

# Gender, HIV/AIDS and the Status of Teachers

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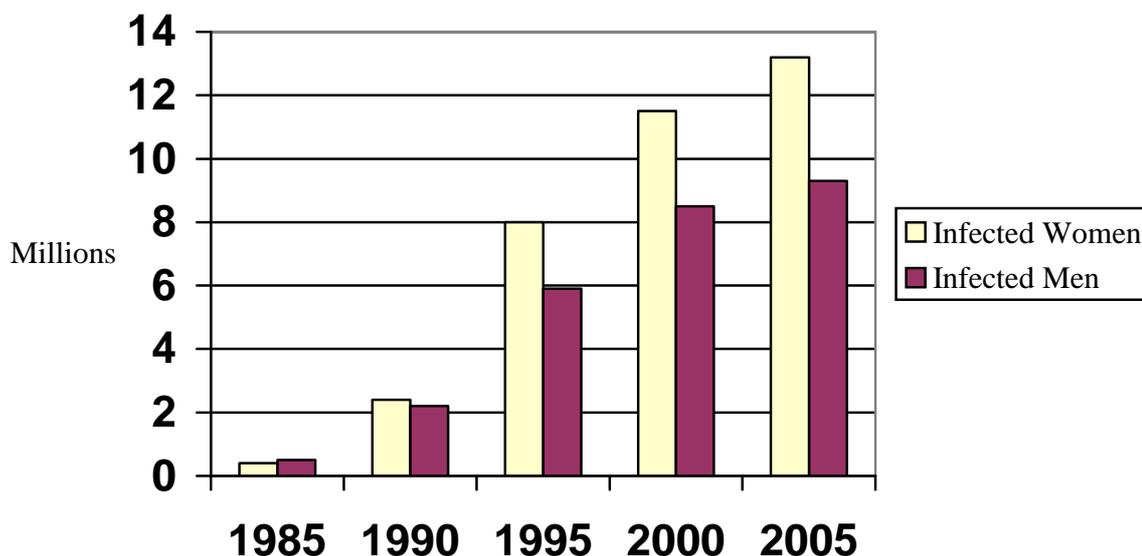
M. J. Kelly (mjkelly@jesuits.org.zm)

## HIV and AIDS in the Commonwealth

Since a symposium convened by the Commonwealth Secretariat in collaboration with Education International is the occasion for this paper, it seems appropriate to begin by outlining the extent of HIV and AIDS in Commonwealth countries.

The Commonwealth is the world's most seriously infected global grouping of countries. Although it contains less than one-third of the world population, it accounted, at the beginning of 2006, for almost two-thirds of global HIV infections. On the basis of data for individual Commonwealth countries appearing in the *2006 Report on the Global AIDS Epidemic*<sup>1</sup>, the HIV infection rate across Commonwealth countries is approximately 1.2 percent, compared with 0.6 percent globally. This means that 12 out of every 1,000 people in Commonwealth countries are HIV infected.

Figure 1: More Women than Men are becoming HIV Infected in Sub-Saharan Africa



<sup>1</sup> Geneva: UNAIDS, June 2006

Slightly more than half of those who are infected are women. Female infection rates, however, are much higher in Sub-Saharan Africa, where 59 percent of infected adults are women - for every 10 infected adult men, there are 14 infected adult women. As Figure 1 shows, the adverse HIV situation of women in Africa developed not many years after the onset of the epidemic and is steadily becoming more pronounced.

This has implications for the teaching profession and the delivery of educational services, since a high percentage of teachers, especially those in pre-schools and primary schools, are female. There is a potential loss of teachers in terms of sickness and deaths. There are also constraints on the freedom of educational managers to post women teachers to remote rural schools (where their services may be very badly needed) because of the possible need of infected teachers to be stationed fairly close to clinics where they can access the monitoring, treatment and drugs that their condition may require. The situation also has implications for teachers' ability to be professionally productive. As will be seen below, this can be adversely affected by HIV infection, at least until such time as the infected teacher has succeeded in coming to terms with her or his sero-positive status.

