? The chapter begins with a newspaper report highlighting rape and sexual coercion in the context of schooling – a male principal arrested for the alleged rape of 13-year-old learner. In responding to HIV and AIDS education, it is vital to understand the gendered social and educational environment where both teachers and learners are actively participating in gendered cultures and through which gender inequalities are re-enacted. The familiarity of gender roles and behaviours and the widespread evidence of sexual violence in South African schools inhibit the interrogation of gender relations in the school environment.

Widespread reports of gender and sexual violence in South African schools question the ability of schools to provide effective HIV and AIDS education and undermine their efficacy. Sexual and gender violence in and

around South African schools is a key challenge to effective HIV and AIDS education. South African schools are not deemed to be safe places with widespread forms of sexual violence and coercion are reported ([Human Rights Watch, 2001](#); [Prinsloo, 2006](#)). Routine propositioning of young women by male learners and by male teachers is not recognised or addressed by the school ([Pattman & Chege, 2003](#)). The vulnerability of young women to sexual violence and HIV is heightened by age inequalities, poverty and unemployment and their subordinate status as women and young women (O'Sullivan, Harrison, Morrell, Monroe-Wise, & Kubeka, 2006). Girls' relatively subordinated status with regard to young men and men is a critical factor influencing greater risk of infection and making gender and sexual issues at the centre of the HIV prevention challenge ([UNAIDS, 2011](#)).

Young South African male adults assert their power in varied ways including violence, sexual assault and rape and the pursuit of multiple partners ([Jewkes & Morrell, 2010](#)). Research has found that a great deal of emphasis is placed on men's control of women and young women as well as sexual interactions ([Bhana & Pattman, 2009](#)). Ideas of masculinity, which espouse male power and associate it with uncontrollable sexual needs and dominance over women has implications for sexual risk. Race and class inequalities in South Africa continue to create vulnerabilities to violence and HIV, particularly for young women located in poor African townships. The history of apartheid and social inequalities as well as patriarchal understandings of power, the economic conditions and AIDS helps illumine the context of rape and sexual violence which diminishes young women's freedoms ([Bhana, 2012](#)). Schools are integrally related to the social contexts and cultures that constitute gender power and expressions of sexual violence. Indeed, HIV and AIDS education is undermined and constrained by the context where gender and sexual violence is pervasive and by gender and sexual norms which privilege male sexual power and women and young women's subordination.

SILENCING GENDER AND SEXUALITY IN HIV AND AIDS EDUCATION

In a country where women's ability to prevent HIV infection is limited by issues of power imbalances, harmful social norms, sexual violence and marginalisation, education in South Africa continues to be largely silent

on gender and sexuality in HIV and AIDS education strategies. 'Silence', according to [Morrell \(2003\)](#), is a feature of gender relations that prevent the negotiation of safe sex, the exploration of the self and the expression of vulnerability, and hence the building of trust and respect and conversely silence contributes to intolerance and fuels prejudice. One of the major challenges in addressing the silences around HIV and AIDS in South Africa is cultural norms that hinder direct communication across different generations about issues that are considered taboo, such as sex, dying and death.

In addition to formal schooling institutions, several community programmes have been involved in the attempts to combat the spread of HIV. In particular, the mass media has publicised HIV and AIDS through television programmes such as *Soul City*, a weekly drama series that covered a wide range of health issues, hence propagating basic information about the epidemic and its consequences. *Love life*, a national youth sexual health initiative, engaged a mass media campaign, using newspaper advertisements, billboards, radio and other mediums to address sexual health issues and the underlying causes of HIV and AIDS, including gender issues and sexual coercion. Within these interventions, the cultural discourses surrounding HIV and AIDS have advocated open communication between adults and young people about sexual activity, and adults are attempting to discuss the long taboo topic of sexuality in South Africa. This has however had limited success, and emerging research in South Africa indicates that despite the overt connection of sexuality and HIV teachers and learners are reluctant to engage with matters around sex (see, e.g., [Pattman, 2005](#); [Pattman & Chege, 2003](#)) When sex is discussed, sex is framed as dangerous, male desire is natural, and young women are victims of male desire. The talk, then, is far from liberating, but is as indicative of regulation and power, as is repression and silence. Sexuality is however never absent from schools, but deeply embedded within normative understandings of childhood, children and schooling leading many to believe that children are not supposed to have sex or have discussions about sex ([Allen, 2005](#); [Mellor & Epstein, 2006](#)). In [Bhana's \(2008, p. 149\)](#) study of South African teachers the following was noted about sex by teachers in two different schools:

No, if they bring it [sex] up I will answer it, but I don't want to get in-depth, because kids are fairly innocent.

I was *beating around the bush* in the classroom when I asked them how AIDS is spread. I wanted them to tell me but maybe I think they are afraid because the word sex, kissing, touching private parts, all those things, they are not allowed to mention those words, though it's happening.

A lack of vocabulary in traditional discourses on sex as a consequence of silences and taboos in South African society has contributed to difficulties in intergenerational talk (Campbell, Foulis, Maimane, & Sibiya, 2005). Whilst there is general agreement about the need to talk openly to children and young adults about sex, and the talk has increased, this has been largely a discourse of danger. The talk has been predominantly about the avoidance of pregnancy and disease. The limited impact of such interventions indicates that the talk has to go further than the medicalisation of sex and disease to include issues of feelings, desire and pleasure (Reddy, 2003). The need for love and romance is understood as an essential part of teenage life (Reddy 2003; Shefer & Foster, 2001). This being the case, it is important to situate sexuality education *within* relationships and not use an approach that discourages relationships. Despite the silences about love in sexuality education, it is clear that love is constituted as something powerful, and its messages are ever-present in popular culture in songs, films and novels. Mcleod (1999) asks whether 'love is not talked about in educational contexts because it is a taboo subject, because sex without love is more containable, or because love is relevant but not really mentionable'.

Addressing silences around love in sexuality education is further complicated by the gendered discourse of love (Reddy, 2003; Shefer & Foster, 2001). Shefer and Foster (2001) highlighted the double standards in the construction of masculine and feminine sexualities in South Africa, with men viewed as positively sexual whilst women being representative of love and relationships. Similarly, Reddy (2003) found that young South African men are usually silent on the issues of love and talked about it has been something that young women focused on. Love is often considered as women's business and is considered to belong in the private realm not to be spoken about, whereas men's business lies in the public realm (McLeod, 1999). It is critical that sexuality education examines the constitutive effects of maintaining the silence about the discourse of love (McLeod, 1999), and that students are given the chance to examine the profound tensions between safer sex practices and the discourse of love (Reddy, 2004; Shefer & Foster, 2001).

GENDER TRANSFORMATION AND SCHOOLING

The basis of an effective HIV and AIDS education requires attention to the social context, the underlying gender norms through which male sexual entitlement is perpetuated and to the pervasive sexual silences in South

African schools (Morrell, 2003). In the context of policy changes and political emphasis on gender equality, gender transformative work is necessary in schools. Gender norms are not fixed, and the context of changing gender identities has been noted by South African researchers (Morrell & Jewkes, 2011). Not all young men assert their masculinity which increases risk to HIV infection and at the expense of young women (Barker, Ricardo, Nascimento, Olukoya, & Santos, 2010).

Whilst initiatives aimed at highlighting gender issues are important in understanding the ways in which gender and sexuality drive the HIV epidemic, it is critical to move beyond that and also aim to change harmful norms and practices. These approaches are called 'gender-transformative' approaches. According to HIV and Healthy Communities: Strategy 2010–2012, International HIV/AIDS Alliance, a gender transformative approach is 'An approach that engages people in changing harmful gender norms, both of masculinity and femininity, which shape and limit individuals' autonomy and capacity, and are key to understanding and addressing HIV risk, vulnerability and effective HIV prevention. The approach engages men and women separately and together, according to local circumstance, and addresses violence, coercion and abuse of all those who are perceived to challenge or transgress gender norms. It addresses both gender inequality and the specific vulnerabilities of men and young men such as sexual coercion between men and young men, sex in prison settings and the legal status of sex between men'.

It is important to focus on how schools can contribute to socially transformative programmes that promote gender equality and discourage perpetration of gender-based violence that are needed to combat the global HIV pandemic. The International HIV/AIDS Alliance (2010) notes that there are few approaches to achieve gender transformation, and many organisations within and outside the Alliance have struggled to overcome the controversies, sensitivities and structural barriers that impede progress.

Dunkle and Jewkes (2007) propose gender transformative strategy to focus on men and suggest that effective interventions to protect both men's and women's sexual health will require not only interruption of intertwined cycles of violence perpetration and sexual risk taking amongst men but also active transformation of underlying gender norms that legitimate male power, male control, male violence and men's sexual risk taking. In understanding risk, sexuality and HIV vulnerability, it is important to note that the reproduction of hegemonic sexualities is predominantly a masculine agenda; and females are defined in relation to masculinities. Shefer and Foster (2001) who focused on women assert that educational interventions,

such as sex education, which presently conceptualised as part of 'life skills' in South Africa, in schools and other educational institutions, have an important role to play in reconstructing discourses on female sexuality. However, femininities and masculinities are constantly created, adapted and contested in everyday interactions amongst men and women, amongst men and amongst women. These constructions offer both young women and men limiting masculine and feminine identities. Relinquishment of power and control is a key defining feature of conventional femininity, as exercising power and control is of conventional masculinity. Gender transformation should therefore focus on both men and women and the relationships between them.

Sexual negotiation is not an issue of free choice between equals but one of negotiations between structurally unequal power relationships. Sexual encounters may therefore become sites of strife between the exercise of male power and the male definitions of sexuality, and of women's ambivalence and resistance. For women to insist on safe sex or to express sexual desire and need for sexual satisfaction is a challenge to male sexual power, and the privileging of men's sexual pleasure. Young South African women, who attempt to assert themselves as responsible agents, fear rejection or 'othering', and are not able to practice safe sex consistently (Reddy, 2003; Shisana et al., 2009). Sexual encounters may be potential sites for both pleasure and danger, but it seems that not too many young adults are prepared for the dangers, or any of the pleasures.

However, the difficulty of deconstructing normative heterosexuality at school level needs not be underestimated. As Harrison (2000) points out, many young men and women have a considerable investment in continuing the privileges that normative heterosexuality brings. Young people are likely to resist partly because traditional discourses are still more convincing to them. Young men have to be prepared to give up the pleasure that exercising power over women brings. Likewise, young women have to be prepared to give up the pleasure they experience in gaining and maintaining conventional heterosexual relationships. The choice to conform to hegemonic notions or to depart from convention is not easy. In order to challenge the imbalances of gender power relations, young adults have to transgress collectively held and policed boundaries and risk becoming 'abnormal' or 'other'. The tightly policed boundaries force young adults to seek private solutions, whilst keeping public values intact. There is, however, some evidence of change being underway (Morrell & Jewkes, 2011). Young people in South Africa have historically been part of a socio-cultural context which has not fostered sexual negotiation skills, and

in which segregated gender roles that are culturally sanctioned exist. There have, over the years, been many changes in the political and social climate, and whilst some socio-cultural traditions are enduring (such as the valuing of marriage and the nuclear family), many others (such as young women being taught to be submissive and young men being taught to be assertive) are in the process of undergoing serious transformations. Culturally sanctioned differences in gender roles and expectations have been important factors in the production of limiting sexual identities that add to sexual risk (Campbell et al., 2005; Dunkle & Jewkes, 2007; Harrison, 2008, Jewkes et al., 2006; Pattman, 2005; Reddy, 2003).

Gender transformative approaches are important in specifically providing useful ways of understanding how particular roles and expectations are constructed, promoted and reproduced by societal, cultural and political forces. It focuses on how roles and expectations affect people's lives, choices in terms of sexual expectations, feelings and expression and link these to the dominant biomedical approach in ways that are meaningful. HIV and AIDS have brought in question many long-standing detrimental, toxic aspects of gender relations that were regarded as normal, and through effective school interventions these can importantly be linked to the broader social and political struggles for equity and justice.

