

The Encounter Between HIV/AIDS and Education

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List of Abbreviations

ADEA	Association for the Development of Education in Africa
AIDS	Acquired Immune Deficiency Syndrome
BCP	Behaviour Change Process
CSO	Central Statistical Office
DHS	Demographic and Health Survey
EFA	Education For All
GDP	Gross Domestic Product
GNP	Gross National Product
HIV	Human Immuno-deficiency Virus
ICASA	International Conference on AIDS and STIs in Africa
IIEP	International Institute for Educational Planning
MOE	Ministry of Education
MOH	Ministry of Health
ONAP	Office of National AIDS Policy
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDCP	United Nations International Drug Control Programme
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
ZCSS	Zambia Community Schools Secretariat

Foreword

Barely twenty years have passed since the human immuno-deficiency virus (HIV) made its first appearance. During those twenty years HIV/AIDS has spread with alarming speed. The disease has struck hardest at developing countries, especially those where poverty facilitates its transmission and inhibits efforts at control. It has devastated families and communities. It is undermining all social and economic development efforts. It is reversing hard-won human and developmental gains.

Currently, two-thirds of those infected by the disease are found in Africa. Already HIV/AIDS has led to 11 million deaths across the continent. But this is only the beginning. Worse is still to come. For all their tragic impact on families, communities and economies, these 11 million deaths represent only 10 percent of the illness and death that result from the epidemic. The storm which has been brewing for two decades has yet to break with full force. When it does, it will be no respecter of persons, rank, qualification, profession, wealth, poverty, age, gender, country. It will strike at all of the 22.5 million people, children as well as adults, living with HIV/AIDS in Sub-Saharan Africa, and at the four million or more who become newly infected each year. It will claw its way into families, communities, organisations, industries,, the public no less than the private sector, the employed no less than the unemployed or self-employed.

Clearly, the HIV/AIDS situation constitutes a human crisis of apocalyptic proportions. It is also a major development crisis that impacts on all sectors, education included. But in the face of this crisis, humanity cannot just sit back, hoping that eventually the worst effects will pass. Neither can humanity give way to despair and hopelessness in the face of the daunting challenges that the epidemic poses. There is no known cure for HIV/AIDS. There is no vaccine. But there are ways of facing up to the crisis, of reducing the transmission of the disease, of mitigating its impact, and of enabling those who have been smitten to live full and productive lives.

Because many of the features of the epidemic have significant cultural dimensions, UNESCO has a special role to play in the fight against it. To this end, it participates in a joint programme with other members of the United Nations family (UNICEF, UNDP, UNFPA, UNDCP, WHO and the World Bank) so that by pooling resources and working collaboratively there may be a more effective alliance against HIV/AIDS. UNESCO also seeks to utilise its own comparative advantage to integrate action against HIV/AIDS into its various educational, scientific and cultural activities.

In pursuit of this aim, UNESCO used the occasion of the All Sub-Saharan Africa Conference on Education For All, held in Johannesburg from 6th to 10th December 1999, to bring the interaction between HIV/AIDS and education to the attention of educational planners and decision-makers. The epidemic makes a massive impact on the education sector, but the extent and complexity of this impact have not always been grasped. Equally important, education has potential to make a massive impact on the epidemic, reducing its further spread, lessening its impact, and strengthening individuals to cope with the illness and death it brings. In addition, education has the potential to contribute in the long term to establishing conditions which make the transmission of HIV/AIDS less likely.

This two-way interaction between education and HIV/AIDS was extensively discussed at the Johannesburg Conference and at the Biennial Conference of the Association for the Development of Education in Africa (ADEA) which was held at the

same time as the EFA meeting. UNESCO believes that the presentations at the Johannesburg meeting would enlighten and strengthen the anti-AIDS work of many who could not attend this meeting. Hence, in keeping with its aim to work strenuously against the AIDS epidemic, UNESCO is pleased to publish this report which deals extensively with the encounter, the struggle, between HIV/AIDS and education. It is UNESCO's conviction that in this struggle education will be the victor. It is its expectation that this publication will contribute to that victory.

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Harare

This booklet is a somewhat expanded amalgam of two papers delivered in the course of 1999:

1. *The Impact of HIV/AIDS on Education*, presented to the XIth International Conference on AIDS and STDs in Africa, Lusaka, 13th September 1999;
2. *What HIV/AIDS Can Do to Education and what Education Can Do to HIV/AIDS*, presented to the Sub-Saharan Africa Conference on Education for All, Johannesburg, 7th December 1999, and to the 1999 Biennial Conference of the Association for the Development of Education in Africa (ADEA), Johannesburg, 8th December 1999.

At the suggestion of Dr. A. Mauno Mbamba, Director and Representative, UNESCO Sub-Regional Office for Southern Africa, Harare, the two papers were fused so that UNESCO could publish and disseminate them to a wider public than could be present at the Lusaka and Johannesburg Conferences.

I am grateful to Dr. Mbamba for encouraging me to undertake this work. I am also grateful for the positive reactions that greeted both papers. I should say, however, that much of the credit for any merit they contain must go to Sheldon Schaeffer of UNICEF, New York, on whose comprehensive earlier pioneering work I drew heavily. It is perhaps indicative of how slow international response to the epidemic has been that his analysis and insights were not mainstreamed into educational thinking and planning when he first elaborated them six years ago. Had that been done, there might have been some slowing down of the spread of HIV/AIDS, some improved management of its impacts on education, some reduction in the suffering of infected and affected individuals.

It is my earnest hope and prayer that, notwithstanding the time which has been lost, this booklet will help practitioners in mitigating the impact of HIV/AIDS on education. More importantly, it is my hope and prayer that it will help them to slow down the rate of new infections. As is said in the text, the picture and prospects are so grim that they seem to undercut hope, but education stubbornly refuses to give way in the face of enormous tragedy and suffering. Education shows that there is hope. Let us all share that hope, making it realisable for the children of the world as we work together to rid the world of the outrage of HIV/AIDS.

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Abstract

HIV/AIDS is conceptualised as having the potential to affect education through ten different mechanisms: reduction in demand, reduction in supply, reduction in availability of resources, adjustments in response to the special needs of a rapidly increasing number

of orphans, adaptation to new interactions both within schools and between schools and communities, curriculum modification, altered roles that have to be adopted by teachers and the education system, the ways in which schools and the education system are organised, the planning and management of the system, and donor support for education.

Nevertheless, in the face of the epidemic, education can generate hope because of its potential to work at the three levels where AIDS-related interventions are needed:

1. while there is as yet no infection: by providing knowledge that will inform self-protection; fostering the development of a personally held, constructive value system; inculcating skills that will facilitate self-protection; promoting behaviour that will lower infection risks; and enhancing capacity to help others to protect themselves against risk;
2. when infection has occurred: by strengthening the ability to cope with personal and/or family infection; promoting care for those who are infected; helping young people stand up for the human rights that are threatened by their personal or family HIV/AIDS condition; and reducing stigma, silence, shame, discrimination;
3. when AIDS has brought death: by help in coping with grief and loss, in the reorganisation of life after the death of family members, and in the assertion of personal rights

In the longer term, and more generically, education plays a key role in establishing conditions that render the transmission of HIV/AIDS less likely—conditions such as poverty reduction, personal empowerment, gender equity. It also reduces vulnerability to a variety of factors, such as streetism, prostitution, or the dependence of women on men, which are a breeding ground for HIV infection.

In order to realise its potential in these areas, the formal education system must

1. do better what it is supposed to be doing in terms of access and real learning achievement;
2. integrate sexual health and HIV/AIDS education into the curriculum for all educational levels;
3. ensure that every school member is adequately equipped with the relevant life skills, and that adequate learning takes place in the fourth 'R', that is, relationships with oneself and with others;
4. manifest an improved human rights profile—in terms of its own procedures and actions and in terms of the curriculum;
5. extend its mission beyond the strictly academic to include more attention to counselling and care for its members, and to promoting care and compassion for people with HIV/AIDS.

Attending to these things implies that school in the future can no longer be school as traditionally known, that school in an AIDS-infected world cannot be the same as school in an AIDS-free world. The seriousness of the situation in Sub-Saharan Africa calls for the schools to be declared in a state of emergency because of AIDS, requiring emergency-type efforts, emergency-type responses. It calls for the HIV/AIDS crisis to be placed at the centre of each severely affected country's national education agenda.

Chapter One

The HIV/AIDS Epidemic

Overview

The global spread of HIV/AIDS has greatly exceeded the most pessimistic projections of a few years ago. By the end of 1999, an estimated 33.6 million people in the world were HIV-infected (UNAIDS, 1999c). In the absence of a cure or freely available therapy, the majority of these will die before the end of this decade, adding to the 16 million people who have already died of AIDS-related conditions.

The HIV/AIDS epidemic has left no part of the world untouched. The problem is world-wide. However, the greatest concentration of HIV infections and AIDS-related deaths occurs in the developing world. Several countries in Sub-Saharan Africa together with the developing countries of South and South-East Asia account between them for 89 percent of HIV infections. Of the 16.3 million AIDS-related deaths which have already occurred, 13.7 million were in Sub-Saharan Africa and 1.1 million in South and South East Asia. By the end of 1999, an estimated 23.3 million people in the countries of Sub-Saharan Africa, including over one million children, were living with HIV/AIDS. AIDS has now become the leading cause of mortality in the region, accounting in 1998 for 1.8 million deaths, compared with one million deaths from malaria.

Notwithstanding the catastrophic effects that are already being experienced, the full consequences of the pandemic are still to be felt. The storm has been gathering for almost two decades. While some countries have begun to experience its impact, there are many where it has yet to break with full force. The bleak prospect is that “over the next decade, AIDS will kill more people in Sub-Saharan Africa than the total number of casualties lost in all wars of the 20th century combined” (ONAP, 1999, p. 4). Across the continent, and in all other severely affected areas, AIDS is already taking a devastating toll in human suffering and death. It is causing untold physical, psychological and emotional suffering. It is carrying off the most productive members of society, those in the 15–49 age range. It is disrupting social systems, exacerbating poverty, reducing productivity, wiping out hard-won human capacity, and reversing development gains. Although it has only begun to scythe its way into many communities and economies, its ravages increase by the minute. World-wide, there are 16,000 new HIV infections every day—about eleven every minute, or one every five seconds (World Bank, 1999).