Another feature of the AIDS epidemic that impinges heavily on Commonwealth countries is the legacy of orphans that it leaves in its wake. Three quarters of the twelve million orphans in Africa who have lost one or both parents to AIDS live in Commonwealth countries south of the Sahara. This too has significant implications for educational provision within those countries and for teachers in their schools. Orphan ability to attend school varies from country to country and according to whether the child is an orphan because of the death of the mother, or of the father, or of both parents. In very broad terms, however, the school participation of orphans tends to be less than that of non-orphans. But the issue goes beyond access to and enrolment in school. Learning to cope with personal orphan status, full integration into the school community, ability to cope with the small cruelties that children can inflict on one another, achieving a sense of security and stability, managing their personal grief and loss, receiving the support, encouragement and love that would have come from the departed parent — these and others are challenges that orphaned children must face in school. Many could not confront these challenges without the help and support of teachers, especially female teachers. In a sense that was not widely applicable before the AIDS era, many teachers are now serving *in loco parentis*, since they find themselves acting as surrogate parents for children who are reaching out for the stability, understanding and love of a concerned and caring adult. They also find themselves having to provide psychosocial support and act as counsellors, roles for which they had not been prepared.

### **Gender and HIV**

HIV and AIDS affect women in different ways than men. On physiological and health grounds women are at higher risk of infection. These physiological and health factors make HIV transmission from male to female seven times more likely than transmission from female to male. On social and economic grounds women are also more vulnerable to infection. Further, when AIDS is present women are more extensively affected. But although AIDS has a woman's face, in general it is women who are leading an effective response.

Gender inequity and inequality in the areas of sexual expectations and behaviour compound this biological vulnerability of women. The stereotyped and socially constructed images of masculinity that are promoted in most cultures portray a picture of the controlling male. The man is seen as the main initiator of sexual activity and the dominant partner in most sexual interactions. Integral to this stereotype are the widespread beliefs that a man “needs” sexual activity in order to establish his identity and that to exert sexual and physical domination over women defines what it means to be a man.

On the other hand, stereotyped femininity portrays women as submissive, docile, and compliant. The interest of girls and women in sexual activity is often seen as being motivated by three factors, operating singly or in combination: images of love and friendship that carry with them the imperative of maintaining a satisfactory relationship; the prospect of childbearing; and acquiring social status, money, material resources and important intangible benefits.<sup>2</sup>

These concepts of masculinity and femininity lead to imbalances in decision-making power, with women almost invariably being in a subordinate role and submissive to men. In practice this means that women are weakly placed to determine the circumstances of their sexual lives. They cannot control when, with whom, and under what conditions they have sex, and may often be forced to have unwanted sex.

The stereotyped concepts of masculinity and femininity also lead to double standards governing the sexual behaviour of women and men in both traditional and modern societies. Men are expected to be knowledgeable and experienced in sexual matters, whereas women are expected to be somewhat naïve — if they show knowledge or interest in sexual areas they may be regarded as immoral or “cheap”. Promiscuity among men is more readily condoned than among women. As a result, boys and men tend to have more sexual partners than do girls and women.

All of these practices, and the attitudes that validate them, increase the vulnerability to HIV infection of both men and women, but because of their subordinate status the risk for women is greater.

The vulnerability of women is further accentuated by harmful social practices, some quite widespread, others occurring in more restricted settings. Widespread practices include age-mixing, where younger women partner with older and more sexually experienced men, and multiple sexual relationships in which an individual maintains a number of sexual partnerships, either successively or at the same time. Age-mixing increases in a number of ways the risk that the girl will become HIV infected. There is a possibility that the older male partner will already be sexually experienced and hence may already have contracted HIV. The girl has almost no power within the relationship to insist on safer

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<sup>2</sup> Kempadoo, K. and Dunn, L. L., “Factors that shape the initiation of early sexual activity among adolescent boys and girls”, in *Meeting Adolescent Development and Participation Rights: The Findings of Five Research Studies on Adolescents in Jamaica*, Kingston: UNICEF and UNFPA, 2002, p. 170.

sexual behaviour, while there is always potential for violence, especially if the girl attempts to end the affair. It seems likely that this form of relationship is responsible for much of the HIV transmission in the 15 – 24 age group. The girl becomes infected through her older and more experienced sexual partner. But she also maintains relationships with her male age-mates and hence can pass infection on to them.