CONCLUSION

This chapter has made two major claims. Gender and sexuality are key to effective HIV and AIDS education. However, its efficacy is undermined by the context of pervasive forms of sexual and gender violence. HIV and AIDS education is premised upon respect, negotiation, empowering young men and women to take charge of their sexuality and sexual health. The chapter began with the newspaper report of the allegations of rape. HIV and AIDS education is delivered within a context that is shaped by persistent forms of gender and sexual violence undermining its efficacy. South Africa has the worst statistics on sexual and gender violence in the world. As Jewkes, Levin, Mbananga, and Bradshaw (2002) note one in four women will be beaten by her domestic partner. It is estimated that 20,000 young women between the ages of 0–17 are raped and reported to the police each year with adult males most often the perpetrators (Jewkes, Penn-Kekana, and Rose-Junius 2005). In an earlier study, Jewkes et al. (2002) found that 1.6% of a sample of over 11,000 women had been raped

before turning 15 years. The association between sexual violence and HIV and AIDS is now becoming clearer in South Africa. Sexual violence and gender power inequalities are associated with higher risk to HIV infection (Jewkes et al., 2010). The links between HIV and AIDS, gender inequalities and sexual violence cannot be ignored in AIDS education and prevention. Some South African research is now pointing to young people's sexual agency (Bhana & Pattman, 2011; Morrell et al., 2009; Reddy & Dunne, 2007). However, in these research findings, the subordinate status of young women remains a concern exacerbated by South Africa's striking social inequalities, poverty and violence. Young women, for example, may be able to assert their agency, but they are limited within the broader context where male power and privilege are linked to patriarchy, culture and the political economy. HIV and AIDS education must be supported by strong resistance to the broader social context in the country which makes sexual violence normative. Ending gender and sexual violence in South Africa remains critical. Educational practice around HIV and AIDS then may be congruous with the messages of gender sensitivity, a strategy that is key to prevention. It is important that HIV and AIDS education must take into account the context specific ways in which gender and sexuality feature in risk and perpetuation of sexual violence which continues to harm young women. HIV and AIDS education must be rooted in the knowledge that young women's ability to negotiate safe sex is limited by unequal gender relations, but the costs to masculinity are also severe. Narrow understandings of masculinity, notions of sexual entitlement and the expectation of a docile female sexuality constrain efforts towards gender just relationships. HIV and AIDS education in South Africa must take into account the context specific ways in which gender and sexual relations manifest. HIV and AIDS education can only be effective if it is located within the knowledge of the context that drives risk.

Beyond the context of gender and sexual violence both in and out of the school, sexuality is an area not often considered appropriate for learners. Despite vast recognition that gender and sexuality are crucial within the AIDS education response, effective approaches that address gender and sexuality have not been successfully incorporated into South African schooling. Culturally sanctioned differences in gender roles and expectations between school learners and between teachers and learners contribute to the perpetuation of the silences surrounding gender and sexuality in schools. There is an urgent need for holistic sexuality education that challenges harmful social norms and promotes greater openness around sexuality. Sexual activity will never be safe as long as young people are told that

sexual expression is bad, dangerous and wrong or where it remains hidden and stigmatised (Harrison, 2008).

However, despite the ways in which gender and sexuality are limited and limiting in South African HIV and AIDS education, gender and sexuality are not fixed and newer research has pointed to changing forms of masculinity and hope and empowering femininities (Morrell & Jewkes, 2011). Effective HIV and AIDS education requires addressing gender and sexuality in ways that are premised upon gender transformative work. Working with teachers and learners where gender is made a central focus of HIV and AIDS education is necessary step to enhancing education's value in addressing the scourge of the disease in Africa.

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PERCEIVED FACTORS UNDERLYING HIV RISK BEHAVIOUR OF YOUNG PEOPLE IN SOUTH AFRICAN SCHOOLS

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ABSTRACT

School-going young people in South Africa engage in HIV risk behaviour despite high levels of HIV knowledge and a variety of interventions focusing on HIV prevention. The lack of empirical evidence on the effectiveness of current interventions leaves programme implementers with little consensus about how best to prevent HIV infection among young people. This research was done to explore factors underlying HIV risk of young people with the aim of developing HIV prevention in the third decade of the epidemic. Focus group discussions were conducted with young people, educators and parents in eight schools in four provinces of the country. A thematic analysis revealed risk factors especially on the interpersonal and community level. Peer pressure, gender norms and culture, poverty and financial gain and a culture of alcohol use were prominent themes. Negative family relationships, lack of role models and

lack of sexual education from home contributed to risk behaviour. Community processes such as exposure to media, lack of recreational facilities, and an erosion of supportive culture and community structures created an environment which did not support healthy behaviour. Factors that prevented risk behaviour were identified as self-respect, open communication with parents, implementation of school programmes, positive peer pressure and a focus on young people's future. Prevention programmes should therefore not only focus on individual factors but should be multi-layered interventions involving various community structures aimed at changing the social ecology in communities to support an alternative lifestyle for young people.

BACKGROUND

South Africa has the largest population of HIV-infected individuals in the world. It is estimated that about 5.6 million people in South Africa (12–15% of the population) are infected (UNAIDS, 2010). Although the disease has stabilised in the past three years, 1.5% of the population still gets infected each year (Department of Health, 2010). High infection rates can be contributed to many social, cultural, economic and political factors, such as the long period of governmental denial of the epidemic (Butler, 2005; Chigwedere, Seage, Gruskin, Lee, & Essex, 2008), the legacy of apartheid (Niehaus & Jonsson, 2005), poverty, inequality (Kasese-Hara, Mayeksio, Modipa, Mzobe, & Mango, 2008), the system of migrant labour (Schoub, 1992) and gender inequality (Campbell, Nair, Maimane, & Nicholson, 2007; Strebel et al., 2006).

The household survey conducted by the Human Sciences Research Council (HSRC) (Shisana et al., 2009) paints a more optimistic picture of the HIV risk of young people between the ages of 15 and 24 years. The research found a decreasing prevalence of HIV among young people when compared with the previous survey done in 2005. The HIV prevalence among young people was 10.3% in 2005 compared with 8.6% in 2008. This change can possibly be related to rising levels of condom use. In 2009, 87.4% of young men and 73.1% of young women reported condom use at last sex (Shisana et al., 2009). This change in behaviour is probably the result of more than a decade of HIV education in schools and through the media.

Young people are the focus point of HIV/AIDS prevention globally (Department of Health, 2011). There is growing evidence from several

countries that when HIV prevalence is decreasing, it is young people who are reversing the trends, since they are the ones who are more likely to adapt new behaviour (Monasch & Mahy, 2006). By virtue of the large number of young people attending schools, educational institutions have been identified as the ideal venue to disseminate health-related information that can reduce young people's sexual risk behaviour.

Young People's Sexual Risk Behaviour

Several South African studies during the past decade highlighted the sexual risk behaviour of young people despite adequate knowledge about sexual health risks (Simbayi, Chauveau, & Shisana, 2004; Visser, Panday, Kumalo, & Govan, 2011). In the Youth Risk Behaviour Survey 2008 (Reddy et al., 2010), 38% of learners in Grades 8–11 reported that they were sexually active and only 31% of them reported consistent condom use. Early sexual debut (before the age of 15 years) was reported by 11.3% of young men and 5.9% of young women. Young women, in particular, experience high levels of risk for HIV infection. Shisana et al. (2009) reported that 32.7% women in the age group 25–29 years are currently infected. Early sexual debut, multiple sexual partners as well as transactional and intergenerational sex were identified as high-risk behaviours that should specifically be targeted in prevention efforts. Intergenerational sex was reported by 27.6% of young females (15–19 years) and 30.8% of young men (15–24 years) reported multiple sexual partners (Shisana et al., 2009).

Numerous studies have been conducted in an effort to understand young people's sexual risk behaviour. Based on an extensive literature review, Eaton, Flisher, and Aaro (2003) explained youth sexual risk behaviour as a function of various factors on three ecological levels:

- 1) Within the person (psychological factors such as cognitions, self-efficacy and self-esteem);
- 2) Within the proximate context (interpersonal environment such as peer pressure) and
- 3) Within the distal context (culture, shared beliefs and values, structured factors such as legal, political, economic and organisational elements of society).

Early in the epidemic the focus of the prevention efforts was on individual variables. As the understanding of the epidemic increased, more attention has been given to social processes and structural factors that

influence behaviour. Recent research thus focuses more on interpersonal and distal contexts underlying risk behaviour. Peer pressure among young people unmistakably undermines healthy social norms and HIV prevention messages (Selikow, Ahmed, Flisher, Mathews, & Mukoma, 2009). Gender role norms and inequalities as well as social norms about sexuality (Mantell et al., 2006; Strebel et al., 2006), sexual coercion, alcohol use (Harrison, Newell, Imrie, & Hoddinott, 2010) and economic conditions (Waafas Ofo-su-Amaah, Egamberdi, & Dhar, 2005) are studied as prominent factors underlying HIV risk.

School-Based Interventions

South African schools have implemented a variety of HIV preventive interventions, using different formats and delivery methods during the past decade. At first interventions were implemented through a variety of non-government organisations (e.g. Mantell et al., 2006). These interventions focused mainly on individual-level behaviour involving knowledge, attitudes and skills. These interventions were often short-term awareness and information campaigns (Mukoma, 2001), educational drama (Harvey, Stuart, & Swan, 2000) and life skills programmes (Visser, 2005). Along with adult-led programmes, peer-led programmes gained popularity as HIV prevention strategy in schools (Mantell et al., 2006; Visser, 2007; Ward et al., 2008). Peer education programmes acknowledge the influence of social norms on behaviour and aim at establishing positive social norms.

HIV prevention and life skills training were eventually integrated into the school curriculum in the form of the *life orientation curriculum* presented by educators. The curriculum focuses *inter alia* on health promotion involving knowledge, values, skills and understanding of gender norms that will enable young people to make informed decisions. The success of implementation varied, with some educators implementing it with more fidelity than others (Mukoma et al., 2009). Educators reported that they preferred a didactic style and provided fact-based information more readily than skills-based topics. Most educators did not feel equipped to provide skills development without first developing their own skills (James, Reddy, Ruiter, McCauley & Van den Borne, 2006). Factors that assisted educators to implement the programme were training and continuous support, a detailed manual, existence of a school HIV policy and students' enthusiasm for the lessons (James et al., 2006; Mathews, Boon, Flisher, & Schaalma, 2006; Mukoma et al., 2009). James et al. (2006) found that in schools where

the programme was implemented fully, learners reported less sex and more condom use compared to a similar control group. Implementation therefore plays an important role in programme effectiveness. This is especially true in the large-scale roll-out of effective interventions. These interventions are often hampered by structural or organisational problems in the educational system, school climate, school-community relationships and social environments (Campbell, Foulis, Maimane, & Sibiya, 2005; Helleve et al., 2009; Mathews et al., 2006; Mukoma et al., 2009; Schaalma, Reinders, Matasu, Kaaya, & Klepp, 2004; Visser, Schoeman, & Perold, 2004).

Despite many HIV prevention programmes implemented in South African schools, systematic and well-designed outcome evaluations are scarce (James et al., 2006; Klepp, Flisher, & Kaay, 2008). Available research results mostly show positive outcomes with regard to knowledge and attitudes (Gallant & Maticka-Tyndale, 2004; James et al., 2006) and only some evidence of reducing reported risky sexual behaviour (often increased condom use) (Harrison et al., 2010; Kirby, Obasi, & Laris, 2006; Mavedzenge, Doyle, & Ross, 2011; Mukoma & Flisher, 2008). There is seldom any evidence of change in biological outcomes (such as sexually transmitted infections) (Medley, Kennedy, O'Reilly, & Sweat, 2009; Michielsen et al., 2010).

Despite large volumes of research publications and guidelines for effective programmes (e.g. Aaro et al., 2006; Kirby, Laris, & Rolleri, 2005), the lack of empirical evidence leaves us with little scientific consensus about how best to prevent HIV infection among school-going young people (Harrison et al., 2010). One indisputable guideline is that programmes should be grounded in the theoretical understanding of adolescent sexual behaviour and the empirical data that may explain adolescent risk taking behaviour. Prevention strategies should be specifically targeted and focused on the specific risk factors underlying behaviour. This research was done to understand the underlying reasons for school-going young people's sexual risk behaviour after more than a decade of HIV education in schools. The research formed part of a baseline study to inform the development of the content and focus of a peer education programme in schools.

OBJECTIVE

The research was done to explore the factors underlying HIV risk behaviour of school-going young people in South Africa. This was done in an

effort to understand young people's behaviour and the communities they live in. This understanding would enable HIV preventive efforts to focus on specific risk factors and to promote a context that could support healthy behaviour among young people.

THEORETICAL FRAMEWORK

The theory of planned behaviour (Ajzen, 1991) and social ecological theory (Bronfenbrenner, 1995, 2005) were used to understand the various factors related to risk behaviour. According to the theory of planned behaviour, which is a social cognitive theory, individual behaviour is related to an individual's behavioural intentions. Behavioural intentions to perform a particular behaviour are, in turn, influenced by the individual's own attitude towards that behaviour (which is based on the person's beliefs about this behaviour) and the individual's subjective norms (based on normative beliefs which are influenced by an individual's perception of social norms). Additionally, the person's sense of perceived control (sometimes seen as self-efficacy) to choose to perform the behaviour, or not, plays a role in behavioural intention.