For a social service sector like education, this apocalyptic scenario has massive consequences. Just what these consequences are can be gleaned from an examination of the potential multiple effects of HIV/AIDS on the education sector, with special attention to the formal school system. Clearly, the world with AIDS is not the same as the world without AIDS. Likewise, school in an AIDS-infected world cannot be the same as school in an AIDS-free world. This is one side of the picture. But equally, education provides reason for hope. Something can be done. Education has the potential to stem the apparently inexorable advance of the epidemic and to assist in coping with its casualties.

Focusing principally on Eastern and Southern Africa and using Zambia as a case study, this document sets out to examine these two aspects, what HIV/AIDS can do to education and what education can do to HIV/AIDS.

HIV/AIDS in Zambia

Zambia is experiencing one of the worst HIV/AIDS epidemics in the world. HIV infection is currently estimated at almost 20 percent in persons aged 15 to 49. This means that one in five of the Zambians who are now over the age of 15 will probably die at a

young age from this disease, mostly over the next 2–12 years (MOH, 1999). The prevalence rate appears to be stable at about 20 percent. This is not because the epidemic has been brought under control, but because the number of new infections is about equal to the rising number of deaths. One estimate, in fact, is that some 280 new AIDS cases occur each day, that is, an average of one every five minutes (MOH, 1999). Seroprevalence rates in urban centres (28 percent) are twice those in rural areas (13.6 percent). They are at their highest in the urban areas of the Copperbelt and Lusaka Provinces, but there is no part of the country in which the reported rates are low. The epidemic has left no corner of the country untouched (MOH, 1999).

Following inexorably in the wake of the epidemic is the growth in the number of orphans. Estimates vary as to just how many they are. However, it is not the differences that matter but the fact that the number is extremely large. The *Children on the Brink* report estimated that in 2000 there would be 1.66 million orphans in Zambia, of whom some 750,000 would be maternal and double orphans and 910,000 would be paternal orphans (Hunter & Williamson 1997, Figure A-4). With 34.3 percent of those aged below 15 having lost a mother or father or both, a percentage that is projected to rise steadily to over 38 percent in 2010, Zambian children rank as the most orphaned in the 23 countries included in the study. Arising largely from this situation, it is estimated that more than 7 percent of Zambia's 1,905,000 households are without any adult member, but are headed by children, that is, by a boy or a girl aged 14 or less (GRZ-UNICEF 1997, p. 2). Moreover, life expectancy, which stood at 54 years in the not too distant past, has plummeted to 37 and is projected to decline in the coming decade to 30.3.

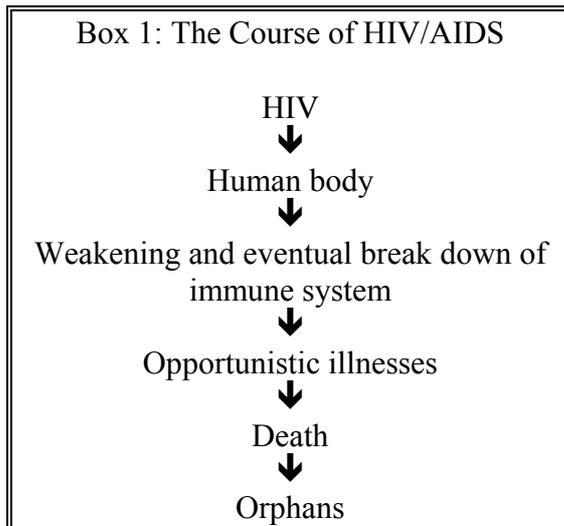
This tragic scenario is already making its impact felt in the formal education system. Not enough field work has been done to support a scientific assessment of the extent of the impact, but various indicators show that it is considerable. HIV/AIDS is affecting pupils. It is affecting teachers. It is affecting curriculum content. It is affecting the organisation, management and planning of education. It is affecting resources for education. It is slowly leading to questions about the very nature, purpose and provision of education. The analytic framework, which is presented in the next section, will facilitate a grasp of the numerous potential impacts of HIV/AIDS on the education system of a severely affected country. It will also serve as a tool for the guidance of education practitioners. In addition to being real possibilities, many of the potential impacts that are outlined are already tearing at the system. It is only when civil and public society comes to grips with the potential and actual extent of these HIV/AIDS impacts that appropriate action will be taken to respond to, and possibly even control, the situation.

It should be noted that the framework and details which follow also include areas where little more than anecdotal information is currently available. Great potential exists for descriptive and analytic investigations in these and the many other areas which are enumerated.

Chapter Two

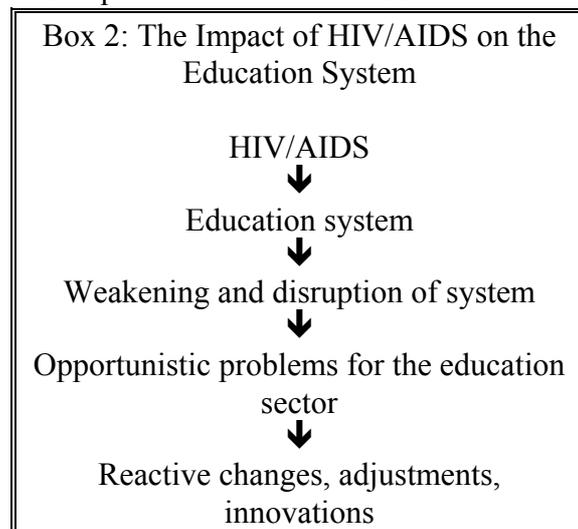
The Impact HIV/AIDS Can Make on Education

Analytic Framework



When a person is infected with the human immuno-deficiency virus, HIV, the body's immune system weakens and eventually breaks down (Box 1). This leaves the individual a prey to the hazards of a multitude of opportunistic infections. In the absence of the costly antiretroviral therapy that can slow the progression of HIV infection, the infected individual will eventually succumb to the serious cluster of illnesses that define AIDS. When infected adults die, they very frequently leave orphans behind. For the adult, life has ended. For the orphan the tragedy is only beginning.

In a similar way, in the absence of appropriate measures, the education system in a country that is as seriously HIV-infected as many of those in Sub-Saharan Africa is also in danger of being weakened and disrupted. It becomes a prey to myriad opportunistic problems which lead in turn to a number of reactive changes and adaptations (Box 2). Critical tasks for policy-makers and planners in education are to identify the potential areas of impact and to design appropriate responses. Some interventions may be designed in reaction to circumstances that have actually been experienced. However, coping with the HIV/AIDS situation in the education sector requires more than this. There is need to be proactive, anticipating what might possibly happen, forestalling undesirable situations, and managing the impact with two objectives in view: (1) enabling the education system to pursue and attain its essential objectives; and (2) using the sector's potential to slow down the rate of new infections, help its infected members to cope, and support those among them who have been bereaved by HIV/AIDS. The analytic framework will help policy-makers and practitioners alike to be alert to the ways in which HIV/AIDS can impact on education, to conceive of potential solutions, and to design interventions that can either offset or forestall the negative impacts of the disease.



Essentially, the HIV/AIDS epidemic can be conceptualised as affecting education through ten different mechanisms (Box 3).¹ It affects the demand for education; its supply; the resources it needs; its potential clientele; its process, content, and role; school organisation; sector-wide planning and management; and donor support for the system.

Box 3: What HIV/AIDS Can Do to Education

¹ The analytic framework that follows draws heavily on a seminal presentation by Sheldon Shaeffer to a workshop held at the IIEP in Paris in December 1993 (Shaeffer, 1994).

HIV/AIDS has the potential to

- affect the demand for education
- affect the supply of education
- affect the availability of resources for education
- affect the potential clientele for education
- affect the process of education
- affect the content of education
- affect the role of education
- affect the organisation of schools
- affect the planning and management of the education system
- affect donor support for education

1. Impact on Pupils and School Enrolments

HIV/AIDS affects the demand for education because of

- fewer children to educate;
- fewer children wanting to be educated;
- fewer children able to afford education;
- fewer children able to complete their schooling.

At the macro-level, AIDS will have the long-term effect of there being fewer pupils to educate. This will be because populations will be significantly smaller than they would have been in the absence of AIDS (Table 1). In each of Botswana, Malawi, Zambia and Zimbabwe, one outcome of the AIDS pandemic is that the populations in 2010 will be smaller by about a quarter than they would otherwise have been, while in other countries in Sub-Saharan Africa populations will remain considerably smaller than if there had been no AIDS. These losses will be because of large increases in adult and child mortality, a lower fertility rate, and some reduction in births because of the premature death of women in their child-bearing years. The possibility exists that in Malawi, Zambia and Zimbabwe infant and child mortality rates, already very high, may increase dramatically—the infant rate doubling and the child rate tripling (Hunter & Fall, 1998, p. 9).

This demographic development will reduce the number of pupils of primary school age. A 1992 AIDS assessment and planning study for Tanzania projected that “in the worst-case scenario, at the primary level there would be 22 percent fewer children to be educated, and at the secondary level, the relevant age groups would be reduced by about 14 percent” (World Bank, 1992, p.68). Estimates for other countries point in the same direction; for instance, a Swaziland Ministry of Education report suggests that because of HIV/AIDS there will be 30 percent fewer children of school entry age in 2016 than if there had been no AIDS (Gachuhi, 1999, p. 4).

