

# **"HIV/AIDS: The Power of Education"**

**BOOK LAUNCH**

***Education & HIV/AIDS in the Caribbean***

**by Michael Kelly**

**in association with Professor Brendan Bain,  
The Honourable Rex Nettleford and Gudmund Hernes**

**At the Opening Ceremony of the  
UNICA/UWI/UNESCO Conference  
HIV/AIDS: The Power of Education  
October 29, 2003**

**Professor Alleyne:**

Your Excellencies Professor George Maxwell Richards, Dr. Jean Richards, Honourable Prime Minister Patrick Manning, Vice Chancellor Rex Nettleford, Pro Vice Chancellor Bhoendranatt Tewarie, Deputy Principal Kochar, Madame H el ene-Marie-Gosselin - UNESCO's representative for the Caribbean, Honourable Minister of Tertiary Education Danny Montano, Honourable Minister of Health Colm Imbert, Members of the Diplomatic Corps, Members of International Organizations, Members of UNICA , Specially invited guests, ladies and gentlemen, welcome to the inauguration of the conference on the theme "HIV/AIDS: The Power of Education", and a special welcome to those friends and colleagues from outside the region whose participation signals the global range of the HIV/AIDS pandemic and the international character of this conference.

This conference is taking place at a particularly critical juncture when we are faced with a veritable do or die situation. We must act very forcibly now to reverse the contagion or see our societies completely overwhelmed and devastated. Indeed HIV/AIDS is matched only by violence as a scourge which threatens to undermine our societies. They are both really public health issues which need to be confronted with a strong education response. Education of course in its broader sense including especially socialization and effective symbolic communication. The conference is the brain child of the Vice Chancellor of the University of the West Indies, Professor the Honourable Rex Nettleford. He announced his intention to hold this conference at the annual general meeting of UNICA last year. UNICA is the association of Caribbean Universities and Research Institutes. Its membership comes from all the language zones of the Caribbean including the greater Caribbean that is Venezuela and Colombia. Its fundamental objective is to enhance higher education in the region through collaboration and cooperation. The Vice Chancellor of the University of the West Indies is the current president of the association and as Secretary General I proposed that the conference be held in conjunction with the annual general

meeting of UNICA scheduled here in Trinidad for Saturday of this week. This proposal was accepted and by this time UNESCO also had become a very willing and resourceful partner to the event. As you see this is a rather long programme to be squeezed into one hour so I will move right away to the distinguished core of speakers assembled here this evening. Ordinarily I would say that our first speaker needs no introduction after all he is Principal of this campus and this is very much his territory. He is as we say in Jamaica, "Man ah yard." However since there are persons here from outside the region who may not know of him I should say a few words about this remarkable man and his remarkable career with a very diverse record of achievement. Dr Bhoedranatt Tewari has moved from academic scholar to militant intellectual to cabinet minister in the Government of Trinidad and Tobago to academic administrator now principal of the St. Augustine Campus. His early scholarship is in the field of the humanities and his PhD thesis was a comparative study of ethnicity in the works of Saul Bellow and Vydia Naipaul and I cannot help observing here for what it is worth in this era of science and technology that three of the four U.W.I. top brass are firmly grounded in the humanities. Dr. Tewari after being a leading figure in the intellectual fervor of the seventies and eighties which sought a fundamental transformation of Trinidad and Tobago and Caribbean societies became a cabinet minister in the Government of Trinidad and Tobago in the 1980s. He then saw himself at the helm of the fledging Institute of Business which he steered to outstanding heights of achievements. While at the helm he found time to conduct research, and to write and publish a series of seminar works on business not only in Trinidad and Tobago but also from a global perspective. In recognition of his leadership roles and his exemplary conduct in the social, political, intellectual and business life in Trinidad and Tobago he received the **Konti-Mar** award which is given to honour citizens who demonstrate excellence and commitment to nation building. Ladies and gentlemen Dr Bhoedranatt Tewari, Pro vice chancellor and Principal of the St. Augustine campus of the University of the West Indies.

**Dr Bhoedranatt Tewari, Pro Vice Chancellor and Principal of the St. Augustine Campus of the University of the West Indies:**

Thank you very much Professor Alleyne. Your excellencies, President of the Republic and Dr. Jean Ramjohn- Richards, Honourable Prime Minister, Honourable Vice Chancellor, Madame H  l  ne-Marie-Gosselin - Director of UNESCO's Office for the Caribbean, Prof. Michael Kelly, Deputy Principal who worked assiduously to organize this particular event, my colleagues from the University of the West Indies, ladies and gentlemen and most especially our colleagues from abroad who have come here as part of UNICA to participate in this event and the UNICA conference itself . It is indeed a great pleasure to welcome you to the St. Augustine Campus of the University of the West Indies for this conference which the Honourable Vice Chancellor you have heard has made possible for us to host.

This conference addresses an issue which the entire society must consider openly and honestly and the University has an obligation not just to provide leadership but also to find solutions. I do not have to tell you about the threat posed by HIV/AIDS in the Caribbean where more than 420,000 people are directly affected. The impact of this epidemic on the Health Care System is leading to the diversion of scarce resources and expertise. It will result in the inability of our society to undertake economic development if it continues. The loss of many talented people in their most productive years will be the reality. The bottom line will be the plight of orphans as the burden of their care and of the sick is placed on family and friends. We stand to lose a generation of adults and acquire a generation of orphans.

While some aspects of this scenario has been well understood, they have not been fully appreciated by policy makers, opinion makers and indeed the wider society. A result perhaps of their fear due in large part because of ignorance of confronting the issue directly. The University of the West Indies therefore has an

obligation to ensure through its ability to create and disseminate knowledge and based on sound research that a rational approach to HIV/AIDS informs policy as well as attitudes. As the leading research and teaching institution in the region, U.W.I. therefore must take some lead in ensuring that HIV/AIDS is seen for what it is, that is as a critical lifestyle issue with important medical and social implications. We must educate the public so that the stigma and discrimination that are all too frequently associated with HIV/AIDS is replaced by an honest recognition that a multi-faceted approach is required.

Just over two years ago Professor Kelly, who is with us tonight, of the University of Zambia, gave an inspiring lecture on this campus on "Why the Education system must respond to the AIDS epidemic". This message is reenforced in his book that is being launched tonight and which was co-authored by Brendon Bain from the University of the West Indies, Mona campus. Professor Kelly emphasised that HIV/AIDS threatens every system and institution and that if the education does not respond appropriately it runs the risk of being overwhelmed by the epidemic. All strategies for prevention, for coping with the disease, for mitigating its impact, and for developing treatment and cure therefore depend on education itself. This is particularly important since young people are at greatest risk. Through HARP the University of the West Indies has taken up this challenge because it needs to be address through education and knowledge and our teaching and research functions as well. As well as our ability to serve the wider society based on the knowledge we absorb or create. We have an obligation to transmit this knowledge through teaching and training, to develop it through study, to expand it through research, to disseminate it through conferences and publications, and promote it use through contact with other institutions and individuals both within and outside the academic world. Consequently more than any other sector we must play the leading role in the region in helping to create sound public policy and change public attitudes towards HIV/AIDS.

It is therefore important that the HARP has become a model for the wider regional response to HIV/AIDS. This is one of the reasons why I agreed to function as the chair for HARP on this particular campus. This programme is designed to educate in all disciplines with the skills needed to retard the spread of the virus, to provide comprehensive care for those already infected, and to sensitize the population to the realities of HIV/AIDS and their role in combatting it. A significant aspect of the programme is therefore curriculum development. The aim of HARP goes beyond the goals of the project however because we recognize that we must provide our staff with both the academic and the personal skills to deal with HIV/AIDS on a daily basis and to play a leading role in the fight against it in the wider society. The role of the school of education in implementing HARP is therefore most vital and it will implement shortly a workshop funded by IDB and associated with this conference that uses UWI students as peer educators for HIV/AIDS prevention in schools throughout the region. Since education influences social attitudes in the young its role assumes greater significance. So its responsibility for teaching primary and secondary teachers enables the School of Education to influence not just teachers in the profession but also Ministries of Education in the region to consider Health Education including Sex education and HIV/AIDS issues in the planning and implementation of curricula to ensure that schools are equipped with the tools and the knowledge to implement such programmes and the teachers are trained to teach them in an appropriate fashion. It does have a vital role in ensuring that HIV/AIDS education makes the entire education system an instrument for positive change.

The University of the West Indies appreciates its role in ensuring that the approach to prevention and treatment of HIV/AIDS is comprehensive as well as appropriate through the collaboration of Health Care professionals and professionals from many fields. Our social scientists are undertaking research into behaviour patterns and the role of the media in influencing those patterns and they must come up with proposals for modifying influences and behaviour where necessary. By providing crucial statistical analysis, the Health Economics

Unit can facilitate research as it has done already in areas with a direct impact on policy formulation and implementation.

The School of Continuing Studies already participates in HARP and can establish linkages with Distance Education Programmes to provide training for teachers and individuals already in the work force who want to increase their knowledge and skills in Health Promotion and Education.

The Student Health Services which have front line contact with the student population has perhaps the most crucial role in educating our students on lifestyle choices including safe sex practices and in dealing with HIV/AIDS among their peers and in the wider community. I must say that the Student Health Services on campus have taken a proactive approach taking the message of healthy lifestyles to the students directly and generally adopting a counselling and preventive approach to HIV. What we must do in the university is not only work with the university community but work with the teaching fraternity to make sure that the message of the management and prevention of HIV/AIDS filters down to the students in primary and secondary schools.

Ladies and gentlemen we are committed to this and I thank you very much for listening to me this evening.

**Professor Michael Kelly, Professor Emeritus of Education Administration of University of Zambia, Senior Consultant Education Response to HIV/AIDS:**

Your Excellency the President of the Republic of Trinidad and Tobago, Honourable Prime Minister, Honourable Ministers and Members of the Government, UNESCO's representative for the Caribbean, representatives of the United Nations family and the Diplomatic Corp, Professor Nettleford - Vice Chancellor, Pro Vice Chancellor, Deputy Principal, visitors from the UNICA fellowship region, distinguished guests, ladies and gentlemen, fellow academics.

We are gathered this evening to inaugurate a conference and to launch a book both of them dealing with AIDS education and HIV/AIDS in the Caribbean. For some of us the information that appears in the book may be disturbing but unfortunately there can be little doubt that globally the HIV/AIDS situation is getting worse and equally unfortunately the same is probably true of the situation here in the Caribbean. However let me use this occasion to reaffirm my personal fundamental conviction and certainty that the pandemic can be defeated no matter how terrible the scourge of AIDS. No matter how limited the capacity to respond, no matter how devastating the human toll, it is absolutely certain that with adequate national, regional and international commitment the pandemic can be turned around. In the words of former President Kyunda of Zambia in relation to this epidemic, www as we see on our e-mails and on our internets, www - we will overcome. And a principal route to that victory is the route of education - education, education and more education. And these are the top priorities in our struggle with the epidemic. Perhaps like John Major you might like to put those priorities in another order but education, education and more education is what is going to help us to overcome this epidemic, to roll it back and to offer the children of this region and the people of the world a better and more promising future. And hence as the book brings out, the most important anti-AIDS strategy for government and education sectors is the development of education giving it the priority, the human resources and the financial means that it needs in order to



accomplish its tasks. A well educated people tends to be an AIDS free people and that is what we want to achieve. Hence the very great importance of ensuring progress towards the achievement of the Education for All and the Millenium Development Goals and factoring HIV considerations into strategies for the achievement of these goals. And in this context it is critically important that the education sector is able to maintain and improve its supply to respond to the demand and stimulate the demand for its services. In the special circumstances of the Caribbean countries this means taking purposeful steps to ensure the participation and satisfactory performance of boys and young men in educational provisions at all levels. And secondly it is important that the curriculum for education includes preventive education. The mere fact of attending school, an education itself, is already a powerful antidote against possible HIV infection. There is plenty of evidence of this from all over the world. But education becomes a much more powerful force against HIV/AIDS when the curriculum treats of the topic in an appropriate way and faces up to young people by developing the knowledge, skills, attitudes and values they need in order to enable them to live responsible, mature, lives. And we should not be afraid that this kind of education will promote promiscuity - quite the contrary. The evidence is that realistic and open education in the areas of sexuality, reproductive health and HIV/AIDS leads young people to delay sexual activity and to reduce the number of sexual partners. Factors that have led to significant reduction in HIV prevalence in other parts of the world.

These issues are discussed in the book that is being launched this evening together with a number of other issues and in its final section the book presents a number of strategies that could help the education sector in dealing with the epidemic. These range from the need for a multi-sectoral regional response in a region where there is so much mobility and the very inauguration of the UWI - UNESCO- UNICA conference is a feature of that multi-regional response. It ranges on focusing on prevention care and to capitalizing on the rich cultural diversity of the Caribbean region. And the final word of the book is to highlight the

vision adopted by so many of the governments' education ministries throughout the region.

The vision of the ideal Caribbean person. That compelling vision presents us an emotionally secure self-respecting person who has a higher regard for human life; appreciates diversity as a source of riches and strength; is environmentally aware; has a strong work ethic; is creative and self-starting; has a great love and respect for his or her cultural background; and is a person of integrity, responsibility and accountability. Perhaps, distinguished guests, perhaps the greatest tribute that could be paid to this book would be that someday it might be said that in the climate of HIV and AIDS it pointed a way towards the development of such an ideal Caribbean person. One who is HIV free; one who knows how to help others keep themselves HIV free; one who shows no form of stigma or discrimination to those who are infected or affected.

And finally allow me to thank the many individuals who cooperated with Professor Bain and myself knowingly or unknowingly in the development of this book: representatives of education ministries, participants in meetings and conferences, the University of the West Indies, those in the regional UNESCO office in Kingston as well as those in UNESCO's Institute for education and planning in Paris, and many others. I feel greatly honoured that I have been associated in this work with so many distinguished persons and especially with so many distinguished luminaries as the Vice-Chancellor Professor Nettleford, Professor Brendon Bain, and **Mr. Goodman Hernes of the IIAP** and that in this work we have received the backing of the University of the West Indies as well as of UNESCO.

Your excellency, distinguished guests allow me to say in conclusion that perhaps most of all my indebtedness is to the many people living with HIV and AIDS whom I have come to know in the Caribbean, in Africa and in Asia. Ordinary people, simple people but people whose courage, dignity and strength of purpose

in the face of appalling problems and much personal suffering are truly awe inspiring. I only wish that we could have done more to represent their interest and their insights. My only hope is that this book will contribute to accomplishing the two things that they wish for more than anything else: better recognition of their personal dignity and worth as human persons and a reduction brought about through education in the number of those at risk of joining their ranks.

I thank you very much and may God bless you all.

**Hélène-Marie-Gosselin**  
**Director, UNESCO Office for the Caribbean**

Your Excellency George Maxwell Richards President of Trinidad and Tobago, Honourable Prime Minister Manning, Vice Chancellor Nettleford, Pro-Vice Chancellors Bhoendradatt Tewari , Professor Gurmohan Kochhar. Most Distinguished Guest Professor Michael Kelly, Rectors, Presidents, Vice Chancellors and Representatives of UNICA institutions, Members of the Diplomatic Corps and Other Distinguished Guests.

I bring tonight the personal greetings of the Director General of UNESCO, Mr Koichiro Matsuura, who met with several of you earlier this year during his first visit to the Caribbean and has wholeheartedly endorsed UNESCO's collaboration with UWI and UNICA in mobilising the education sector of the region against AIDS.

On behalf of UNESCO, I am delighted to be here tonight to participate in both the opening of the region's first-ever Conference on Education as well as in the launch of the first strategy to guide Education's response. It is most rewarding to be in partnership with institutions and organisations of such stature as UWI and UNICA.

I view tonight and the days that follow a defining moment for the Education community in the Caribbean - a critical step on the road to push back the daunting threat of the AIDS epidemic.

UNESCO, as the global organisation for the promotion of education, culture, science and communication, has been called upon by the world community to make a significant contribution in its spheres of expertise to the intractable challenges of AIDS, a challenge affecting people of all nations, all cultures, all ages, and every segment of society.

As the Caribbean arm of UNESCO, my Office is fully mobilised in support of the Heads of Government of the Caribbean Community who, at their 30<sup>th</sup> Anniversary earlier at the Summit in Montego Bay in July this year, committed themselves to a heightened and intensified response to the scourge of AIDS. UNESCO, along with other members of the United Nations family, in the context of our joint effort through UNAIDS, is committed to support every member state to the fullest. There is no issue more pressing on our joint agenda, and you will find HIV/AIDS in the agenda of every meeting of UN agencies.

The Council of the University of the West Indies seems to have agreed with this. They have selected as the University's new Chancellor no less a distinguished HIV/AIDS activist than Sir George Alleyne. Allow me to use this opportunity to publicly congratulate Sir George on his appointment. Coming as he does to the position of Chancellor on the eve of the Conference, in tandem with his appointment earlier this year by UN Secretary General Kofi Annan's as a Special Envoy to the Caribbean on HIV/AIDS, creates a wonderful opportunity for higher education in the region to step up its response to the epidemic.

It is extremely satisfying to find the Caribbean's academic community responding to the call of national leaders to join wholeheartedly this fight. The intellectual discourse, the research, the persuasiveness, the cultural relevance, and the leadership that you will bring endorse and strengthen the efforts of agencies like my own and amplify their effectiveness. It has been increasingly recognised that nothing short of a multisectoral, multi-agency, integrated and coordinated approach, as Professor Kelly just reminded us, will generate success in this critical endeavour.

Professor Michael Kelly brought with him from Africa the statement, "HIV/AIDS is a weapon against Education, but Education is also a powerful weapon against HIV/AIDS", and introduced it in the Caribbean. It was this concept of Michael

Kelly's that inspired the positive title of this Conference: "HIV/AIDS: The Power of Education".

May I use this opportunity to thank Professor Kelly on behalf of UNESCO for accepting the invitation to join us in the Caribbean in this critical endeavour, and trust that his experience in the Caribbean has also contributed to his great work in Africa. Michael, Father Michael, you have been so generous to apportion part of your time to the cause in the Caribbean over the last two years, and share with us your insights from Africa.

Michael Kelly has defined the magnitude of the task ahead of us and given us - through this strategy that we launch today – a framework for every nation in the Caribbean. Michael worked closely with one of the Caribbean leaders in this field, Professor Brendan Bain of the Mona Campus of UWI, to ensure that the strategy was culturally-relevant to the Caribbean.

Professor Kelly was there with us in Havana just one year ago when the Ministers of Education of the Caribbean jointly endorsed the need for such a strategy. Indeed Michael, together with Vice Chancellor Nettleford's Envoy, Professor Ronald Young, made a compelling case to the Ministers for the need for an education sector response alongside that of the health sector. I am personally indebted to the support and encouragement of Trinidad's Minister of Education, Hazel Manning, who helped in Havana with drafting the Declaration and having it adopted.

This joint declaration of Ministers is included as an annex to the strategy we launch this evening. I believe that session in Havana was a "wake up call" to Ministers of Education. Since then, individually and collectively, they have reiterated wholehearted their support; the task now is to convert commitment to action.

This book gives countries a solid strategy to begin the process of accomplishing this plan of action, no mean order.

UNESCO, with its global UN mandate to support countries to meet their Education for All commitments by 2015, and meeting Millennium Development Goals, has a responsibility to support Governments by all the means at our disposal to achieve these worthy aspirations.