Behavioural intentions are important in determining behaviour, but the relationship between behavioural intention and actual behaviour is influenced by contextual factors (Bronfenbrenner, 1995). The social ecological theory is used in this research to capture some of the multiple spheres of influence of ecological interaction that influence the behaviour of an individual. The social ecological theory recognises that behaviour takes place in a dynamic social context where the individual and the social context are in constant interaction. The individual is shaped by the social context while the individual also influences the social context. The socio-cultural context that influences sex and sexuality and the realities of sexual risk behaviour needs to be taken into account. Therefore, in addition to various individual or proximal factors (such as knowledge of HIV, risk perception, attitudes, subjective norms and psychological factors), HIV-risk behaviour is also influenced by interpersonal relationships (such as with parents and peers), and community and cultural climate (such as socio-economic factors, cultural and gender norms) as well as community resources and policies (Eaton et al., 2003; Harrison et al., 2005). The wide range of factors that influence risky sexual behaviour can be organised into

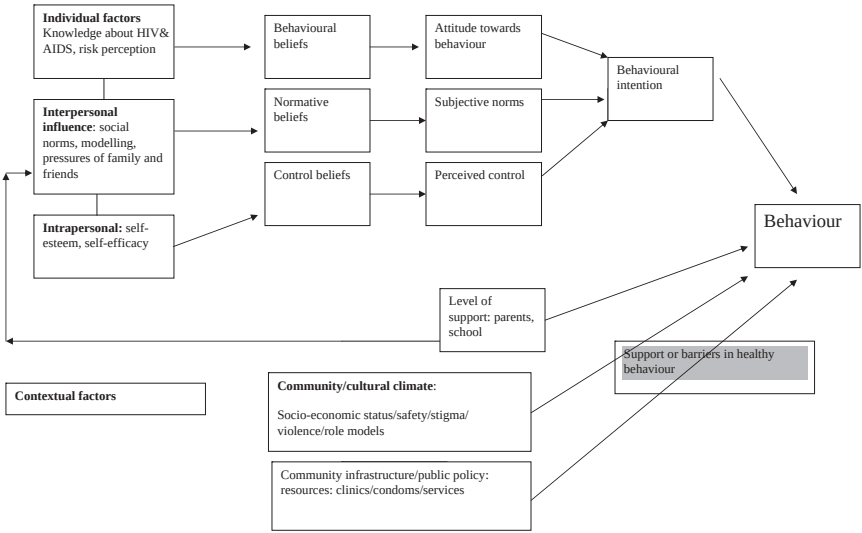


Fig. 1. Theoretical Model: Theory of Planned Behaviour and Social Ecological Theory.

a multi-level framework to account for the complex interaction between personal, interpersonal, community and cultural influences. A representation of the theoretical framework is given in [Fig. 1](#).

METHODS

This research formed part of a mixed methods baseline study to inform the development of a peer education program in schools. The Department of Education selected schools in specific districts in four provinces in the country for the implementation of the programme. These districts, mostly rural areas, were selected because they have been most adversely affected by the HIV/AIDS epidemic ([Department of Health, 2010](#)). This chapter reports on the qualitative study done to explore underlying factors of HIV risk behaviour from the perspective of various stakeholders in the school context.

Selection of Participants

Two schools per province were selected randomly from the schools identified for programme implementation. The schools were approached to participate in the research and principals and school governing bodies of the schools gave their permission.

Focus group discussions (Greef, 2005) were conducted with various stakeholder groups in the schools. It was assumed that different stakeholders would provide different perspectives that would enabled the researcher to understand learners’ behaviour. In each school a focus group discussion was conducted with each of the following groups:

- 1) a group of learners in Grades 8–9 (about 12–14 years old – junior learners);
- 2) a group of learners in Grades 10–12 (about 15–18 years old – senior learners);
- 3) a group of learners in leadership positions (peer educators and members of student representative body);
- 4) a group of educators teaching life orientation; and
- 5) a group of parents that volunteered to participate.

Groups consisted mostly of ten to twelve participants, except for the educator groups where there were an average of 6 educators in the groups. A summary of the number of groups and participants is given in Table 1.

Learners’ groups were mixed-gender groups and comprised of equal numbers of boys and girls. Previous research (Visser et al., 2004) alerted the researchers to the advantage of mixed-gender groups. Mixed gender groups create the opportunity of debate about gender roles that could elicited a clearer view of the gender dynamics between learners. Because of

Table 1. Number of Focus Group Discussions and Participants.

	Number of Groups	Number of Participants	Gender	
			Male	Female
Junior learners	8	96	45	51
Senior learners	8	96	47	49
Learners in leadership positions	8	80	38	42
Educators involved in life orientation	8	56	4	44
Parents	8	80	2	78

the sensitivity of the topic, facilitators were instructed to observe the interaction between boys and girls closely and to mediate if it had a negative effect on the discussion. Fortunately, this was not necessary because the discussions were open and constructive. Parents of learners involved in the group discussions were informed of the discussions and gave permission that their children could participate.

Educators' and parents' groups consisted mainly of females. It was difficult to recruit fathers to join the group discussions, as fathers in these communities were not intimately involved in raising their children.

Data Collection

Each stakeholder group was asked to discuss their perceptions of the underlying reasons for high-risk behaviour among young people. Additional to questions related to peer education, two questions were introduced in each of the focus group discussions:

- 1) In your opinion what motivates young people to engage in behaviour that places them at risk of HIV, despite their knowledge of the risks of HIV?
- 2) In your opinion, what conditions would prevent young people from getting HIV?

Using the same questions in different groups of stakeholders enabled the researchers to triangulate the data from different sources to understand the various perspectives.

The focus group discussions were held after school hours not to disturb the normal school day. Focus group discussions were facilitated by trained interviewers using a discussion schedule. During the two-day training workshop for facilitators, simulation and role play exercises were used to focus on facilitation skills and how to probe for information when necessary.

Before the focus group discussions started, the purpose of the discussions was explained to the participants. They were asked to sign consent forms if they agreed to participate in the discussions. Group discussions were conducted in the language of the group's choice. Most of the learners' and the parents' groups were conducted in the vernacular of the groups to enable the participants to freely discuss their issues. The focus group discussions were tape recorded with the permission of the participants, transcribed and translated into English by the facilitator who had

conducted the discussion. The quality of the transcriptions was controlled by the research team.

Data Analysis

A thematic analysis was done of discussions with each group of stakeholders. The first phase of analysis involved open coding, to identify the essence of the interviews and classify it into manageable units of data, as described by [Straus and Corbin \(1998\)](#). Thereafter, the codes were organised into broader conceptual themes. This involved the integration of different components into meaningful wholes in order to develop an understanding of the essence of the data. In this analysis, the frameworks provided by the theory of planned behaviour and the social ecological theory were used to classify the spectrum of socio-cultural risk factors in terms of various levels of the ecological system (individual, interpersonal, organisational and community level). Findings from the different stakeholders were then compared and integrated.

Due to the risk of qualitative data being interpreted subjectively ([Denzin & Lincoln, 2000](#)), specific attention was given to the validity of interpretations. Two interpreters analysed the data and discussed discrepancies in order to reach consensus on the interpretation. This process enhanced the validity of the results.

RESULTS

Themes from discussions with learners, parents and educators were integrated to identify the most common themes. Themes were organised into aspects on an individual, social, family and community level. When a specific stakeholder group expressed a unique perspective, this was indicated in the description of the themes. To be true to the nature of qualitative research, verbatim quotations are given to give participants a voice and to assist the reader in understanding their perspectives.

Reasons Underlying Young People's Risk Behaviour

Recurring themes on various levels were identified.

Themes Related to Individual Factors

Knowledge of HIV

Although learners generally had high levels of HIV-related knowledge, there were some gaps in their knowledge. For example, it seemed that girls were more concerned about preventing pregnancy and they did not always realise that oral contraceptive or injections does not protect them from HIV:

They know about HIV, because if they are asked about prevention, they will tell you about abstinence and all other prevention methods, but they do not practise them. (Educator)

Girls think if they get injected at the clinic that will prevent them from getting HIV and they sleep with many boys freely. (Junior girl)

Lack of Risk Perception

Young people did not see themselves as being at risk of contracting HIV. HIV was not a prominent theme in their discussions. They were more concerned about pregnancy, peer relationships and alcohol abuse. Additionally, some of them were not afraid to contract HIV since they knew there is medication that they can use to keep them healthy in case they do get infected. These perceptions have negative implications on risk behaviour:

Young people are aware of HIV, but they don't believe they will get it. (Senior girl)

We are no more afraid of AIDS because we know that if I take treatment I will live long. So, whether I get AIDS or not, I don't mind anymore. That is why we are no longer afraid of it, we can continue sleeping around. (Male leader)

Lack of Responsibility and Personal Control

Young people often engage in sexual behaviour without protecting themselves from HIV. In a few groups boys described sex in terms of self-centred actions of pleasure without considering the consequences:

To be honest, we guys always do things before we think. We need to relieve ourselves but we enjoy doing it with a girl. (Senior boy)

According to me sex time is anytime. Sex is like having tea, any time is tea time if we are in a private place. (Senior boy)

Developmental Stage

The educators explained that adolescents are at the age where they want to gain independence from adults. They want to explore aspects of adult life, including sexuality. They regard the problem as the lack of appropriate guidance on how to deal with their sexuality in an HIV context.

*Social Processes That Influence Risk Behaviour**Peer Pressure*

Peer pressure was identified as the root of risk behaviour among young people. Young people depend on their peers, like to be popular and do not want to lose their support. Therefore, they engage in similar behaviour as others to be accepted and to gain status in the group. Learners in the current study perceived the peer group norms to encourage risky sexual behaviour as illustrated in the following quotes:

You can be influenced by your friends and if you don't do what they tell you to do, they will say 'you are a fool'. Then you will end up doing what they want you to do. (Junior boy)

We always do things to try to impress our friends and we are deeply influenced by friends. Because many young people are talking about sex, if you don't have sex you look stupid. You are convinced to go and try to have sex. (Female leader)

They are making a mockery of those who have never had sex before. (Educator)

It is not easy for young people to resist peer pressure, as one learner said in the following quote:

I feel lonely when I see them chatting and having fun, and it makes me want to go and do it and sit with them and have fun all together. You don't think that this thing will put you at risk. (Junior girl)

Educators and parents perceived negative peer pressure to be the major reason for sexual risk behaviour, alcohol and drug use, doing crime and losing respect for their parents. Parents experienced that their children do not listen to them and forsake their education to gain peer acceptance. Taking part in risk behaviours resulted in children not going to school, not getting an education and even in getting raped. The parents' reactions illustrate this:

Young people are behaving in a strange way. They tend to ignore what they have been taught in school and at home and start doing all the wrongs. Our children listen to their friends and end up doing what their friends are doing. They end up getting babies and die and leave babies behind because of AIDS. This worries us. (Mother)

I think that young people are doing things to impress their friends, then they lose focus of their dreams and goals in life and lose respect for their parents. That is why they end up having kids as teenagers or find themselves using drugs. (Mother)

Gender Norms and Culture

Boys and girls have different motivations to engage in risk behaviour. Boys want to prove their masculinity by having many girlfriends. Girls want to be loved. Culturally a woman does not have the power to refuse a man sex, and her role is to obey and please men. Girls in the current study reported that boys pressurise them or manipulate them into having sex to prove their love. The girls do not want to lose their boyfriends and agree to sex even if they do not really want to. This is illustrated in the quotes:

Girls are scared to say 'no' to the guys, because we get scared to lose a guy. So she thinks that if she has sex with the boy he will have her forever. But most of the time the guys are using us to get into bed. (Senior girl)

Girls don't have the power to say no to boys. It is culture from home. As a girl, you have to agree on everything a boy says. (Senior girl)

Boys and girls have different expectations from one another and do not openly discuss condom use. The girls felt that they could not insist on condom use because boys would refuse. Boys felt they could not introduce it, because the girl did not even ask to use condoms. For them real love means having sex without a condom:

The thing is they want to prove that they are being loved or do really love. To them love is about having sex without protection. (Educator)

Myths About Sexual Behaviour

Young people believe the myth that if a person does not have sex, bad things will happen to him/her:

Your friends say to you that your virginity is going to make you sick. In ten years' time you will have disabled children, so you better have sex before you are 18 years old. (Junior boy)

Poverty and Financial Gain

A recurring theme in these discussions was that young people are having sex for financial gain and not always by free choice. Poverty was described as the root of many problems. Some young people trade sex as a survival strategy because of poverty, and others to gain rewards and status. For

some, sex has become a commodity that can be exchanged for various favours. For example, boys can ask girls for sex in exchange for helping them with their school work. Parents describe the problem as young people having a materialistic value system in a context of poverty:

I think sometimes we are missing the point. I think poverty at home forces our children to do things that they do not know. Poor children find themselves under a lot of pressure because they compare themselves with their friends who might be from rich families. This pressure forces them to risk their lives. (Mother)

Children are in trouble because their parents don't work, they don't have any money. They are doing this because they need money for food, school fees and for some household needs. (Female leader)

Young people are after status and style because of peer pressure. They will have sex with older men with money who drive expensive cars and that puts them at high risk of getting HIV – as long as they get their money. (Senior girl)

Some children do not get involved in trading sex out of free will. Some are forced to do so by their caregivers:

(The stepfather) will force that girl into having sex with people who have money so that she can bring money in the house. (Junior boy)

A Culture of Alcohol and Drug Use

The use of alcohol became a recreational activity or a way of life for young people which can lower their sense of responsibility and can increase risk behaviour:

Like now, if you can ask everybody in the community what they do for fun they will tell you about alcohol and nothing else. (Senior girl)

Sometimes a person is high on drugs or under the influence of alcohol; they don't realise that they didn't use a condom; they realise when they are sober that they had sex without a condom. (Senior boy)

Condom Use

Some learners were of the opinion that their friends who are sexually active use condoms. Others had negative perceptions of condoms such as that condoms, especially those provided free at clinics, are not safe to use and that they reduce sexual pleasure. Condom use is associated with a lack of trust and promiscuity in relationships. Young people expressed the opinion that condom use is not part of their culture, but rather part of the 'white culture'.