Table 1: Projected Demographic Impact of HIV/AIDS in Selected Countries, 2010

	Population (millions)			Population Percentage Loss to AIDS	Life Expectancy (Years)
	Without AIDS	With AIDS	Loss to AIDS		
Botswana	2.1	1.6	0.5	23.8	33.4

Dem. Republic of Congo	74.6	69.3	5.3	7.1	51.3
Cote d'Ivoire	23.5	20.3	3.2	13.6	44.8
Ethiopia	87.0	81.2	5.8	6.7	51.3
Kenya	39.1	33.9	5.2	13.3	43.2
Malawi	14.1	10.7	3.4	24.1	29.5
South Africa	53.6	49.2	4.4	8.2	47.8
Tanzania	43.9	36.1	7.8	17.8	36.5
Uganda	32.7	26.4	6.3	19.3	35.2
Zambia	15.7	11.5	4.2	26.8	30.3
Zimbabwe	16.4	11.9	4.5	27.4	33.1

Source: Hunter & Williamson, 1997, Figure A-1

Projections for Zambia are that the population aged 15 and below will reach 5.4 million in 2010, instead of the 6.8 million it might have attained if there had been no AIDS (Hunter & Fall, 1998, p. 14; CSO 1995). Ironically, with 750,000 to one million fewer than expected children of primary school age, Zambia's task of achieving universal primary education will become easier, but this gain will have been bought at very high human and other costs.

But the negative impact of HIV/AIDS on school enrolment and attendance has already commenced. Since the early 1990s Zambia has been experiencing stagnation, and at times even decline, in the numbers attending primary school. This has been happening at a time when the number of school-aged children is increasing, when the number of children not attending school is already very large, and when school facilities are not being used to the full. This decline in school participation rates is attributed mostly to poverty and to parental disillusion with the low quality of education which the schools provide. Although no rigorous studies have been conducted, it seems likely that some of the decline in school participation is also due to AIDS, and to the impact this is having on poverty, on levels of employment, and on the quality of school provision.

Some evidence for this comes from micro-studies into the situation of orphans. A study in the Copperbelt—one of the regions in Zambia most badly affected by AIDS—found that 44 percent of the children of school-going age were not attending school, but with proportionately more orphans (53.6 percent) than non-orphans (42.4 percent) not attending (Rossi & Reijer, 1995). Each of these percentages departs significantly from the Copperbelt's overall primary school attendance rate of 79 percent. Something similar was found in a rural area in the eastern part of the country where only 38 percent of the orphaned children of school-going age were attending school, compared with the provincial average of 51 percent (Katete Hospital, 1994). More recently it was found that 32 percent of urban and 68 percent of rural orphans were not enrolled in school. These percentages are considerably higher than those for non-orphans who were not enrolled—25 percent of urban non-orphans and 48 percent of rural non-orphans. (UNICEF, 1999).

Two features stand out from these findings. One is the very low overall level of school participation. The studies found that the principal reason for this was inability to pay school costs. For many of the affected children this inability was AIDS-related. It occurred because, with AIDS in the family, either there was no longer a source of regular income or else whatever income was coming in was diverted to palliative care of the sick person. This is confirmed by interviews with Lusaka teachers whose classes included pupils whose parents had died of AIDS. All reported that, following the death of the

parent, the pupils stopped attending because of school fees and the costs of school requisites (UNICEF, 1996). The second feature is the extensive difference in attendance rates between orphans and non-orphans. Given the close link in these particular studies between AIDS and orphanhood, it seems clear that one major impact of AIDS on pupils of school-going age is to reduce the likelihood of their school attendance.

Further evidence comes from a study of two high density areas in Lusaka, which found that of 1,359 children, aged 18 and below, just two-thirds (67 percent) had lost one or both parents (Webb, 1996). Some 7 percent of these had dropped out of school in the twelve months prior to the study. The same year, the drop-out rate for urban primary schools in Lusaka was 1.7 percent. Thus, orphans, mostly those from families affected by AIDS, appear to be at greater risk than non-orphans of dropping out of school.

The adverse impact of HIV/AIDS on demand for education also surfaces in a report from a remote northern area where the community has been so extensively ravaged by AIDS that it has migrated elsewhere, in the hope of leaving the fatal disease behind. This has led to uncertainty about the continued need for one school, as well as to some increase in the pressure on the schools in the places where the affected families have settled.

To sum up, HIV/AIDS affects the demand for education because

- there will be fewer children to educate;
- fewer children can afford the costs of education;
- for social and economic reasons, more children will drop out of school without completing the normal primary school cycle.

It also seems likely that fewer children will want to be educated, partly because of the traumas they have suffered through the experience of AIDS in their families, partly because they have to work to generate income for family support or are needed to care either for the sick or for younger siblings. Heart and hope have gone out of many of them. They see little value in education as a way of surmounting their problems. They are so overwhelmed by these that they have lost interest in getting a formal school education.

2. Impact on Teachers, Teaching and the Supply of Education

HIV/AIDS affects the supply of education because of

- the loss through mortality of trained teachers;
- the reduced productivity of sick teachers;
- the reduction in the system's ability to match supply with demand because of the loss, through mortality or sickness, of education officers, inspectors, finance officers, building officers, planning officers, management personnel;
- the closure of classes or schools because of population decline in catchment areas and the consequent decline in enrolments.

There are at least four dimensions to the impact that HIV/AIDS is already having on teachers and teaching in Zambia: teacher mortality, teacher productivity, teacher costs, and teacher stress.

Teacher Mortality

Application at district level of HIV adult prevalence estimates suggests that, out of approximately 31,600 primary school teachers in 1996/97, some 6,300 (20 percent) were HIV-positive. This is in keeping with the international finding of a positive correlation between educational status and HIV-risk (Deheneffe, Caraël & Noubissi, 1998), recent evidence from Malawi that the rate of infection among school-teachers is higher than 30 percent (UNICEF, 1999), and earlier Zambian evidence that teachers are a very high risk group (Fylkesnes, Brunborg & Msiska, 1994). It is also in keeping with early World Bank projections that by 2010, 14,460 teachers will have died from AIDS in Tanzania, with the number mounting to 27,000 by 2020 (World Bank, 1992, p. 69).

The infections are now resulting in deaths. Ministry of Education data show that 680 teachers died in 1996, 624 in 1997, and 1,300 in the first ten months of 1998. This means that the number of teacher deaths rose from less than two per day in 1996 to more than four per day in 1998. The number of teachers who died in 1998 was more than one-fifth of the number estimated to be HIV-positive. While one cannot attribute all of these deaths to AIDS, the 1998 teacher deaths represented a mortality rate of 39 per thousand, which is about 70 percent higher than the mortality rate of 23 per thousand for the 15–49 year old age group in the general population (MOH, 1997). For the education system, the 1998 deaths were equivalent to the loss of about two-thirds of the annual output of newly trained teachers from all primary level training institutions combined.

Teacher Productivity

Ministry of Education officials also observe that teacher posting has become more difficult. The records show that trained teachers are concentrated in urban areas while rural schools are denied their full and fair complement. What the records do not show is that illness, much of it AIDS-related, is a major contributing factor to this situation. There has been a steady increase in the number of chronically ill teachers who, on medical grounds, must be posted near to hospitals, properly staffed clinics or medical centres. This means that they must live in or near towns, but not in remote rural areas. Thus, because of its proximity to medical centres and doctors, a large urban school in Lusaka receives a disproportionately large number of such chronically ill teachers.

The urban posting of these teachers does little, of course, for the work in the urban schools, since many are too ill to assume a full teaching load or to guarantee some continuity in their teaching. Reports from school authorities, from Parent-Teacher Associations and from communities complain of loss of teaching time due to the prolonged illness of teachers or to their erratic attendance (Milimo, 1998). Communities see this as one of the factors contributing to a decline in the quality of education (and consequently, to a reduction in their preparedness to commit the time of their children to school). With an expected 12 to 14 AIDS-related sickness episodes occurring before the terminal illness, the contribution of many teachers to what goes on in schools becomes progressively more episodic until in the end it peters away.

Teacher Costs

Apart from distributional issues, this wasting loss of serving teachers has grave financial repercussions on the education system. Since it is very difficult to terminate the services of a teacher who is ill, the system must needs carry a currently unknown but large number of non-productive persons. In addition to the high salary costs this implies, there are also the financial costs of replacements, both in the short-term through the hiring of part-time substitutes and in the long-term through the training of additional teachers. There are also the costs of the initial training at public expense as well as the unquantifiable loss of valuable experience. A management problem arising from the

silence and stigma that attach to AIDS is that good information does not exist on the number of teachers who are HIV-infected, or even on the number who are chronically ill. This blurred picture makes rational planning for teacher numbers and cost-effective deployment extremely difficult.

Teacher Stress

Teachers are also deeply affected personally by the incidence of HIV/AIDS among their relatives and colleagues. Though this is a major cause of concern for them, it is an area in which they receive little support. Thus, it has been found that less than one-third of a sample of teachers who had experienced AIDS sickness or death among their relatives had talked about the problem with friends or relatives (UNICEF, 1996). The remainder felt either unable or unwilling to do so. More recently, a survey to ascertain teachers' knowledge, attitudes, practices and skills in the teaching of HIV/AIDS found that "approximately 25 percent of the teachers admitted to worrying about their own HIV status, and nearly 40 percent would like to talk to somebody about their own HIV/AIDS related problems" (Siamwiza & Chiwela, 1999, p. 11). The unresolved HIV-related stresses which teachers experience, in the classroom and at home, need to be acknowledged in initial and ongoing teacher training. Recognising the magnitude of this personal problem, the Zambian Ministry of Education's strategies for addressing HIV/AIDS include "comprehensive HIV/AIDS education and counselling in teacher training programmes" (MOE, 1999, p. 3).

3. Impact on Resources

HIV/AIDS affects the availability of resources for education because of

- the reduced availability of private resources, owing to AIDS-occasioned reductions in family incomes and/or the diversion of family resources to medical care;
- reduced public funds for the system, owing to the AIDS-related decline in national income and pre-emptive allocations to health and AIDS-related interventions;
- the funds that are tied down by salaries for sick but inactive teachers;
- reduced community ability to contribute labour for school developments because of AIDS-related debilitation and/or increasing claims on time and work capacity because of loss of active community members.