We all know that access to information alone is not sufficient to break the back of this monster. Responses must be fashioned in the cultural context in order to bring about the wide-scale behavioural changes that are required. This book would not have been possible without the icon of Caribbean Culture, the Honourable Professor Rex Nettleford. Without Professor Nettleford's initial invitation to Michael Kelly to take his university by storm in February 2002, this book might never have been written.

Rex Nettleford, Vice Chancellor and current President of UNICA, has long been associated with UNESCO's highest governing bodies and has provided inspiration for UNESCO's global and regional programmes. He has encouraged the writing team for this book from inception, and has graced it with an Introduction which unifies culture and education into one.

He has committed UWI, through the Memorandum of Understanding with UNESCO that we jointly signed in January, to continue and heighten cooperation with UNESCO in the field of Education & HIV/AIDS. Professor Nettleford, I pledge my Office - and the support of UNESCO globally - to expand and enrich this partnership.

UNESCO is planning a significant Caribbean presence at the 15th International AIDS Conference in Bangkok next July, and we have already begun dialogue

with UWI, UNICA – together with the UN Caribbean team - on collaboration in this major initiative.

Professor Brendan Bain, Head of UWI's HIV/AIDS Response Team is another dedicate ally. He fashioned the structure of the book with Michael Kelly and meticulously reviewed every word of the draft to ensure Caribbean credibility. We must thank not only the power of Education, but the power of the Internet, that allowed their collaboration to continue across oceans and continents. Professor Bain, we applaud you, not only for this but for the twenty years you have dedicated to HIV/AIDS in Jamaica and the Caribbean, and your leadership of UWI-HARP as a model for other members of the UNICA family and – perhaps- for universities in Africa and beyond.

UNESCO's International Institute of Educational Planning in Paris has also been a key ally, and has co-published the book with my Office. Its Director, Gudmund Hernes, wrote the *Afterword*. The Institute has produced this initial edition of the book in record time; it will appear in a definitive edition later this year for wide distribution.

At present we are planning how to disseminate the content and recommendations of the book most effectively to Governments and institutions throughout the region. We would like to discuss with the Rectors of four Haitian U niversities – brought to this Conference with UNESCO support – whether a French version of the publication would be of value to their country – as you know, the hardest hit of all Caribbean countries by this epidemic.

The Director of UNESCO's International Institute for Higher Education in Latin America and the Caribbean, ESALC in Caracas, also pledged last week to contribute to this effort through Caribbean universities.



It gives me great pleasure, at this point, to invite Professors Nettleford, Kelly and Bain to join me in launching this important book by presenting a copy to His Excellency the President of Trinidad & Tobago and to the Prime Minister.

Before we so do, I would like to close by reiterating, on behalf of the United Nations community in the Caribbean, our continued commitment to building the capacity of education in the region.

**Professor Nettleford - Vice Chancellor of the University of the West Indies:**

In the Caribbean it is good to hear nice things about oneself from ones peers - it doesn't come very often. Your excellency, former colleague, President Richards and your excellency Dr. Richards and his excellency is a Professor emeritus. Honourable Prime Minister who meritoriously got his degree from the University of the west Indies, Madame Gosselin, my colleagues from UNICA, members of the Diplomatic Corps, other Ministers of Government, distinguished everyone else.

I would not wish to gild the anthurium so much good things have been said eloquently and other wise, otherwise meaning better than eloquently, up to now, and we are yet to hear the Prime Minister from whom I want to get something more than what I have been reading that he has been saying about HIV/AIDS in the newspapers. I want to thank both himself and the President for their presence here at this ceremony because it is indicative of the significance, of the importance, that they both give and this country to the challenge of this pandemic because it is very serious. I am grateful to Professor Kelly for really bringing to me certainly and others the fear of God by indicating that in his own experience in the University of Zambia a fairly high percentage of the academic staff was likely to go, to depart this life because of AIDS. And then to be sitting down and to be looking at young graduates coming up to receive their certificates and wondering whether these kids were not being prepared for their coffins rather than for jobs. It is a critical statement and observation for people like us in the Caribbean who have been dedicated ever since the forties to finding a place and purpose for our people and for ourselves. Your last injunction, Professor Kelly, was indeed very instructive, it made a connection between what is a long term interest and hope of this region with a threat of HIV/AIDS which in fact could decimate the flower of our youth, and deprive us of the product ivity and intellectual energy of the next generation. I think if we see it in those terms we would understand how important our own efforts in the university of the West

Indies and our sister universities in the UNICA fellowship is towards the development of this region. And I need not say anymore because I think you Professor Kelly and others have brought this out very clearly. Only to say and to repeat and emphasize the commitment of the University. The University of the West Indies is impatient of the debate. We have got to be responsible for serious investigation, serious analysis, serious means of transmission of the findings from such analysis so that we in fact can save ourselves from a particular kind of self destruction which indeed is waiting in the wings for us. My forward speaks to many of these things and the text of course is far better than the forward but if you really want to know buy the book. I am just going to in closing to quote what I said at the very end, " I congratulate Professor Michael Kelly a tireless worker educator in Zambia and a man of enormous compassion for this succinct text and Professor Brendan Bain who gave critical support. Taken seriously by our educators and health personnel it provides the roadmap to prevention even if not yet to total cure. The threat of annihilation is a shockingly awesome thing to contemplate let only to witness. The very thought tempts one to keep wondering whether the pandemic is not truly the worst weapon of mass destruction nevermind what Washington thinks. A weapon that deserves much more of the attention and on time financial assistance from the 1<sup>st</sup> World and structured public education within the 2/3 world than it now receives. And we in the Caribbean are part of that 2/3 world. Thank you Professor Kelly, Professor Bain, all our friends in UNICA and of course my own very close colleague Professor Hamilton who was behind me in getting this Caribbean wide, Professor Alleyne.

This region which has had this long history of textured diversity and the capacity to go to the brink but never plunging over. We do take risks but we have a way of finding creative responses to the challenge of change. I want to thank you Professor Kelly and all others who have worked with you to bring both this conference and the book to where it now is at. Of course my friend from UNESCO, Madame Gosselin, she has come at the right time when women are ruling this region and she certainly struts her stuff magnificently. But then she if

from French Canada which is very similar to the Caribbean. Thank you everyone for being here.

**The Honourable Prime Minister Patrick Manning of the Republic of Trinidad and Tobago:**

Your excellencies President George Maxwell Richards of the Republic of Trinidad and Dr. Jean Ramjohn- Richards, our chairman Dr. Alleyne of UNICA, Professor the Honourable Rex Nettleford, Vice-Chancellor of the University of the West Indies who describes himself as hailing from Taylor Hall, that is not known to us, we know of Taylor Place, Professor Kochar -Deputy Principal and of course Pro Vice Chancellor Bhoendranatt Tewarie and campus principal, Madame Hélène-Marie-Gosselin - UNESCO's representative for the Caribbean, Professor Michael Kelly and Professor Brendan Bain whose book we launch this afternoon, other distinguished ladies and gentlemen.

Permit me to begin by thanking the joint sponsors of this conference the University of the West Indies, the association of Caribbean Universities and research institutes UNICA, and the United Nations Education, Scientific and Cultural Organization UNESCO for affording me the opportunity to address this very distinguished forum. I must tell you that I accepted the invitation most graciously, enthused straight away as I was by the very theme of the conference **HIV/AIDS: The Power of Education**. Additionally the proposed launch this evening of a related and a critically important publication entitled "Education and HIV/AIDS in the Caribbean" which was co-sponsored by the International Institute for Economic Planning and UNESCO and co-authored by outstanding scholars in the field Professors Micheal Kelly and Brendan Bain further aroused my curiosity and rendered the present engagement the more alluring.

To my mind, in a manner in a speaking, if ever there was a conference of importance this one is it. HIV/AIDS is the most deleterious and formidable bio-social challenge facing the Caribbean and the wider world at this time. For years it hung over our region like a dark, polluted and ominous cloud which like the rest of the world we allowed to overshadow us through neglect and under estimation.

With the threatened escalation of the HIV/AIDS virus all over the world by the second decade of this century, the cloud has now burst into a torrential downpour and the only way out of the acid rain is to seek an escape inspired by education. If ever there was a worthy agenda, this conference which seeks to discuss the manner which through education HIV/AIDS can be better understood and how education in the Caribbean can be made more relevant and appropriate to the challenge set us by this destructible and deadly pandemic. This conference is it.

In a similar way if ever there was a text worthy of the effort of its authors, the present publication by Professors Bain and Kelly designed as it is to equip all in the Caribbean with information and understanding of what HIV/AIDS mean and the diverse ways in which education can contribute to managing the disease is such a text.

I wish upfront to commend the organizers of this conference and just as well to commend the two professors on a book that is not only sorely needed but from which I am already beginning to perceive has been well researched and well written. Ladies and gentlemen the present conference effort all the more to be appreciated given that when less than a month ago I addressed the Caribbean United States Chiefs of Mission Conference on HIV/AIDS, United Nations Development Programme in its report on human development had complained that the world over countries and institutions had not been doing enough to combat the spread of the deadly HIV/AIDS virus. The reasons that have been advanced to explain the tardy attitude of states and institutions are multi-farious and complex. However more and more we are being told of the lack of leadership and vision at the global, regional and national levels and of the silence and denial by individuals and their families and about the harmful attitudes and behaviours that negate and discriminate against those whose misfortune it was to find themselves infected by the dreaded disease.

We have been told also about the failure of the international community and of national governments to commit financial and other resources to fight against HIV/AIDS and of the inability of states and institutions to design and deliver adequate and appropriate response programmes and measures. We have too much focus on quick fix solutions, stop gap measures and the lack of comprehensive policies to deal with HIV/AIDS and of the focus on the problems of individuals rather than on the implications of HIV/AIDS for social degeneracy, nemesis and vaporization. You are the experts but I wager that somewhere at the root of all of these problems of HIV/AIDS lies a fundamental lack of education.

Ladies and gentlemen, since the discovery of the disease in 1981 its prevalence has multiplied by leaps and bounds. The number of HIV positive people in the world has quadrupled from 10 million in 1990 to 42 million in 2001. Some 9,000 people die from AIDS each day, about 5 or 6 every minute, some 360 every hour, some 3 million each year. As you are no doubt aware in the Caribbean we are certainly up against it. Our region ranks second in the world in terms of HIV infection. At the end of 2001 some 2.4% of the Caribbean population or 500,000 people were living with HIV/AIDS. Currently for many Caribbean countries someone in every household knows a person who has been infected. You would imagine that we are in no way proud of our record and that no one has a desire to recall the statistics or recount the disturbing tale. What is more, even the figures themselves raise more questions than answers. And some rather disturbing ones at that.

The frightening and alarming statistics on HIV/AIDS in the region are neither well-known or appreciated by the masses in the region. Nor are they as accurate or up-to-date as they should be. Of course this is merely a reflection of the situation regarding HIV/AIDS education in the Caribbean. HIV/AIDS is spiralling in the Caribbean because HIV/AIDS education is lagging, being neither adequate, accurate, up-to-date or relevant to the challenge.

The vast majority of people of the most affected group among us those between fifteen to forty-four years would probably know the HIV/AIDS constitutes a formidable problem. But it has to be that too many among them are unaware of just how serious the problem is. Almost everyone might agree that the HIV/AIDS pandemic is far more deadly than it seems although just how deadly it is, the society on account of behavioural patterns does not quite seem to know.

Ladies and gentlemen, there exists among us in the region far too much ignorance about what HIV/AIDS is, how it is spread, what are its symptoms and how to evaluate the risks and options relative to personal health and safety. The knowledge shortfall is as threatening as the disease itself. Even among HIV/AIDS victims themselves, for example, there exists too much ignorance about the availability and use of treatment, the existence of support groups, conditions for maximising the effect of therapy and so on. One will find that many are not aware for example of the mutational quality of the HIV/AIDS virus and of its overwhelmingly phenomenal capacity for resilience. HIV/AIDS victims on anti-retro-viral drugs are often unaware that when they are irregular in their application of their medication they help to develop and transmit even more resistant strains to the virus. The list of concerns indicative of the need for a more comprehensive orientation towards education and research in respect to the HIV/AIDS pandemic is quite long.

Among policy planners themselves, there continue to be too many grey areas concerning individual and as well as group social and psychological behaviour among infected classes and their families. And those involved in providing welfare and support, the health care professionals themselves and so on.

Similarly, ladies and gentlemen, thinkers and activists in the field are finding out more about the potentially devastating long-term effects on the society and the economy, sustainable growth and development, future population optimality, manpower depletion and health care costs. But there remains much to be



discerned about the direction that health administration and international institutions might take as countries, regions and the world at large struggle to do battle against the HIV/AIDS enemy.

One need not mention that we are still searching for a cure. An HIV/AIDS vaccine remains the most difficult challenge ever for science and medicine. However, while mankind continues to search for a vaccine which at any rate experts say is not likely to come before the year 2010, HIV/AIDS is killing not only the individual's immune system cells but just as well the global society's immune system at an accelerated pace. Indeed an HIV/AIDS vaccine remains the most pressing challenge for science and medicine.

Someone once likened the search for an HIV/AIDS vaccine to playing a lotto game. In both instances if one gets lucky he or she wins. But there is a phenomenal element of improbability involved and the question that emerges is, "What happens if one does not win?" As it stands, ladies and gentlemen, there is still no cure for HIV/AIDS. Mankind has so far not secured an out right win in this regard. Our best option still lies in education for waiting for a vaccine to happen is like placing all our income on a bet that we are not sure to win. It is important for us to recognize, ladies and gentlemen, HIV/AIDS is the most opportunistic virus the world has ever seen. Its development and spread has been more than a function of our ignorance. At the individual, social and institutional level AIDS has exploited every intelligence gap or shotcoming in our human and social systems. In fact, since its discovery 22 years ago its survival and spread has been in inverse proportion to our ability and capacity to gather information and use it against this most deceptive enemy against mankind's peace, stability and progress. It follows then in this war against HIV/AIDS education is the key and we need to strengthen the very foundation and reach of education and research on HIV/AIDS. All our schools, colleges, institutions of learning, religious or secular, private and public, local or otherwise must become involved. Everyone

must become more involved because everyone is involved whether we like it or not. However in the new dispensation involvement must mean awareness.

Ladies and gentlemen, it is time to take control over HIV/AIDS to put a stop to its advance and roll back its defenses through the acquisition, interpretation and application of far more knowledge and information about the disease. It has come down to the fact that all our institutions must facilitate this most important quest. However you at the University of the West Indies and related institutions such as UNICA, U.W.I., HARP, CAREC, and a host of other such institutions represented at this conference have a critical role to play. It goes without saying for example that we need the involvement of those operating in the field of medical sciences. But there is the need for the collaboration of those involved in the social and behavioural sciences also. And of course, it would be remiss of me to leave out the political sciences. But even if you have done this as I have observed in respect of this conference, it is certainly clear that the organizers of this conference understand fully that in respect of the struggle against the spread of HIV/AIDS we need to mount an educational coalition to which all the knowledge bases integrate and feed from and into each other. The institutions represented at this conference and the diversity of its speakers and panelists bring to us all a certain wealth of experience that in the final analysis ought very well to lift the context of research and education on HIV/AIDS in the region. One can only hope that all of our deliberations would be transferable to rational and comprehensive policies.

As can be appreciated on the matter of HIV/AIDS we in the Caribbean can enjoy no future without action but action must be within the realm of possibility and practicality. Your experience and expertise will figure here tremendously. When all is said and done the situation regarding HIV/AIDS in the Caribbean is a call to work and this conference must help us to set the basis and orientation for the proactivity to which we must be led and which naturally ought to follow. The large fact looms from the HIV/AIDS situation in the Caribbean and the world at

large is that we must harness the potential of the education sector to prevent further HIV/AIDS infection. There exists but little choice other than for us to mobilize the widest educational constituency to offer all the knowledge, information, support and direction needed by this country, the region and a wider world traumatized by HIV/AIDS in order to relieve ourselves of the viral HIV/AIDS and do away with the burden its unrelenting death sentence on humanity.

In the Caribbean therefore we need very much to appreciate the global response to the challenge. There are countries that have introduced programmes that have made a significant difference to how the problem is addressed in terms of treatment and containment: Uganda, Thailand, Senegal, Zambia and Cambodia. How therefore do we benefit from these experiences? How do we draw from and constitute a regional perspective? How do we develop adequately and appropriately in respect of a Caribbean resolve? Ladies and gentlemen this is about our collective quest for sanity on the question of HIV/AIDS. There is a saying that only further education can instruct education further as to what next to do. This to my mind is the reason why this U.W.I., UNICA, UNESCO conference is so important.

I take this opportunity to welcome all participants to the conference. This country and the Caribbean wish you well in your deliberations. Our region and the world are looking towards that new something that you might contribute or even pass on. As you proceed it might be encouraging to be aware that this government is neither insensitive nor blind to the challenges that face us in this country regarding HIV/AIDS. Last year the government agreed to allocate \$500,000,000 to be used over a five year period for education and research and the treatment of HIV infected persons in this country. We continue to source funding and expertise from international agencies in order to advance our local struggle against the spread of HIV/AIDS acquiring recently a loan of \$20 million from the World Bank to support additional initiatives against HIV/AIDS.

Additionally only recently, the government appointed a high level coordinating committee in the Office of the Prime Minister and involving non-governmental organizations and the public service to monitor and coordinate our efforts in the fight against HIV/AIDS. Further to this the government is in the process of finalising our first ever National HIV/AIDS Strategic Plan which will be launched very shortly indeed. I will say no more on the matter except that in this country the government is determined to take on the challenge of HIV/AIDS with a clear vision and policy orientation and that the contribution that will flow from this conference already had the making of a welcome addition.

As you go to your deliberations, you must know that history and necessity have challenged you with a tremendous responsibility. You have literally taken on a matter that will affect the lives of so many in the Caribbean and in the world. Go to these deliberations with all the concern for them that you can bring to this discourse and with more than ordinary awareness of the importance of the conclusions that may be arrived at or the decisions that may be taken or on the perspectives that will be formed. What you will discuss here is far more important than the moment bound up as the issues are with the urgent questions surrounding the survival of Caribbean peoples and the future of the human race. Allow yourselves, ladies and gentlemen, to be guided accordingly.

God bless you all. I thank you.

**Professor Kochar- Pro Vice Chancellor, Deputy Principal of the U.W.I. St Augustine, Special Advisor to the Vice Chancellor in External Funding:**

Your excellency President George Maxwell Richards of the Republic of Trinidad and Tobago and Dr. Jean Ramjohn-Richards. Honourable Prime Minister Patrick Manning and Minister of Finance of the Republic of Trinidad and Tobago. Professor Rex Nettleford, Vice-Chancellor of the University of the West Indies, Dr. Bhoedranatt Tewari, Principal of the University of the West Indies, St. Augustine Campus, Madame Hele Marie Gosselin, Director of UNESCO's Caribbean office, Professor Brendon Bain and Professor Micheal Kelly, Professor Compton Bourne. my colleagues from UNICA, members of the Diplomatic Corps, other Ministers of Government, distinguished ladies and gentlemen.

I think the Prime Minister has covered the agenda of our conference so very well. I am so heartened that he has in fact studied the agenda of the conference that really shows us the amount of interest that he has taken in this evening's proceedings. We really want to thank you Prime Minister. But more than that I want you to carry a message for me of thanks and I am sure you know what I mean. Vice-chancellor when we were planning this conference I approached the Honourable Minister of Education Hazel Manning for her support in this venture and she was most gracious in acceding to our request. Prime Minister, one of the request was that we target school principals. This particular conference is targeting 100 participants and out of that we have reserved 50 slots for the principals from schools in Trinidad and Tobago. On my organizing committee I had the benefit of two representatives from the Ministry of Education in the persons of Dr. Senah and Mr. Gittens. This conference is a UNICA, U.W.I., UNESCO conference but in association with the Ministry of Education of Trinidad and Tobago.