Learners discussed the difficulty to obtain condoms. Young people feel ashamed to collect condoms from the clinic. They are aware that adults in their community do not approve of their sexual behaviour and in collecting condoms, they expose themselves to criticism:

There is still stigma attached to condom users. For example, when you are seen taking condoms, people will start calling you names and the adults will think you are a bad influence on their children. (Senior girl)

In rural communities, it can even be more difficult to obtain condoms:

This is a deep rural community – people from this community don't talk about condoms. Some don't even know what a condom looks like, which means a condom is not being used because even clinics are miles away. (Educator)

Family Relationships

Negative Relationships and Role Models

Many learners in the study came from poor families or had parents who were ill or who abused alcohol. They experienced a lack of parental involvement, which led to ill discipline and a lack of support. Some parents worked far from home and only returned home once a month. Many learners felt they did not receive guidance and support from their parents:

Some parents go to work far away from the village, so when that child lives alone, there is no one. So you find that kids don't have shoes, they will go and sleep with some guy in order to get money to buy shoes. (Educator)

Some learners expressed that their parents and other adults in the community did not set a good example for them. The educators felt frustrated because young people did not get consistent messages about acceptable behaviour from school and home. A lack of guidance from parents and negative role models created an environment that did not encourage or reinforce behaviour that could protect them from HIV. In growing up, young people are actually imitating the behaviour of adults that they observed in their communities. The educators thus felt that they were standing alone in their efforts to educate young people on HIV/AIDS. One of the educators expressed this concern as follows:

The way in which adults handle themselves impact a lot on these youngsters. The youngsters are doing what we adults are actually doing in the community. That is why. To them this is a game that we are all busy playing. (Educator)

Lack of Sex Education

According to traditional culture, sex is adult behaviour. Parents are therefore not supposed to talk to their children about sex, because sex-talk is reserved for adults. Parents therefore did not feel comfortable to provide sex education to their children. The traditional structures where sex education was done in the past, like uncles or initiation schools, were not functioning any more in modern times. There is thus a lack of guidance for young people. Additionally, parents also expressed that they did not have enough time to give guidance to their children, being at work most of the time. The following quotes illustrate this:

Most parents in our community feel that they are too old to talk about sex and HIV with their children; they also feel ashamed to speak since they are uneducated and know nothing about such issues. Besides, talking about such things is still a taboo to them. (Mother)

The other challenge is that most parents are unable to make time for family life. Parents are always busy and as a result they do not have a bond with their children. That open relationship is difficult to establish. (Educator)

Parents have no relationship with their children. They don't talk about sex, relationships, even HIV. Because of this inability to communicate, children turn to their peers for guidance and advice. They normally get wrong advice that puts them at risk. (Educator)

Most of the learners felt that they could not talk to their parents about sex. Even if parents gave them guidance, learners felt that they lived in separate worlds and did not regard the parents' guidance as relevant:

The problem is that our parents are not educated in terms of sex education and we are not free to talk to our own parents. (Senior boy)

Parents talk to us and give us information. We ask why our parents have to tell us what to do and what not to do. They do talk and they are trying to show us a bright way which we can take. But we see things differently and we live our lifestyle our way. We do not want to take the direction that they are suggesting to us. (Senior girl)

Parents Felt Out of Control

There were various reasons why some parents felt disempowered and/or completely out of control. Parents were often not well educated and could not provide financially according to their children's expectations. These parents felt that they had failed their children by not being able to provide financially.

The most important challenge for parents was to accept that their children were growing up and could make decisions that were not in line with the parents' expectations and values. For the parent, it was important that the child got a good education to be able to have a different and better life than the parents had themselves. But some of the adolescents had different values and often behaved differently from what the parent expected of them. Young people often strive for material gain and pleasure. Some parents felt disappointed and out of control. A few quotes from parents illustrate their sense of helplessness – whatever they did, their children's behaviour was not under their control:

The challenges that we face when raising our children are that you take your child to school so she can have a future and she starts going around with boys sleeping with them until she ends up having HIV. Our children are dying while we are still expecting a lot from them. (Mother)

Today's children are uncontrollable, they do not listen. Their lives are totally in their hands and we can't show them the way. They are influenced by bad friends even if you try guiding them, they go their own way. (Mother)

I talk to my kids about a variety of issues, but you realise that they are not interested. They even tell me that I am old fashioned and that they will move out as soon as they can. (Mother)

You raise your child looking at making sure they succeed in life. Because you cannot afford expensive clothes, they will drop out of school and say they are going to work but they end up dating older people who could provide for them or doing criminal things and they get arrested. (Mother)

Child Abuse

Child abuse was a prominent theme in the discussion of junior learners and educators. They described the negative influence of various forms of abuse in families. They emphasised that children did not always become sexually active by their own choice. The learners explained how parents and other adults forced their children to have unprotected sex and to keep quiet about it. In this process, young people were exposed to HIV.

Some mothers force their children to get into unprotected sex, even the fathers force their children to have unprotected sex with them and they will ask them not to tell anyone. (Junior girl)

Children are being abused sexually and physically at homes but they are silenced and can't open up to their teachers because silence in this community is a norm that has been instilled in them. (Educator)

Community Infrastructure

The parents and educators expressed the opinion that the environment in which young people grow up does not encourage or reinforce behaviour that protects young people from HIV. They mentioned a few factors that could encourage sexual risk behaviour.

Cultural Practices

When boys came from initiation school (a cultural 'school' where they learn to be men), they have the instruction to have sex without a condom to prove that they were 'man enough' (Senior boy). Because many of the boys were circumcised as a cultural practice (which also lowers the risk of HIV), boys ended up practising unsafe sex, while believing that they were protected. Initiation school therefore does not prepare them for adult life in an HIV-contaminated context.

Exposure to the Media

The media is often blamed for stimulating young people to engage in risk behaviour. Some young people often watch pornographic films or download such material from the internet which influences their behaviour:

Young people are exposed to media containing pornography and they are likely to imitate acts of pornography they see on movies and television. In most scenes shown in these movies, condoms are not seen being used. (Female leader)

Lack of Recreational Facilities

Educators highlighted that there were very few entertainment opportunities for young people especially in rural areas. In such conditions sex became their way of finding entertainment:

The truth is when you look around, it is clear that there is nothing these learners can do, absolutely nothing. The infrastructure is poor and not conducive to leisure activities. As a result, sexual activity becomes some form of entertainment because there is nothing they can do to pass time. (Educator)

Social Grants

Educators and parents felt that young girls wanted to get pregnant to obtain the child grant the government provides to support the development of young children in disadvantaged communities:

Girls see the child grant as an easy method of running away from poverty. They simply make babies to qualify for these grants and put their lives at risk of getting HIV. Some end up having more than one baby in order to get more money. (Educator)

Eroding of Supportive Cultural and Community Structures

Some parents felt that various cultural and community structures that were previously available to manage behaviour had eroded. For example:

Most cultural practices like virginity testing have been abandoned and as a result children are uncontrollable and engage in all sorts of unhealthy and unacceptable behaviour. (Mother)

Parents also felt that the spiritual dimension of children's lives was not strengthened in school any more since religious education was eliminated from the school curricula. One parent said:

I think because religious education is no longer taught in schools there is no spiritual connection today. That is why our kids are so lost. It makes it very difficult to raise your children under these circumstances. (Mother)

Other parents experienced that community support structures of family and neighbours sharing the care and education of children had disintegrated. People did not assist one another anymore:

Our societies have changed so much that at times you will see that your neighbour's child is engaging in risky behaviour and you maybe try to communicate and advise her, but your neighbour will tell you to mind your own business. (Mother)

Factors That Could Prevent Risk Behaviour

An alternative theme that was expressed strongly in the focus group discussions with learners was that *not all learners engage in risk behaviour* and that these individuals were proud of that. These learners aimed to put effort into their education and to encourage one another to abstain from sex. They mentioned a few protective factors contributing to their decision not to engage in sexual risk behaviour.

Self-Respect and Self-Control

Learners described the decision to engage in risk behaviour as an individual's own decision. They felt that taking responsibility for their own behaviour protected them from risk behaviour. The following quotes illustrate this:

One big preventive way is self-respect, my mother taught me that. I have the right to say 'no' and a 'no' is a 'no', and it goes with respect. (Senior girl)

It is my choice; you only live once, so how can I do that just to please a guy? So if he doesn't want to use a condom, he can go. I will find somebody else if I have to.
(Senior girl)

Open Communication with Parents

Despite the negative picture of family relationships described above, there were learners who were happy that they had good relationships and *could* talk to their parents. The learners expressed that children who had positive communication with their parents and whose parents talked to them and gave them advice were in a better position not to engage in risk behaviour. They especially mentioned that fathers need to talk openly with their young boys. One learner said: *'The support they get at home is the best policy'*. (Senior girl)

Programmes at School

Learners mentioned various programmes at school that informed young people about HIV/AIDS. They mentioned that the life orientation educators and clinic officials who visited the schools occasionally inform them about risk behaviour.

Positive Peer Pressure

Learners felt that they could protect themselves from risks if they had the support of their friends. It was especially girls that expressed how important it was to choose friends who could motivate them to abstain from sex. They were proud to say that they were virgins.

Recreational Facilities

Recreational facilities such as sport were considered as constructive activities for young people. One learner said:

Soccer is one of the activities to keep us busy so that it takes the minds of young people off sex. (Junior boy)

Future Perspective

Some learners aimed to put effort into their education and future planning to improve their lives. This was mainly expressed by younger learners:

I think it is not good to start having sexing at our age because sometimes we find that our families are affected by poverty and when we get pregnant we end up leaving school in order to take care of our babies. (Junior girl)

What can help the young people not to get HIV, is to abstain while you are still young and then you can have sex when you are old enough. (Junior girl)

DISCUSSION

Through focus group discussions with various stakeholders in the school context, various patterns of factors perceived to influence young people's sexual risk behaviour were identified. Influencing factors were identified on all levels of the socio-ecological framework – from individual, social and family to community and national levels. These findings confirm various previous studies (Eaton et al., 2003) and show that the underlying processes of HIV transmission have not changed despite more than a decade of preventive efforts. The research findings reflect the complexity of risk behaviour and explain why behavioural preventive interventions implemented in schools are not more successful in changing risk behaviour.

On a personal level, attitudes and level of responsibility played a role in risk behaviour. Most of the learners were aware of the risks of HIV and had sufficient theoretical knowledge to protect themselves. They engaged in risk-taking behaviour nevertheless. Adolescents are at the development stage where they want to become independent of their parents and want to experiment with adult behaviour (Santrock, 2008). In the focus group discussions sex at this age was candidly labelled as self-centred pleasure seeking behaviour, without considering the consequences.

The learners' lack of risk appreciation in the third decade of the HIV epidemic was indeed an alarming finding. It seems as if some young people do not see themselves at risk of HIV and some even do not care if they get infected or not. They have learned that HIV is not a deadly or socially isolating disease anymore, but that there are free medication and national grants that would keep them healthy and supported even if they contracted AIDS. The implication of this finding is that HIV education and stigma

reducing interventions have a negative effect on young people's attitudes towards protecting themselves and taking responsibility for their own health. Even well-motivated and well-meant medical and financial support programmes are not beyond reproach.

This research highlighted the various social processes that influence individual risk behaviour. It was mostly perceived social norms in the form of peer pressure, gender roles, the culture of alcohol use, and the role of materialism in a context of poverty that negatively influenced the behaviour of young people. Peer pressure was identified as the root of risk behaviour among a large proportion of young people, as found in previous studies (Selikow et al., 2009). Peer pressure was also associated with high levels of alcohol use which increased young people's HIV risk (Kalichman, Simbayi, Kaufman, Cain, & Jooste, 2007). For many the influence of peer pressure overshadowed the corrective influences of educators and parents.