The epidemic affects the availability of both public and private resources for education. One international estimate is that because of HIV/AIDS, global economic growth is 1.4 percent lower than it would have otherwise have been (UNDP, 1999). The adverse economic impact would be due to decreased revenues and increased costs. Absenteeism due to illness, time off for funerals, time spent on training and a less experienced labour force, would result in reduced productivity and hence in lower revenues. Spending on health care costs, burial expenses, and recruitment and training of replacement employees would lead to increased costs (MOH, 1999, p. 45).

This impact on economic growth is felt most seriously by countries which are most severely affected by the epidemic. A recent evaluation for Zambia states that "without unprecedented infusion of foreign aid, national income could be reduced by as much as 10 percent" (Seshamani, 1999, p. 55). The impact of the disease on other economies is equally severe (Table 2). One implication of this is that with public resources being

smaller than they would have been in AIDS-free circumstances less will be available for national spending, in education as in other sectors.

Country	Economic Impact of HIV/AIDS
India	By 2000, AIDS will cost \$11 billion or 5 percent of GNP
Kenya	By 2005, GNP will be 14.5 percent smaller than if there had been no AIDS
Namibia	AIDS cost almost 8 percent of GNP in 1996
South Africa	AIDS costs 2 percent of GNP every year
Tanzania	GNP will be 15–25 percent lower as a result of AIDS
Zambia	AIDS could reduce national income by as much as 10 percent

Source: ONAP, 1999, pp. 8 & 10; Seshamani, 1999, p. 55

There are also the effects on the health budget, and the likelihood that even though economic growth is being retarded, this will have to increase if it is to cope with the disease. Zambian projections are that AIDS care expenditures in the health sector will increase five-fold in a fifteen year period, rising from US\$3.4 million in 1989 to US\$18.3 million in 2004 (MOH, 1999, p. 44). This increasing expenditure on AIDS care would not only divert spending from other important health care needs, but would also threaten efforts to protect expenditures in sectors such as education.

At the private level, AIDS sickness and mortality strike disproportionately at the working age population. Deprived of the breadwinner, households are left without the resources to pay school fees and to meet the many educational needs of their children. Within the household, a large proportion of greatly reduced resources may be devoted to traditional healing, local and other medicines, special foods, and cleansing materials for an AIDS-infected person, to the detriment of what might be spent on meeting the education costs of children particularly girls. Meanwhile, reports from communities tell of many being so weakened through poverty, hunger and sickness that they are unable to participate in self-help activities in schools. Rural communities also state that even those among them who are strong and healthy cannot participate in such activities because so much of their time is given to back-stopping for those who are ill or who have died.

4. Impact on the Potential Clientele for Education

HIV/AIDS affects the potential clientele for education because of

- the rapid growth in the number of orphans;
- the massive strain which the orphanhood problem is placing on the extended family and the public welfare services;
- the increase in the number of street-children;
- the need for children who are heading households, orphans, the poor, girls, and street-children to undertake income-generating activities.

The most visible demographic impact of the HIV/AIDS epidemic is the growth in the number of orphans. Estimates in the *Children on the Brink* study are that the year 2000 would see 14.3 million children in the 19 African countries included in the study who would have lost their mother or both parents, plus a further 17.5 million who would have lost their father (Table 3). More than half the maternal and double orphans would have

lost their parents as a result of AIDS. These figures can be compared with the 13 million children orphaned in Europe during the 1939–1945 war, or the 440,000 children separated from their families in the 1994 Rwanda genocide. More than one quarter of the children aged below fifteen in each of Malawi, Uganda, Zambia and Zimbabwe are believed to have lost one or both parents, mostly due to AIDS. In Zambia, it is estimated that one-third of the children below age 15 have lost a mother or father or both.

	Maternal & double orphans from all causes (thousands)	Percentage of maternal & double orphans from AIDS	Paternal orphans from all causes (thousands)	Total orphans from all causes (thousands)	Total orphans as percent children below age 15
Botswana	67	70.6	82	150	23.4
Dem. Republic of Congo	1,760	45.6	2,151	3,910	15.8
Cote d'Ivoire	654	92.7	800	1,454	19.2
Ethiopia	1,998	28.5	2,442	4,439	15.2
Kenya	686	65.5	838	1,524	12.0
Malawi	554	69.6	677	1,231	27.4
South Africa	813	60.9	993	1,806	11.6
Tanzania	1,349	65.7	1,649	2,999	21.7
Uganda	1,243	66.7	1,520	2,763	25.5
Zambia	745	78.4	911	1,657	34.3
Zimbabwe	611	84.7	746	1,357	27.4
Totals, 19 Countries in Sub-Saharan Africa	14,317	52.7	17,498	31,815	15.5

Maternal orphans have lost their mothers, paternal orphans their fathers, double orphans both parents.
Source: Hunter & Williamson, 1997, Figure A-4

The growth in the number of orphans is taxing the coping strategies of families and society at large. In many cases, the extended family is finding it extremely difficult to cope economically and psychologically with the numbers it is required to absorb. Few orphans are able to pay their school or training fees. Many have to care for others in the homes where they live. Many have to work to support themselves or younger siblings dependent on them. Many carry responsibilities well beyond their capabilities as children. Some are so traumatised by what they experienced when a member of their family died of AIDS that they cannot learn. A significant number are at risk of contracting HIV/AIDS through virtually inescapable income-generating prostitution. Most are excluded from the joy and gaiety of a normal childhood. Economically and psychologically, they have needs that differ from those of other children in school, needs to which the school must necessarily respond.

The number of street-children is also increasing rapidly. In Zambia it doubled in the period 1991–1996, and has continued to grow steadily since then. Street-children include children of the street (those who live, work, eat and sleep on the street) and children on the street (those who work on the street but go home to their families at the end of the day). Poverty and family disintegration, due to death and divorce, are the major factors leading to children being on the street. The family structures that should have

supported them have collapsed, frequently because of HIV/AIDS, leaving them with no choice but to have recourse to the streets to support themselves. Their counterparts in rural areas are children from HIV/AIDS affected families, who do not attend school because AIDS care has absorbed the meagre family resources, leaving nothing for school fees, or because they are engaged in household chores, caring for the sick or for children, herding cattle, fishing, or petty trading that can no longer be undertaken by infected adults.

5. Impact on the Process of Education

HIV/AIDS affects the process of education because of

- the new social interactions that arise from the presence of AIDS-affected individuals in schools;
- community views of teachers as those who have brought the sickness into their midst;
- the erratic school attendance of pupils from AIDS-affected families;
- the erratic teaching activities of teachers, who are personally infected, or whose immediate families are infected, by the disease;
- the increased risk that young girls experience of sexual harassment because they are regarded as 'safe' and free from HIV infection.

Through its impact on social interactions arising from the presence of HIV-infected individuals in schools, AIDS has affected the process of education in Zambia. Some rural communities have accused teachers of being responsible for the introduction and spread of HIV/AIDS. There is at least one report of AIDS wiping out almost an entire community, with a teacher (since dead) being named as the source of the disease (Milimo, 1998). Incidents like these have led to strained teacher-community relationships, in some instances undermining the likelihood of adequate community participation in school affairs.

The process is also affected when children witness the physical deterioration of classmate or of a teacher dying from AIDS. Trauma arising from experience of the way AIDS can degrade and humiliate a fellow human being, especially when this occurs in school surroundings, can have a shattering impact on a young person's psychological stability and learning capacity (cf. Siamwiza, 1999, p. 24). Although there is no evidence of system or parental objections to the presence in school of an infected teacher or pupil, children who have lost a parent through AIDS speak of being taunted and mocked by their peers, and sometimes being excluded from peer groups.

At a different level, because they are believed to be HIV-free, young girls run an increased risk of sexual harassment on their way to and from school. This has led to isolated cases of such girls being withdrawn from school, and to pressure from parents for schools to be built closer to their homes.

6. Impact on the Content of Education

HIV/AIDS affects the content of education because of

- the need to incorporate HIV/AIDS education into the curriculum, with a view to imparting the knowledge, attitudes and skills that may help to promote safer sexual behaviour;

- the need to develop life-skills which equip pupils for positive social behaviour and for coping with negative social pressures;
- the need for earlier inclusion in the curriculum of work-related training and skills, so as to prepare those compelled to leave school early (because of orphanhood or other reasons) to care for themselves, their siblings, their families.

The most obvious impact of AIDS on the content of education is the incorporation of AIDS education into the curriculum with a view to bringing about behaviour change. The Zambian Ministry of Education recognises the importance of education and the formation of attitudes in relation to HIV/AIDS. Consequently it is currently revising the school curriculum to provide space for addressing the attitudes and behaviour of youth through the inclusion of life skills and reproductive health (MOE, 1999, p. 2). Because of the multi-dimensional nature of HIV/AIDS, the Ministry has adopted the integration approach. In this, HIV/AIDS is not given the status of a separate subject. Neither does it become an integral part of an existing carrier subject. Instead it is taken to be a cross-cutting issue which is to be addressed in all subject areas and which will be examinable as part of those subjects.

A major policy objective for education is to use the sector's potential to slow down the rate of new HIV infections, help its infected members to cope, and support those among them who have been bereaved by HIV/AIDS. Part of the sector's response in this area is the introduction of life-skills programmes. These aim to influence health and social behaviour by seeking to develop student ability in five key psycho-social areas: self awareness (self-esteem) and empathy; private communication and interpersonal relationships; decision making and problems solving; creative thinking and critical thinking; and coping with emotions and with stress (Gachuhi, 1999, p. 11). Countries in Eastern and Southern Africa have endeavoured, with mixed success, to integrate programmes of this nature into their school curricula. Common problems are lack of teacher knowledge and confidence, tendencies to gloss over sensitive sexuality issues, the perception that because it is not examined the area is not important, and inadequate efforts to mobilise the support of parents and other key stake-holders (Gachuhi, 1999; Chiwela & Mwape, 1999).