Professor Richards, your excellency it is always a pleasure to see you on campus. Dr. Richards we also want to thank you for gracing us with your

presence this evening. I want to take this opportunity to specially mention some of the people who worked very hard with me to put this evening's function together and also to put the conference together. I will single out some of those people and I will start with Dr. Zulaika Ali, she has been working tirelessly in putting the programme together, Mr. Carole Keller from the School of Education who is an Education Specialist, Dr. Brader Brathwaite from the Faculty of Medical Sciences, Mrs. Betty Mc Comie from the Principal's office, Mrs. Donna-Marie Defour-Gill from our Marketing and Communication office, Ms. Christine Lapez from the Health Economics Unit and Professor Carl Theodore. There have been several other people including the two I mentioned from the Ministry of education who have been very supportive. I must specially thank the Vice-chancellor for putting his weight behind the whole conference. I want to thank UNESCO, the Secretary General of UNICA. I want to thank especially the campus principal for giving me the support in putting this together. And I want to thank him in advance for the goodies he is laying out for us when we are finished this evening's function.

We are hoping that this particular conference will in fact help us to show a way forward in strategising our curriculum both at the tertiary level and at the school level. Both primary and secondary school level. That is why the school principals must participate.

I thank everybody who is present this evening for their contributions to this evening's proceedings.

**“HIV/AIDS: The Power of Education”**

sponsored by

**UNICA/UWI/UNESCO**

**Port of Spain**

Trinidad

**Sir George Alleyne**  
**Chancellor**  
**The University of the West Indies**

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**EDUCATION-A KEY PARTNER IN A MULTISECTORAL  
RESPONSE TO HIV/AIDS  
(Port-of Spain, Trinidad)<sup>1</sup>**

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First let me congratulate UNESCO, UNICA and UWI for taking the initiative to host this Conference, and let me say how much I have enjoyed the enthusiastic advocacy for this field by Ms. Helene-Marie Gosselin of UNESCO. Her quarterly reports on Education and HIV/AIDS are a joy to read, both for substance and method of presentation. I also wish to congratulate Professor Kochhar and PVC Hamilton for their work in organizing the conference which as I understand it is to “marshal and galvanize action by and within the education sector, particularly tertiary education against HIV/AIDS to complement and support efforts already being made in other sectors of Government and within civil society”. It is impressive to see so many institutions and disciplines taking part.

I take it that our main focus will be to discuss the role of the formal education sector in consort with other sectors in addressing the problem of HIV/AIDS. I make a distinction here between the education that is carried out in other sectors to address the problem and the activities that are discharged within the education sector itself, because as you all know well, other sectors can also claim a role in educating the public about HIV/AIDS. Do not think me overly precise to the point

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<sup>1</sup> Presented at the Conference on “HIV/AIDS: The Power of Education”, sponsored by UNICA/UWI/UNESCO, Port of Spain, Trinidad



of minutiae when I characterize the education sector as a part of the economy as are other sectors, and as containing various systems and resources that are uniquely focused on education. I will try to examine what the institutions, particularly the tertiary ones in the education sector bring to the table that will be a critical complement to the offerings of other sectors and their institutions. I will attempt to separate tertiary education per se from the responsibilities of the tertiary institutions of the education sector. Formal education is only one of the responsibilities of the institutions in the sector.

As a matter of history, the Caribbean response has from early been multisectoral and although the health sector defended the thesis that the main reason for the concern about the epidemic was that it causes ill health and death, there was ready acceptance that the response went beyond the kinds of expertise that was traditionally found in the health systems of our countries. Indeed the initial signatories to the Pan Caribbean Partnership for the fight against HIV/AIDS were two Prime Ministers, Peter Piot of UNAIDS and myself. UNAIDS represented the multisectorality of the UN system's approach to the problem of HIV/AIDS. I like to think that even at that early stage it was clear that the health sector, the education sector and many others had to work in a partnership with other sectors and the representation at the highest political level showed that there was a multisectoral perspective.

The education sector brings to this partnership a unique set of resources – human, informational, organizational, physical and financial. In addition to the institutions of the sector that are the main focus of this conference, it brings pedagogical and research skills that are unique. The question is how will the application of those skills and resources advance the fight against HIV/AIDS.

I have read some of the extensive literature on education and HIV/AIDS and have been impressed with the attention given to the impact of the epidemic on the human and financial resources of the sector. I have been also taken with

the predominant emphasis on the schools as a critical part of the sector and the focus on the young. The InterAgency Task Team on Education that was formed by UNAIDS, in elaborating an overall strategy, prioritized certain actions that the sector should consider with a focus on reducing individual risk as well as vulnerability that derived from the societal context. These were

- Efforts to ensure that teachers are well prepared and supported in their work on HIV/AIDS through pre-service and in-service education and training;
- Preparation and distribution of scientifically – accurate, good quality teaching and learning materials on HIV/AIDS, communication and life skills;
- Promotion of life skills and peer education with children and young people. And among teachers themselves;
- Elimination of stigma and discrimination, with a view to respecting human rights, and encouraging greater openness concerning the epidemic;
- Support for school health programs that combine school health policies, a safe and secure school environment for both teachers and learners, skills based health education and school health services, and that explicitly address HIV/AIDS
- Promotion of policies and practices that favor gender equity, school attendance and effective learning.

These are general recommendations, and I take it as a given that the tertiary institutions in the education sector will see it as their responsibility to train teachers and to produce materials for their use, for example. The use of the pedagogical approaches that may be peculiar to HIV/AIDS will clearly be a matter for attention. I see also education not being confined to the traditional physical spaces and the traditional groups. The education sector must seek to reach the traditionally unreachable and untouchables who need the information and knowledge as much as or more than others. There is a constant cry for the

involvement of civil society in the fight against the disease. My experience has been that the civil society organizations also need education about the possible roles they can play as much as the young students who are the usual target of the educational offerings at the various levels of the education sector.

But I wish to enter more into the research capability that almost by definition must lie within the tertiary institutions of the sector. As I have reflected on the Caribbean situation and my own role as the UN Special envoy I would focus on three issues that should be of prime importance for the tertiary institutions of the education sector. The answers or at least better exploration of these areas would make a tremendous contribution to the fight against the disease. The three areas are the increased and increasing prevalence rate among young girls, the pervasive stigma and discrimination and the mechanisms for increasing coverage both with respect to voluntary testing and counseling and the wider use of antiretroviral therapy.

For many years the phenomenon of teen-age pregnancy has been studied here and various theories advanced as to its high prevalence. I have heard an eminent professor aver that our perception of who is a teen-ager and the inappropriateness of pregnancy at an early age stem from a perception that is not in keeping with our ancestral origins. I know of the benefit of keeping girls in school in delaying pregnancy. Hitherto this was looked upon as an unfortunate consequence of early sexual exposure, but now we know that this early sexual exposure is leading to increased rates of infection and the health sector is being awakened to the fact that the phenomenon of early sexual exposure is an egregious manifestation of the unequal gender power relationships that exist in our society. It will be for the tertiary institutions to undertake better research at unraveling the nature of these relationships with a view to proposing some societal solutions as I do not believe that the present situation is immutable. Teenage pregnancies are harmful, but early HIV infection is lethal.

I have become increasingly concerned about the many faces of stigma and discrimination in the Caribbean and am anxious to see the tertiary institutions engaged in the research that attempts to explain its origins. I accept that the disease is now a heterosexual disease, but it is not only the stigma that attends the perception of different life-styles, but the discrimination against persons with HIV/AIDS that concerns me. The fear of such discrimination drives the epidemic underground. Are our laws and legislative practices in keeping with the declarations of adhering to basic human rights principles that all our countries affirm? Discrimination does not exist only in relation to another different group and the groups against which there is discrimination are society-specific. These are areas of enquiry that are within the province of the tertiary education institutions, and they owe it to the societies and to the other sectors of the society to explore them.

All HIV/AIDS programs accept that prevention is key, but attention must also be given to therapy with the drugs that are becoming available. In the early days after treatment became available, the drugs were prohibitively expensive, but it was not only the cost of drugs that seemed to be a block to developing countries undertaking universal treatment. The view was taken that the basic infrastructure to ensure delivery and compliance with the complicated regimes was not present. Brazil has shown that this is not so. But I would ask if whether in anticipation of the more ready availability of therapy there has been the research to determine the various non-traditional methods of giving and monitoring therapy here in the Caribbean. There is yet another issue related to treatment. Given the nature of the epidemic, is voluntary testing and counseling a cost-effective modality here as it has been shown to be elsewhere? This is an important researchable question, the answer to which is absolutely vital for the control of the epidemic.

Finally, let me deal very briefly with the more traditional view of the input of tertiary education. It is a legitimate call on these institutions to be responsive to

the main social concerns of the region. The concern with the overall health situation of the region led to the medical faculty being the first to start in our University and we can see the growth of the various faculties and disciplines taking shape in response to the problems of the region and the need to find Caribbean solutions. The situation with HIV/AIDS has reached the stage when there must be educational offerings that accommodate that concern. Thus I see specific teaching in terms of content and skills about the many facets of the disease being incorporated into not only the health sciences, but into other faculties as well. I do not like the expression “mainstreaming” but I do hope that the educational content of more of our programs will include material on HIV/AIDS.

I hope your conference will be successful and the tertiary institutions will be galvanized to address some of the issues raised here and I plead for research into the areas I have mentioned above. I also hope that my University will play a leading role in stimulating education about HIV/AIDS- education that the World Bank has dubbed the “social vaccine” against the disease.

Thank you.

**Dr. Bhoë Tewarie:**

Good morning ladies and gentlemen, all, members of the Head Table. My task is very simple, it is to chair this morning's proceedings. Last night we had the formal opening ceremony at which both His Excellency the President and Her Excellency were present and the Honourable Prime Minister who gave, I would say, a significant talk. This is Day 1 of the conference itself, conference organized by three institutions in collaboration UNICA, UWI and UNESCO and the theme of the conference is **HIV/AIDS - the power of education** and it is my distinct pleasure to ask the Honourable Vice-Chancellor - Professor Rex Nettleford to welcome you here at the conference.

**Honourable Vice-Chancellor - Rex Nettleford:**

Chairman, Chancellor, Colleagues at the Head Table, and colleagues in the audience you will have noted that the Principal Pro-Vice Chancellor Tewarie added and not in parenthesis but rather in emphasis he is asking me to welcome you to the conference. To the conference making a clear distinction not to Trinidad. Well it is my pleasure as President of UNICA, outgoing I should say, to welcome you all to this very important exercise. I also want to take this opportunity, because he is very special, to welcome on your behalf our new Chancellor of the UWI, Sir George Alleyne. Sir George is a Medical by profession and is an envoy for Mr. Kofi Annan in this particular area of HIV/AIDS. That is the Chancellor Sir George has very strong views about the place of the discourse on this pandemic in the world but specifically in the Caribbean where we hear that we are second only to Southern Africa in the incidence of infection of HIV. As I indicated last night this is not good news. The threat to the decimation of the next generation with which people like us are concerned for their own preparation to enter life is something which of course we cannot take lightly. I am very happy that a number of educators are here from the school system and as I was speaking last night I remembered, much of what I had to say in the foreword of this book which we launched last night, of my own experience in Jamaica

growing up. At a time as I subsequently discovered which followed a Nutrition Commission that was sent to the Caribbean to look into malnutrition in the late 1930s (mid to late 30's). Following on that was an action plan. I like to feel that youngsters of my generation were the beneficiaries of that particular report and of the action plan because the Colonial Government, the English speaking part of the Caribbean that is really launched a very successful campaign for health education in primary schools. Primary Schools where we learnt from very early things about Health, about Nutrition, about the structure of this very magnificent entity called the human body and imagine at age seven one being able to spout who had discovered the whole thing of the circulation of the blood. One knew and understood the digestive system. One understood that one had to keep one's teeth not only clean but keep them in your head for proper mastication and so on for food to digest properly and as I so often shared with audiences, I was fascinated since I was very interested in words from those early days, in oesophagus, how to spell that and where it was placed in the body. Then of course the communicable diseases of the time we learnt excellent preventive medicine what AIDS is to this generation, Tuberculosis -TB - was to mine. You know they really taught us how not to be infected by TB and you know I grew up being told by friends that I was very scornful because I wouldn't drink out of a glass which somebody had drank without washing it. And of course the good old anopheles mosquito, and what that was likely to do to me if I encourage the breeding in stagnant waters. To this day to my at my great age if I see some stagnant water in a can or coconut shell I immediately turned it over because a mosquito must not be allowed to breed in there for malaria. Then of course I learnt about quinine that little tablet and following that that came from the SYNCONA plant and that plant was largely to be found in the Amazon Basin. So my Geography and my what else all the interconnectiveness of knowledge, it was magnificent what the Colonial Government did. Now we are independent we had better be better. Or else as they say in Jamaica, "Dog eat our supper." But this thing of health education is critical and ought to be integral to the curriculum in school and not at University Level or Secondary School but from Primary School.

As yet Sir George, and I have said this to Professor Kelly, I am yet to see any study which has convincingly link for me the correlation between nutrition and personal hygiene and the spread of AIDS and the prevalence of AIDS. I really would love to see something because I am not sure they are not connected. But then I am a lay man, I know nothing about medicine really. This would help considerable because you know even among the poorest of the poor in the region we were told about a balanced diet with different vitamins which are supposed to be there and as children we really grew up understanding it. As to personal hygiene, that was critical. Grandmothers kept telling you, "Cleanliness was next to Godliness." And you had better be Godly in the Caribbean else of course you had never get to heaven or live too long. These things are very critical so it is not simply teaching about AIDS but its interconnectiveness with everything else about life.

And of course at the macro-economic level this is very important because the threat to the real producers of wealth in the society which mean the flower of our youth between the ages of eighteen and forty when you really are likely to be firing on all cylinders. If you are attacked by this debilitating disease then there is no way that you are going to produce. And for the percentage of the affected people to plan there are very serious implications for macro-economics.

The next thing of course, and Sir George is very strong on this is the stigma which all of this carries. TB did carry that stigma too. We even said that certain types of people were more vulnerable than others. This leads to all sorts of things and don't forget that in our own history in this region there is a tradition still in the minds of lots of our people that there are people like us are given to natural indolence. In other words we turn up lazy at work. Well we may be lazy at work because there is some debilitating disease we know not of whether it might be hypertension or diabetes. It seems to me that in thinking about AIDS we have to put all of these things together to help get rid of the stigma that we are all vulnerable and that in fact it has serious implications for our life and living. I am



very happy about this particular exercise which UNICA, UNESCO and UWI have collaborated on and that the book authored by Professor Kelly has come out at this time. I hope that educators will use this book really and will in fact even call for a primary school edition. Professor Kelly watch out. You know that in fact it can be easily accessed by our young people. I think we have to start from the beginning. You know by the time I had reached adulthood, I was hearing that life expectancy in the region had increased considerably and many of us could in fact expect to get to three score years and ten. This was not so when I was growing up and I feel that we have to get this across to our young people and teachers are critical in this. So all the principals of schools who are here, I am appealing to you to take this conference seriously and better still to go beyond whatever we do over the next day and a half and get the information out to your constituencies throughout the region of course and in Trinidad and Tobago. This particular collaboration with UNESCO is indeed very good. I have been associated with all three, UNICA, UWI and UNESCO. They are three organizations when they get together can be very powerful. They are three organizations that don't have much money but a great deal of will and a good deal of expertise. I am expecting all of us who will be gathered here over the next two days to really bring all of this to the benefit of what is in store for us. So I thank you and welcome to the conference. That is what I was supposed to do, Mr. Chairman, and I will dare say welcome to the University of the West Indies which happens to have a campus in Trinidad but is a regional institution and therefore whenever I am in the region I like to feel that I am on my own ground. So thank you Mr. Chairman for giving me this opportunity and welcome to you all.

**Dr. Bhoë Tewarie:**

Thank you Vice-Chancellor for giving me the opportunity to say welcome to Trinidad and Tobago to everybody. A special welcome of course to all the representatives of Universities and Tertiary Institutions which are part of the UNICA group. And a special welcome also to the principals who were specially invited by the Deputy Principal who took charge of this conference from the beginning, Professor Kochar. My next task is to introduce someone who is very, very knowledgeable in the field. He is the head at CAREC - the regional research and information institution which advises governments around the region on health issues and health policies. Or health issues which have policy implications - this is CAREC and he is the head of the sexually transmitted disease division. His name is Dr. Bilali Carmara - he is a very, very knowledgeable person, a virtual encyclopedia of information in this area, and he is going to talk to you this morning on the HIV/AIDS epidemic - global and regional perspectives.

**Dr. Carmara:**

Thank you Mr. Chair, the Representative of UNESCO, the Chancellor of UWI, our own PAHO Emritus Director, and dear colleagues. Thank you for this opportunity and I am certainly telling you on behalf of Dr. James Hospedales who can't be here today and who is a UWI product actually to say thank you for this invitation and certainly we will try together in the twenty minutes to discuss what the situation is with regard to HIV/AIDS in the world as well as in the Caribbean.

However before getting into that I will chat a little bit on the Vice-Chancellor. I have heard nutrition, I have heard circulation, I have heard respiration, I have heard malaria, I have heard AIDS, I have not heard sex education, I have not heard sexuality, I have not heard sex. I think that we have to go beyond some I will say tradition, we have to move and to make sure that in our schools we can talk about sex. We can talk about sex education, it is important HIV/AIDS is about sex, it is about lifestyle. However culture, history and sexuality are critical in this issue and if we have to tackle it we cannot avoid the words, sex, sexuality and human reproduction. I think that is capital. I will stop there.

And certainly to say that at the end of 2001 we had almost one million people living with HIV/AIDS in North America that is including Canada and the United States. In the Caribbean we are close to half million I would say, in the Latin America one and a half million, Western Europe we have almost the same as the Caribbean, and Eastern Europe and Central Asia we have one million people living with HIV/AIDS., East Asia and the Pacific we have one million people living with HIV/AIDS, South East Asia almost half a million

North and Middle East --- 500,000

Last and most affected continent which is Africa , we have almost 30 million living with HIV/AIDS.

Sub Saharan Africa --- 28, 500, 000

Total = 40,000,000 with on the sad side 18.5 million women and 3 million children living with this epidemic.

Total deaths in 2001 = 3 million with 1.1 million women and 580,000 children  
AIDS Orphans = 14 million children living without parents.

**Source WHOUNAIDS**

And those children certainly UNESCO, UNICA and UNICEF will try to look after because it is important and they have no opportunity to go to school. You help the one in school and you help the one who does not have the opportunity to go to school. I will encourage you to think of them and certainly to bring them into the school system.

What is own lack is generally we can see in our own Caribbean and Latin American position we have close to 2 million people living with HIV/AIDS with the absolute majority in Brazil but when we look at the reality in terms of the incidence or rate the Caribbean is certainly not doing well. What is important at the end of 2001 as you can see the majority of the affected countries which are between 2 and 8% having a population living with HIV/AIDS in Guyana, Suriname, Haiti, Dominican Republic which are seriously affected but the same countries if you could see like Trinidad and Tobago and Jamaica.