Women's vulnerability to HIV infection may also be increased in societies that have preserved long-standing traditional practices, some of which are in flagrant violation of human rights. These include early marriages for girls, before they have reached physiological maturity and when they should still be attending school; ritual cleansing which requires that a widow have intercourse with a member of her late husband's family; dry sex where herbs are used to dry out and tighten the vagina (in order to increase male pleasure, but at the risk of vaginal abrasions that facilitate the entry of HIV and other viruses); and female genital mutilation (the partial or total removal of the external female genitalia) which causes chronic genital injury, easy tearing and possible ulceration, thereby heightening HIV risk<sup>3</sup>.

In addition to all this there are the many impediments that girls face in accessing education, staying in school, and performing well while there. These range from the insufficiency of school places and low levels of educational quality, through the costs that prohibit poor families from ensuring the school education of girls, to the ease with which girls are taken from school in order to provide household labour. There is now strong evidence that school education can reduce girls' vulnerability to HIV in a variety of ways, principally by helping them to build their self-esteem and capacity to act on HIV prevention messages, influencing the level of power within sexual relations, and leading to better economic prospects, which in turn lead to lifestyle changes that can influence HIV vulnerability.<sup>4</sup> But persisting gender inequalities in education continue to exclude a disproportionate number of girls from these benefits and thereby heighten their vulnerability to potential HIV infection.

### **Gender, Teachers and HIV**

Teachers grow up, live and work in societies where these norms, attitudes and practices are accepted. They are integrated into their lives through the normal processes of socialisation. Hence they become accepted principles that guide both female and male teachers, in their personal behaviour and interactions and in the expectations they form for their pupils, colleagues and others in their communities. As with others in society, teachers may find these norms problematic and strive towards a more lofty value system. But until substantial change occurs within the outlook of society itself, these remain the norms that exercise a strong influence on the attitudes, practices and even values of teachers.

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<sup>3</sup> The World Health Organisation estimates that between 100 and 140 million women and girls have undergone female genital mutilation and that about two million more are added to that number each year.

<sup>4</sup> Hargreaves, J. and Boler, T. *Girl power: the impact of girls' education on HIV and sexual behaviour*, London: ActionAid International, 2006, p. 4.

Recognising, but not condoning, the deep personal and peer pressures to which these norms may give rise, makes it necessary to ask about the extent to which they contribute to HIV transmission among teachers, reported (though not always proven) cases of sexual abuse in schools, and the global ignominy of gender-based violence (GBV).

Like an intense spotlight, the AIDS epidemic has helped to focus world attention on various problem areas within society. Among these are the extent of gender-based violence and the sexual abuse of children. Violence against women is the most pervasive of all human rights violations — up to half of all adult women have experienced violence at the hands of their intimate partners, while one in five women worldwide will survive rape or attempted rape. The shocking situation for children is that globally 20 percent of girls and 10 percent of boys experience sexual abuse as a child. For girls the situation is especially grave since it is estimated that almost half of all sexual assaults in the world are against girls aged 15 or younger. Moreover, the sexual abuse of children frequently takes place in the home, school, or community, with the perpetrators often being individuals the children know and trust.

Unhappily, teachers may be among these child abusers. Although the documentation is not very precise, as many as 50 percent of school-children in some countries report having been physically or sexually assaulted while at school. Where it occurs, pupil abuse tends to be inflicted mostly by male teachers on girls, though cases have been reported of boys being abused by male as well as female teachers. One commonly alleged reason for sexual interactions between educators and learners is the willingness of learners to trade sexual favours for good grades, access to the contents of examination papers, or entrée to a higher educational level. This has led to what some countries now refer to as “sexually transmitted grades” or STGs.