Inequality in gender roles is associated with sexual risk behaviour (Jewkes, Penn-Kekana, & Levin, 2002). This research highlighted how traditional gender roles encouraged boys to be sexually active and to prove their masculinity by having multiple partners. Girls, on the other hand, were socialised to be submissive. Girls then often wanted to please their boyfriends to gain their love and trust which did not include condom use. Against this background boys often manipulated girls into unprotected sex as proof of their love. Gender dynamics thus create powerful barriers to HIV prevention (Mantell et al., 2006; Strebel et al., 2006).

For some, in disadvantaged communities, sex was a way of survival. For others, it was a way to gain resources and peer group acceptance. Sex has become a commodity for young people who are materialistic in a context of poverty (Nkosana & Rosenthal, 2007; Waafas Ofofu-Amaah et al., 2005). Some educators considered the social grants the government provided for child development to add to this tendency and to encourage girls to become pregnant as a means of survival. Research is currently conducted to establish the validity of this claim.

Various reasons emerged for young people not wanting to use condoms as protection against HIV transmission, which confirm previous research (James et al., 2006; Moyo, Levandowski, Mac Phail, Rees, & Pettifor, 2008). They perceived condoms as culturally inappropriate and symbolising a lack of trust in relationships. Many of them believed condoms were unsafe to use, especially those provided by the government. They felt shy to collect condoms at clinics or public places because they feared people's reactions (Mantell et al., 2006). They were aware that their sexual

behaviour was not approved of in the community, but they nevertheless engaged in risk behaviour to prove their independence and maturity.

Positive family relationships could provide the adolescent with the strength to defend their values in the face of peer pressure. For young people who did not have positive parent-child relationships, acceptance in the peer group became even more important. When young people became independent of their parents, they often chose behaviour their peers approved of, but their parents disapproved of, because of different value systems (Santrock, 2008). The research results indicated that many young people experienced negative relationships with their parents. For various reasons, parents did not provide guidance related to sexual matters. Even if they did, many young people disregarded the guidance because they regarded their parents as old-fashioned. They therefore did not get or accept appropriate guidance from home to counteract the negative impact of peer group pressure.

Both educators and parents felt disempowered in their efforts to promote young people's health. Educators were frustrated because they did not perceive parents as good role models providing adequate guidance to their children. What was taught in school was therefore not reinforced at home. Parents on the other hand, felt isolated because they experienced that community structures and support systems, including religious systems and cultural values, had disintegrated. Additionally, the modern rights-based approaches to education (Vally, 2005; South African Schools Act, 1996) prevented parents from disciplining their children. Parents thus felt too disempowered to influence their children's behaviour.

These findings show that communities where young people grow up did not support protective behaviour. On the contrary, communities did not provide constructive recreational activities. They often exposed young people to negative role models and various forms of child abuse. The statement of an educator, that young people were actually just imitating the behaviour of adults they observed in their communities, emphasised that community change is necessary for HIV prevention to be successfully implemented among young people (Campbell et al., 2005; Mukoma et al., 2009).

Prevention efforts should therefore deal with individual factors to enhance personal control, based on accepted guidelines (Kirby, 1997; Kirby, Obasi, & Laris, 2006; Nation et al., 2003). The focus should not be on sex education and individual behaviour alone, but also on structural changes in the social ecology (Gupta, Parkhurst, Ogden, Aggleton, & Mahal, 2008). Prevention programmes should address the gaps between

educational and social messages (Selikow et al., 2009), especially with regard to peer group and gender norms, poverty and alcohol use that influence HIV risk behaviour. Young people should develop a critical awareness of the influence peer groups, gender and cultural norms have on their decision-making (Campbell & MacPhail, 2002). They also need the skills to oppose negative influences and to make informed choices amidst contradicting influences. This can be achieved through group interaction and using the influence of peer leaders to change the existing social norms. Even open discussions between boys and girls, such as in the focus group discussions in this research, enhanced understanding between them. Boys seemed surprised that some girls valued their virginity. Strong positive peer group pressure can become an alternative way of influencing young people's behaviour (Campbell, 2004).

Young people and their parents should be involved to address the quality of parent-child relationships. The role of parents as role models has to be strengthened. Collaboration between parents and educators could be the initiating step to counteract some negative community influences which adolescents are exposed to.

Change in structural and institutional contexts is necessary to achieve behavioural change (Gupta et al., 2008; Harrison et al., 2010). The provision of recreational and sport activities could create an alternative life style among young people. Media content and cultural practices should be discussed at community and governmental level. Practices that encourage risk behaviour should be discouraged, while practices that support healthy behaviour should be strengthened using media campaigns. Programmes to relieve poverty in communities can change the social climate to re-create hope. Through such interventions young people can learn alternative ways of securing their survival. Additionally, institutional change in the educational system is essential to enable effective implementation of these prevention efforts in schools (Mukoma et al., 2009; Visser et al., 2004).

HIV prevention should therefore consist of much more than short-term individually-focused behaviour change programmes. Multi-layered interventions involving various community structures should aim at changing the social fabric of communities and assist young people to create an alternative lifestyle. Although the research was specifically focused on young people in rural areas of South Africa, the results are widely applicable. The main finding that HIV prevention in schools should move beyond the individual to address social processes that influence behaviour is globally applicable. It also confirms the conceptual framework that HIV is

embedded in a social context (Bronfenbrenner, 2005; Campbell et al., 2005; Gupta et al., 2008).

ACKNOWLEDGEMENT

This research has been done by Link Community Development for the South African Department of Basic Education and was sponsored by USAID. I acknowledge the contribution of Anita Govan in collecting the data and Dr Faith Kumalo and Dr Saadhna Panday in overseeing the research.

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“NEW MUTUALISM” IN SMALL (AND MICRO) STATES: THE AIDS GENERATION AND AIDS FATIGUE IN THE CARIBBEAN EDUCATIONAL POLICY SPACE

Tavis D. Jules

ABSTRACT

This chapter is an exploratory piece to comprehend how national policies react to regional policy solutions designed to cope with the HIV/AIDS epidemic. It uses data from the national strategic plans for HIV/AIDS from 13 of 15 Caribbean Community (CARICOM) members to illustrate how they interpret the regional response to the pandemic. In drawing upon the existing literature on transfer, it focuses on what I term cooperative policy transfer – explore how policy concepts flow back and forth between the national and regional levels through cohesive harmonization – to understand how new policy trends emerge. A cross-sectional analysis based on a content analysis reveals the emergence of three new policy trends distinct to the region that guide HIV/AIDS

education: (i) creating a multisectoral approach; (ii) setting international targets; and (iii) establishing regional benchmarks. These new trends are identified as what I call the rise of new mutualism in education. The chapter concludes that the national and regional policy responses to HIV/AIDS in CARICOM countries, centered on new mutualism, became a rallying cry based on the belief that the Caribbean Single Market and Economy (CSME) can only function if CARICOM countries combine their resources to reverse the effect of HIV/AIDS on national educational systems.

INTRODUCTION

The prevalence of HIV/AIDS continues to pose significant challenges to economic development in the Caribbean region where the adult HIV infection rate, of 1 percent, is second globally to sub-Saharan Africa (UNAIDS & WHO, 2009). Currently, HIV/AIDS is the leading cause of death among 25–44-year-olds in the region. National governments are trying to limit the impact of the disease through prevention and awareness education programs, and by increasing access to health facilities and anti-retroviral drugs. In 2010, it was estimated that the region has received over US\$1.3 billion for its HIV programs (UNAIDS, 2010). Although previous studies have assessed the economic impact of the HIV/AIDS crisis in the Caribbean (CAREC & UWI, 1997; Laptiste, 2004; McLean, 2004; Theodore, 2001) and have used moderate-case scenarios to project the potential average increase in the total population living with HIV and AIDS in the region over the coming decade (UNAIDS & WHO, 2009), none have explored the impact the disease has had on education at the policy level. Therefore, this chapter builds on this existing work to understand how regional agenda setting practices on HIV/AIDS, including the policy recommendations contained within the 2002 Pan Caribbean Partnership Against HIV/AIDS (PANCAP),¹ *Caribbean Regional Strategic Framework on HIV and AIDS* (CRSF), influence the construction of national policies. In essence, this chapter explores how, in an era of heightened regionalism, the education policy response constructed by CARICOM (abbreviation for *Caribbean Community*, a regional consortium of 15 Caribbean nations)² is interpreted by member states to combat the effect of HIV/AIDS on national and regional development. Further, this chapter explores: (i) how the epidemic affects the Caribbean Single Market and Economy (CSME)

in an era of intensified integration and (ii) how national educational policies reconcile regional education mandates.

First, HIV/AIDS is historicized within the regional Caribbean context to provide a chronological genealogy of the epidemic and responses to it. Second, a review of the literature on educational isomorphism/convergence is detailed to provide concepts to frame the approach seen in CARICOM's response to global issues such as HIV/AIDS that impact both region and individual nations. To facilitate this discussion, I will take up the concept of "educational transfer" as applied within Comparative and International Education (CIE) (Beach, 2006, 2010; Phillips & Ochs, 2004; Rappleye, 2012; Steiner-Khamsi & Waldow, 2012) a bit further by focusing on what I term *cooperative policy transfer* – exploring how policy concepts flow back and forth between the national and regional levels through cohesive harmonization. As such, this chapter moves away from "methodological nationalism" (Robertson & Dale, 2009) and uses the regional level as the unit of analysis to investigate how a regional policy on HIV/AIDS influences national policy responses. Third, a content analysis of National Strategic Plans (NSP) for HIV/AIDS of 13 of 15 CARICOM members is utilized to illustrate how national policies interpret the regional response to the pandemic. Fourth, a cross-sectional analysis based on the content analysis reveals the emergence of three distinct new policy trends to guide HIV/AIDS education: (i) creating a multisectoral approach, (ii) setting international targets, and (iii) establishing regional benchmarks. These efforts spring from what I term *new mutualism*. Finally, this chapter concludes by arguing that policy advancement and practical implementation of policy at the national level are bound within the scope of the CSME and its call for the free movement of skilled labor; therefore, the economic consequences of HIV/AIDS will have disastrous effects on national and regional development, and ultimately will affect the delivery of educational services, forcing the AIDS generation to turn away from efforts to reach them.

Overall this chapter is meant to be an exploratory piece to comprehend how national policies react thematically to regional policy designed to cope with the epidemic, and the findings unveil the creation of *new mutualism* within policy adoption; an empirical piece designed to discuss the efficacy and impact of the policies within national education systems of individual CARICOM nations is outside the scope of this project. This chapter contributes to the significance of this volume by looking at a specific regional response to a global epidemic. By using a regional perspective to investigate the impact of HIV/AIDS on education as CARICOM forges ahead with building the CSME, education has reemerged as a "collaborative

dialogue” (Innes & Booher, 2003), which engenders the stimulation of non-economic integration to (i) increase the efficient operation of common service and activities; (ii) heighten internal understanding of cooperating states and the advancement of their social, cultural, and technological development; and (iii) intensify activities in such areas as education and health.

HISTORY AND COMPLEXITY OF HIV/AIDS IN CARICOM

CARICOM countries share and are shaped by numerous characteristics that impede their development³ and are often classified as “small states” or “small island developing states (SIDS)” (Armstrong, Kervenoael, Li, & Read, 1998; Commonwealth Advisory Group, 1997; Commonwealth Secretariat, 1985; Commonwealth Secretariat/World Bank Task Force, 2000; Read, 2004) – terms used interchangeably to describe the “vulnerability and fragility” of these countries (Briguglio, 1995; Bune, 1987; Holmes, 1976). The nations of CARICOM have been hit with many setbacks in the aftermath of gaining independence in 1960s and 1970s,⁴ and while still reeling from these difficulties, HIV/AIDS infected its first Caribbean persons in the early 1980s,⁵ originally identified only in men who have sex with other men (MSM). Today in the Caribbean, HIV/AIDS is transmitted mainly through heterosexual sex and “driven by the deadly combination of early sexual activity and frequent partner exchange by young people” (UNAIDS, 2000, p. 18). Allen (2002) found that 55 percent of boys and 24 percent of girls in CARICOM countries state that they had sexual intercourse prior to age 10 (last year of primary school), while an additional 23 percent of boys and 16 percent of girls reported that they had engaged in sexual activity between the ages of 11 and 12 (first year of secondary school). Within this context, Caribbean youth today are seen as part of the “AIDS generation” (Kiragu, 2001) because of two specific indicators: (i) the high prevalence rate of HIV/AIDS in the region and (ii) youth of the Caribbean have come of age in a region plagued by the epidemic; it is an everyday fact of life for them. Further, the sexual activity of youth makes them extremely vulnerable to HIV infection, which can affect educational attainment, reduce life expectancy, and diminish economic development as the availability of capable and healthy human resources decline.