Given that school education has an essential role to play in combating the HIV/AIDS pandemic, and that it has played this role very successfully in Uganda, it is somewhat surprising that one notes the relatively low-key presentation of this approach in the World Bank's policy research report *Confronting AIDS*. Although the report does acknowledge that "HIV/AIDS education is likely to be a good investment in preventing HIV" (World Bank, 1997, p. 149), it goes to greater lengths in dealing with risky sexual and injecting behaviour and with prevention programmes for sub-populations that are at greatest risk. While it is of the utmost important to deal with these areas, it is regrettable that the report does not pay comparable attention to the one window of hope that exists for the worst-affected countries, the children in primary school who have not yet been infected. Damage limitation appears to attract greater attention than damage prevention.

There has been a shift, however, in the Bank's position, with its more recent strategic plan for dealing with AIDS in Sub-Saharan Africa—*Intensifying Action Against HIV/AIDS in Africa*—giving more prominence to the role that can be played by education-related interventions. Thus it singles out the importance of integrating HIV/AIDS into existing school and training curricula, educating girls, expanding gender initiatives, reducing poverty, assessing the impact of HIV/AIDS on sectors and helping countries plan

for the long-term impact, supporting research efforts to provide national leaders and international partners with basic and accurate AIDS-related information, strengthening capacity building, mainstreaming HIV/AIDS in all Bank activities, and redirecting ongoing project funds to HIV/AIDS activities (in the Bank's terminology, 'retrofitting' projects). (World Bank, 1999, ch. 4). These are welcome initiatives. Their implementation should go some way to make up for the late start in making a wholehearted commitment to dealing with the epidemic.

7. Impact on the Role of Education

HIV/AIDS affects the role of education because of

- new counselling roles that teachers and the system must adopt;
- the need for a new image of the school as a centre for the dissemination of messages about HIV/AIDS to its own pupils and staff, to the entire education community, and to the community it serves;
- the need for the school to be envisaged as a multi-purpose development and welfare institution, delivering more than formal school education as traditionally understood.

Because of HIV/AIDS, the role of the school appears to be changing. Traditionally, there were very high expectations that schools would educate the whole child across the broad spectrum of the intellectual, social, moral, aesthetic, cultural, physical and spiritual domains. In practice, most schools found this impossible. Instead, they concentrated on only a few of these areas, and gave the greatest emphasis in their curriculum to intellectual development (Beare, Caldwell & Millikan, 1989).

But the intrusion of HIV/AIDS necessitates psychological support for the children from affected families. Teachers find that increasingly they are being called upon to counsel their pupils and help them deal with the stresses arising from HIV/AIDS in their families. Studies on orphans have identified the need to help children express their feelings in appropriate ways and the need for those working with children to be able to adopt suitable communication and counselling roles (Colling & Sims, 1996). In Zambia, programmes in counselling are being established in the universities and some teacher training institutions. The need is being increasingly perceived for teachers who can stand by children who are affected by HIV/AIDS as they strive to come to terms with their psychological turmoil. In other words, in addition to their traditional concern with intellectual development, schools are slowly recognising the need to play a more proactive role in pupil psychological support and counselling.

The Zambian education policy endorses the role of the school as a health-affirming and health-promoting institution for all pupils and, through them, for the community from which the pupils come and for the families which they will eventually establish. It also undertakes that it will introduce HIV/AIDS counselling for teachers and other education personnel.

8. Impact on the Organisation of Schools

HIV/AIDS affects the organisation of schools because of the need to

- adopt a flexible timetable or calendar that will be more responsive to the income-generating burdens that many pupils must shoulder;

- provide for schools that are closer to children's homes;
- provide for orphans, for children from AIDS-infected families, and for children who are themselves AIDS-infected, for whom normal school attendance is impossible, by bringing the school out to them instead of requiring them to come in to some central location;
- examine assumptions about schooling, such as the age at which children should commence, the desirability of making boarding provision for girls, the advisability of bringing together large numbers of young people in relatively high-risk circumstances.

The problems experienced by orphans in attending normal schools have given a strong impetus to the development of community schools. These schools operate on a more flexible timetable and can be more accommodating to the special needs of orphans, street children and those whom AIDS-related causes have induced to abandon the normal school system. A data collection study on community schools in Zambia has found that more than a quarter of those attending such schools in Zambia's worst affected HIV/AIDS provinces are orphans (ZCSS, 1999).

The needs of orphans, of children from HIV/AIDS infected families, and of children with AIDS are also calling in question the traditional frontal teaching technology, whereby one teacher faces (usually literally) a class of 35 or more pupils in a dedicated and appropriately furnished room. Obligations to provide home-care for sick relatives and/or siblings and to generate income prevent many of these children from participating in such a traditional arrangement. Psychological trauma prevents others from doing so. The illnesses from which AIDS-infected children suffer prevent still others. But all retain their basic human right to education, and somehow the education sector must re-organise itself so that it can provide for that right. By doing so, the sector might also succeed in making a better response to the needs of other children with special educational needs who have hitherto been excluded from its scope.

9. Impact on the Planning and Management of Education

HIV/AIDS affects the planning and management of the education system because of

- the imperative of managing the system for the prevention of HIV transmission;
- the loss through mortality and sickness of various education officials charged with responsibility for planning, implementing, and managing policies, programmes and projects;
- the need for all capacity-building and human resource planning to provide for (a) potential personnel losses, (b) developing new approaches, knowledge, skills and attitudes that will enable the system to cope with the epidemic's impacts and will monitor how it is doing so, and (c) establishing intra-sectoral epidemic-related information systems;
- the need for more accountable and cost-effective financial management at all levels in response to reduced national, community and private resources for education;
- the need for sensitive care in dealing with personnel and the human rights issues of AIDS-affected employees and their dependants
- the need for a sector-wide strategic approach that will spell out how the education ministry intends to address HIV/AIDS.

Managing and planning for a developing education sector are demanding activities which require the education ministry to be firmly in charge of policy and strategy development and implementation. At all times this is a challenge, but more so when there is risk that HIV/AIDS may decimate key human resources. AIDS is not restricted by authority or hierarchical levels but crosses all boundaries.

To minimise its impact on the ministry's core activities, key aims should be to prevent further HIV infection in its workforce and to help those already infected to live positively. While the ministry must show this double concern for students, teachers and those working in schools and colleges, it should be equally diligent in extending similar concern to its own immediate staff—senior officials as well as other employees in finance, planning and personnel divisions; professionals and support staff in inspectorates, examinations, curriculum development, and other support areas; senior policy-makers and implementers and all of their back-up staff; those located at the central headquarters and those spread across the country at provincial and district levels. They are all at risk. They all stand in need of ministry guidelines and directives that will strengthen their determination to avoid HIV infection and that will enable them to continue to live and function positively, should they be or become infected.,

A good epidemic-related information system is central to managing and planning the education sector in an AIDS-dominant environment. Ideally such a system would show, by category, the number of employees currently HIV-infected or ill with an AIDS-related condition; the number of employees maintained on the payroll but unable to work; the number of employees with HIV/AIDS in their immediate families; the extent of HIV/AIDS-related sporadic absenteeism and sick leave; the impact of such absenteeism/sick leave on the ministry's ongoing activities, both in schools and colleges and in the various ministry offices; the number of employees, especially females, in need of more flexible timetables that will facilitate their provision of care to sick household members; the number of hours or days given to funerals, and the funeral costs which the ministry bears.

In addition, the ministry needs to evaluate how, when, in what numbers and at what cost it will recruit personnel to assist or replace those affected by the epidemic. This will require a close study of policies on part-time or short-term appointments. It will also require a strengthened personnel section that will be fully apprised of staff turnover, how long it takes to recruit replacement staff, and how to draw up training plans for new staff and for those who have to be transferred to other areas of work.

Much of this points to the need for the education ministry to formulate a strategic approach that will clearly express its policy on HIV/AIDS, its proposals for dealing with it in its institutions and throughout the system, its strategies for personnel and human resource support and replacement, guidelines for use in concrete situations in schools, colleges and at lower levels in the system, and the development of an information base to guide policy and planning.

10. Impact on Donor Support

HIV/AIDS affects donor support for education because of

- the diversion of donor attention to coping with the epidemic;

- donors' concern to promote capacity-building and develop a self-sustaining system, both of which are inhibited by the widespread incidence of HIV/AIDS;
- donors' concern lest the effectiveness of their inputs be undermined by the impacts of the epidemic;
- donor uncertainty about supporting extended training abroad for persons from heavily infected countries.

The HIV/AIDS epidemic is the very antithesis of the all-round development which donors and country cooperating partners strive to promote. Donor assistance and interventions are guided by the principles of poverty reduction and sustainable human development. But they see HIV/AIDS causing unspeakable human suffering, making poverty worse and less bearable, reducing productivity, depleting hard-won human capacity, and reversing the development gains they struggle so hard to promote.

Faced with this scenario, the donors and cooperating partners are turning more and more of their attention to the HIV/AIDS problem and how to cope with its impacts. They find that of necessity the AIDS dimension must be built into all their activities. Given the limitations on their personnel and resources, this means that they are able to give less attention to other pressing issues, since they must consider every issue in the light of HIV/AIDS. The epidemic has constrained their freedom of choice. It is with them as with the local education or other ministry. At the local level, scarce national human resources have to be dedicated to planning and managing the impact of the epidemic; at the donor level, scarce donor human resources likewise have to be committed to interventions that will support the management of existing infections and contribute to slowing down the rate of new infections.

One practical outcome of this very necessary concern of the donor community with the HIV/AIDS situation is the added impetus it gives to education and other ministries to develop their own strategic plan for addressing the epidemic.

HIV/AIDS has other implications, positive and negative, for donor support to education. For instance in a positive vein, the World Bank has recommended that assistance to capacity building be specially directed to the countries most severely affected by AIDS (World Bank, n.d., p. 21). Negatively, however, those who are HIV-positive may be refused entry to some industrialised countries and hence be unable to participate in training programmes that are based in such countries.