Individual teachers, school heads, education ministries, teacher unions and communities have to maintain unflinching diligence to ensure that proscribed sexual interactions never occur in a school setting. Apart from the violations of trust that these entail, they constitute grave human rights abuses and in most countries are serious criminal offences. Pedagogically, they create a great divide between the values that educators seek to communicate and those that they practise, while in relation to HIV they open a ready channel for the transmission of the virus from a possibly infected older educator to a young learner.

Without minimizing in any way the gravity of sexual activities between teachers and students, one must ask whether the stance of society is firm enough and whether the sanctions fit the crime. Fearing that it will lose the services of a teacher, a community may persuade the family of a violated child to take no action. Moreover, the circumstances of sexual abuse at school may be such that in the absence of anything more than allegations, education ministries may not be able to take action. And in an environment that reflects the truth of the 17<sup>th</sup> century legal adage, “in a rape case, it is the victim and not the defendant who is on trial”, a family may not wish to pursue investigations that might bring other family matters out into the open.

### **General Considerations on HIV/AIDS and Teachers**

The possibility that teachers may be HIV infected and the potential consequences of this for education systems in terms of teacher attrition and replacement needs have received considerable attention in the literature. As has happened with the Millennium Development Goals, gender-based equality, and the education of orphans, the discussion frequently revolves around the numbers. The importance of numbers cannot be doubted, but the quantitative aspects do not tell the whole story and often they do not tell the most important parts of the story. In many cases, qualitative aspects may be considerably more significant. In a world that dedicates massive human and financial resources to measurement, Einstein's maxim is very relevant: "What can be counted does not necessarily count, what counts cannot necessarily be counted". In the circumstances of HIV/AIDS and teachers, what really counts may be teacher status in relation to the epidemic, the multiple demands on female teachers, protecting educational quality, the sexual norms and expectations in society (considered above) and the school culture.

A second consideration is the importance of enabling teachers arrive at authentic learning and understanding of the epidemic. Many programmes stop short at superficial, factual knowledge. Important as this is, it needs to be complemented by authentic learning that leads to personal knowing, changes in attitudes, and the adoption of values. There is considerable need to develop teacher capacity to get in touch with what HIV/AIDS means in their lives, and to examine and deal with the challenges that being HIV infected or affected presents for them as persons, living in *this* community, working in *this* school, and with *these* terms and conditions of service. Developing this capacity would lead to more authentic understanding of the epidemic, something that would help teachers take better charge of their own lives in a world with AIDS. It would also equip them better to guide the young people entrusted to them in an ethical human response to the epidemic. Moreover, teachers who have reflected critically on the epidemic in ways that engage the whole person may be better able to communicate effectively on HIV and AIDS issues with learners.

A third consideration is the image or role of teachers in a community. Parents and others usually see teachers as responsible for fostering much of the overall development of young people so that they might achieve personal fulfilment and become significant members of society. Because of this, teachers tend to hold a position of respect and special status in society, even though they may not be recompensed proportionately. This may lead to their feeling more compromised than others if they are directly affected by HIV, either in their own persons or in their families. Likewise, stigma and misunderstandings continue to be so insidious that parents may raise questions if they learn that an HIV positive teacher is teaching their children.

### **HIV/AIDS and Various Teacher Roles**

The majority of teachers live out their lives in a variety of different roles. They have a personal life, as family members and frequently as heads of households. They have a professional life within the school and classroom. They are employees of an education ministry or of a school's governing board. They are community members. HIV and AIDS say different things to teachers in each of these roles.

At the individual level, a teacher who is personally HIV infected, or in whose immediate family there is HIV, experiences extensive psychological and emotional turmoil. Although antiretroviral drugs should prevent the infection from running its course to potentially lethal AIDS conditions, there are deep personal concerns both about the infection itself and accessing all that the treatment requires. Stigma ranks high among these concerns, not only the stigma coming from others that reaches deep into the hearts of those affected, destroying their spirit more effectively than the HIV virus destroys their bodies, but also the self-stigma that relentlessly eats away at their self-esteem in intense disabling feelings of anguish, shame, dejection, self-doubt, guilt, self-blame and inferiority.