Additionally, the consequence of HIV/AIDS on gender issues in the region has been drastic. During the 1990s, when more men were infected

than women, the disease was viewed only as a gay issue, prompting discrimination from secular and religious organizations; the Jamaican dance-hall culture condemned HIV/AIDS as the work of "sinful sexual orientation" (Kelly & Bain, 2003, p. 21). However by 2001 the regional portrait changed as 48.8 percent of those living with AIDS in the region were women – and of that group, women of childbearing age, 15–45, were those most infected. Allen (2002) argues that higher infection in women occurs "because [women] are more interested in maintaining their femininity by playing the passive sexual role – though their roles in the rest of their lives may be at odds with this" (p. 11). Gender issues are further amplified since men maintain a "double standard whereby they have multiple partners but women should not" (Allen, 2002, p. 11). Further, the "myth" that sexual intercourse with a virgin will cure sexually transmitted diseases gave rise to the number of infected women in the Caribbean while simultaneously propelling the exploitation of children and increasing the number of rapes. While gender issues further complicate the epidemic of HIV/AIDS in the Caribbean, poverty in the region has also worsened the impact of the disease.

The prevalence of poverty heightens the exposure of the poor to HIV, given their overall low levels of health and lack of access to condoms, information, nutrition, and proper health services. Further, HIV/AIDS aggravates poverty regionally since it removes "wage-earners from employment, deflects resources to medical and health care, and draws down on savings and capital" (Kelly & Bain, 2003, p. 45). Therefore, HIV/AIDS drastically hinders economic development in the Caribbean, engendering sickness, death, losses of professional personnel, and increases in absenteeism, medical care expenditure, and the cost needed to recruit and train auxiliary labor. In education, the effect of HIV/AIDS on the region fosters truancy, reduces resources, contributes toward the decline of education quality, and impairs teaching and learning. As education serves as the primary vehicle to enable policymakers and educators to combat the disease, it is essential to understand how the regional response was created, how it functions, and how it integrates with education policy on the national level.

CARIBBEANIZATION: ISOMORPHISM, TRANSREGIONAL REGIMES, AND POLICY TRANSFER

The section amalgamates the literature on neoinstitutionalism (shaped in sociology), regime theory (produced in international relations), and policy

transfer (generated in political science) to construct a theoretical lens to understand the regional policy response undertaken by CARICOM to HIV/AIDS. From diverse studies on industrialized countries in the field of CIE, neoinstitutional theory, (convergence or isomorphism), investigated the similarities that occur across different national education systems after the global expansion of mass education in the 1960s. Following [Kerr \(1983\)](#), convergence can be defined as the “tendency of societies to grow more alike and to develop similarities in structures, processes, and performances” (p. 3). Several scholars have therefore utilized neoinstitutional theory to establish that educational convergence occurs discursively at the international level in the form of common global scripts and blueprints – that is, similar policy problems were treated with similar policy solutions ([Meyer, Boli, Thomas, & Ramirez, 1997](#); [Meyer & Ramirez, 2000](#)). Furthermore, [Wiseman and Baker \(2006\)](#) note that educational isomorphism is often a product of “national legitimacy-seeking efforts and leads national educational systems to develop, encourage, or require relatively similar modules for local schooling and instrument” (p. 7). Within this framework, [Bennett \(1991\)](#) stipulates that emulation, elite networking, penetration, and harmonization are the key attributes of convergence that occur through *policy goals* (common policies), *policy content* (a formal policy manifestation), *policy instruments* (use of common instructional tools), *policy outcomes* (consequences of implementation), and *policy style* (policy diffusion). These four concepts are applied in CIE to understand the rise of international modules such as mass education ([Meyer et al., 1997](#)), the global model of schooling for the creation of citizens through a standardized curriculum ([Benavot, Cha, Kamens, Mey, & Wong, 1991](#); [Benavot & Braslavsky, 2006](#); [McEneaney & Meyer, 2000](#); [Meyer et al., 1997](#)), cross-national assessments such as TIMSS and PISA ([Baker & LeTendre, 2005](#); [Hutcheson & Schagen, 2007](#); [Kamens & McNeely, 2010](#); [Simola, 2005](#); [Wiseman & Baker, 2006](#)), institutional isomorphism/convergence as it relates to teaching practice ([LeTendre, Baker, Akiba, Goesling, & Wiseman, 2001](#)), evidence-based education policy ([Wiseman, 2010](#); [Wiseman & Baker, 2006](#)), and the dissemination of global norms and targets through nongovernmental organizations (NGOs) ([Chabbott, 1998](#); [Chabbott & Ramirez, 2000](#); [Jansen, 2005](#)).

Historically, the countries of CARICOM recognized the strategic importance of regional cooperation dating back to regional trading agreements (RTAs) commencing in the contemporary era with the West Indies Federation (WIF) in 1958.⁶ CARICOM, a descendant of the 1968 Caribbean Free Trade Agreement (CARIFTA), is built on the pillars of *economic integration*, *foreign policy coordination*, and *functional cooperation* – that is,

the noneconomic policy process through which integration is to be achieved. Within CARICOM, functional cooperation creates the efficient operation of common services and activities for the benefit of the Caribbean people; accelerates the promotion of greater understanding among the people; advances social, cultural, and technological development; and intensifies activities in areas such as health, education, transportation, and telecommunications (CARICOM, 2007). As such, CARICOM operates as a "transregional regime" (Jules, 2008), mapping national discursive patterns and scripts through cooperative and collaborative policy processes. Transregional regimes such as CARICOM are integrated through networks, competition, and cooperation, and are often influenced by "exogenously driven constructions, including isomorphism, decoupling and expansible structuration" (Meyer et al., 1997, p. 1). Further, if regimes are seen as "principles, norms, rules, and decision-making procedures around which actors' expectations converge in a given area of international relations" (Krasner, 1983, p. 1), CARICOM represents a new type of a transregional regime that arose during an era of heightened regionalism. With the end of the Cold War, CARICOM concentrated on harmonizing the social and political positions of its member states to rebut the various challenges associated with post-socialist development and moved toward deeper regional integration and the construction of what I term the *Caribbean Educational Policy Space* (CEPS).

Using neoinstitutional theory to analyze deeper regional integration within a transregional regime, such as CARICOM, it is argued that convergence emerges as a policy outcome to engender the CEPS. Therefore, regional forces are at work in CARICOM through and on the CEPS, and educational policy isomorphism occurs on the national level (Boli & Thomas, 1997; Kamens & Benavot, 1991; Meyer, Ramirez, & Soysal, 1992; Meyer et al., 1997). In other words, the amount of policy isomorphism that CARICOM member states exhibit in their organizational structure derives from the amount of exposure these nation-states have in relation to CARICOM and to other nation-states within the CEPS. CARICOM serves as a neoinstitutional actor to facilitate the exchange of policy ideas and cooperation. Since CARICOM acts as a multilevel governance institution responding to gaps and inabilities of national governments to control global, regional, and transnational interactions, additional research through the lens of *policy transfer* (e.g., Dolowitz & Marsh, 1996, 2000) presents a way to understand the mechanism that describes the policymaking procedures within transregional regimes.

Researchers in CIE have identified these processes of educational imports through an examination of national governments that find solutions to

similar policy challenges found in other countries that are eventually adapted or localized as solutions to national problems (Beach, 2006; Steiner-Khamsi & Stolpe, 2006). Recent works have examined this process from the perspective of “cross-national attraction education” (Phillips & Ochs, 2004), the global politics of educational borrowing and lending (Steiner-Khamsi, 2004), and marketplaces in training and educational reform (Finegold, McFarland, & Richardson, 1993). Additional studies have sought to understand the link between these processes, regional integration, and policy challenges in industrialized countries, particularly the European Union (Dale, 1999; Jakobi, 2010; Robertson, Bonal, & Dale, 2002; Simons, Olssen, & Peters, 2009), and the globalized policy trends of international institutions at the heart of regional entities (Jakobi, 2010; Verger, 2008). Therefore, policy transfer is often asserted as a part of the globalization process propelled by industrialization and integration. Overall, this investigation of policy transfer, or the “policy mechanism” (Dale, 1999) used by transregional regimes, provides a strong conceptual framework to understand the emergence of isomorphic domestic reforms around a specific issue area – in this case, the convergence of education reforms used to combat the HIV/AIDS pandemic in the Caribbean. Therefore, educational policy transfer is used to explore the domino effect of the HIV/AIDS epidemic by seeking to understand which policy solutions are transferred between regional and national levels.

METHODOLOGICAL TOPOGRAPHY

This research analyzes policy at the discursive level – the level of “policy talk” and not at the level of “policy action” or “policy implementation” (Brunsson, 1989) – to understand CARICOM’s response to the impact of HIV/AIDS on educational systems. For the purpose of this chapter, policy talk represents various policy-making discourses that exist in national and regional frameworks – specifically, official regional and national educational policy documents – to understand how regional discursive distinctions are negotiated given that they are governed by differences in power structures (Wodak, 2005).

First, the CARICOM and PANCAP’s *Caribbean Regional Strategic Framework for HIV/AIDS 2002–2006* (CRSF) was chosen as the benchmark for regional documents to establish the regional response to the impact of HIV/AIDS. The first CRSF covered the period 2002–2006 – later

extended through 2007 – and was developed in response to the growing recognition of HIV as a major developmental problem in the Caribbean. In 2008, the second CRSF (CARICOM & PANCAP, 2008) was developed. However, for the purpose of the current study, themes (regional priority areas) and thematic categories (regional sub-priority areas) were derived from the first CRSF (see Table 1). The CRSF (CARICOM & PANCAP, 2002) classifies the common opportunities and challenges that CARICOM members face and the framework identifies “priorities with regional public good...that could be best addressed collectively at a regional level, while identifying key issues for national level focus that would advance the regional fight against HIV” (p. 11). Implementation of the CRSF is based on “close collaboration among regional level organisations and national programmes” since the CRSF is not “intended to be a substitute for action at the national level, but to complement it” (CARICOM & PANCAP, 2002, p. 11). Moreover, the CRSF allows for measuring the extent to which regional isomorphism occurred in education policy because “the objective of the CRSF and of the regional plan of action that flowed from it was to support national efforts to prevent and

Table 1. Regional Priority Areas and Categories.

	Themes (Regional Priority Area)	Thematic Categories (Subregional Priority Area)
Priority 1	Advocacy, policy development, and legislation	11
Priority 2	Care, treatment, and support for people living with HIV/AIDS	8
Priority 3	Prevention of HIV transmission, with a focus on young people	8
Priority 4	Prevention of HIV transmission among especially vulnerable groups:	
	(i) Men who have sex with men (MSM)	3
	(ii) Sex workers	2
	(iii) Drug and substance abusers	1
	(iv) Prisoners/uniformed populations	1
	(v) Mobile populations/people in the work place	2
Priority 5	Prevention of mother to child transmission	4
Priority 6	Strengthen national and regional capacities for analysis, program design, implementation, management, and evaluation	3
Priority 7	Resource mobilization	2

control the HIV epidemic and mitigate its consequences at the national and regional levels” (CARICOM & PANCAP, 2002, p. 11).

The next step was to identify the relevant NSP that would be used as the basic unit of analysis since they were developed based on the vision and goals of previous national policies and reports, as well as situational country assessments, poverty reduction strategy papers (PRSPs), situation and response analysis of data from stakeholder participatory methodology (SARA), behavioral surveillance surveys, and a review of review of epidemiological data.

Thirteen of fifteen⁷ NSPs – Antigua and Barbuda, Barbados, Belize, Dominica, Guyana, Grenada, Jamaica, Montserrat,⁸ St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago – were selected for a thematic content analysis (see Table 2). NSPs were collected, and two coders individually read them for qualitative evidence of convergence between individual NSPs and the regional CRSF. Each coder identified policy references or “policy congruencies” (Jules, 2008) – that is, the existence of the exact text (word for word) or the conceptual thematic constructs. Each occurrence was given a rating of 1. If themes or thematic categories were not present, coders gave a rating of 0. Therefore, if a direct reference to themes or thematic categories were found in any NSP, that reference was given a positive rating and designated as congruency. For example, the *Government of Belize (2006–2011)* noted that “a multisectoral approach will be used in regard to planning, programming, implementing, monitoring and evaluating all stakeholders in support of the National Strategic Plan” (p. 11) and the *Government of Trinidad and Tobago (2004)* called for “building and sustaining partnerships for multisectoral action” (p. 10). Both coders recoded these passages as the existence of policy reference or policy congruence for the thematic category of Priority Area 1-to *promote awareness at the multisectoral level on HIV and human rights issues* and assigned a rating of 1.