The Apparent Power of HIV/AIDS to Undermine Education

The examples that have been brought forward are largely illustrative. In some areas the evidence is not yet rigorously based, and some is anecdotal. But the evidence is sufficient to show that many of the effects that have been discussed have already begun to manifest themselves. Doubtless, other severely affected countries can amplify the picture, regrettably confirming what has been delineated here. Likewise, as more focused qualitative and quantitative studies are conducted, ever more of these effects will surely be detected. In addition, it seems likely that the analytic framework will facilitate understanding of the impact of HIV/AIDS on other sectors and that, *mutatis mutandis*, many of the effects will be detected in them also.

What has been put forward suggests that HIV/AIDS is creating a host of problems that threaten to overwhelm the very fabric and structure of educational organisation, management and provision as we have traditionally known it. This is a correct impression. As noted in the opening chapter, the school in an AIDS-infected world cannot be the same as the school in an AIDS-free world. The crucial questions are, what to do about it all, how to stem the tide. The following chapter deals with these issues.

Chapter Three

The Impact Education Can Make on HIV/AIDS

Education Generates Hope

In the absence of curative drugs and prophylactic vaccines, the only way currently available for dealing on a large scale with HIV/AIDS is through developing appropriate standards of behaviour, with information being translated into behaviours that promote a healthy state of mind, body and spirit (Siame, 1998). In this and in other AIDS-related areas, education can be a powerful ally.

In the 14th century, Europe was ravaged by a great plague known to history as the Black Death. This was another period when it seemed that an incurable disease was set to wipe out the achievement of a whole section of humanity, with the death of one-quarter to one-third of the population of Europe. Around that time, a popular allegory developed, which personified death as a devouring monster, consuming every living creature. But as it did so it consumed an individual who possessed within the principle of indestructible life. Thinking it was making its greatest conquest, death consumed this individual, only to find that it had swallowed the one poison that could destroy it. The result was a progressive weakening and the ultimate destruction of death's lethal power.

Applying the allegory to our current situation, death is HIV infection and AIDS. The individual with the principle of indestructible life is education. As the previous chapter has shown, HIV/AIDS appears to be in the ascendancy and to have virtually overcome education, swamping it with a wide range of problems. But education is indestructible. It is buoyant. It is resilient. It will not be put down. The picture and prospects are so grim that they seem to undercut hope, but education stubbornly refuses to give way in the face of so much tragedy and suffering.. It has the extraordinary ability to forestall tragedy and to help its clients begin again after being touched by tragedy. Education shows that there is hope.

At the opening ceremony of the Eleventh International Conference on AIDS and STDs in Africa (the ICASA Conference) held in Lusaka on 12th September, 1999, an 8-year-old girl, Tsepo Sitali, addressed the participants. She said:

As you talk about the problems of HIV/AIDS, think about us, the children. ...We are trying to reach you, trying to tell you something, to draw your attention to how we feel...We have our dreams... We ask you to help us realise these dreams. The name Tsepo in my language means hope. When we do meet again, perhaps soon, I hope you will bring good news that there is hope, hope for us little children of Africa (<http://www.hivnet.ch.8000/africa/af-aids>).

The response of every educator should surely be: “Yes, Tsepo, there *is* hope, and that hope lies in education.” The long, arduous and costly search for a HIV vaccine must continue, but in the meantime every community is equipped with a structure that can boost society's immune system, the structure of education which is not always exploited to the full. By the very fact of sending a child to school, parents expect the school to work the wonder of transforming the young person from being a child into being an adult. Equally the schools, and the entire education sector, can work the wonder of slowing down the spread of HIV/AIDS, transforming young people into individuals who are temperamentally immune against infection. It may be many years before the medical vaccine is developed and becomes available. But every educator should have the conviction that through education children and young people can be “immunised”. Through education, they can be safeguarded. Education can equip them intellectually, affectively, morally, so that they can make sound decisions, deal with pressures, keep themselves free of HIV infection, and extend compassion, solidarity, and care to all who are affected by the disease.

Why Work with Young People is of Such Special Importance

At the outset, it is worth recalling the many reasons for taking special steps to stand by young people, whether in or out of school, whether in the formal school system or in other types of educational undertaking:

1. They are very numerous—the school-age population of more than 230 million accounts for over 30 percent of the people in Sub-Saharan Africa.
2. They are very vulnerable to HIV/AIDS—UNAIDS estimates that in 1998 alone, 590,000 children under the age of 15 became infected, while by the end of that year one-third of the 33 million people in the world living with HIV were young people aged 15–24 (UNAIDS, 1999a).
3. They are crying out for help as they suffer from the experience of HIV/AIDS, some in their own persons, many in their families and among their friends, many as orphans.
4. They are young, idealistic, optimistic, hopeful. They want to make a world for themselves and they want that world to be a better place than that which they have inherited from their parents. At the Lusaka ICASA Conference, the message from adolescents was: “If you adults want to crawl, then crawl; if you want to walk, then walk; if you want to run, then run. But for heaven's sake don't stop us young people from moving on” (Session 14/B/T1).
5. They are at a period of sexual awakening, learning and experimentation, and need extensive help and support in making constructive use of their new-found powers.
6. Most important, they are the window of hope for the future—even though some may already be HIV-infected, the overwhelming majority are not. The general picture is that in heavily infected countries, the individuals most likely to be HIV-free are those in the 5–14 year age group, that is, those who should normally be in primary school. This is where hope for the future really lies. The challenge that formal and non-formal educational provision faces is to work with these disease-free children to enable them remain so.

Reaching out to Youth through Formal and Non-Formal Education

The concern is with both formal and non-formal education. Many of the better-documented programmes and interventions, especially those that rely on peer education and peer counselling, are in the latter category. Work outside the formal school setting, with various youth, club and religious groups, can be especially productive because participants take part freely, without any coercion. Their interest and commitment are reasonably well assured from the outset, though the fact that they are self-selected could mean that qualifications should be added before successes can be generalised to other groups.

The self-selection factor could also mean that the positive outcomes of anti-AIDS clubs and similar groups in schools might not extend beyond the actual membership, though in this case the participants may experience rather more pressure from their peers and from the school authorities to take part in such activities.

But the greatest potential lies in AIDS education programmes that are coherently integrated into the curriculum of the formal school system. Undoubtedly, such integration faces the challenge that many students, being part of a captive audience, may regard AIDS education as just another school subject. But despite this challenge, there is the great merit that in principle, for some continuous period between the ages of five or six and thirteen or fourteen, every child attends, or is meant to attend, school for six or seven years. This sets the school system apart as a social structure with virtually limitless potential in the struggle against HIV/AIDS. The formal school system is unique in that it can reach every young person, and if AIDS is to be successfully combated, every young person must be reached.

The fact that the formal school system must deal with a captive audience highlights the need to make sure that content and methods of presentation, as well as audience involvement, are first rate, so that whatever their age students will feel personally engaged in the material, internalising it in a way that will affect their subsequent behaviour. What is needed is knowledge that will inform behaviour in the right direction. AIDS awareness among young people is generally quite high. Levels of factual knowledge are frequently satisfactory. But the quality of knowledge and the way in which it was communicated are not always such that they can motivate. What is needed is to engage the student's affectivity, thereby contributing to the development of a set of personally held principles and guidelines that will help the student make the right choices.

The Correlation between HIV Infection and Level of Education

Before developing some ideas on the potential role of education in combating HIV infection and the impact of AIDS, it is necessary to say something about one troublesome issue, namely, the positive correlation that regularly appears between HIV infection and level of education. The probability of having a non-regular sexual partner, and hence the risk of contracting STDs and HIV, rises with the level of education (Filmer, 1998; Ainsworth & Semali, 1998). An early Zambian study found a strong linear relationship between level of education and HIV infection—the percentage of infected persons in a hospital population rose monotonically from 8.0 percent for those with 0–4 years of schooling, through 14.7 percent for those with 5–9 years, to 24.1 percent for those with 10–14 years, before climaxing at 33.3 percent for those with more than 14 years of education (Melbye *et al.*, 1986).

This apparent relationship between level of education and vulnerability to HIV/AIDS could be occurring because higher levels of education are associated with higher income and greater mobility, factors that increase risk through their potential facilitation of greater sexual promiscuity. It could be because those who are in an education system establish transient relationships to compensate for the almost necessary deferment of a stable partnership in marriage. It could be because schooling has engendered a more liberal set of values, freeing the individual from inhibitions and restrictions transmitted through family and community systems.

But even in this regard there are signs of hope. Very recent evidence from Zambia shows a substantial decline in HIV prevalence among younger people in both urban and rural areas (Fylkesnes & others, 1999). In Lusaka, HIV prevalence in the 15–19 year-old age group fell over the past five years from 28 to 15 percent, while in a rural area it fell from ten to five percent. A consistent finding, restricted to urban areas, was a marked decline in prevalence rates among 15–19 year-olds with medium or higher educational backgrounds. On the negative side, the trend was for HIV prevalence to increase amongst young people at lower educational levels. This suggests that the correlation between HIV infection and level of education is no longer linear as in the past. It also suggests that education may be realising its expected impact of slowing down the spread of HIV infection, though so far the effect is limited to medium and higher educational levels, and is not yet seen to be operative at the primary level.

What Education Can Do to Mitigate the Impact of HIV/AIDS

There are three levels or times when AIDS-related interventions are needed:

1. while the individual is still HIV-free,
2. when the individual has become HIV-infected and eventually suffers from AIDS-related illnesses, and
3. when AIDS has resulted in death.

In the first time, a major objective is to preserve one's HIV-free status. In the second time, a major objective is to live positively and productively. In the third time, a major objective is for the concerned survivors to adjust to the changed psycho-social and economic circumstances occasioned by the death of a salient other.

In the short and medium term, and very specifically, education can mitigate the impact of HIV/AIDS and its consequences through its potential to work at each of these three levels (Box 4).