**ESTIMATE OF PEOPLE LIVING WITH HIV/AIDS  
in the Caribbean: End of 2001**

Caribbean	Total close to 500,000
CAREC Member Countries	92,000 - 19.2% of Total cases
Dominican Republic	130,000 - 27.4% of Total cases
Haiti	250,000 - 52% of Total cases

Cuba 3,200 (fast growing epidemic with 28% increase between 2000 and 2001) - 0.78% of total cases.

However what is important into this perspective is certainly if the epidemic has matured enough. Several parts such as Cuba we have still a recent epidemic which is really fast growing and a cause for concern.

What is our situation now compared to the rest of Latin America as well as North America the blue curve down is representing North America in terms of annual incidence per 100,000 population and the red one is CAREC member countries. Clearly forgetting about the numbers in terms of AIDS incidence, the region is number one in the Western hemisphere, number one in terms of AIDS incidence generally, number one among women, and number one in terms of AIDS incidence among our children. What is the classification of our member countries in terms of death prevalence rate? As you can see, Haiti is the first position followed by Guyana, Turks and Caicos - where also we have to certainly imagine that this small island is close to Haiti where Haitians are certainly living and coming and working in the construction industry. Followed by Belize, Belize is another country of migration, where Honduras the epidemic is playing a role in the situation followed by the Bahamas where also 25% of the AIDS cases are from Haiti. Dominican Republic, Trinidad and Tobago, Antigua, Barbados, BVI, Grenada and finally Jamaica.

The first AIDS cases were reported in Haiti in 1991, Jamaica was in 1982, Trinidad and Tobago was in 1983. All of those cases were reported amongst gay men who had had sex with North America Gay men in North America or in the Caribbean meaning of course that migration had played a role in the history of AIDS in the region. And this observation is reinforced by the fact that we share the same molecular structure of HIV which is declared to be of the HIV1 type. Clearly the linkages have been established.

At the end of 2002, the accumulative of 23,000 AIDS cases were reported to CAREC by its member countries. Clearly taking into account the reporting, we believe that this is close to 35,000 cases. When we compare for example the case of Trinidad and Jamaica during 2001 and 2002 we know that annually Jamaica is reporting 1000 AIDS cases and Trinidad has reported half of that on an annual basis. And at the end of 2002, the annual incidence was estimated at 44 in our member countries and that annual incidence was a few years ago at 28 meaning nearly that we have almost twofold increase of the AIDS incidence in our CAREC member countries. This is the historical perspective and we believe from 2000 there is a little decline however we cannot really confirm, we hope that it will be a serious decline but we will wait a little bit more to see how the situation will evolve. The majority of the cases are of course between 25 and 44 years old. The 0 - 4 years which represent 6 % is due to mother to child transmission.

Professor was talking about Tuberculosis. He was concerned about public health. Unfortunately Tuberculosis is coming back because of this epidemic and you can see in several countries, the trend is even growing among the population of people living with HIV/AIDS. There are six countries which are seriously affected by the TB epidemic also, the TB is co-affecting people living with HIV/AIDS. And you could see that the majority of the Bahamas, Trinidad as well as Guyana, they have more than 30% persons living with HIV/AIDS who are infected.

Some disturbing facts, I have said it so it is true that almost 5000 people died already of AIDS in Trinidad and Tobago since 1983, and since 2001 in Jamaica AIDS is killing 50 people per month and during the year 2000 people in the age group 25 to 44 years old had their risk of dying of AIDS increased by 124% in Guyana, compared to ten leading causes of death. Still we are struggling but our mortality or AIDS fatality rate has remained within 60 - 75 in many of our member countries.

Is there some hope? YES, I will certainly say so and we are seeing it. I have two examples here we have clearly notice some decline, persistent decline throughout the years since since 1997 in the Bahamas. The decline in the reported AIDS cases, the decline in the AIDS death among adults as well as children, decline in HIV cases. Bermuda is also the same scenario and we are seeing the same good news in showing its head in Barbados.

This is to show you how the situation is evolving in the Bahamas in terms of reported AIDS cases and the trend is declining and 2002 the same scenario is there. In terms of HIV cases almost a 50% decline from the end of 1994 to the end of 1999. The number of people dying is also declining and the hope is that the number of people living with HIV/AIDS is growing and the decline in terms of AIDS death amount children is certainly clear specifically for the 0 - 1 year old and specifically that can be explained by the Sister School Programme on the prevention of Mother to Child AIDS Transmission which is reflected also in the 1 - 4 years old with the declining trend in terms of AIDS death among children. Again for the 5 -9 years old. And this is also the summary for the case scenario in Bermuda. And this decline had continued in 2002 and had reported only 8 cases of AIDS. In 2003 we are following this situation closely and they have just four cases so far. It means simply that there are some success stories in the Caribbean which we can learn something from.

In conclusion what is important we know that to achieve success we should really focus our efforts in three specific areas:

- Prevention using the A,B,C approach. A for abstinence, B for Being faithful and C for condom use. Tthis can be done only when we are talking about sexuality when we are educating our future generations about sex and sexuality and reproductive health and that is clearly very critical.

- And that the over important element is care and treatment and I certainly will not say that can be done, achieved for, promotion of voluntary counselling and testing, Prevention of Mother to Child transmission and
- Promotion of anti-retro -viral treatment.

We know that in developed countries there was a recent publication which showed that the use of anti-viral had reduced by 80% the AIDS death in those countries. However I would like to tell you that there is no dichotomy between prevention and care and treatment. We say in CAREC who cannot care, who cannot treat, cannot prevent. All of this can only be done as the Professor has mentioned it when stigma and discrimination are certainly under control. The important epidemic which we have to fight and to fight daily against because despite the fact you can have a good prevention programme, you can have a good care and treatment programme, if you do not fight to reduce stigma and discrimination your people will continue to die because they will die of this injustice. And really they will need to get social justice somewhere. These are key elements I would like you to look at and see how better you can collaborate with our regional institutions or regional programmes to see how better we can get those programmes implemented and strengthening each other because they are interconnected they cannot be tackled one after another they have to be tackled all of them together this really the only way we can get this issue under control. I am convinced, last week I was telling two National AIDS Programme coordinators that we can really use this approach to reverse this whole issue we have a certain means and we have a certain expression and we have certain interest. This conference is another expression of that interest. We certainly can do better by joining our forces, by fighting together, and by fighting against HIV/AIDS. Thank you very much Mr. Chair.



**Mr. Bhoë Tewarie:**

Thank you very much Dr. Camara. We now move on to the next item on the agenda which is the keynote address and this is being given by Madame H  l  ne-Marie-Gosselin, Director of UNESCO office the Caribbean. Her theme is, "Why education is the Key? and UNESCO's role in the global response to HIV/AIDS. Madame Gosselin.

**Madame Hélène-Marie-Gosselin:**

Honourable Chancellor, Sir George Alleyne, Vice-Chancellor Nettleford, Pro-Vice-Chancellor Bhoendradatt Tewari, Professor Gurmohan Kochhar, Rectors, Presidents, Vice-Presidents of UNICA Institutions and other distinguished guests. Sir George I would like to reiterate what I said yesterday briefly. UNESCO's most heartfelt congratulations on your recent appointment. We in the UN community surely feel that this most venerable institution of UWI is extremely privileged to have you at its arm. Ladies and gentlemen. Distinguished participants. First of all let me assure you that I will not speak for half-hour this morning but I will be happy to answer some questions should there be.

Let me begin by quoting from UNESCO's *Strategy for HIV/AIDS preventive education* (2001):

*"The cost of non-intervention – of not initiating the huge efforts in preventive education needed – can be counted in millions of lives lost, in the destitution of communities and in reversals that will last throughout the whole century."*

I speak today as the representative of UNESCO, a global organisation supported by all countries of the world and as director of UNESCO's Office for the Caribbean, the arm of my organisation that is the listening post and service provider for nineteen Caribbean nations. We have a global mandate for building the capacity and effectiveness of education, and the UN Secretary General - Mr. Kofi Annan has given UNESCO a special responsibility as lead UN agency in mobilising the education sector of vulnerable countries in the fight against AIDS.

When this Conference was first conceptualised a year ago, UNESCO endorsed the idea without hesitation and has worked hand-in-hand with senior officials of UNICA and the University of the West Indies to create this opportunity for leaders of Caribbean universities and research institutions to exchange ideas on ways to

enhance the response of their countries to the scourge of AIDS. I am therefore delighted to be with you this morning to highlight UNESCO's role, responsibilities and perspectives.

As a UN organisation, UNESCO has responsibility for advocacy, innovation and capacity building in the fields of education, culture, science and communication. As HIV/AIDS has persisted and expanded, it has become apparent that health sciences (the purview of our sister organisation WHO/PAHO) cannot alone contain and defeat the epidemic. I applaud again Professors Nettleford, Kelly and Bain who most eloquently underscore this reality in the book we launched last night. And by the way there are sufficient copies - this is a free edition that was specially rushed here for this conference so I encourage everybody to pick up a copy of that book. Professor Nettleford although you put the challenge to Professor Kelly on the school edition I am quite sure that Professor Kelly will put the challenge to us at UNESCO as the publisher of this book. I find this idea extremely interesting and useful and definitely we will look into that I am sure. Professor Kelly will be most delighted.

Without education of course and I don't need to repeat that to this distinguished audience this morning there now seems little hope of halting the spread of the epidemic particularly in vulnerable developing countries of the world but also I will contend in all the countries of the world. For education to be effective and universal in its reach it must incorporate the fields of culture, the natural and social sciences as well as communication.

UNESCO's contribution must be multisectoral, integrated and immediate. The organisation's priorities, at both international and Caribbean levels, have therefore been changed drastically since the beginning of the twenty-first century to respond better to the urgent needs of member states, as reflected in the new UN mandate to UNESCO.

At the Caribbean level, the shift in UNESCO strategy is reflected in our new education programme endorsed recently through an all encompassing consultation last month that we conducted with most of our Caribbean stakeholders and endorsed more recently through consultation as well as an evaluation of our overall education programme.

Our efforts in the HIV/AIDS arena now has prominence in our education programme and we are currently examining how to strengthen and coordinate inputs of culture, the sciences and communication as well to create a truly integrated and multi-sectoral response in this region. We have reported our effort in HIV/AIDS regularly over this past year to our partners through a quarterly electronic report, ***Education & HIV/AIDS***.

I would also like to outline for you UNESCO's strategies - both global, as a member of the UN family, and internal, as an individual organisation. And at both levels, I will describe how the global theory relates to grassroots practice here in the Caribbean.

Before I begin, may I draw your attention to the final word of the title of my address – “**Epidemics**”, **the plural**. We at UNESCO are ever-aware of the need to contribute to the fight against four faces of epidemic - the hidden epidemic of HIV infection, the more visible epidemic of AIDS, the social epidemic of stigma and discrimination - still an enduring facet of HIV/AIDS in the Caribbean - and the fourth and growing epidemic of orphans – a huge challenge to the world and to the Caribbean.

There may be as many as 500,000 AIDS orphans in the Caribbean already, and the number is growing daily. Professors Kelly and Bain speak forcefully of the four facets of HIV/AIDS in the opening chapter of the book - *Education and HIV/AIDS in the Caribbean*. As I speak of UNESCO's role, I speak of our role in the response to all four epidemics.

### ***UNESCO as a UNAIDS partner***

UNESCO is one of the founding members of the coalition of UN agencies that combined to establish the Joint United Nations Programme on HIV/AIDS, known as UNAIDS. This programme has its Caribbean office here in Port of Spain. UNAIDS is an innovative UN venture that builds on existing strengths harnessing the energy of each member organisation. UNAIDS prompts collective action by UN agencies against HIV/AIDS.

At the national level in each Caribbean country, the UN Theme Group for HIV/AIDS secures collaboration and coordination of all partner UN agencies in support of that country's HIV/AIDS response.

UNESCO is a member of each UN Theme Group, and actively contributes to each national programme. Last week, for example, UNESCO joined with sister UN agencies in St Vincent and the Grenadines to discuss - among other matters - our joint response to the HIV/AIDS epidemic in the eastern Caribbean.

In the Caribbean, we have been working closely with UNICEF, WHO/PAHO, UNFPA, UNDP, FAO, UNIFEM and the UNAIDS Secretariat to accelerate our joint support to the region's education sector. UNESCO has established an annual meeting at Strawberry Hill in Jamaica where these agencies come together and focus on collaboration in education.

The UNAIDS programme has five core functions to which UNESCO contributes in the Caribbean. First, it provides leadership and advocates effective action. Secondly it provides strategic information to guide country effort against HIV/AIDS. Thirdly it tracks, monitors and evaluates both the epidemic and responses to it. Fourthly, it mobilises technical, human and financial resources and finally it actively develops partnerships.

UNESCO has provided **leadership** - in partnership with key regional institutions such as CARICOM, UWI and UNICA - in raising the consciousness of countries throughout the Caribbean region for the need to enhance the response of Education to the epidemic. This first conference on Education and HIV/AIDS is one of the outcomes of this initiative.

Secondly, through the publication of *Education and HIV/AIDS in the Caribbean*, and the development of an advocacy package which is scheduled for release in 2004, we shall provide Ministries of Education and educational institutions of member states with **guidance** in planning the educational response to HIV/AIDS.

Thirdly, in this current year, as chair of the UN Inter-Agency Task Team on HIV/AIDS and Education, UNESCO has developed a mechanism for national education sectors to **monitor** their individual response to the epidemic: Jamaica contributed to the design of the global instrument as one of the pilot countries earlier this year.

Fourthly we have been active in **mobilising resources**, both technical and financial. Professors Kelly and Schenker, both on your programme this morning, are testimony to our effort. The Caribbean is only now developing home-grown expertise in the field of Education and HIV/AIDS; UNESCO has been bridging the gap by scouring the world for the best in this field. We are most honoured that Professor Michael Kelly of the University of Zambia agreed to return to the Caribbean for his third visit in two years.

Finally, in articulating our response, we have developed and consolidated **partnerships** not only with Caribbean regional institutions, but with development banks, donors and non-government organisations. Such partners include the Inter-American Development Bank, JICA and the Regional Youth Coalition against HIV/AIDS, and we are in active consultation with many other international

partners including the World Bank, the Caribbean Development Bank, DFID, and USAID. And indirectly, through Funds-in-Trust, our efforts in this region have been supported by the Governments of Japan, Norway and Israel.

It is important to emphasize that globally, UNESCO is the convening agency for the education sector in the Joint United Nations Programme on HIV/AIDS. In this context, in 2001 and 2002 we published the global strategies required of education in response to HIV/AIDS. These strategies are available on the UNESCO website. The book launched yesterday translates these global strategies in the Caribbean epidemiological and cultural context.

### ***UNESCO's role in prevention and mitigation***

In preventive education UNESCO focuses its efforts around five core tasks:

1. support for advocacy,
2. customising messages,
3. creating strategies to prevent risky behaviour,
4. building capacity for care of the infected and affected within the school populations, and
5. strengthening institutions' ability to cope with the impact of HIV/AIDS.

As UNESCO's Caribbean strategy evolves, we envisage lending support for each of these. Again, permit me to give a concrete example in each of these areas.

First, how will UNESCO undertake its task in **advocacy at all levels**? We have started at the policy-making level, by presenting to Ministers of Education, Chief Education Officers, educational planners other key public officials with the rationale for involvement in this sector.

I have just come from an workshop in Curacao, a joint enterprise of UNESCO and the *Caribbean Publishers Network* (CAPNET) which extended advocacy to the region's commercial educational publishing industry about the need for

proactivity in response to the epidemic. One of your presenters today, Professor Inon Schenker, is currently developing advocacy materials for use in 2004 with the management and staff of teacher education institutions across the region.

Secondly, how does UNESCO plan to give support for **customising the message** to marry international experience with peculiarities of the Caribbean cultural milieu. Just last week we supported the University of Technology, Jamaica, in documenting its innovative use of experiential learning to increase student awareness of HIV/AIDS - using Caribbean artistic creativity as the strategy - I will leave it to Dr Nancy George to share this exhilarating experience with you later in the Conference programme.

Of course, all our work in the Caribbean will be grounded in the cultural tapestry. This was our rationale for developing a partnership between Michael Kelly's African experience and the Caribbean experience of Professors Rex Nettleford and Brendan Bain, in the authorship of a strategy tailor-made for the region.

Thirdly, how does UNESCO intend to contribute to **changing risk behaviour**? We have begun already begun; publishing last month a set of instructional materials designed for disadvantaged urban youth - particularly young men, including those in correctional institutions. The three pilot books in the series, written by a Jamaican Dr. Ramsey and published by a Trinidadian, are designed to help youngsters deal with issues of violence, HIV/AIDS and self esteem. We are distributing sets to all CARICOM countries for pilot testing through their literacy programmes and in their youth centres

Next year, we begin to experiment with the concept of training suitable tertiary-level students as peer educators with secondary students in HIV/AIDS, in an organised and professional way. On November 1, following this Conference, the School of Education of the St Augustine Campus has partnered with IDB and UNESCO to hold a brainstorming workshop - including students from several



countries - that will contribute to the design of the pilot. One of UNESCO key Caribbean supporters in the field of education, Professor Carol Keller, has been instrumental in organising this post-Conference event.

Early next year we will begin particularly important projects with Ministries of Education in Jamaica and Guyana to tackle behaviour change through formal primary and secondary schooling. Both Ministries are currently in the process of selecting textbooks published for countries in sub-Saharan Africa and will evaluate the suitability of the approaches for their schools. If these materials have a positive effect (increasing knowledge, reducing risk, reducing discrimination), we anticipate that similar materials will be developed for the Caribbean.

Currently there are no commercially published HIV/AIDS materials for the Caribbean, and UNESCO has begun the process to fill that gap. We have also undertaken to support UNICEF in its effort - in partnership with CARICOM and the Cave Hill Campus of UWI - to develop materials on HIV/AIDS for the *Health and Family Life Education* initiative.

Fourthly, how will UNESCO support **care for the infected and affected** within the educational sector? In a region where the stigma attached to HIV/AIDS has resulted in silence and denial, it is difficult to know where to begin. So we have begun with research to try to get identify some of these issues.

We have partnered with the *Caribbean Child Development Centre* (CCDC) and UWI's *HIV/AIDS Response Programme* (HARP) on the issue of infected and affected in early childhood education. The pilot is in Montego Bay, an area of Jamaica with particularly high HIV/AIDS prevalence. Ms Hope Ramsay is a Conference participant and lead researcher with CCDC and is prepared to share her preliminary findings with interested colleagues.

Finally, what of UNESCO's support for capacity building to **cope with the institutional impact** of HIV/AIDS? Professional officers in Ministries were already overstretched prior to the epidemic, and find it difficult to take on HIV/AIDS response requirements without support and training. In Jamaica, UNESCO has partnered with UNICEF, the World Bank and JICA, to develop an *HIV/AIDS Response Team* in the Ministry of Education Youth and Culture's Headquarters and its six regional offices.

This team will be dedicated to HIV/AIDS prevention and mitigation, and will train Education Officers in the field to assume HIV/AIDS response responsibilities over the two years of the programme, cushioning the impact of new demands on their professional time. This will be the first Ministry of Education in the Anglophone Caribbean to have such a team. The team leader, Ms Mavis Fuller, is here at this Conference, thanks to UNICEF sponsorship, and I am sure will be willing to share with you her Ministry's plans.