Like others in similar circumstances, the ability to access ARVs will be of concern to a teacher. Will the drugs be available? What costs will they entail? How can a person stationed in a school in a remote rural area access these every time they are required? How much will travel to the nearest clinic cost? Will the school authorities always be accommodating in giving time off for clinic attendance? What will teaching colleagues at the school think when they are asked to cover for absences of a day or more every month? How possible will it be to ensure the regular nutritious diet that should accompany ARV treatment?

Worrying about these and similar issues goes beyond the personal level. The worries can lead to various degrees of “mental absenteeism” and lack of concentration on the teaching duties in hand. As an HIV infected teacher has put it, “teaching is a psychological job, I need to have my mind settled”.<sup>5</sup>

The infection of somebody in the household affects teachers in their families in much the same way as it affects others in the settings of their own families. It entails care, financial outlay and deep anxieties. Attending to the person whose HIV has progressed to AIDS may be a labour of great love, but it is also very demanding on time and on the caregiver’s psychological reserves. There are further demands on time, as also on financial resources, in the special shopping that AIDS-care in the home requires and in ensuring regular contact with the clinic for the monitoring of the patient’s condition, the treatment of opportunistic infections and the dispensing of antiretroviral drugs.

As with childcare, much of this health care in the home is provided by women, the same women who form the majority of primary school teachers and, in some countries, of secondary school teachers. Female teachers frequently find themselves pulled between three competing roles, that of their professional work area, that of managing a household, and that of attending to sick persons who may require almost round-the-clock care. Very seldom does one hear of flexible arrangements that would enable such teachers handle more effectively and humanely their responsibilities in these three areas.

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<sup>5</sup> *Supporting HIV positive teachers in East and Southern Africa*. UNESCO and EI-EFAIDS Report of Technical Consultation, Nairobi, 30 November – 1 December 2006, p. 9.

In relation to what teachers do as teachers, AIDS can affect their professional role within the school or classroom in a variety of ways:

- They may have to take on additional responsibilities to cover for a sick or absent colleague.
- They may be required to teach in areas where they do not feel competent because the teacher who knows the subject is sick or has died.
- They are increasingly being asked to integrate HIV and AIDS perspectives into their classroom work, but many do not feel competent or able to do so.
- The teaching of life-skills has become integral to the curriculum for education in an AIDS-infected society, but many teachers are not conversant with the methods or approaches needed for effective teaching in this area.
- Teachers face new demands because of the behavioural, emotional and psychological problems that infected and affected learners (especially orphans) bring into the classroom.
- Many teachers find that in addition to their teaching work they are also expected to provide counselling services for affected or infected learners.
- Teachers find that an increasing amount of their time is taken up by workshops and in-service training activities designed to make them knowledgeable and competent in HIV-related areas.

Workplace implications of HIV and AIDS affect teachers in their capacity as employees. Many are reluctant to reveal their HIV status within the school setting because they fear that confidentiality will not be maintained. Some experience intense personal pressure to perform, partly to counteract their debilitating self-stigma, partly to protect their employment by showing that they are productive. Frequent and mostly unavoidable absenteeism causes worry about what is being entered on one's personal record, as well as concerns about the way this is affecting the learning of pupils for whom one is responsible. There are also workplace issues such as those relating to the prohibition of discrimination and stigma, the prevention of risks, safety in the school environment, and the absence of violence and abuse.