First, and in certain respects, the most important, ***while as yet there is no infection and students are HIV-free***, education can work to reduce the likelihood of infection by developing values and attitudes that say yes to life and no to premature, casual or socially unacceptable sex and sexual experimentation. This it can do by

1. providing information and inculcating skills that will help self-protection,
2. willfully seeking to commit students to values—‘what ought to be’—that will motivate them to place a high regard in theory and in practice on sexual abstinence,
3. promoting behaviour that will strengthen the young person's capacity to prevent personal disaster,
4. enhancing capacity to draw others back from the brink, and
5. reducing the stigma, silence, shame, and discrimination so often associated with HIV/AIDS.

Second, ***when infection has occurred***, education can strengthen the capacity of those who experience AIDS, whether in themselves or in their families, to cope with the problem. It can show care for the infected student or teacher, promote care and attention for infected family members, speak out on behalf of the threatened human rights of an infected pupil, teacher or family member.

Third, ***when AIDS has brought death***, education can assist the student or teacher in coping with grief and loss. It can help in the reorganisation of life in the aftermath. It can help the affected individual contend with the loss of a cherished relative, with orphanhood, with possible ostracism, with economic disarray, with the need to forge a totally new future after the death of a salient family member. It can also give support in the assertion of personal rights.

In the longer term, and more generically, education plays a key role in establishing conditions that render the transmission of HIV/AIDS less likely—conditions such as poverty reduction, personal empowerment, and gender equity. It can also reduce vulnerability to a variety of factors, such as streetism, prostitution, or the dependence of women on men, which facilitate the transmission of HIV infection.

Box 4: What Education Can Do to HIV/AIDS

In the short and medium term:

while as yet there is no infection, education has the potential to

- provide *knowledge* that will inform self-protection
- foster the development of a personally held, constructive *value system*
- inculcate *skills* that will facilitate self-protection
- promote *behaviour* that will lower infection risks
- enhance *capacity to help others* to protect themselves against risk

when infection has occurred, education has the potential to

- strengthen the ability to cope with personal infection
- strengthen capacity to cope with family infection
- promote caring for those who are infected
- help young people stand up for the human rights that are threatened by their personal or family HIV/AIDS condition
- reduce stigma, silence, shame, discrimination

when AIDS has brought death, education has the potential to

- assist in coping with grief and loss
- help in the reorganisation of life after the death of family members
- support the assertion of personal rights

In the long term, education has the potential to

- alleviate conditions, such as poverty, ignorance, gender discrimination that facilitate the spread of HIV/AIDS
- reduce vulnerability to the risk situations of prostitution, streetism, dependence of women on men.

How Education Can Slow Down the Transmission of HIV/AIDS and Modify its Impact

If it is to reduce the likelihood of HIV transmission, strengthen the capacity of infected and affected individuals to cope with their situation, and support bereaved and disoriented school members and their families, the formal education system needs to do certain things. It should

1. do better what it is supposed to be doing in terms of access and real learning achievement;
2. integrate sexual health and HIV/AIDS education into the curriculum for all educational levels;
3. ensure that every school member is adequately equipped with the relevant life skills, and that adequate learning takes place in the fourth 'R', that is, relationships with oneself and with others;
4. manifest an improved human rights profile—in terms of its own procedures and actions and in terms of the curriculum;
5. extend its mission beyond the strictly academic to include more attention to counselling and care for its members, and to promoting care and compassion for people with HIV/AIDS.

1. Ensure Access and that Real and Relevant Learning Occurs

In 1990, the World Conference on Education for All was held in Jomtien, Thailand. Ten years later, the world is examining the way in which countries have given expression to the commitments adopted at that Conference. Two of the fundamental articles of the World Declaration on Education for All, which emanated from the Jomtien meeting, are particularly relevant in the context of the encounter between education and HIV/AIDS:

1. Every person shall be able to benefit from educational opportunities designed to meet their basic learning needs (Art. 1).
2. Whether or not expanded educational opportunities will translate into meaningful development—for an individual or for society—depends ultimately on whether people actually learn as a result of those opportunities, i.e., whether they incorporate useful knowledge, reasoning ability, skills, and values (Art. 4).

Education in the sense of schooling can do nothing to reduce the transmission and impact of HIV/AIDS for children who, for whatever reason, are denied access to school. It can work only with children who attend school. Hence the AIDS epidemic underscores the crucial importance of universalising access to primary school. It also underlines the tragedy of Africa where, in 1995, an estimated 40 percent of children were not enrolled in school and where, on present trends, the number of children not attending school seems set to increase dramatically in the coming years (Oxfam, 1999).

Attention to real learning achievement is necessary on two grounds. First, as the World Declaration states, if there is no real and worthwhile learning, then no meaningful development occurs. No matter how well attended, the schools will not contribute as they should to poverty reduction, personal empowerment, or gender equity. Neither will they promote the knowledge and understanding which are fundamental to the reduction of HIV transmission. Those leaving school will remain a prey to the poverty trap which will see many of them being sucked into prostitution, streetism, gender subordination, and other conditions of life that will increase their risk of HIV infection. They will also remain much weaker than they should be in the face of HIV risks.

Second, if there is real learning achievement then it becomes more likely that school messages about HIV will be taken on board, that learners will incorporate the “useful knowledge, reasoning ability, skills, and values” that will contribute to their protection against HIV/AIDS and that will help them mitigate its impacts.

2. Integrate HIV/AIDS and Sexual Education into the School Curriculum

Good quality sexual health and HIV/AIDS education is needed in order to equip young people with the information which they rarely get from their parents or senior family members, which they no longer get from traditional training such as is customarily provided at the time of initiation, which they frequently pick up haphazardly from peers and books, and which they sometimes augment by high-risk experimentation. This education should go beyond the biological facts to include many aspects of behaviour and ultimately of attitudes and values.

It is nothing new that a school should seek to influence behaviour and inculcate values. This has long been seen as part of its traditional role. The school consciously seeks to influence students through its curriculum and through the values that the curriculum embodies. We need to have a clearer perception of “education as being the process of identifying the valuable, opening it to others and, yes, inculcating it into them” (Greenfield, 1991, p.194). This view is reinforced by the modern approach to the school as an organisation. Contemporary theory recognises that organisations, from the simplest village school to the most complex multinational, are built on marshalling people around values, those learned concepts of the desirable which have motivating force and which serve as criteria against which we appraise and evaluate actions (Beare, Caldwell & Millikan, 1989). Through its sexual health and HIV/AIDS programmes, the school should also seek to help each student to develop a personally held value system which will empower the young person to make correct and safe choices, while at school and throughout life.

Incorporating these areas is also integral to the universal right to education. Article 26 of the United Nations Declaration on Human Rights proclaims the right to an education that is directed to the full development of the human personality. Since HIV infection inhibits the possibility of such full development, the right to education includes the right to the knowledge and skills needed for HIV prevention. Such a right can only be exercised if the school curriculum deals effectively with sexual health and HIV/AIDS prevention and care. Article One of the Jomtien Declaration stated that the basic learning needs, which should be met for every person, included the content required by human beings in order to survive. In our AIDS-scarred world, sexual health and HIV/AIDS education are a prerequisite for individual and community survival.

Fears are sometimes expressed that integrating reproductive health and HIV/AIDS education into the school curriculum will increase sexual activity among youth, thereby potentially aggravating rather than alleviating the problem. On the basis of findings from numerous investigations, these fears do not seem to be well-grounded. In a comprehensive literature review, UNAIDS found that

of 53 studies that evaluated specific interventions, 27 reported that HIV/AIDS and sexual health education neither increased nor decreased sexual activity and attendant rates of pregnancy and STDs. Twenty two reported that HIV and/or sexual health education either delayed the onset of sexual activity, reduced the number of sexual partners, or reduced unplanned pregnancy and STD rates. Only three studies found increases in sexual behaviour associated with sexual health education (UNAIDS, 1997, p. 5).

The UNAIDS study concludes that there is little evidence to support the contention that sexual health and HIV education promote promiscuity.

The review also reported study findings that

- responsible and safe behaviour can be learned;
- sexual education is more effective when it occurs before puberty;
- effective programmes encourage openness in communicating about sex;
- programmes 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 behaviour takes place and of the personal and social consequences of such behaviour;
- effective programmes equip young people with skills to interpret the conflicting messages that come from adult role models, television, other media and advertisements (UNAIDS, 1997, p.27).

It should be noted, however, that the studies in question were evaluations of school-based programmes in industrialised countries, principally in the United States. Until recently, little more than anecdotal evidence was available about the relationship between reproductive health education in developing countries and delayed sexual activity and safer sex. However, a clearer picture is now beginning to emerge, confirming that the benefits in developing countries are similar to those in the industrialised world. Reproductive health programmes in Africa are not leading young people to more frequent sex or to an earlier initiation of sexual activities. Instead, they have been found, as elsewhere in the world, to bring significant and positive adolescent reproductive health benefits and behaviours, including some delay in the initiation of sexual activity (Gachuhi, 1999, p. 12).

3. Promote the Development of Life Skills

Quite apart from the HIV/AIDS epidemic, schools have a responsibility to help students develop practical psychological and social skills which equip them for positive social behaviour and for coping with negative pressures. They need to know how to analyse a situation, how to evaluate the element of risk that it contains, and how to extricate themselves before they succumb. The Zambian Ministry of Education sees a core set of these life-skills as including “decision-making, problem-solving, creative thinking, critical thinking, effective communication, interpersonal relationships, self-awareness, stress and anxiety management, coping with pressures, self-esteem, and confidence” (MOE, 1996, p. 43). The Ministry also calls for the investment of time and resources in the fourth ‘R’, that is, seriously conducted human relations education and the development of interpersonal skills that will lead to a better understanding of oneself and of others (ibid., p. 56). Promoting these skills is the responsibility of all who are concerned with the education of youth. It is doubly so because of the HIV/AIDS crisis.