One of the immediate actions of her team in early 2004 will be to disseminate the new *Schools' HIV/AIDS Policy* to every educational institution in the country, a policy that covers all HIV/AIDS issues that a school may need to confront – the infected, sexual activity, orphans, stigma, discrimination, and so on. UNESCO will ensure active sharing of lessons learnt from this Jamaican model with other Caribbean countries.

As this long list indicates, we have begun work on all fronts. We have been heartened by the response from our partners and beneficiaries. In the Caribbean, the UNESCO operation is modest, with only a handful of professional officers. We could not - for example - have mounted a Conference such as this alone. However, with UNICA and UWI, we have been able to realise the dream of a first Conference.

Indeed it is important to stress that it is only through partnership that the scourge of AIDS will be defeated. I look forward to receiving proposals for new partnerships in research, advocacy, capacity building and creative action from all the universities and institutions represented here today. I wish you well in the sharing of experiences that will now commence, and the strategy development Caucus of university leaders that will follow the academic exchanges. Thank you very much.

## **Selected UNESCO Documents & Resources**

### **Global**

UNESCO's strategy for HIV/AIDS preventive education. 2001.

Planning for Education in the context of HIV/AIDS. Michael Kelly. UNESCO International Institute of Educational Planning. 2001.

Preventing HIV/AIDS in schools. Inon Schenker and Jenny Nyirenda.

International Academy of Education & UNESCO International Bureau of Education, 2002.

HIV/AIDS and Education: A Strategic Approach. 2002.

Global HIV/AIDS Impact on Education Clearinghouse. UNESCO/IIEP website established 2003.

International Clearinghouse on HIV/AIDS and Education. UNESCO/IBE website established 2003.

Global Readiness Survey Instruments. 2003.

### **Caribbean**

Caribbean Education Strategy 2002-2007. Revised 2003

Education & HIV/AIDS Quarterly Report. Issues 1, 2 & 3. 2003.

Findings of the Joint Programme Identification Study (JPIS).

UNESCO/CARICOM/IDB. 2003.

Plan of Operation for HIV/AIDS Capacity Building for the CARICOM education sector. UNESCO/CARICOM/IDB. 2003.

Education and HIV/AIDS in the Caribbean. Michael Kelly and Brendan Bain.  
2003

Literacy and Life Skills Series. Workbook 1: Understanding HIV/AIDS and Drug  
Abuse. Angela Ramsay. UNESCO/Morton Publishing. 2003.

**Dr. Tewari:**

There is no provision for questions or discussion on the agenda but I will take the liberty after the presentations of giving you the opportunity to ask three or four questions you have on your mind. I am sure there are questions but before I do so I want to acknowledge two of my colleagues who have come here from Mona they are: Professor Marlene Hamilton who is in the Vice-Chancellor's Office and responsible for International programmes as well as alumni and ask her if she will let people acknowledge her and our University Registrar, Mrs. Gloria Barrett-Sobers. I will ask the panel to come back here for a minute or two and we have had some rich presentations and good news. One of the pieces of good news was the reversal in the Bahamas and Bermuda and secondly the significance of education in making a difference. Professor Kelly said last night that the prevalence of HIV is less in countries that are pretty well high up on the education ladder in terms of participation in the education system.

**Dr. Camara:**

Since there are no questions I will like to make one small comment. Sometimes people have the feeling that when the education level is high it can be translated into skills but I believe there is a difference particularly looking at the Caribbean context and even the African context. In the beginning of the epidemic, what has happened is the rich people who can buy sex, who are educated are the ones who were dying of this condition. After that there was a reversal and in the Caribbean what I am seeing is clearly specifically looking at your population at the University of the West which is dominantly women. The reality is that despite the fact of the education level they are still at risk of contracting HIV. That is a serious issue. I think we need as educators to make the difference between the two notions of education. One which we call in French educate and two what we call in French formate meaning really that there is a fundamental difference between the two. I can go to school, I can learn very, very well. I was not as lucky

as the Professor has said I couldn't wash the little cup which someone else had used because the African tradition is that you have to use it. And if you are eating the head of the family will wash his hands and they will push the water to the next and I was the youngest so when the water got to me it was as dirty as I don't know. I had to wash my hands in that. When I tried to reversed that in my family I had to bring concrete examples and to show the linkage between the well in my family and the toilets. We had on a regular basis, venereal disease among my cousins etc. when I said to my uncle, "When you drink the water from this well, do you smell something?" He said yes it smells like some soap. I said, "Do you know where this soap is coming from?" I said I believe where we are washing ourselves is too close to where the well is - maybe we can close this well and do another at a distance. He said you are thinking as a white again. I said no. I was at the Dominican school but still I have to dialogue to move them forward to really understand. I believe it is really important, you have a serious challenge to break this taboo that when you go to school you are okay, you are protected. No, it is not really protection and clearly I will encourage you to bring the education and skill building together to marry the two so that we can protect the next generation. Thank you.

**Ms. Sherilyn Whitman:**

Dr. Camara and Madam Gosselin thank you so much for your remarks. My name is Sherilyn Whitman from the Education Development Centre and in the work I do on HIV so much of the attention is on Prevention Education for teachers. I will like to think in this meeting too about teachers themselves and how we can learn more about the prevalence rate among teachers. How can we bring anti-stigma campaigns into the school system? How can teachers themselves be models for voluntary testing and counselling and health care for teachers too? And doing this early on may be steps we can take to mitigate the impact on teachers as the primary force in the educational system. Thank you.

**Dr. Camara:**

I certainly appreciate very much the suggestion. It was a very good suggestion and clearly Professor Kelly will talk about that. The only country that is gathering that type of information and it will help us really to help UNESCO to understand what the impact is if HIV/AIDS is in the school system. There are two countries, Guatemala is one good example where in 1999 they have looked at what was going on and have found that the drop outs had increased by 30% and when they looked into this it was because parents had died and they could not pay school fees etc. and the children have to stay home. There are many good examples around the world in Central Africa, Zambia, Kenya, etc. where schools had been closed down because there were teachers who were dying or because schools were empty because children couldn't come into the schools etc. etc. It is a serious issue which we need to avoid. What is important and Jamaica is collecting that information and they have been able to show that among the AIDS cases, 4% are among what they have called professionals - lawyers, teachers etc. If we can dip into that kind of information we can find out how far, how deep or how bad the situation is. It is really critical.

There is one point which we will talk about this afternoon - emotional intelligence. Many times when we try to teach something we take ourselves out of it and that is wrong. In HIV/AIDS we cannot do it. We are at risk and the professor has said it, everybody is vulnerable. You can say personally I am not but you have a partner for whom you cannot talk. You have children who are also part of you. You can be vulnerable to this issue. To tackle all of this we need all of us to use that approach and that is why I am real anxious to talk about this approach of emotional intelligence which will bring us down to the level of real people not intellectuals, not teachers but to the level of real people to look at this issue as a social issue a community issue a family issue and an individual issue which we have to tackle as much as possible and I certainly will encourage you to help teachers to reach that level first before you undertake the voluntary counselling, testing and those functions of themselves. That is really what is very critical.

They have to be at ease to talk about sex and sexuality and understand that it is just a human behaviour.

**Professor Nettleford**

Thank you very much Dr. Camara. I noticed that you made a distinction with the thing of sex education, you are so right. That is one kind of education that we didn't get in school. We got it elsewhere particularly from our peer group but you know that there were very wise grandmothers who used to say certain things and we had to pick up. Now your ABC formula interest me a great deal. The abstinence thing that speaks for itself which I dare say may be an impossibility in this part of the world where that is almost regarded as civic duty. I very interested in these things and I haven't as yet spoken to Dr. Kelly about this but you know you are in a strongly Catholic country as well as a Hindu one but when you get a Papal Injunction against the use of condoms this has serious implications not at all dissimilar to President Emike's own position on AIDS and the tremendous difficulties this produced for so many young people. I would like to hear what is CAREC's view on this because there are very important forces now - it is more than tension, it is warfare. You talk about emotional intelligence and some of the poor teachers. What do they do? If in the confession box they are hearing something on a Friday and they come on Monday to hear something else. What do we do?

**Dr. Camara:**

I think what is important, what is critical and I will ask UNESCO to certainly look at that, is to get the church involved as quickly as possible. Anything you want to undertake in this region you should get the church with you. Without the church you don't have anybody and that is the reality. I remember there was a big fight between the National Authorities in Barbados and the Church Group. When they talked about introducing condoms in the present system and I was working with the CCC -the Caribbean Conference of Churches as their advisor - quietly because they don't want me talk very much about it. The important piece in it is



internally between us when we discuss frankly we agree on several things -they understand several things which they want to implement. However the command is coming far from Port of Spain. The command is coming from the Vatican. It is in Italy. The point which is important is that condoms have demonstrated, in the largest study which was conducted by UNAIDS service recently, that in 90% of the times condoms have protected people against HIV/AIDS. The remaining 10% is due to how you keep it, how you use it and how accidents can occur. Important piece is that I have told the church let us share the work, you do A and B and I will do C. That is it. If we agree on that we don't have anything to fight about. All about us are about people. You do not want to see your church empty. I do not wish to see my communities dying of HIV/AIDS. That is the reality but it is a challenge. I think we need to dialogue with the church as quickly as possible so that our actions will really bear fruit. Thank you

**Dr. Tewari:**

We are running late so I am going to close this session. I want to thank you very much.

**Professor Theodore:**

Thank you very much Deputy Principal. Good morning to you all. We are about to begin this second session. I would like Dr. Shenchker to join us at the table. I am sure you will agree we had a very interesting opening session this morning. As these sessions go, those of us who are in HIV, we are sort of accustomed to hearing bad news, but the thing that gets me is that you really never get accustomed to it and seeing the information that Dr. Camara presented us with this morning it really drives home the point. The point which was made very strong last night at the inauguration that what we are really looking for are new ways and means to intervene, new ways and means to respond or to strengthen the response we are developing to HIV/AIDS and the use of education and the education sector is what we are focusing on in this conference.

In this session we have three presentations. I will very briefly tell you about each presenter and he will carry on when his predecessor stops. Roger Maclean works with us in the Health Economic Unit. He is an economist and he has been working mainly on the issue of the economic impact. He has been working most recently in Suriname and Guyana on an EU Project and his presentation is more a contextual one and he will be giving us a review of the social and economic impact but I think he will also be telling us a little bit about the work that the EU has been doing recently in this area.

He will be followed by Professor Kelly - there is no real need to introduce Professor Kelly except to say that he is the world expert in the area we are discussing now HIV/AIDS and he has not only travelled and published a lot but he has been a force in this area and we are very pleased to have him here. He will give us the second presentation but he tells me however that his presentation is entitled "Higher Education" but because of the audience he will be more general and will not concentrate on higher education.

And finally Dr. Shencter, he is an international expert on HIV and Education and has done a lot of work which has been translated into prevention measures in some countries. He is now consulting in the area with the IDB and UNESCO and today he will be telling us about the Asian experience in respect to HIV and Education. I will now call on Dr. Roger Maclean.

**Dr. Roger Maclean:**

Sir George Alleyne - Chancellor UWI, Honourable Vice Chancellor Nettleford, Dr. Tewari, Distinguished Ladies and Gentlemen -Good Morning. I must thank my chairman for allowing me 12 minutes to speak. I will try my best to keep within the twelve minutes. I must share with you, on my way here I got a call from a colleague in Mexico and I remembered when we were at a conference in Cancun and he shared with me a story which I will share with you in two minutes and do my presentation in ten. A farmer was going over the hills one day with his horse and pack mule. He loaded all his goods on the mule and proceeded over the mountain half way through the journey, the mule turned to the horse and said, "My friend I am growing weaker can you help me?" To which the horse replied, "That is not my concern, your load impact does not impact on me and in no way affects me." They proceeded and later on the mule turned to the horse again and said, "My friend I am pleading with you, I am growing weaker, can you assist me?" The horse replied, "It is not my concern it does not impact on me and in no way affects me." A few miles up the hill the mule died, collapsed and died. At which point the farmer loaded the mule and the load on the horse and proceeded over the hills. My talk to you is essentially going to look at the social and economic impact and in so-doing we are going to address a few areas quickly. We are going to pursue the question of why focus on the social and economic impact and we are going to look at ways in which the epidemic affects the economy briefly, also we are going to look at where we are in our response and end with reflections, looking at where we are and a question PLWHA -Persons Living With HIV and AIDS.

**Why focus on the epidemic?** I think after having heard Dr. Camara's presentation these rates would have been put forward and so they are by no means new to you. We are second to Sub-Sahara and Africa, we are second in terms of the percentage of HIV adults who are women in Sub-Sahara and Africa.

**Why focus on the epidemic?** Well based on what we are looking at and again you may have seen this in Dr. Camar's presentation but we are looking at epidemic by way of the diagram which you are seeing before you. It focuses for a large part on our productive labour force. Productive in terms of the age group 20 - 59 years, 20 - 49 years but more importantly if we look at the second set of bars where the darker colour represents the female we are seeing that the 18- 19 years age group -our young women are at higher risk of contracting HIV than our men. As a matter of fact if we were to look at the diagram in its entirety we would see that the darker bars are skewed more to the younger age group than the lighter bars implying that women are contracting and more at risk at an earlier age than our men folk are.

**So why focus on this epidemic?** We need to understand as we look at the focus of the epidemic that HIV impacts at a number of levels and so in the case of Trinidad and Tobago looking at the cases between 1982 and 1999 this is what we have found. The mark gets progressively darker as we progress from 1982 to 1999, the darker tones of course reflects higher prevalence rates across our country. So why focus on the epidemic we are therefore looking at an epidemic which affects individuals in their most productive years. We are looking at cost of treatment and care but are not only expensive relatively speaking but can be incurred over a long period of time. Our colleagues will make reference to HIV and AIDS as chronic, infectious disease so it brings an interesting dynamic to the list of diseases we have been dealing with over the years. Of course the number of individuals infected continue to increase despite some of the success stories we have been exposed to and as a result we are therefore looking at an epidemic that has the potential to place a significant burden on the resources of our region. So as we look to the social and economic impact we are going to look at the individual or micro-economic impact at the level of the individual and household and then we are going to sort of expand that to see what in fact or the channels through which it is going to impact on the larger national picture.

Looking at what we refer to as, or what Professor Theodore refers to as the impact of the bomb, I have identified a number of roles. Roles that we can place within the context of an impact of an individual or household. The individual infected is in fact affecting his/her role as family member and by extension will therefore affect his/her role as income owner, caregiver and educator within the family context. The individual infected will also affect his role as consumer and by so doing his/her role within the context of purchasing, influencing the market, using the use of health and welfare services and his/her role as a tax payer in this system. The individual infected is affecting his/her role as community member providing critical leadership and service and support to communities. Lastly the individual infected will also affect his/her role as a critical producer in the system and so illness, death and so will impact significantly on his/her role in that productive capacity impacting on the savings. So we are looking at the individual impact here but we need to be mindful of the fact while one individual is being impacted on there are larger roles that are affected as a result of the individual impact. If we were to multiply that impact particularly the individual's impact within the productive capacity, understand that an individual is operating within his/her realm in a particular sector and so if we add those contributions up that essentially is what our GDP is. The contributions of individuals in sectors that we are aggregating to get some output - Economic 101 in thirty seconds. So our GDP is essentially the quality of the labour supply and the savings and capital that we are investing to ensure that we can expand our GDP. And out of that we can our Government expenditure given the context in which we are sitting here today we can speak to the issue of the impact of expenditure on our future education, health and training speeding directly into the standard of living of our people. Clearly there are going to be some direct impacts on GDP on standard of living and directly on education, health and training. All however directly impacting on your supply of labour. And that is how our system works. Our Gross Domestic Product feeds into the critical education and health functions impacting on our standard of living and enhancing that and feeding in providing that fuel to our labour supply. But then we have HIV and AIDS in our equation and illness

and death, mortality and mobility impacting negatively on the supply of labour while simultaneously demanding more of the supply of savings and capital. As those infected require more resources and at the same time the very resources that we are turning to address our concerns - that GDP that is providing that - Government expenditure is eroded because it is also eroding our labour supply via illness or death. We are therefore faced with a situation where the required expenditure cannot be met and there will be a continuous gap between what is actual or required expenditure based on what the demands are from the persons who are infected and affected and what is the state's ability to pay. Based on actual expenditure, a gap that continues to widen and that will feed back into what in fact will be an increasing vulnerability to HIV and AIDS as the labour supply continues to feed negatively into our own Gross Domestic Product.

**What are the figures like?** Based on our last study which looked at the cases of Jamaica and Trinidad and Tobago we estimated based on those very labels you saw earlier on GDP, Savings, Capital etc., Supply of Labour, Government expenditure. These are some of the figures we came up with, on average for the Caribbean Region implying that we are expected. This study was done from 1997, 1998 projected to the year 2005 at which point we estimated that the lost per GDP by the year 2005 will be roughly 5% with reductions in savings to the tune of 17%, investment 16.5%, and employment in all the key sectors particularly the service and more labour intensive sectors impacted on significantly. Of course with HIV/AIDS expenditure being the only positive (+30.3%) in that table.

**What therefore are some of the key points?** Well we are looking at an impact of HIV which is essentially related to mortality and mobility on key sectors and that impact is clearly both real and significant. In the case of the Caribbean we are looking at an impact that is equal to what in fact what we are spending on health. Five percent is what we are roughly spending on health. Most nations right now. Clearly the more labour intensive sectors are going to be impacted on

and there are clear implications for Tourism in Small Island Developing States and other sectors that are driven in large parts by larger intensive organisations. The key sectors are likely to be impacted on by both the demand and the supply sides because we are looking at a situation where the supply of labour is going to be impacted on because individuals are being lost to HIV and AIDS. The demand functions are going to change as individuals adjust their consumption patterns. So we refer to the original diagram, both sides of the equation we are looking at HIV impacting on it. We are therefore spiralling downwards.

**Key points.** The potentially significant impact on the macro-economic indicators will clearly have an impact on the key roles that the state plays in its provision of public goods. The state continues to have a role to play in some of the key public investment and public investment as a critical impetus to private investment. Roads, electrical facilities and other public investments are critical elements of what is fact necessary to ensure that our private investors come in. And so these things are going to be negatively imparted on and will of course impact on our private investment opportunities.

If we look at the nature of the response, these have been the key areas of response thus far. The structure of what we have identified as the standard response, some of what you have heard here today mentioned by previous speakers speak to the need of identifying the key priority areas of the response:

- Capacity building
- Prevention
- Advocacy and human Rights
- Surveillance and Research
- Programme Management, Coordination and Evaluation
- Treatment, Care and Support

The central feature of the Pan-Caribbean partnership on HIV and AIDS is a recognition of the proposed response to the epidemic will not be effective if health care and medical treatment of those infected is not seen as a core or



central element of the response. And therefore there is no question that prevention remains the anchor of HIV and AIDS and contains elements which show that caring for persons involved much more than supplying them with anti-retroviral drugs. It involves a lot more than that, it goes into other features in addition such as counselling so that persons can stick with the medication. It insures that we provide an environment that allows individuals to continue to assume their roles as family members, as consumers, as producers in the system and not be alienated from the system.

We have over the last few years been speaking to HIV and AIDS and moving towards getting HIV on the agenda and within recent times we have achieved some level of success in that Countries have embraced the issue of HIV, and understood and have made significant moves in introducing HIV within their larger strategic planning framework. Trinidad and Tobago has recently identified some TT\$500 million over a five year period (this translates to just over US\$18 million per annum) but putting US\$18 million into perspective so that we understand what in fact we are speaking to. US\$18 million represents just 2% of our GDP. Quite well within our ability to respond on our own resources. For St. Kitts, Nevis and for Barbados again in each case we have not crossed 1% of our GDP. This is an epidemic that is going to erode our productive capacity and undermine our developmental goals and we have not cross 1% of our GDP. So we are therefore looking at an investment that is clearly capable of significant returns.