### **HIV Prevalence and AIDS Mortality among Teachers**

Considerations of HIV/AIDS and the status of teachers almost inevitably force one to ask whether the rate of HIV infection among teachers is the same as that in the general population, or is it higher or lower. It is also necessary to ask about the levels of AIDS-related teacher mortality. Conventional wisdom held that early in the history of the epidemic, the three M's — men, mobility and money — fuelled HIV infection. Relative to others in the community, teachers had money and were more mobile. In some countries the need for teachers to travel each month to a district centre to collect their salaries accentuated the risk arising from the money and mobility combination. Teaching practice arrangements that do not address trainee teachers' need for suitable accommodation may also place individuals in a position where the money and mobility combination might contribute to an increase in risk-laden casual sex.

But even though teachers may have more money and greater mobility than others, they remain members of their communities, living according to the same cultural and

behavioural norms. There are no a priori grounds for believing that infection rates among them should be higher than within these communities. Indeed, the opposite may be the case. The fact that in relation to the general population, teachers tend to be better educated, better nourished, and have better levels of information about the epidemic, might actually predispose them to less risk.

Perhaps the best evidence on this whole question comes from South Africa. A survey conducted in 2004 found that 12.7 percent of over 17,000 teachers who gave specimens for testing were HIV positive.<sup>6</sup> This was similar to the prevalence rate among the general population. But unlike the situation in the general population, the HIV prevalence rates among men and women educators were the same. It would be valuable if national level HIV surveys in other countries allowed for the disaggregation of information on teachers so that there could be better understanding on whether or not teachers constitute a special category that is at high risk of HIV infection.

Additionally, it seems that teacher mortality due to AIDS does not differ much from AIDS mortality rates for similar occupational groups. Moreover, mortality rates for teachers do not seem to be unduly high. In some countries, male teachers have a higher mortality rate than female teachers, even though there is more HIV among female teachers. In Zambia, for instance, 342 male teachers, or 0.88 percent of the male total, died in 2006, compared with 251 or 0.75 percent of the female total. In a number of high prevalence countries, teacher mortality due to AIDS is decreasing, largely due to the increasing availability of ARVs<sup>7</sup>. National and global moves to universal access (to HIV prevention, care, support and treatment) are likely to see even further decreases.

Thus, while the epidemic continues to have major impacts within the education sector, it is not causing as much turbulence as had earlier been anticipated in terms of morbidity and mortality. There is need to capitalise on this positive situation so that teachers and the system can better institutionalise the epidemic within the sector and respond to it in a way that will enhance education's significant potential to protect its own personnel and its millions of young clients against HIV infection and its numerous negative outcomes.

### **HIV/AIDS in the Curriculum**

Education is often considered as providing a "social vaccine" against HIV infection. "It is often said that people who wear a tie do not get cholera. In the case of HIV/AIDS, education is likely to determine a person's vulnerability to HIV infection"<sup>8</sup>. Various studies continue to support this view that HIV prevalence will be lower among those who are attending school or have higher levels of educational attainment<sup>9</sup>. This positive

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<sup>6</sup> Human Sciences Research Council (HSRC) and Medical Research Council (MRC) of South Africa, Fact Sheet No. 6, HIV Prevalence among South African Educators in Public Schools, 2005.

<sup>7</sup> Anti-retroviral drugs are driving down AIDS mortality in Sub-Saharan Africa, Paul Bennell, Knowledge and Skills for Development, Brighton, U.K., December 2006.

<sup>8</sup> "The 'education vaccine' against HIV/AIDS", J. Vandemoortele and E. Delmonica, *Contemporary Issues in Comparative Education*, Volume 3, Number 1, December 2000.

<sup>9</sup> Cf. "The association between school attendance, HIV infection and sexual behaviour among young people in South Africa", J. Hargreaves et al., *Journal of Epidemiology and Community Health*, 2008; 62; 113-119.

benefit from education does not occur in a vacuum but is largely the outcome of what teachers can accomplish in the classroom.