Finally, once all documents were read, analyzed and coded, secondary policy sources were consulted to understand the regional dynamics and the policy landscape. The coders found three distinctively new trends emerge – (i) creating a multisectoral approach, (ii) setting international targets, and (iii) establishing regional benchmarks – as a regional policy response (later categorized as *new mutualism*). The finding of isomorphism across the regional level was expected given CARICOM’s mandate of deeper integration; however, what was surprising was the way educational isomorphism was coordinated under the guise of new mutualism that will be discussed in more detail.

Table 2. National Strategic Plans Analyzed.

Country	National Strategic Plans on HIV/AIDS (NSPs)	Policy Period	Total Pages Analyzed
Antigua and Barbuda	Strategic plan for the national response to HIV/AIDS Antigua/Barbuda 2002–2005	2002–2005	26
Barbados	National strategic plan for the prevention and control of HIV 2008–2013	2008–2013	54
Belize	Strategic plan for a multisectoral national response to HIVAIDS in Belize (2006 – 2011)	2006–2011	63
Dominica	National HIV and AIDS response program training plan	2009	3
Grenada	Grenada national HIV & AIDS strategic plan 2009–2015	2009–2015	73
Guyana	Guyana national HIV/AIDS strategy 2007–2011	2007–2011	73
Jamaica	HIV and AIDS in Jamaica national strategic plan 2007–2012 March 2008	2008	74
Montserrat	National strategic STI/HIV/AIDS plan 2005–2010 and work plan 2006–2010	2005–2010	21
St Kitts and Nevis	National HIV/AIDS Strategic Plan Saint Kitts and Nevis 2009–2013	2009–2013	34
St Lucia	The Saint Lucia national HIV/AIDS strategic plan 2005–2009	2005–2009	49
St Vincent and the Grenadines	HIV and AIDS national strategic plan 2010–2014	2010–2014	85
Suriname	National strategic plan - Republic of Suriname	2009	38
Trinidad and Tobago	Five-year national HIV/AIDS strategic plan January, 2004 – December, 2008	2004–2008	144

THE RISE OF NEW MUTUALISM IN THE CARIBBEAN EDUCATIONAL POLICY SPACE

A content analysis of the NSPs for HIV/AIDS of CARICOM’s members indicates that national best practices are often transferred to the regional level and subsequently enshrined into regional institutions, declarations, conventions, and strategies. These, in turn, are transferred back to the national level under the assumption that the agreed upon regional principles will guide national policy protocols, legislations, performances, strategies, and processes. Therefore, disseminating ideas and national best practices at ministerial meetings lead national governments to seek a regional solution to collectively transfer and enshrine their “best practices”

into a regional body. Thus, the utilization of policy transfer, the institutionalization of functional cooperation, and the creation of a common regional strategy form the policy response to the impact of HIV/AIDS on education level in the Caribbean. I identify this as the rise of *new mutualism* in education policymaking, which is based on the belief that the CSME can only function if CARICOM countries combine their resources together to reverse the effect of HIV/AIDS on national educational systems. Therefore, it is argued that new mutualism incorporates functional cooperation and policy transfer to seek regional solutions to national problems in an era of enhanced regionalism. Here, new mutualism can be seen as an understanding of regional educational policy practices, processes, and performances and their relation to national structural dynamics through an examination of multiregional governance arrangements and its nexus to a policy process.

The upsurge of new mutualism in education began in the Caribbean as nations paved “the way for a regional consensus on the necessity of market oriented policy reforms in domestic economic management and for its correlated ‘Open Regionalism’ [cooperation across national borders in a region to reduce transaction costs], as the model of regional integration” (Girvan, 2001, p. 1). Although open regionalism was developed as a way of protecting RTAs in an age of greater trade liberation, its application in CARICOM became a way of protecting intraregional trade dynamics, and allowing for the coordination and sharing of resources to enable the mutual benefits of public goods. While in recent years CARICOM has expanded its integrative project to accommodate open regionalization, the open regionalism that exists today is a mere extension of the functional cooperation. Moreover, the Grand Anse Declaration (CARICOM, 1989) calls for the transformation of the CSME into a space to facilitate open regionalism by liberalizing internal markets for goods, services, and factors of production through combining and opening up the region to the rest of the world.

The content analysis shows that cooperation and collaboration within CARICOM’s health and education policy is not new. Thus, following Bennett (1991) and Dolowitz and Marsh (2000), it is argued that policy transfer occurs in transnational communities that share information and common viewpoints on policy. However, since functional cooperation is one of the core pillars of CARICOM, it is suggested that new mutualism is operationalized through what I term *cooperative transfer* – the movement of policy concepts back and forth between the national and regional levels. Cooperative transfer is way in which national policy ideas are escalated to the regional level and then sent back to the national level in the form of

regional mandates. For example, the Caribbean Cooperation in Health Initiative (CCH) adopted in 1984 by national health ministers was the first regional cooperative endeavor to “optimize the utilization of resources, promote technical cooperation among member countries, and to develop and secure funding for the implementation of projects in priority health areas” (CARICOM, 2010, p. 1). In February 2001, the second regional cooperative iteration, PANCAP, was created to scale up national responses to HIV/AIDS in the region by: (i) advocating for HIV/AIDS issues at government and highest levels; (ii) coordinating the regional response and mobilizing resources; and (iii) increasing country-level resources, both human and financial, to address the epidemic. In June 2001, PANCAP gained full legitimacy within CARICOM when the Conference of Heads of Government of the Caribbean Community (CHGCC) endorsed it at the regional level in the *Nassau Declaration on Health 2001: The Health of the Region is the Wealth of the Region* (CARICOM, 2001). This validation signaled a regional response to address the disease and suggested nations’ need for regional level guidance and assistance. The CHGCC noted they were “cognizant of the critical role of health in the economic development of our people and overawed by the prospect that our current health problems, especially HIV/AIDS, may impede such development through the devastation of our human capital” (CARICOM, 2001, p. 1). The Nassau Declaration (CARICOM, 2001) formally institutionalized the operationalization of policy transfer by recognizing the importance of pan-Caribbean governance issues when it tasked PANCAP with de facto status of supporting the seven priority areas, discussed below, that were identified in the CRSF (CARICOM & PANCAP, 2002). Data analysis shows that the CCH was advanced by cooperative transfer focused on building capacity and leadership in public health. Additionally, during the Twenty-First Inter-Sessional Meeting of CHGCC (CARICOM, 2010), the Caribbean Public Health Agency (CARPHA), a merger of the five Regional Health Institutions (RHIs) – Caribbean Environmental Health Institute (CEHI), Caribbean Epidemiology Centre (CAREC), Caribbean Food and Nutrition Institute (CFNI), Caribbean Health Research Centre (CHRC), and the Caribbean Regional Drug Testing Laboratory (CRDTL) – was approved and came into existence in 2011 as a new single regional public health agency for the Caribbean. In sum, the Caribbean’s cooperation on health is now in its third phase and being engineered under cooperative transfer, which has existed in the Caribbean for years.

When the Report of the Caribbean Commission on Health and Development (PAHO, WHO, & CARICOM, 2006) cited the “harm that ill health

could have on development” (p. XIV), the region acknowledged that HIV/AIDS has the potential to roll back economic gains. HIV/AIDS became seen as a regional security crisis when CHGCC noted that the epidemic was having “devastating effects among young adults in their most productive years, and [has the] potential to seriously compromise the economic growth of the Region” (CARICOM, 2001, p. 4). Thus, the HIV/AIDS epidemic threatened to reverse the economic development achievement of the region since the 1980s because the loss of productive adults would have widespread adverse effects on the major sectors of regional development, including tourism, agriculture, mining, fishing, timber trade, and finance (World Bank, 2002). In what follows, it is argued that the rise of new mutualism, premised upon deeper cooperation and coordination, led to emergences of three new and distinctive policy responses to combat the impact of the disease on students, teachers, schools, and curricula: (i) a multisectoral approach; (ii) international target setting; and (iii) regional benchmarks to combat AIDS Fatigue.

Multisectoral Approach

It is argued that the rise of new mutualism led the CCH to enact the first regional policy response to combat the impact of the disease on education. Before the push toward a multisectoral coordination, the epidemic was seen as a health issue, not necessarily crossing over into the education sector. Discursively, the multisectoral approach became a way of mitigating the consequences of the disease through a shared vision of policy priorities. Collective responsibility for the impact of the disease was placed on both sectors of society – public and private – as well as community-based organizations (CBOs), NGOs, and faith-based organizations (FBOs). A multisectoral response involves:

... all sectors of society – governments, business, civil society organizations, communities and people living with HIV/AIDS, at all levels – pan-Commonwealth, national and community – in addressing the causes and impact of the HIV/AIDS pandemic. Such a response requires action to engender political will, leadership and coordination, to develop and sustain new partnerships and ways of working, and strengthen the capacity of all sectors to make an effective contribution. (Commonwealth Secretariat, 2001, p. 2)

It was only with the involvement of NGOs, CBOs, and FBOs in the treatment of vulnerable populations that the diseases became seen as multisectoral rather than single-sectoral. As the Government of Guyana (2007) notes, the comprehensive multisectoral response is intended to guide all

"government ministries and agencies, international agencies and partners and civil society in designing and implementing programs as part of the national response in the fight against HIV/AIDS" (p. 36). A multisectoral approach also allows for governments to advocate regional ownership rather than national ownership as the [Government of Jamaica \(2008\)](#) notes "each [sector] must recognize and take ownership of their unique role in achieving universal access to treatment and prevention" (p. 17). For some national governments, an approach involving "identification and costing of needed inputs and the mobilization and management of necessary resources" (Government of Montserrat, 2006, p. 6) was needed to recognize the ongoing commitment, support, and involvement of all sectors within the society since the disease also has economic, social and cultural aspects ([Government of Saint Vincent and the Grenadines, 2010](#)). The multisectoral approach also helped set a regional policy that could be used to assuage the impact of the disease on education once the consequence of the epidemic on educative attainment was observed.

When it was recognized that education should be a central component to battle the spread of the disease, the regional partnership through PANCAP produced the first CRSF in 2002 and updated that framework in 2008. The second CRSF identifies the provision of "regional public goods and service" and the "roll[ing] out [of] national strategies that are based on regional and international best practices" (CARICOM & PANCAP, 2008, pp. 9, 37). The policy response of a multisectoral approach to deal with HIV/AIDS represents a pan-Caribbean regional reaction that not only embraces all CARICOM member states but also Cuba, the Dominican Republic, the British and Dutch Overseas Territories, the French Departments of the Americas, and the United States Territories in the Caribbean. The response also calculates a reaction that delineates the policies and public goods to be distributed at the regional level while safeguarding the delivery of tangible benefits at the national level. Once the multisectoral approach was identified in the form of the CRSF, regional attention turned toward seeking international legitimization for contested domestic reforms.

International Target Setting

In 2006, when the CSME eventually came into effect, national governments sought to benefit from its provisions for the free movement of labor, goods, and services across national borders. The immediate impact of HIV/AIDS

on education became apparent as national governments realized that several cultural taboos and stigmas about the disease still persisted at the national level. Specifically, the disease had negative, unintended, consequences for students, teachers, schools, and curricula in relation to the rise of national discriminatory practices of vulnerable groups including Commercial Sex Workers (CSW), MSM, youth, single, unemployed dependent women (SUDW), persons with disabilities (PWD), bisexual men, drug and alcohol abusers, mini bus drivers, uniformed personnel, prisoners, and fisher folk. If Caribbean citizens were to truly enjoy the benefits of the CSME, national legislations needed to be updated to combat stereotypical cultural norms. It is within this context that data analyzed shows the second regional policy response to combat the impact of HIV/AIDS, international target setting, emerged.

In the first instances, the policy response of subscribing to international targets to combat the efficacy of HIV/AIDS stemmed from low levels of respect for human rights for vulnerable populations. Currently, sex remains taboo and sexuality or sexual orientation is not discussed at all. Moreover, gender issues are confused with women issues, and women in particular fear violence from their partners if they disclose their HIV status ([Government of Jamaica, 2008](#)). Globally, in 2001 for every 100 HIV-positive young men (aged 15–24), 170 young women (aged 15–24) were infected ([Kelly & Bain, 2003](#); UNAIDS, 2000). Regionally, the epidemic is following the classic global feminization trend where during the early stages of disease it affected more men, particularly MSM, than women; however, today more females are infected through heterosexual transmissions. Male-to-female ratio infection rates across the region are now 1 to 1. The [Government of Saint Kitts and Nevis \(2009\)](#) argues that double standards are used for women when it comes to sexual behavior and promiscuity where “women are supposed to be faithful to one partner, but men are allowed, and encouraged by their peers, to have multiple partners” (p. 3). Further, gender role differentiation stems from inequalities in male/female relationships in which men extort physical control or influence prevention options because “men are often the sexual decision makers, thus condom use negotiations are difficult for women” ([Government of Jamaica, 2008](#), p. 22).