As we wrap up some brief reflections, we have a history of successfully responding to HIV and AIDS, we have done it within the context of health, we have done it within the context of battling with cholera, yellow fever, malaria, tuberculosis, typhoid, polio and measles so we have the wherewithal to respond. There is of course a special behavioural and social dimension to AIDS but is wrong to assume that there is something inherently intractable about HIV/AIDS. What therefore matters is the scale and quality of the response to the HIV/AIDS

epidemic. And it speaks therefore to issues of public policy and community action. We therefore as a region, as regional institutions, must take responsibility for the HIV problems. The Ministry of Health will continue to play a role, there continue to be role for Health Care and Health Care Institutions but we must also recognize it is a development problem and it therefore requires an expanded response from all sectors. HIV goes into and affects all areas of our economy so our response must therefore be a multi-sector one. The response must be coordinated to allow for a well-planned, well-monitored response. The scale of the investment must match the dimension of the problem and if we are identifying a problem as serious as this we therefore must step up the pace at which we are responding. This is just to put things into prospective as well, we speak of the Caribbean region but on a Global scale we are second to Sub-Sahara and South Africa but we are hardly visible by way of the map. One of our major constraints is our size and vulnerability as small islands states. Hurricane season brings jitters to some of our small island states, we cannot afford to have HIV/AIDS hovering over us while we have to deal with other variables over which we have no control. Vulnerability around size is something we live with on a day to day basis. If in fact we are recognizing HIV/AIDS as a critical problem the acronym PLWHA should be expanded as we speak of an expanded response to every single member in this room. Persons living with HIV and AIDS, we are all persons living with HIV and AIDS. Thank you.

**Professor Theodore:**

Thank you very much Roger. That is one set of letters I have to include at the end of my name. I now call on Dr. Kelly to tell us about the experience in Africa.

**Dr. Kelly:**

First of all allow me to say how grateful I am to UNICA, UWI and UNESCO for giving me the opportunity to speak with you this morning. I will be speaking about **Education and HIV/AIDS**. I want to begin and if the slide comes up we will see it by just looking at where the epidemic has continued to grow and continues to grow out of hand. It is very, very destructive and very, very alarming that the number of people infected is increasing year by year, the number of deaths is increasing year by year and the number of orphans is also increasing year by year. This is something that is of great distress to all of us. There is one good sign perhaps that the increase in the number of people infected with HIV/AIDS has declined ever so slightly in the last two or three years and that decline is being maintained. That is something that is positive and that is good, this is on global figures - global estimates. But there is also a large looming threat of a huge acceleration of the disease in India, in China and in Russia where the disease is growing faster than in any other part of the world. Growing at an enormous rate. I want to say something just to give the picture just a little bit about Africa that Africa is carrying at present a very disproportionate part of the AIDS burden. Africa accounts for about 10% of the world's population, one in ten of the people of the world are from Africa but it accounts for more than 70% of the HIV infection. More than 70% of the deaths occur in Africa and of the 14 million children who are orphaned by HIV more than 11 million of them live in Africa. So Africa has a very disproportionate burden and those of us who live in highly infected countries in Africa can echo very strongly what Dr. Maclean was advocating only a few moments ago and what Professor Theodore agreed to put as part of his title, we are all PLWHA, we are all people living with AIDS. I don't have HIV virus in my body, at least I didn't have it the last time I was tested but I am a person living with HIV and AIDS, my cook has HIV, the man who washes my clothes has HIV, the woman who dusts the house and keeps it clean has HIV. Three people, house servants, each of them with the disease and at the end of

March this year I was away and when I came back one of my gardeners had been buried, he had died of the disease.

This is the reality that we are living with in Africa, it is very, very real and very, very close. But being so real and so close you might think then there is no stigma, no discrimination and it is easy to talk about it and so forth. Far from it. Stigma and discrimination for some reason seem to be built in to the human system and we are experiencing still quite an amount of it. Stigma, discrimination, silence, denial. At institutional levels, for instance at universities throughout Africa, investigations have shown that the universities are ignoring the disease largely or at least were doing so up to 2 to 3 years ago. They have been trying more recently to get their act together in a better way. But the stigmatization, that judgement of people adversely or negatively because of something in themselves or in their physical makeup, language, colour or in this case their health situation that is still quite strong. It is now 15 years I think, since the then director of the World Health Organization global programme for HIV/AIDS said that we are speaking here not just about an epidemic called HIV which is silent and invisible, not just about an epidemic called AIDS which is very visible and very manifest, but also about a very quiet, silent, insidious, hateful epidemic which is fueling the other two, the epidemic of stigma and discrimination. Since that time the world has focused on how to eliminate this so that people can speak about this disease so that it can become something that people are not ashamed of. So that it can become something that communities can speak about and cope with because it is brought about into the open. And if I have a recommendation to bring to you from Africa to the Caribbean, to the peoples of the Caribbean, it would be for the love of your people and for the good of your children and the certainty of your future to do everything in your power as educationists and community members to break the silence, to overcome the stigma, to exclude the discrimination. How can that be done, not very easily but if there is much more public speaking and much more speaking out about the disease I think this will be a help.

Secondly, I think we have to be very careful of our language, research in a number of countries is showing that we are stigmatizing even though we are not fully aware that this is what we are doing. Language which we are using is putting people with HIV/AIDS into a separate class, separate category and an undesirable class and undesirable category. It is the language that we use in our newspapers and in the media. We speak of AIDS victims, people with the disease find this a very, very negative way of approaching them. We speak of HIV and AIDS as a life threat not recognizing that because of developments in science and in medicine it is no longer necessarily a life threatening situation and a person with the disease can live a very good and full and rich life and if the modern medicine- the anti-retro virals are available that person can survive for an indefinite period we don't as yet know how long that future will be. So I think to watch our language and the way we speak of people who have the disease. We have a strong tendency to associate HIV/AIDS with moral fault, with sin. It is not sin, it is sickness and these are two very different things. Because of the history of the disease, the way it came on to the human scene, men having sex with men in the western part of the United States then its association further with heterosexual activity we have come to associate HIV very strongly with moral behaviour or with immoral behaviour - promiscuity. And this is adding fuel to the flames of stigma and discrimination. I think we have got to work hard to make sure that we do not associate HIV and AIDS with moral fault.

It was said earlier this morning that there was need to bring the churches on board in relation to much concerning this epidemic and this is one area where the churches can speak out and where they can give a real strong lead and you who are educators in schools can also give a very strong lead that this is not a sign **xxx xxxx (second tape)** to that and propogate that much more strongly. This does not mean that in individual cases they may not have activity which in certain circumstances we might characterize as undesirable but we cannot attribute promiscuity or immorality to others. I think we have to look at ourselves. And this

is another feature that we find in Africa and I think it is being found elsewhere in the world, there is a very strong tendency with HIV and AIDS to think of it as belonging out there, belonging to somebody else. It is a problem of the commercial sex workers, it is a problem of men who have sex with men, it is a problem of certain communities in the United States, it is a problem of the people of Africa, it is a problem of the poor, it is a problem of everybody else except me and we dissociate ourselves from it. And I don't think we have as yet a sufficiently strong understanding of why it is we are separating ourselves from the people who have HIV/Aids and regarding them as different kinds of human beings to what we are ourselves. I think there is very strong challenge here to higher education institutions in particular to investigate this. The Faculties of Social Sciences to try and get to the root of why it is that this is so strong to push this disease over onto other people and not recognize it as belonging to ourselves. Another area where I think they can do some excellent work and where it is needed is again relating to stigma and discrimination. Why is it that many people would prefer to face a lifetime of unbearable sickness and illness and possibly the potential death of their children rather than acknowledge that they have HIV? We see this terribly strong in Africa and I am sure you may be even seeing it here in Clinics – mothers who are HIV infected do not want to receive the treatment, which will prevent the transmission of the disease from themselves to their children, the **VIROPHENE** -which is very cheap and so very easily administered, because it involves them coming out into the open and acknowledging they are HIV positive. So once again, what is it in human nature that is causing us to say I would prefer to go through with the sickness and all that it entails and even the risk of of that of my child rather than acknowledging that I have HIV? I think we have got some very fundamental things here in our human psychology that we have to face. The disease is causing us to raise these problems and it is university communities and higher education communities that face these.

Turning now to another issue that was raised in questions this morning, the question of preventative education and ultimately the question of condom and condom use. Many of you here know that I am a Catholic Priest. I am a Jesuit priest and a practicing one not a former one. And it is the support of my life that I am so. I could not do the work I am doing if I did not have the support I derive from my Christian Catholic faith and my catholic Priesthood. As a Catholic Priest I join thousands and hundred of thousands of other Catholic priestly colleagues and specialists in the world in saying we see no problem whatever in advocating condom use. We see no problem whatever in it. We have a number of moral principles which go back centuries to the time of St. Thomas Aquinas. Those of you who may know anything about church history will know he was about the 15<sup>th</sup> century and we go back that far with these principles and these principles accommodate the use of condoms. And as recently as of November last year, the Bishops the hierarchy in Chad, just South of the Sahara, they issued a pastoral statement and in it they were considering a husband and wife and one of them is HIV positive and asked whether it is lawful for us to tell them that they should abstain from sexual activity because of the infection of one of the partners. They said **No it is not lawful** – we have no right to interfere in that marriage - in that union. If they want to demonstrate their bonding together by sexual activity at a time when one is infected they probably need the emotional support that they get from one another more than at any other time in their lives, and they said that in such circumstances if they feel that they should use a condom God will bless them. There is no problem about it and the principle, I am not going into details of it but if you want to look it up in books or go to a nearby Seminaries to ask about it, ask something about the principles of ‘double effect’ – and that principle which has been there for centuries accommodates that. If they are not married which is a different situation the church does not legislate for people who are not married to have sex, it isn’t the church’s role. The church legislate for people who are married if they legislate for unmarried people then the church is telling them to do wrong in its own eyes but there is another principle and a very simple one, the principle of the lesser of two evils.



If an individual is intent upon doing something that one regards as objectively or morally inappropriate or wrong, in fact it is perfectly lawful and in fact it is the correct thing to do to try to influence that person so that an additional evil will not be added. If a person says I am going out and going out to crush the first person I meet and swipe the wallet and I may kill the person then it is lawful for you - in fact it is your duty to suggest to him that he gets the wallet without doing damage to the person. That is the lesser of two evils. This young man is going out and you know he is going to have sex and he's not married and he has HIV or he could have HIV you must tell him to wear a condom otherwise you are doing the two evils:

- 1] having sex outside of marriage and
- 2] potentially transmitting HIV.

And the basic commandment which underlies all of the precepts that we have is 'thou shalt not kill' or the Christian way of that, "I have come that they may have life and have it to the full." And in the era of HIV/AIDS, protecting life to the full is the availability and legitimacy of condom use in certain circumstances. Professor Nettleford said this morning that the Vatican had issued a condemnation of the condom, he is a wonderful authority, the icon of the Caribbean, but I am not aware of any Vatican statement condemning the condom. The condom is morally evil, the Zambian Bishop said that just this time last year. Frankly I never heard such rubbish. The glass is morally evil because I can use it to get drunk. Could you support such a statement? I don't think you could. Could you support a statement that a piece of latex is morally evil? You can't. It is we who are moral not the latex. It is the use that is made of it. The Bishops are slowly, slowly coming around to recognising the reality of the situation. And that situation was formulated for us about forty years ago, and when I say us you will excuse me some of you - us as Catholics. About forty years ago in the Vatican Council, they laid down the supremacy of the conscience of the individual. The individual must decide ultimately what is right and what is wrong for that person

in these circumstances. And this is only an application of that. So the condom question as a moral question is not one that causes much problem to those who are thinking about it but unfortunately it has drawn a huge amount of discussion, and of debate and we are in a war with HIV and AIDS but we are fighting on the edge. We are only fighting a little battle out there over this condom use instead of fighting the real battle of helping people to prevent the spread of the disease to bring a better future to humanity. So I think we have got to be careful not to go too far.

The final thing about the condom on a more practical and evidence based information, the country which has shown the best success in reversing HIV/AIDS is Uganda. The prevalence fell from 16-17% about a decade ago to in and about 5%. Now the investigations have been going on. What happened in Uganda? Why did it come down? They have finally come out with three answers and these are in order of importance:

- Be faithful and reduce the number of sex partners - this was the most important thing that happened in Uganda. That is substantial behaviour change. That is not behaviour change like wearing a condom which is like putting on a hat or wearing a tie. It is substantial.
- The second thing that was found in Uganda contributing to the decline of HIV was that young people was either postponing sexual activity by one, two or three years or again by having fewer sexual partners amongst themselves. They were going steady much more. That was the second feature.
- The third feature was the use of condoms but condom use could not have been a very large player in the Ugandan situation because a survey there just two years ago showed that only 8%, less than 10% of the people were using the condoms consistently and effectively and properly.

It is part of the answer but it is only one part of the answer. The really substantive answers are the answers of fidelity, mutual fidelity and abstinence and when

these are no longer possible the availability of condoms to provide some protection. These are not easy issues, I would imagine, for teachers to talk about in this part of the world, no more than it is easy for teachers in my part of the world. But they are important issues and I think we all need a great deal more education on these issues so that we can discuss them, so that we can be rational about them, and so that by offering young people high ideals. If we do not offer them the high idealsthey won't perform well - we know that from so many other spheres. We offer them the high ideals but we have back up services. Just as we send young people to be trained how to drive - they are learner drivers for a period and they are under trained - but there is the back up always of the safety belt. The safety belt does not make them good drivers. The condom does not make them good sexual partners. But it is a back up in case other things fail just as the seat belt is a back up in case other things fail. I think we have got to bear these things in mind and and see what we can do and how we can help our teachers to come to an understanding of this so that we can together work against this disease. Thank you very much, I apologise for the technology.

**Professor Theodore:**

Thank you very much Professor Kelly. Now we move straight into Dr. Schencker who will tell us about the Asian experiences.

**Dr. Schencker:**

Coming to talk to you from the land of the bible. I have been brought up, I have been raised in Jerusalem. It is always inspiring to listen to the wisdom of Fr. Kelly and to be enriched by his ideas and inspirations. We have started this session by a small story and part of the importance of working in Education in the Caribbean is matching culture and reality. I would also take the liberty to share with you a little story of the desert which is just around the corner of my own city Jerusalem which is the Jordanian desert. I will title it '**Defining Education**'. It talks about a bedouin and his son in the Jordanian desert. The sun is up in the sky and they are walking quietly with their camel, and as they strolled with the camel suddenly the son who was quite young asked his father, "Tell me my father, why is it that the sun rises in the east and sets down in the west?" Quietness. They go in the desert, the camel with them. Then the father says, "Well my son, I don't know." They go on more and more miles and then again the son asks his father, " Tell me my father, why is that our camel drinks so little water and can live with us in the desert for such lengthy periods?" Going within the desert, quietness. Then the father says, "Well my son, I don't know." Then they go on and there are several more questions like this. Then suddenly the son asks the father, " Does it disturb you that I am asking you all those questions?" And the father says, "Well my son, if you don't ask how would you know?" So defining education is part of our role and responsibility as educators.

As we go to talk about the HIV/AIDS epidemic in Asia, taking some lessons from that huge part of the world, I would like to share with you the fact that actually we are just like with Africa, just like with other parts of the world as well as the Caribbean the need to estimate and we are gaining more and more knowledge of the epidemic. And as you can see when we are talking about the Asian situation, 1.2 million people in East Asia and the Pacific, another 6 million in South and Southeast Asia. These are dramatic figures. While the prevalence rate of HIV in the Caribbean is second to Sub-Saharan Africa. Definitely in numbers, Africa

is number one in terms of the number of individuals affected and infected by the epidemic and Asia is second. The numbers are already incorrect , it was shown 42 million raised to 60 million. We are now talking about 62 million people in the world infected by the AIDS epidemic.

**What is happening in the Asia region, in Asia and the Pacific?** We have a total of around 2000 people who are dying daily from AIDS. Which means actually that you are coming close to 450,000 deaths per year in that region alone. Every day there are close to 3,000 new infections with that adding to over one million infected with the virus in Asia and the Pacific every year. Fifty percent of them are young people between the ages of 15 to 24. Fifty percent of them are women. The rise is not only rapid but it is actually predicted that it might outstrip Sub-Sahara and Africa in absolute numbers by the year 2010.

Some more figures, 7.2 million people were living with HIV/AIDS by the end of 2002. The number is coming close to 9 million. One million adults newly infected in 2002 and the number of children living with HIV/AIDS has been over 225,000 thousand. These are orphans, young people who have lost one or two parents to AIDS have been another important indicator to us to understand where this epidemic is driving without the safety belt and how and where should our resources be put in terms of reversing its effect on societies and communities as we have heard some of the economic implications just before hand.

What is very disturbing of course in Asia as it is in Africa is the number of individuals who have access to the available drugs that can either prevent infections from mothers to newborns or prolong the life of those already affected with HIV. If we look at the situation of Asia and the Pacific in 1986 and compare it to 2002. You can see what happened in India, Thailand, Nepal and in other countries in Asia where we are seeing a prevalence rate of over 2%, 3% in infection. When we are looking at the young adults population which is an

important population definitely to all of us being in the area of education and HIV/AIDS. Some examples from countries in Asia. The prevalence rate is a good estimate for us to see where is the impact on a national level. In Cambodia 2.77, in Myanmar 1.99, in Thailand 1.85, in India 0.75% (coming soon to be 1%), in Malaysia a huge muslim country 0.36%, in Vietnam 0.29% and China 0.1%. There is a lot of under reporting which influences our estimation and our ability to the concrete and real picture of HIV anywhere around the world.

We have heard the figures for the Caribbean and you probably know that there are UN Agencies which consider the Caribbean figures to also represent estimated figures. In Asia being a huge continent this is even more disturbing. The issue of women among the infected is an important issue not only because of the role that women play in education all over the world but also in the fact through their being infected and being fertile and delivering they are also bringing to the world new people, young ones who are infected with the virus, their newborns.

In Cambodian women represent 46.3% of the infected,

- in Indonesia 22.5%,
- in Lao PDR 26.9%,
- in Thailand 33.8%,
- in Viet Nam 26.9%,
- in Philippines 26.6% and
- in China 25.9%.

This is all rapidly increasing and changing.

The estimated number of children orphaned by HIV/AIDS and I have already stressed the importance of orphans.

- Thailand 290,000
- China 76,000
- Cambodia 55,000

- Malaysia 24,000
- Vietnam 22,000
- Indonesia 18,000

These are children who are orphaned by the disease.

I talked until now about East Asia and coming from the western part of Asia which is called the Middle East. I will like to share with you something from a more developed country Israel and to show you how the epidemic was still being, in one of the countries that has enjoyed "a very low prevalence rate of HIV", is seeing also the effects on one hand of an increase in the epidemic through the years up until the point where the anti-retro-viral drugs have been introduced and that is the shift that you can see and that is just one example of many around the world where the access to drugs is free, available and comprehensive to one hundred percent of the affected and the infected people with AIDS. From 1996 downwards we are seeing the reduction in the number of Aids cases.