The UNAIDS review of research highlighted the importance of the skill of interpreting the conflicting messages that come from adult role models, television, other media and advertisements. Society creates an almost impossible task for young people, expecting them to behave in a certain way but confronting them with social norms, expectations and role models that point in a very different direction. The young are expected to know how to protect themselves, but information about sex has to be acquired furtively and almost by osmosis, while sexual behaviour is kept under wraps. At the same time, society tends to associate masculinity with extensive sexual knowledge and practice, femininity with naïveté and inexperience. The models placed incessantly before the young through advertisements, in the media, and through the entertainment industry glorify the physical aspects of sex, but say little about the arduous task of building enduring human relationships which support and are supported by sexual practice. A critical life-skill that schools should seek to develop in today's young people is the ability to interpret and challenge these and other social norms that put pressure on them to run their lives on the pleasure principle and to experiment with sex, with the attendant increase in the risk of HIV infection.

4. Establish a Vigorous Human Rights Approach

Human rights and HIV/AIDS are intimately connected. “An environment in which human rights are respected ensures that vulnerability to HIV/AIDS is reduced, those infected with and affected by HIV/AIDS live a life of dignity without discrimination, and

the personal and societal impact of HIV infection is alleviated” (UNAIDS, 1998, p. 5). It is all too easy for educational institutions to fall into the trap of denying access to HIV-infected students, whether because of their HIV status, because of pressure from the parents of non-infected students, or because their HIV status makes it difficult for the students in question to meet attendance requirements or pay educational costs. It may also be tempting for the institutions to restrict the participation of infected students in certain curricular and extra-curricular activities.

It is even easier for educational institutions to ride rough-shod over the rights of HIV-infected teachers and other employees. It is incumbent on the school authorities to protect students from witnessing some of the more humiliating effects of HIV/AIDS in teachers and other employees. But this must always be done in a way that increases and does not demean the dignity of the affected individual. No matter how troublesome their illness, teachers and other education employees maintain their rights as human beings. Schools and the entire educational system need to be constantly on the alert to ensure that these rights are not violated and that infected teachers and other employees can exercise such rights as those to health care, employment, privacy, companionship, association with others, and accommodation. The rights of an infected individual also include the right to work, so long as this remains possible for and is desired by the person concerned.

Provisions for dealing with these and other aspects of human rights and education need to be developed and implemented by education ministries and teaching and research institutions, with clear guidelines being provided to schools and colleges. At the school level, social science and other disciplines that deal with human rights need to extend their treatment to HIV/AIDS applications, such as the right to marry and found a family, the right to privacy, the right to work, the right to expression and information, and the right to the highest attainable standard of physical and mental health (UNAIDS, 1998, pp. 40–51).

A crucial need is for the schools' human rights programme to bring HIV and AIDS out into the open, to contribute to breaking the silence, the secrecy, the stigma, the shame that are associated with AIDS. The Executive Director of UNAIDS reminded the Lusaka ICASA Conference that

stigma remains our most significant challenge in AIDS. It make prevention through education very difficult. ... (It) undermines the political support we know is so necessary. Therefore eliminating stigma must be central in the response to AIDS. It is a key way to break the silence and move the response forward (Dr. Peter Piot, Address at Opening Ceremony, Eleventh ICASA Conference, Lusaka, 12th September, 1999).

AIDS in itself is a calamity for an individual, a family, a community. It does not need the inhuman response of aggravating it through stigma, silence and shame. Through its sexual health and HIV/AIDS programmes, through equal treatment for all its members, through vigorous action against petty hole-in-the-corner teasing and bullying of those infected or affected by the disease, through arranging for people living with AIDS to address the school community, through role-playing and drama presentations that bring HIV/AIDS out into the open, through consistent manifestation that it is ashamed of the shame itself, the school can counter the silence and reduce the stigma and discrimination surrounding HIV/AIDS. By doing so, it moves the response forward.

5. Increase the Attention Given to Care, Counselling and Compassion

AIDS has greatly increased the number of orphaned school pupils, the number who are living in households containing an infected member, the number who have lost or

may shortly lose a grandparent or other close family member, and the number who have had to change home and possibly school because of various AIDS effects. Tragically, it has also increased the number of school pupils who are themselves infected by AIDS—in 1995, a newspaper report stated that out of 63 secondary school pupils who donated blood in a Zambian hospital, only 11 were not HIV infected (*Times of Zambia*, 21st July, 1995). Situations such as these point to the urgent need that school children have for more guidance, counselling and psychological support. Referring back once again to Article 26 of the United Nations Declaration on Human Rights, the full development of the human personality of these young people requires that they be provided with the special counselling and psychological support they need so badly in this situation. This, in turn, requires that the school extend its mission beyond the strictly academic to include more attention to counselling and care for its members.

Important life-skills in the HIV/AIDS area include showing compassion and solidarity towards infected individuals; and caring for people with AIDS in the family and community (UNAIDS, 1999b, p. 18). As a significant social service provider, which is found in all parts of a country, the school cannot remain aloof from the tragedies that affect families, and possibly some of its own members, in the community it serves. Instead, it can translate its health and hygiene studies programmes into action by training in home-based care for children from all families; it can modify its social studies and works programmes to include activities in support of affected families; it can extend its religious education programmes to the practical and universal manifestation of the human compassion and concern that are at the heart of all true religion.

Lessons from Experience

Several school systems in Eastern and Southern Africa, in what is now coming to be known as the HIV/AIDS “hot zone”, have established life skills programmes which, for the greater part, also serve as the channel for education on HIV/AIDS and reproductive health. Gachuhi (1999) has reviewed such programmes in Botswana, Lesotho, Malawi, Namibia, Swaziland, Uganda, and Zimbabwe, while the programme in Zambia came under intense scrutiny in the late 1990s (Siamwiza, 1999; Siamwiza & Chiwela, 1999; Chiwela & Mwape, 1999). In her review, Gachuhi reports that programmes are more likely to reach their goals of changing student attitudes and promoting behaviour that will lower the risk of HIV-infection provided teachers take certain steps. Specifically, life skills and HIV/AIDS education programmes are more effective when teachers

- explore their own attitudes and values and establish a positive personal value system;
- establish an open and positive classroom climate;
- place education about STIs/AIDS within the context of a general programme on personal development, health and living skills;
- use a positive approach which emphasises awareness of values, assertiveness and other relationship skills, decision-making, and self-esteem; and
- apply teaching about STIs/AIDS to situations with which students identify (Gachuhi, 1999, p. 15).

This enumeration draws attention to the central role the teacher must play if effective life skills and reproductive health programmes are to be established within schools. This heavy dependence on teachers points to what currently may be the weakest aspect of well-conceived programmes—their failure to take adequate account of the situation prevailing on the ground in terms of

- the inadequacy of teacher knowledge and confidence,
- teacher embarrassment in treating of sexuality issues with the young and with those of the opposite sex,

- teacher concern about lack of preparation to teach psycho-social life-skills and HIV/AIDS prevention,
- arising from awareness that they, or members of their families are HIV-infected, the reluctance of teachers to teach something which is so painfully close to home;
- teacher feelings that this part of the curriculum is not critically important; and
- teacher anxiety that in dealing with sexuality and sexual behaviour they would break traditional taboos and offend parents.

Responding to these concerns necessitates four things:

1. extensive pre-service and inservice training of teachers to enable them teach psycho-social life skills and HIV/AIDS prevention and impact mitigation correctly and in ways that have potential to impact on student attitudes and behaviour;
2. the development of manuals aimed at improving teacher knowledge and teaching competence in these areas, and of a wide variety of teaching materials for use at different school levels;
3. an extensive advocacy programme that will speak to all stake-holders, but in particular will win over the support of parents, churches, and traditional leaders; and
4. very delicate sensitivity, understanding and compassion when dealing with infected or affected teachers.

Put HIV/AIDS at the Centre of the National Education Agenda

Much that has been said in these pages may sound like a call to transform the education system, to remodel school relationships, to reconstruct the school curriculum. The considerations that have been brought forward make it sound as if the whole system is to be thrown topsy-turvy, so that education and school will no longer continue in the way they were traditionally known.

This is a correct impression. What the severely affected countries are facing—indeed, what the world is facing—is not another public health problem that is different because on so large a scale. It is a crisis, a development crisis, that is engulfing whole peoples, economies, societies. It is different from anything the world has ever known before. And the response to it must be different from anything the world has known before. The world with AIDS is not the same as the world without AIDS. Likewise, the school in an AIDS-infected world cannot be the same as the school in an AIDS-free world. In September, 1999, the World Bank called on “African leaders, civil society, and the private sector to put the HIV/AIDS crisis at the center of their national agendas” (World Bank, 1999, p. 1). Almost at the same time, the Director-General of UNAIDS appealed to Africa's leaders “to declare AIDS in Africa a state of emergency, requiring emergency-type efforts and emergency-type resources” (Dr. Peter Piot, Address at Opening Ceremony, Eleventh ICASA Conference, Lusaka, 12th September, 1999).

The time is now to declare education systems and schools in Africa in a state of emergency because of AIDS, requiring emergency-type efforts, emergency-type responses. The time is now to put the HIV/AIDS crisis at the centre of national education agendas—not as an add-on, not as a peripheral, but at the centre as the heart of the matter.

Taking the emergency-type measures proposed in the previous pages, and working with all diligence to devise other emergency-type responses, should go some way to stem

the advance of the infection. These measures may help to make infection more bearable. They may help to make the impact of the disease more manageable. Refusing to take these or comparable actions means burying our heads in the sand, hoping that somehow the storm will pass. But it will not pass. With only 10 percent of the illness and death that accompany HIV/AIDS being experienced so far (World Bank, 1999, p. 5), the situation is worse than anticipated. Unless education, along with every other sector, takes appropriate measures it will become even worse still.

What then will be the response to little Tsepo Sitali and the millions of other African children who are looking to their educational leaders to give them hope—“when we do meet again, perhaps soon, I hope you will bring good news that there is hope, hope for us little children of Africa”? That hope is education, education that responds imaginatively to the crisis and not necessarily education as it has been traditionally known. It is up to every educator—teachers, planners, policy-makers—to commit themselves to the necessary changes and transformations. It is up to them to put HIV/AIDS right there at the centre of the national education agenda. It is up to them to bring hope to the children of Africa and the world.

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