In many school systems, however, teachers feel that they are not properly equipped to contribute as they could in the area of HIV and AIDS. Many complain that they have had little training in the areas of HIV/AIDS and sexual and reproductive health, at either pre-service or in-service level. Surveys have also drawn attention to many of the shortcomings in teacher knowledge on the epidemic. Education International has summed up the situation in terms of reports received from teacher unions in many countries:

[Teachers] often feel hopelessly incompetent when confronted with questions posed on HIV and AIDS. Teachers tell their union leaders about the lack of training and the poor supply of materials they are faced with. In other instances, education authorities are providing teachers with books but not the training they need to be able to diffuse the knowledge contained in them. They often face resistance to teaching on HIV and AIDS related issues from parents and even the education authorities themselves.<sup>10</sup>

Teachers also need help in teaching HIV/AIDS matters competently and with assurance in the circumstances of large co-educational classes where the pupils may be of widely differing ages. Because of the subject matter they are dealing with, women and men teachers will face different problems, but neither may get the help they feel they need. In many situations all that is being provided is rather superficial teaching of facts, with little consideration of key sexuality and relationship issues. As with almost every other community member, many teachers feel they can offer little more than partial information, some facts, considerable embarrassment, and sometimes almost total silence.

A major concern of teachers is their fear that dealing with sensitive topics in sexuality may expose them to community criticism that they are teaching promiscuity and opening the door to the very practices they are seeking to discourage. The task of teachers would be greatly facilitated if they themselves, communities and the cultural and religious leaders who are the gatekeepers of society became more aware of the strong evidence from developing and developed countries alike that school-based sex and HIV education interventions do not lead to an increase in sexual activity. Instead they contribute to delay in participants' reported sexual activity, reduction in the number of sexual partners, decrease in their frequency of sexual activity and increase in their use of condoms.<sup>11</sup>

### **Conclusion**

It should be clear that gender, HIV/AIDS and the status of teachers involve interactions at many different levels. Measures directed at one member of this triptych very quickly find themselves dealing with the other two. Many specific interventions can be proposed for responding to some of the challenges that present themselves. But in line with the greater stress that this paper puts on qualitative perspectives it is suggested that one of the

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<sup>10</sup> *Training for Life: EI Report Teacher Training on HIV/AIDS*, July 2007, p. 4.

<sup>11</sup> *Preventing HIV/AIDS in Young People. A Systematic Review of the Evidence from Developing Countries*. Eds. David A. Ross, Bruce Dick & Jane Ferguson. UNAIDS Inter-agency Task Team on Young People. Geneva: WHO Technical Report No. 938, 2006.

greatest needs is for the establishment within schools and every kind of educational institution of a positive life-affirming institutional culture and organisational milieu.

Such a culture should be strongly rights-based, affirming gender equality in principle and in practice. It should show zero tolerance for all forms of violence and for every manifestation of stigma or discrimination. It should encourage the development of life-affirming attitudes and values. Most importantly, it should seek to transform understandings of what it is to be a woman and what it is to be a man. In this it should involve male teachers and pupils in a way that will expand their gender understanding beyond the limits of the male sexual dominance model that is so widespread and that wreaks so much harm. In this way it would address one of the major drivers of the AIDS epidemic and a feature of society that is demeaning to women.

This will not be easy. In particular, it will not be easy for teachers either to grasp or communicate such understandings. But even small beginnings will be of great worth. The essential point is that teachers, whether female or male, should recognise that they have a special role in the formation of values and that these values persist with young people long after they have left school. In this regard, the school culture is the great ally of teachers. A school that runs on the principles of the full equality of every man and woman, of every infected and non-infected person, and of the dignity of every individual, will help to build up in members of its community the recognition that being human is what counts. And that is the first step in transforming the negative gender norms that debase women and maintain HIV infection.

In many respects, Jonathan Mann, Director of the World Health Organization's Special Programme on AIDS (the predecessor of UNAIDS) summed up the issue when he said, "The central [AIDS] issue isn't technological or biological: it is the inferior status or role of women. ... When women's human rights and dignity are not respected, society creates and favours their vulnerability to AIDS."

Ensuring that women are no longer relegated to an inferior status or role and that their human rights and dignity are at all times respected is the real challenge that consideration of HIV/AIDS, gender and the status of teachers places before every educator and education system.

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