This table/figure shows us the AIDS cases not HIV infected. When we are talking about the reduction in aids cases it just means that the anti-retro-viral drugs work fine and they prolong the state of being HIV infected. But there is another issue which is represented in the next light and that is that there are parallel epidemics in Asia and as well as Eastern European countries and these are the epidemics of STIs - Sexually Transmitted Infections. Syphilis, Gonorrhoea, Chlamydia are all transmitted sexually and we know that in many countries when you are looking at the STI epidemic situation you have a very good understanding of what is going to happen just thereafter. Because when there is a rapid increase in STI as we are seeing now in Israel for example after many years of actually a very low prevalence rate of syphilis primary syphilis in this case you can already see the propagation of heterosexual and homosexuals intercourse contributing to the spread of STI and thereafter to HIV.



A few more insights into research of a group I was leading on the risk-taking behaviour of adolescence. One of the issues which I hope can be taken by the Universities involved in this day and in other initiatives in the region should be in looking more precisely at the behaviours of young people. Not only their knowledge, not only their attitude and values but also their actual behaviour when it has to do with indicators for HIV/AIDS infection. And also a way to determine our effectiveness in changing their behaviour which will lead to less infections in the future.

The Israeli study has shown actually that boys and girls in Israel do have sex although they are Jewish. They are having sex at a rate that is very much similar to that shown in other countries, in other societies and other cultures. When we are comparing 9<sup>th</sup> graders, 10<sup>th</sup> graders and 11<sup>th</sup> graders we see that in the upper strata of high schools, kids at the age of 17-18 just before they are engaged in Army service which is compulsory in Israel. You see that the boys are having sex, or at least reporting that they are having sex much more than the girls. There is a question of reliability of this data when you use self-administered questionnaires. I am told that there are a very good set of methodological ways to overcome the issue of reliability. Even if we down-size this by a percentage we are still seeing quite a phenomena of engagement in homosexual and heterosexual sex. The rate of 21.7% is representing out of the national sample the self-reporting of having at least one intercourse. Kids in this sample, 21.7% were reporting having had at least one sexual intercourse with at least one partner. It is less disturbing perhaps if we listen to Professor Kelly's remarks. If it was with one steady partner over a long period of time. It is true from the answers to the questions that you see in front of you that most of those who had a sexual intercourse had it with a friend. A boyfriend or a girlfriend most of them their own age or or a year or two older. We are not talking about the sugar daddy situation where a friend is considered or a friend is defined somewhat differently. In this particular study a friend is considered to be a boyfriend or girlfriend which will be a maximum of two years older mostly girls having two years older

boyfriends. But what is quite disturbing is the two very last figures , the fact that 16.7% of those who have reported having sex had it with many partners, casual contacts, one night stands, going to a party, not drinking too much, having some drinks and going out and having sex. Again it is a relatively small number, it is only part of the one-fifth, part of the 21.7% of the total population and the fact that there are several friends needs even more investigation as we have learnt that having the definition of having several friends does not mean having serial monogamous relationships but is actually the value that is to be questioned is the sincerity, intimacy and loyalty to a friend because we do see the phenomena in which you are having parallel relationships which translate themselves also to sex.

Coming back to the broader Asian region perspectives for the future, by 2010 we are expecting that the world will see 45.4. million new infections with 18.5 million accounted for by Asia. We are also expecting that the infections as you can see will be in Asia 12.8 million which represents actually 69% of the projection of infections which is showing actually what we can see in this slide the cycle of the influences of the infection of HIV/AIDS and education which is in a very spiral way affecting both an enlarge number of people infected and all the consequences the economic ones, the ones that relate to the men and other means of effect on the education sectors.

### **How HIV/AIDS affects the Asian education sector?**

There is already an effect on the education sector in Asia we see:

- radical changes in demography,
- decrease demand,
- affect teachers,
- great increase in numbers of orphans,
- reduce budget resources,
- require policy changes.

This all is not at the beginning but different states in different parts of Asia, different countries and these are processes that are ongoing. Is it that bad? Yes. But is there hope? Yes as well. We could see in several countries on the Asian continent such as Thailand, Cambodia even a parts of India and others whereby there are good regional examples that the HIV/AIDS epidemic could be curbed by strong public campaigns which focus also on education.

Thailand for example has been seen as one of the key countries to draw attention to, in terms of success story, in its ability to control the epidemic. If we look at the situation of HIV about a decade ago comparing two countries Thailand and South African. How they started off in 1990 -1991 and this is the present situation of Thailand and South Africa. How come has Thailand been able to control the epidemic? Why is it that South Africa sees a dramatic situation? An answer coming soon. We do see in Asia good examples to policy and leadership. We have examples of well-grounded training, thoughtful ways to address cultural and societal as well as religious issues in addressing the training and the capacity building of both healthcare workers, individuals in the education sector, in groups like NGOs and others that are involved. You very well know the Kamasutra, well it's an Indian originating way of teaching us something about sexuality. What you see here is a postcard which is bilingual, a Hebrew/English one, and I read to you the English because it might not be too clear which has actually been a very well-received postcard by Israeli adolescents. The reason being that on one hand it shows the sexual organs through the Kamasutra pictures so it touches on some of the issues in training them that are interesting, sexy etc. The message is perhaps the important thing, that is the way to present a message which is contradicting some of the essence of Kamasutra. It reads, "The kamasutra prescription to avoid AIDS: many postures with one, better than one posture with many." And in that sense we are coming back to the B and perhaps the ability to control

NGO collaboration. The Phillipines has shown one excellent example to how the NGO community can be strongly involved in both addressing particular issues in AIDS prevention with subgroups which are practising risky behaviour, the sex worker, immigrants, and others as well as participation in a more global effort. Phillipines has been one of the first countries in Asia to introduce health and family education with a strong component of HIV /AIDS in the school system. It is well regulated by the Ministry of Education and in all schools there are programmes addressing HIV/AIDS.

Up-to-date with prevention. You see here the introduction of the female condom into the training of young teachers. This is not the only technology that needs to be acknowledged, promoted and perhaps looked at but there are more simple technologies that also need to be addressed. The idea here is that training cannot be a one time shot. In Asia we are seeing the ability of the education sector, together with the health sector in many countries to facilitate updates on HIV/Aids and prevention technologies. Working with religious leaders it is enough to look at the eyes of a lady and gentleman to understand that as we have heard before there are a few conflicts. But definitely we see from the example again of Thailand, where the religious leaders -the Thai Monks - have been taken on board their responsibility, their religious responsibility. Translating it into a very powerful weapon within the global fight against HIV Aids in Thailand. The idea of packaging innovative materials to be easy to use is another concept that we can draw from the examples in Asia as well as East and Southeast Asia. Not one time posters or postcards but packaging the comprehensive packages and the essence of easy to use is important. because we are dealing with teachers who are overwhelmed with other issues of work.

I promised an answer to the differentiation between South Africa and Thailand just one example. But I think that this can be summarized in the following manner. A strong political leadership and a commitment, for example in Thailand it is the Prime Minister who heads the National Aids committee which is the key

to success. I was not here but was very happy to hear the strong words of the Prime Minister of this country and the efforts of the leadership in the Caribbean through CARICOM and other leaders to really initiate the development of a comprehensive policy and leadership in this direction. Openness is very important in the open discussion. The absence of denial, admitting to the fact that there is a dreadful disease around us, within us, and we need to work and fight it. Targeting high risk groups, or groups who are practising high risk behavior, sex workers or in Africa, truckers and in Asia also migrants. Adequate public health provision, a consistent set of non-conflicting messages is very important. In Asia it works when the messages are very consistent coming from civil society from religious leaders, traditional leaders and others. Of course AIDS prevention integrated into school education. When integrated it works and it works fine.

I am sure you all are familiar with “**education for all**”. I am using a paraphrase developed by Professor Kelly who is here with us which is using the words 'education for all' to indicate to us how powerful a weapon it is against HIV AIDS. And at the same time knowing and realizing that HIV/AIDS is a very powerful weapon also for education for all. Very true for Asia as well. The number of children who are able to enter schools, young girls in terms of entering schools is a problem in Asia. One of the efforts of our 'education for all' movement is to really to increase the participation of children again mostly young women in the school .So schools are the focus to stop AIDS in schools is not a paraphrase it is perhaps a goal or an immediate objective and target but it is a shared responsibility. I am coming to my very last slide.

We have seen the United Nations AIDS is just representing the Global joint program of the U.N. which represents to us now ten (10) agencies of the UN that have come together under the wings of UN AIDS as a collating body to really sent forward normative and advocacy roles and fund raising at the Global level. But also the national and local levels of governments that must take a share in the responsibility of combating HIV/AIDS and developing services and delivering

them in an appropriate way. We cannot leave out the parents and the home environment being the key factor when we are talking about influence on the young population and developing partnerships with others in the community to facilitate better education for kids. So these are united efforts that may stop the further spread of HIV and AIDS.

In concluding I would like to remind you that you can choose any condom that would suit your characteristics if you are able to read the small titles. I was listening carefully to the suggestion to add a person living with HIV/AIDS to our credentials qualifications and I think this is true but I listened to a passive voice in the words a person living with HIV/AIDS - PLFA. I would like to see some pro action in that and would recommend to all of us to add a letter F. PLFA – People Living and Fighting Aids. Thank you.

**Professor Theodore:**

Thank you very much Dr. Schencker and I think you will agree me that we have had some interesting presentations. We have fifteen minutes for questions.

**Ronny Young UWI - Mona:**

Talking about the use of anti-retro-viral and all of that and reducing the incidence of AIDS but of course increasing the number of persons living with HIV - the number of HIV positive persons in society. One of the questions which obviously must emerge is the question of how infective are the persons who are living with HIV but not developing AIDS. And of course the consequences that could arise from that.

**Dr. Schencker:**

I am having to answer that not being a Physician but a Public Health expert and say that the **xx 44 17** of the virus in people who are receiving the HEART - Highly Effective Anti -Retrol Therapy is very low. Actually one of the aims and success stories of HEART is to reduce the **xx** of the virus in the blood to an undetectable state. That does not mean that there is no virus, that we are cured from the virus. Not at all. But it means that there are very few viruses in comparison to those who are not receiving the treatment. We know that the lower the number of viruses per micromillilitre of blood there are, the less infectious you could be to others. And this is the normal development of the disease, actually not many people know that you can't even if you are HIV infected that you cannot be as effective in infecting others throughout the whole period of your being HIV infected. It is actually two very specific periods of your life. The initial months of your being infected and its at the very end of your life when the virus has already been making the immune system become a factory for reproducing massive amounts of viruses. The HEART treatment on one hand reduces the **XX(titer)** but it is an important issue relating to the fact that we have many more people who are infected living amount us to get the HEART treatment you must be

constantly engaged with a medical facility. It is not that you are sent the drugs or that you are getting a package of drugs for five years. This constant on-going process of being engaged and treated in a medical facility also facilitates education through the meeting with those Doctors and Nurses who are taking good care of you as a patient. They are also communicating to you, I hope, that is at least what we are training when we are training Health Care Professionals, to work with the patients to also provide the on-going education and ensuring that the patients are aware of the fact that they are feeling good, they are smiling, they have a fine way of living, but they are still having in their blood a deadly virus.

**Lee Gaxxx -President of University of Aruba:**

I was very much interested in the examples that you gave in Thailand, how they manage to have a decline in the cases of AIDS. Especially the strategy that they used to get youngsters to be more engaged in having only one partner. I would ask you if it is possible for you could tell us a little bit more about that especially taking into the fact of peer pressure, the insecurity of youngsters at that age. How did they manage to have that success?

**Dr. Schencker:**

I would be very happy to provide any references and further researches we are on a three man's panel but very briefly I think the success story of Thailand has to do with the fact that:

1. very early in the epidemic there was a recognition that HIV is a problem for Thailand on all sectors of the society,
2. second the fact that while there is peer pressure and there are always temptations to being engaged in highly sexual activity. There was definitely a workplan that try to first to do a Needs Assessment and address the messages to young people in Thailand. Not coming in a patronizing way but in a way that would be matching the culture, not being too far away from the normal life of young people, and



3. Thirdly, it is just action, action, action. Meaning training of teachers, making sure that there is policy on all levels and a multi-sectoral approach, it is not a slogan, it is a reality in many countries.

And also engaging very quickly and that was heavily supported by International Funding in Research into not only the risk-taking of adolescence but also the effectiveness of programmes so one can document. What I want to say is that in other countries perhaps there are similar success stories but they are more in the shadow because they are less coming forward with data as there are limited funds for that.

**Professor Kelly:**

If I could also just add also to what Dr. Schencker has just said. As educators I think we have to recognize that we are part of the society and if the same message that we are giving through education is given through other organs of society, through the media in particular, what we are doing in education is in many ways is making it possible for young people to hear, I mean really to hear and to evaluate the messages that are coming from other parts and to make these their own. So if there are a consistent set of messages coming I think that is also very important. And we contribute to that.

**St. Axxx - Curriculum Division, Ministry of Education:**

Just an observation and a soft question. In terms of the data that was presented about Asia it was clear that Thailand was way ahead of the league in the Asian region and given the cultural similarities it is a little bit baffling that why certain regions always seem to be ahead of the rest of the few.

The soft question is that when it comes to Africa, when we talk about AIDS in the context of Africa because we make the general distinction in terms of you know Sub-Sahara and South Africa as against you know Upper Sahara and Africa. Sub-Sahara and South Africa is a huge region, is it possible for us to get some

idea as to whether there are concentrations of the AIDS epidemic even within Sub-Sahara and Africa and why are those concentrations possible?

**Professor Kelly:**

Yes, there are undoubtedly areas of concentrations. The epidemic is at its worst in eastern and southern Africa working your way from Ethiopia right down to South Africa. There is a big swerve there and the worst affected countries in the world are there Botswana, Swaziland, South Africa itself, Namibia, Zimbabwe, Zambia and then there is some also in western Africa. Why is there so much and why is it happening? This is something we continually ask ourselves. We are not satisfied that it is all due to sexual activity. In fact we quite certain that it cannot all be from sexual activity. There is something more at work. A century and a quarter ago Louis Pasteur the great scientist said, "The virus is nothing, the terrain is everything." The HIV virus needs a fertile terrain in which it is to propagate, in which it is to be distributed. And that terrain is facilitated by malnutrition, by a load of parasites particularly the malarial parasites and other parasites that are in the body, by micronutrient deficiencies and other health problems as well as by untreated sexually transmitted infections. That is likely one strong contributor effect. The biologist are not prepared to say without qualification that the virus is more virulent in eastern and southern Africa but it would appear to be. It is a different strain than is found in some other parts and it seems to transmit much more easily and readily than in other parts.

In recent years, in the last eighteen months really, there has been a good deal of attention paid to undesirable or unprofessional medical practices not so much by doctors themselves but by paramedics by clinics reusing syringes and reusing needles and thereby potentially transmitting the disease. While the World Health Organization said that the figures produced by the University of Harvard suggesting that this accounted for about 60% of the transmission - that these figures were too high. **AIDS** as itself to be revised upwards its estimate of the

influence of this on transmission in Africa and it appears to be much more considerable than we thought possible in the past.

There are other things that I don't think have been considered adequately yet, one is genetic influence. I think is something that has got to be faced. There is evidence in Nairobi, that there are a certain set of women there, they are mostly from the commercial sex work community who appear to be incapable of being infected with the virus. They are protected, whether it is genetic protection or not I don't think people are quite sure yet. But there is some evidence being brought forward in some investigation in that there is a genetic element and I don't think that this is being faced up to. Yet it is a very risky one as you can appreciate - one fraught with a great deal of danger that it will be label as racist even though it doesn't have to refer just to one race. I think this is an issue that science has got to confront and deal with. In other words, I don't think we have the full answer to why we have so much HIV/AIDS in certain parts of Africa.

**Ms. George - University of Technology, Jamaica:**

I just wondered, one of the successes that is pointed to in Africa is Uganda. Having been in that part of the world when Uganda was considered to be the place most at threat of HIV/AIDS, I wonder if you could talk about the role of NGOs and young people who were infected with HIV in reducing and turning the figures around in Uganda.

**Professor Kelly:**

Well I think apart from the practices that I mentioned when speaking of the "**BAC**" - **be faithful, abstain and condomize**. The success really of Uganda I think was the openness that was brought into the whole issue by the leadership in the country and the united front that was displayed. Everybody was prepared to speak about it and to present the same consistent message. As Dr. Camara said this morning if they could not promote the condom message they would speak about the abstinence and fidelity message but would not undermine the

condom message. Likewise those who promote the condom message would not undermine the others saying these are unrealistic or impossible ways of going about it. There was a unified and consistent message and it was coming on all fronts. This made it easier for people who had AIDS to come out into the open. There is still stigma and discrimination in Uganda. Only last week I heard of a teacher who had been told by her headmistress that she is not to teach anymore because the headmistress had learnt that she was HIV positive. That's against the law but as we know laws are made and they sometimes sit in centres and they don't get worked out in village schools. But the people living with AIDS were able to play a very strong role in this and they were able to give the message and that message was of very great importance in making people much more comfortable with the disease and able to deal with it.

The NGOs were the people who actually did the work with the people at the ground level. The number of NGOs in Uganda has proliferated at an enormous rate. One of them **TASO - The AIDS Support Organization of Uganda** has given a model for many parts of the world how to deal with this problem and its issues and also the home-based care programmes that were developed in Uganda. These have come out very, very strongly and the Youth Alive programmes where young people were communicating with one another about the disease and were speaking frankly and freely through a great deal of peer education and were presenting peer models from the media - **XXXX Utier** - one of the great singers of Uganda, he came out openly about his status and this was a very powerful thing. So there was a whole combination of work there on the part of civil society, working with national society, and working with religious society both the christian and the muslim faiths were all together unanimous in the message that they were giving and all of this helped. Education itself was not shown to play any direct role but it played the indirect role of making it possible for young people to accept the messages that were communicated.

Thank you.

**XXXX:**

I just really needed a clarification. Did I hear you say that some women in Nairobi seem to be immuned to getting the infection?

**Professor Kelly:**

Yes, there are a number of commercial sex workers in Nairobi and the experience is that no matter what their contacts with the disease they don't become infected and it is from the tissue of some of these women that they are collaborating in research with The University of Nairobi and Oxford University for the development of a vaccine.

**XXXX:**

So this means that they are not affected at all. Is it a situation like typhoid where they are infected and they are passing it on? But they don't get the disease.

**Professor Kelly:**

I don't think it is quite well known. One thing I have heard but I have not seen this well documented is that if these women cease sexual activity and subsequently resume it then they are at risk. The safest thing for them is to continue. As I say I haven't seen this confirmed.

## **CLOSING REMARKS**

**Dr. Schencker:**

In perhaps giving a closing remark, I will add another piece of information which is relatively recent as to what protects the human being from being infected sexually. And that is actually circumcision, when you were asking before about African regions that have more of a concentration of HIV infected individuals than others it has been documented that male circumcision is a protecting factor of HIV infection. More than several studies that have been very well controlled, methodologically perfect or close to perfect, have been shown that in those

African communities where by tradition there has been an on-going for lots of decades - a practice of male circumcision they have been more protected from HIV infection than others who have not practiced male circumcision and who are living in the very same vicinity as these tribes.