Independent of the CRSF (CARICOM & PANCAP, 2002), all countries agreed that it was essential to adopt the “Three Ones” key principles to combat stereotypes and the spread of the epidemic – “(i) one agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; (ii) one National AIDS Coordinating Authority, with a broad based

multi-sector mandate; and (iii) one agreed country level Monitoring and Evaluation System” (UNAIDS, 2004, p. 1). The goal behind the implementation of the Three Ones principles was the ability of national governments to organize self-coordinating entities, partnerships, and funding mechanisms for concerted action in a country-led response to HIV/AIDS. This coordinated initiative identified resource allocation and accountability, as well as the connection between HIV/AIDS to poverty reduction and development, and the building of human capacity to meet national and regional needs. In moving to legitimize national reforms toward international principles, the regional HIV/AIDS response was couched as a human rights issue and people living with the disease were seen as needing protection under international instruments given the region’s history of discrimination. The ten principles from the International Labour Organization (ILO, 2003) on HIV/AIDS in the world of work – (i) recognition of HIV/AIDS as a workplace issue; (ii) nondiscrimination; (iii) gender equality; (iv) healthy work environment; (v) social dialogue; (vi) nonscreening for purposes of exclusion from employment or work; (vii) confidentiality; (viii) continuation of employment relationship; (ix) prevention; and (x) care and support – subsequently became the cornerstone of regional NSPs that call for legislation against discrimination and the outlawing of buggery and sodomy laws in an appeal to reach vulnerable groups. Once international benchmarks were established as a way to enact national reforms, the next policy response was establishing regional targets to combat AIDS Fatigue – that is, the desensitization to the efficacy of the epidemic.

Regional Benchmarks for AIDS Fatigue

The region recognized that the current youth generation is suffering from AIDS Fatigue. Here AIDS Fatigue within CARICOM is premised upon Knowledge that students know enough about the disease but are desensitized due an oversaturation or overexposure of information. Students are exhausted of hearing the same cautionary messages and have become disassociated. Thus, data analyzed shows that regional benchmarks to combat AIDS Fatigue represent a third regional policy response. These efforts sought to identify and correct behavioral traits and practices that existed at the national levels by utilizing and implementing the Health and Family Life Education (HFLE) program.

Coupled with the susceptibilities that vulnerable populations face, NSPs identified that although youth hear the AIDS message, it does not resonate with them and several behavioral patterns are still endemic to national policy

situations and thus responsible for AIDS Fatigue and rising infections in the youth population. These behavioral traits included having multiple partners, participating in transactional sex, failing to use condoms with nonregular partners, having sex with CSW, and substance abuse (primarily alcohol and ganja). There is also a lack of perception of personal risk, inconsistency between knowledge and behavior modification change, myths on transmission, and taboo discussions of sex that all continue to lead to the aforementioned risky behaviors among youth. The [Government of Jamaica \(2008\)](#) identifies that “risky behaviours...have fuelled the HIV epidemic over the last decade since persons who deny or are unable to calculate their personal risk often times get caught in the trap of unprotected sex” (p. 22). In order to survive, poor and marginalized groups sometimes indulge in risk-taking behaviors, which also make them more susceptible to HIV infection.

Another factor identified was the difficulty in reaching high-risk populations beyond the obvious CSW, including “rent a dread” ([Government of Antigua and Barbuda, 2002](#)) and “beach boys” ([Government of Barbados, 2008](#)) – male prostitutes for tourists. The [Government of Jamaica \(2008\)](#) cautions that although behavioral change theories have been used as a strategic framework, “insufficient attention has been given to constructs that highlight the need for changing or impacting the environment” (p. 36). These include the sugar daddy syndrome or transgenerational gaps where older men pay schoolgirls for sex, informal sex – sex for gifts or favors, – and unidentified transactional or freelance street-based workers. These factors also increased the risks among girls who are nonprofessional sex workers both within and external to the tourism sector, forced to have sex, have sexual intercourse with HIV-infected older men, and were in visiting partner relationships – sex with more than one partner.

The second regional behavior trait contributing to AIDS Fatigue is sociocultural wherein the stigma and discrimination of the disease – enhanced by religious conservatism and buggery laws – against persons with HIV/AIDS or those perceived at increased risk of the disease or infecting others is high. These two factors were driving the most-at-risk, including MSM, CSW, and prison inmates, underground and away from seeking testing. Work discrimination is also pervasive and in some instances private sector firms still practice HIV screening for purposes of exclusion.

The third behavioral trait is that of economic hardship stemming from inadequate economic growth, high levels of unemployment and underemployment, persistent poverty, the burgeoning informal sector in relation to the illegal drug trade and commercial sex tourism, rural/urban migration, mobile population in search of economic opportunities, increase in

cross border travel, and international travel and population movements ([Government of Guyana, 2007](#); [Government of Jamaica, 2008](#)).

The first Caribbean HFLE ([UNICEF, CARICOM, & EDC, 1996](#)) curriculum framework endorsed by the CARICOM Standing Committee of Ministers of Health and Education in 1996 provides goals, objectives, standards, outcomes and sample lessons in four thematic areas: (i) Sexuality and Sexual Health (which includes HIV/AIDS prevention); (ii) Self and Interpersonal Relationship (which integrates violence prevention); (iii) Appropriate Eating and Fitness; and (iv) Managing the Environment. The implementation of HFLE curriculum targeted to early childhood, primary, and secondary education was a regional policy response to combat the disease. HFLE curricula include life skills and health teaching in the curriculum framework for students' ages 9–14. The application of HFLE is based on a whole institution that emphasis "life skills that better prepare the students to make informed choices with regard to sexual and reproductive health" ([Government of Jamaica, 2008](#), p. 38).

In sum, new mutualism as a regional policy response to combat the impact of the epidemic was identified as "... the sharing of information on best practices within the member states in relation to human resource and performance management strategies affecting our teachers and our schools" ([CARICOM, 2002](#), para. 2). Thus, new mutualism – as a policy reaction in the form of a multisectoral approach, international target setting, and regional benchmarks – became a way of providing a coordinated regional response to the epidemic, but also a way to engage in building a new regional educational space in the form of the CEPS through mitigation of transactional costs, sharing of policy best practices and techniques, and dissemination of information.

CONCLUSION

In seeking understand to the impact of HIV/AIDS education within CARICOM, this chapter argues that the response to the epidemic was a regional policy reaction in the form of the CRSF ([CARICOM & PANCAP, 2002](#)) that gave rise to new mutualism. CARICOM, defined as a transregional regime, is identified as responsible for a regional response and that response is analyzed within the theoretical framework of neoinstitutionalism, where functional cooperation and cooperative transfer facilitated the regional policy response. Both the emergence of isomorphism and the mechanism of policy transfer enable a deeper understanding of CARICOM's policy response to HIV/AIDS, highlighting the paradigmatic

shift that has occurred from creating national policy solutions to focusing on a regional mandate to eradicate the disease. Given the smallness of the region and its numerous vulnerabilities, CARICOM undertook regional steps to facilitate cross-national transfer in policies and processes to combat the diseases. Additionally, policy transfer facilitates the movement of local knowledge between the nation and the regional level. This movement between the local and regional is seen as cooperative policy transfer fostered by functional cooperation and characterized by the development and exchange of policies and programs, dissemination of information, human resource development at the regional level, and monitoring and evaluation. A content analysis revealed that regional policy recommendations do indeed influence national level policymaking and practices in what has been described as the emergence of new mutualism. This influence stems from the ability of national governments to collaborate and cooperate at the regional level and engender national level reforms despite the smallness of CARICOM countries.

In understanding the regional response to the epidemic in the AIDS generation era, the appearance of educational isomorphism was shown to be deliberate, inorganic and necessary to combat the epidemic and foster integration within the CEPS. The deliberation came about because “international knowledge banks” (Jones, 2004) were trading PRSPs for the ills of SAPs while its inorganic nature stems from the core foundation on which CARICOM was erected. CARICOM is first and foremost premised upon integration, and as such, isomorphism at varying levels is expected among its entities. In this respect, regionalism is given preference over internationalism, and consequently, internationalism must conform to regional standards, not vice versa. The appearance of regional policy convergence around the HIV/AIDS agenda stemmed from realization that if CARICOM was to succeed in pushing its agenda through, member states needed to collaborate. Therefore, the extent to which regional isomorphism exists depends on the amount of regional discourse that national governments have incorporated into their respective national policies.

In light of these applications, this chapter concludes by suggesting that new mutualism provides a way of explaining the three distinctively new policy trends: a multisectoral approach, international target setting, and regional benchmarks, that have emerged at the regional level as a policy response to the impact of HIV/AIDS in the region. New mutualism operates as a policy way of thinking, acting, and being at the regional level and concedes that the various policy responses to the epidemic stem from the region’s ambition of creating seamless economic and educational spaces for the movement of labor, goods, and services. Therefore within the CSME,

the first policy reaction identified was a multisectoral approach, arising out of recognition that the epidemic affected all sectors and subsequent policy prescription should not only be provided by the ministries of health but also by other ministries – especially the ministries of education – as well as involving other stakeholders and civil society. The identification and subscription to international targets as a way to enact legislation at the national level, represents a second use of new mutualism. CARICOM's members had difficulty in protecting vulnerable groups, but couching policy reforms within a human rights framework allowed national movements to commence the reforms that have far reaching implications for education. The final approach identified in this chapter to new mutualism was the setting of regional benchmarks in the form of establishing regional best practices through HFLE that national governments could draw inspirations from. The fact that HFLE was created at the regional level with the aid of cooperative transfer means national governments had a say in the regional strategic framework that they were expected to implement into their national curriculums.

By building on the discourse of globalization and using convergence as the centrifugal construct, this chapter demonstrated how the process of functional cooperation constructs regional policy isomorphism. Additionally, within the context of new mutualism, this chapter shows that within the CEPS, regional isomorphism differs greatly from traditional isomorphic research about world culture. In fact, the argument is that isomorphism at the regional level is more organic in nature, since it exists within a policy space and flows across space and time, and that it is the only viable way to combat the effect of the pandemic if the microstates of the Caribbean are to survive the challenges of both globalization and the HIV/AIDS epidemic.

ACKNOWLEDGEMENT

I am grateful for the support of my colleagues Kristin J. Davin, Lara Semata and my graduate assistant Landis G. Fryer who provided comments on earlier drafts of this chapter, and to the two external referees who provided extensive critical feedback.

NOTES

1. PANCAP members include Anguilla, Antigua & Barbuda, The Bahamas, Barbados, Belize, Bermuda, British Virgin Islands, Cayman Islands, Cuba, Dominica, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Montserrat, The Netherlands Antilles, Puerto Rico, St. Kitts & Nevis, St. Lucia, St. Vincent & The Grenadines, Suriname, Trinidad & Tobago, Turks & Caicos Islands, and The US Virgin Islands.

2. CARICOM's full members are Antigua & Barbuda, Barbados, Belize, Bahamas, Dominica, Guyana, Grenada, Jamaica, Montserrat, St. Kitts & Nevis, St. Lucia, St. Vincent & the Grenadines, Haiti, Suriname, and Trinidad & Tobago. Five associate members are Anguilla, Bermuda, British Virgin Islands, Cayman Islands, and Turks & Caicos.

3. These include vulnerability to external events; natural disasters that create havoc on national incomes; limited capacity in the public and private sectors; and the uncertain and difficult economic transition to a changing world trade regime. Additionally, these small states experience remoteness and isolation; susceptibility to natural disasters and environmental change; limited diversification; and poverty, all of which affect income volatility and access to external capital (see [Commonwealth Secretariat/World Bank Task Force, 2000](#)).

4. During those decades CARICOM countries suffered from three significant pestilences: (i) the fallout of the 1973–1974 and 1977 oil shocks that made the terms of trade and interest rates decline so states had to scramble to preserve their balance of payments; (ii) ideological pluralism when Guyana (guided by Prime Minister Linden Burnham), Jamaica (aided by Prime Minister Michael Manley), and Grenada (under Prime Minister Maurice Bishop) opted for socialism in contradiction to the rest of the region that maintained Western liberal democratic principles; and (iii) the subsequent imposition of structural adjustment programs (SAPs) under the World Bank and the International Monetary Fund.

5. The first case in the Caribbean of what was later identified as AIDS was officially recorded in Jamaica in 1982. See CAREC (2002), CAREC Surveillance Report Supplement, Vol. 23 (1).

6. The West Indies Federation functioned between 1958 and 1967. The Caribbean Free Trade Association (CARIFTA) followed and ran between 1965 and 1973. Finally, CARICOM was established in 1973 and continues to operate.

7. Although CARICOM currently has 15 full members, 2 of those countries, Haiti and the Bahamas, were excluded from this survey because they are not members of the CSME.

8. While Montserrat is currently awaiting entrustment of the United Kingdom to accede to the CSME, it was included in this study.

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