**Dr. Roger Maclean:**

Taking a different spin and putting the discussion within the Caribbean context, there has been a well-coordinated regional response to the epidemic. We have had a fair amount of success of course manifested by the success we have had in the global fund. There is a regional strategic framework and a number of the key institutions including the University of the West Indies, we have also been responding. There is an HIV/AIDS response programme that you should know of. I say all of this to simply to bring to the table as we formulate our response within our respective sectors/organizations we need to understand it has to be brought and kept within the larger planning framework so that we can as we move forward in responding to this epidemic have a coordinated effort that can be monitored and evaluated over a period of time. We are not going to get up tomorrow and realize that our incidence and prevalence rates have fallen. But if we continue to put systems in place whereby we can track our progression, learn from the lessons of others, share the experiences as we move forward, share the experiences of other countries. I think we have a possibility to turn what is in fact a vulnerability based on size a quick and efficient response to the very factors that are driving the epidemic in our region.

**Professor Kelly:**

I like to speak to the educators amongst us here and to recommend to them the four strategies that UNESCO has put forward in its report on education for the 21<sup>st</sup> century. That we should try to organize our educational programmes around four pillars of learning:

1. Learning to know,
2. Learning to be,

3. Learning to live with one another, and
4. Learning to do.

Learning to know - young people need the knowledge and a great deal of knowledge in a whole lot of areas. So that is one aspect.

Learning to do - as Dr. Camara rightly emphasize this morning they need skills and to give them help them to develop the life skills and the physical skills such a skill in condom use. Learning to do we have to do that.

Learning to live together. To live together as citizens of the communities but in respect for one another so that there is no stigma no discrimination on any ground whatsoever.

And finally learning to be - that they are able to learn how to develop themselves fully as human beings who have life affirming attitudes and who will live according to those attitudes and values and therefore adopt appropriate behaviour.

**Professor Theodore:**

Thank you very much we were certainly enriched by their presentations.

**Professor Kochar:**

On behalf of all of us who are gathered here I want to thank the presenters for their excellent presentations that they have made. I want to take this opportunity also to recognize the presence of one of our educators from the school system in Trinidad. I really pleased as to the number of persons who have in fact responded to our invitation to come and attend the conference. These are the people from the Ministry of Education. I want to specially welcome them to our conference. I also want to now thank everybody for this morning's session and we look forward to the continuation of this series this afternoon.

## Country Reports

### **Mrs. Merle Ali -**

Representatives of UNICA, UWI, UNESCO, distinguished guests and fellow workers in the fight against AIDS. Good afternoon. It is indeed an honour to share on this important topic of religious and ethical issues in HIV/AIDS education. I will start by quoting a section of the report or statement by the Faith based Association facilitated by the World Council of Churches dated February 2001. It says, " After many years of watching the AIDS pandemic evolve all around the world we need a radical rethinking of the ways and how we respond to this crisis. Experience has shown that countries such as Senegal and Uganda which have courageously restructured their AIDS policy by bringing the Faith based Organizations - FBO - to the table of planning and implementing national strategy have seen dramatic changes in the course of the epidemic." The report reflected further, "From the beginning of the HIV crisis, local communities out of sheer necessity have been at the forefront of caring for those affected by the disease. Faith based Organizations are among the most important structures at the community level but unfortunately they are often overlooked when it comes to mobilizing communities to respond to the major problems such as HIV and AIDS. The capacity has remained largely untapped and underutilized because Faith based Organizations have not received either adequate levels of training or the resources needed to maximize their potential capacity to address the impact of the disease."

Considering that over 80% of the world's population can identify itself with a religious community the impact and influence of Faith based Organizations is critical to stemming the tide of the AIDS crisis. AIDS is largely a behavioural problem that requires a behavioural solution. A disease which was initially associated with a certain kind of lifestyle such as homosexuality, promiscuity and even God's judgement has now crossed every social, ethic and religious barrier.



It has become our problem. Our lives have been touched by AIDS in one way or another. So what are some of the problems among the religious communities.

The first one I will like to identify is denial. Believing that it will go away, that it is not so bad after all. Or that it does not happen among our religious group of people. Others are ignorant of the facts and underestimating the seriousness of the problem. Still there are those who hold to the believe that it is God's judgement or punishment for deeds done while others remain complacent of the reality that we are in a battle of which we all have a part.

Discrimination. We have heard a lot about discrimination this morning. It has been the theme for the past year, Discrimination and Stigma - but how guilty are we as religious organizations of the way we treat people? How do we really admit them into our fellowship or into our belief system? And how often do I hear of individuals who have been stripped of their responsibilities so say if they were actively involved in the children ministry or in hospitality or in doing special things such as home visitations it is amazing how the tables turn and an attitude of a difference is shown that is not in keeping with our religious beliefs. But we are still guilty of it.

The language we use - Dr. Kelly mentioned this. The language we use can really turn people off. In the way we deliver our messages, in the way we talk, instead of attracting those that we want to win and to help we turn them off by the words and the tone in which we say those words. However as we look at Faith-based Organizations historically we see that these organizations have engaged in values and practices that promote health and wellness. Following these teachings will help people from becoming infected and in controlling the spread of the infection and provide care and support for those infected. Seeing that AIDS is a behavioural problem, the values taught are to guide individuals to make right choices to live a life governed by moral and spiritual principles. The principle of what you sow you reap becomes evident. Some of the glaring messages or the

strong messages that religious organizations send out are - one is the message of abstinence. A very controversial issue in the minds of a lot of educators. The sexual practices before marriage. Also faithfulness within the marriage relationship, faithful to one partner - the marriage partner. These are forceful messages that are sent but there is much debate - there is much controversy. Again I would reflect on what Dr. Camara said, "We concentrate on the A and B and you concentrate on the C." And once we get that straight we can see how much as we join forces that we can really fight this battle.

Another area Faith-based organizations are so involved in is caring for the sick and dying. All part of any organization, we are generally the first to response to the basic needs of people affected by the disease. We also see that many seek pastoral care, pastoral counsel in helping to deal with their cares and problems in areas of bereavement and other needs that are so wide a range.

Now let us look at some of the research that has been done among Faith-based Organizations to validate the message of the effectiveness of FBOs. I will refer to three ares. The first one was done in 2000 by Dr. Brader Brathwaite - she is here with us. She conducted a study among FBOs right here in Trinidad and Tobago. These involved the major religions of Christianity, Hinduism and the Muslim religion. There were 26 denominations represented. All groups upheld the teaching and practice of chastity before marriage and fidelity within the marriage relationship which I thought was very interesting that all the religions share this common belief. Some of the religions had policies regarding HIV/AIDS while others are in the formation or others did not have and some believed that this was already enshrined in their holy books.

The Presbyterian church of East Africa spearheaded an HIV/AIDS Intervention from religious groups in Kenya. They supported the Health Board Policy to provide accurate information on HIV and AIDS. They trained the local community education officers to teach and assist local people in speaking about issues on

AIDS. In the congregation AIDS was discussed openly and AIDS education was incorporated in the curriculum of these religious sponsored schools.

Other case. Uganda which we have heard so much about this morning in the presentations this morning. This is another country that is proving to the world that combined efforts of the government and the church yielded a significant reduction in the number of AIDS cases. In 1991 the prevalence rate was 21%, 2000 it was 6% and by 2002 it was 5%. The government's latest awareness campaign promotes the A, B, and C, D of HIV. A -abstain, B - change behaviour before we said be faithful but they have adapted that, C - use condoms or D - die. According to President Yoweri Museveni said, "We made it our highest priority to convince our people to return to their traditional values of chastity and faithfulness or, failing that use condoms. The alternative was decimation." US President George Bush in his recent visit to Uganda commended the President: "You have shown the world what is possible in terms of reducing infection."

Here in Trinidad and Tobago I speak of the evangelical churches that are involved in awareness programmes in the communities and in the schools. Youths are encouraged to use their talents and abilities in the form of drama, song and peer educators. The media -radio and television -are maximised. However because of the lack of finances there is generally a problem. The curriculum of Life at the Crossroads and Sex lies in the Truth are used in the schools when permission is given.

Now let us look at some of the support systems, the care and the consolation that is provided by Faith-based Organizations. They have a ready pool of resource persons with skills in lay counselling, teaching and support skills which can be used in responding to the challenges posed by HIV and AIDS. Voluntary assistance is generally readily available. There is a capacity to meet the spiritual, physical and emotional needs of the people. Many times this fountain of resources is overlooked. These resources are utilized in the following ways:

- We provide education and training in caring for persons.
- Being informed and sensitive to the needs of persons living with HIV/AIDS (PLWHA).
- Understanding that it is not just the person who is infected that is involved but it is an entire family.
- Expressing compassion and Jesus showed that in his example. He was not afraid to touch anyone even when the leper came to him seeking help. He physically touched him and that is an example for us to follow that we should not be afraid to physically touch and embrace those who are infected.
- Being able to be of emotional support as pastoral counsellors. allaying fears, dealing with loss, grief, guilt, shock, depression, denial, anxiety, and a whole long list, suicidal tendencies.
- Dealing with spiritual concerns & providing religious support as in the case of impending death, and coping with loneliness, guilt, forgiveness, a big area. How many people harbour unforgiveness because of the situation that they are in that is of being HIV positive and having AIDS. In the areas of reconciliation and acceptance, helping individuals to work through those issues, helping them to cope with illness – the physical, emotional, and psychological aspects, the disfigurement that is experienced and the feeling of isolation.
- In the social realm – we see the loss of income, the discrimination, social stigma, relationship changes and changing requirements for sexual expression.

These are all areas in which we become intimately involved in helping those in need. And we are also:

- Providing hope – giving reasons to live productively not only through lip service but in our actions and in our attitudes. And in providing a hope beyond death.

Some of the major ethical issue that we face are:

- Stigma & Discrimination. We as individuals have to confront our own biases. How do we treat those who are infected?
- The area of confidentiality. A big issue. Many people will not want to come to us because they are afraid of having their secret being divulged to others but then there are also ethical issues with the counsellor - how much of a secret do you hold? Do you reveal the result of a husband who may confide in the Pastor and say, "I am HIV positive, I have AIDS but I don't want my wife to know." The teenage who comes for counselling and he does not want his parents to know. In the area of confidentiality there are many issues to be worked out.
- The area of denial and judgment. That it is not our problem. It is not God's punishment and it is His judgment those are issues that we have to work through.
- Another big one is condom distribution. I know we are up in arms and say that it must not be done but the aspect of distributing condoms to minors without parental consent or without consultation with the schools that pose a problem too.

And I would say as I conclude that Faith-based Organizations with their already captive audience are major influences in changing behaviour in a positive way. Taping into this resource can produce results as seen in Uganda. The message of the President of Uganda emphasizes the return of the traditional values of chastity and faithfulness in a marriage relationship and these are proving to be life-saving. They are tested and proven and are workable solutions. Intentionally including Faith-based Organizations in the system at all levels, from government to community can yield positive results in the war against AIDS. Our combined resources can be maximised in saving lives and providing hope. For too long we have remained at number two position here in the Caribbean statistics. Together we can make a difference.

Thank you.

## RELIGIOUS & ETHICAL ISSUES IN HIV/AIDS EDUCATION

### 1. Overview

- The AIDS problem is largely a behavioural problem that requires a behavioural solution.
- Initially HIV/AIDS was associated with a certain lifestyle – homosexuality, promiscuity, even God's judgment.
- Now we see that HIV/AIDS has crossed every social, ethnic and religious barrier and has become our problem
- Though some still live in denial believing that AIDS is not a problem among religious bodies, the reality is that AIDS is with us.
- The Church has a pivotal role in the prevention of HIV infection and support for infected persons.

### 2. Influence of Faith Based Organizations

- a. Reference to the research done in 2000 by Dr. Brader Braithwaite on Faith Based Organizations in T&T. These involved the major religions – Christianity, Hinduism and Moslem - 26 denominations altogether. All groups upheld the teaching and practice of chastity before marriage and fidelity within the marriage relationship  
Some of the organizations have policies regarding HIV/AIDS while others do not. Some believe that these are already enshrined in their Holy books.
- b. The Presbyterian Church of East Africa (PCEA) spearheaded an HIV/AIDS intervention by religious groups in Kenya, supporting Health Board policy to provide accurate information on HIV/AIDS. They trained local community education officers to teach and assist local people in speaking about issues on AIDS. In congregations, AIDS was discussed openly and AIDS education was incorporated into the curriculum in the PCEA sponsored schools.
- c. In Uganda the combined efforts of the government and the Church yielded a significant reduction in the number of AIDS cases. In 1991 the prevalence rate was 21%, 2000 6% and 2002 5%. The government's latest awareness campaign promotes the A,B,C,D of HIV - ABSTAIN, change BEHAVIOUR, use CONDOMS or DIE. According to President Yoweri Museveni, "we made it our highest priority to convince our people to return to their traditional values of chastity and faithfulness or, failing that use condoms. The alternative was decimation." US President George Bush in his recent visit to Uganda commended the President: "You have shown the world what is possible in terms of reducing infection rates."

### 3. Resources Available

- Faith based organizations have a ready pool of resource persons with skills in lay counseling, teaching and support skills which can be used in responding to the challenges posed by HIV/AIDS
- Teachings which promote abstinence before marriage and faithfulness in the marriage relationship
- People access the faith based organizations for pastoral counseling and support
- Volunteers with a wide variety of training and skills.
- These organizations have a large, ready and captive audience with persuasive leaders who can influence behaviour and hence aid in preventing HIV infection, promoting HIV testing, supporting and caring for those who are infected and affected  
Ways these are accessed
  - a. Premarital counseling. This includes abstinence before marriage, fidelity in the marriage relationship, trust in each other, HIV testing, responsible behaviour for the HIV positive person.

- b. Being informed and sensitive to the needs of persons living with HIV/AIDS (PLWHA). Understand that not just an individual is affected but the family
- c. Being compassionate. e.g. Jesus' example of reaching out to all persons without discriminating
- d. Being able to allay fears, deal with loss, grief, guilt, shock, alienation, discrimination, depression, denial, anxiety, anger, loss of self-esteem, suicidal tendencies.
- e. Dealing with spiritual concerns & providing religious support – impending death, loneliness, guilt, forgiveness, reconciliation and acceptance
- f. Coping with illness – physical, emotional, and psychological.
- g. Responding to social issues – loss of income, discrimination, social stigma, relationship changes and changing requirements for sexual expression
- h. Providing hope – giving reasons to live productively not only through lip service but in actions and attitudes. Hope beyond death

### **ETHICAL ISSUES**

1. Stigma & Discrimination. How do we treat those who are infected? What is preached and taught must be acted out for the leaders and followers.
2. Denial and judgment. Accepting that HIV/AIDS is also a problem affecting the religious community. It is not God's judgment / punishment for sin.
3. Condom distribution to minors without parental consent. The notion that condoms offer protection, not considering other risk factors such as not being 100% safe, contracting other sexually transmitted infections (STIs), pregnancy, abortion.
4. Adults and educators who assume that "young people are going to have sex anyway" without empowering them with the information to choose abstinence.
5. Not giving the full picture on STIs, some of which are deadly such as Human Papilloma Virus (HPV), and focusing primarily on HIV/AIDS
6. The ability to live by the Golden Rule "*Do on to others as you would have them do to you.*" This involves treating others as you would like to be treated.

**Dr Macabe XXX The prevalence of HIV/AIDS in the Education sector in Jamaica:**

Good Afternoon. What I am about to present this afternoon represents work that is on-going and collaboration between Professor Wilma Bailey of the Department of Geography and myself in the Department of Community Health.

There have been reports coming out of Sub-Sahara and Africa and over the past three years there has been an acceleration of losses from the teaching profession due to HIV related deaths. In Kenya, mortality tripled in four years, in South Africa one in eight teachers were reported to be HIV positive, in the Central African Republic there were reports that schools were being shut down because of teacher deaths due to AIDS, and BBC World predicted that one in seven in Malawi were expected to die in the year 2002. For the Caribbean there were projections that by 2010 more than 3000 teachers would be infected with HIV. And therefore we were asked to look at the issue: **Is HIV affecting the education sector in Jamaica?**

The approach we took was to look at supply and demand issues:

- On the supply side the hypothesis was: Since HIV is the leading cause of premature death in the reproductive age group and because the education sector employs many persons in this age group, the education sector could be losing teachers to the epidemic.
- On the demand side two converging forces were in operation. Lifestyle changes such as increased condom use could reduce fertility while growing numbers of mother to child transmission could increase child mortality and could together reduce the number of children seeking an education.

On the supply side we had access to a database of registered and unregistered deaths for the years 1998 and 1996 and this included information on the decedents occupation. For the deaths due to HIV we compared those with



information from the Ministry of Health HIV Surveillance Unit and whether or not they were aware of all of these deaths. We went to the Ministry of Education to find out about deaths among teachers.

On the demand side we are looking at secondary data to see if there was any indication from information available whether or there were changes in fertility behaviour. Were more women reporting planned pregnancies? Was there any change in the general fertility rate? In terms of the mortality we looked at the pediatric deaths and what was the contribution of HIV to deaths in these age groups.

For the database on the deaths it used a multi-source methodology to identify all deaths in the two year period. We looked at data from the Registrar General, all public hospitals, the police and the coroner - and compared all of those that were identified to see how many of them were registered. We found for 1998, while ten percent of all deaths were not registered only 4.2 percent of HIV deaths were not registered. So there wasn't any problem in terms of the timely registering of HIV deaths. For 1998 our database identified some 646 HIV deaths. The Ministry of Health Surveillance Unit was aware of 507 of these deaths so they did not know of 22 percent of them.

When we looked at the characteristics of the cases that the Ministry did not know anything about we did not find any association with gender, where the people lived or whether the death was registered. However we found interesting information in terms of the age and occupation of the decedants. The Ministry was less likely to know about HIV deaths in infants and in persons 45 years of age or older where on average thirty percent of these cases had not been notified compared to eighteen percent in the 1 to 44 years age group. This age group however accounted for 73% of the deaths so they knew about most of the deaths in the age group in which most of the cases were occurring. When we looked at the occupation on the death certificate, persons who were less likely to

be notified occurred among persons in the lower socio-economic classes namely unskilled persons, those who were unemployed and persons employed in basic clerical and sales occupations as well as children. Persons who were skilled or who had managerial and professional occupations were more likely to have had their deaths notified. However when we looked at - there were 29 cases however where the death certificates did not include HIV on it and misclassification was occurring in the opposite direction to the notification process. That is persons in the professional, managerial and skilled categories were more likely to have their death registered as not being due to HIV. Twelve of these deaths were infection related causes and four were neoplasms which are likely to occur among HIV infected persons. Four deaths were due to external causes including one possible suicide. Among the teachers in our mortality database we identified 74 deaths, two-thirds of them were in women. Among men circulatory disorders and external causes were the main cause of death, that is accident and violence. Among women it was cancer followed by circulatory disorders. When we looked at them by age for the younger persons it was cancer and the external causes and for the older persons it was circulatory disorders such as stroke and heart attacks.

The Ministry of Education database identified 137 teacher - deaths between 1993 and 2001 in the 29 to 60 year age group. 21% among males and 79% among females. We are seeing more female deaths from the Ministry of Health database than from our mortality database. There were only 9 cases common to both sources. For the three men their occupations were listed on the death certificate as teachers however for the women two were listed on the death certificates as housewives. This may explain why we were picking up fewer female deaths from our mortality database than when we looked at the Ministry of Education data. However of the 9 HIV deaths that were among professionals none of them occurred among teachers.

On the demand side. When we compare the general fertility rate which looks at the number of births occurring expressed as a percentage of the total number of women at risk we see a 21% percent decline over the ten year period. So we are seeing fewer births occurring in Jamaica. Now when we break this down in more detail and we look at the age specific fertility rates what we find is that in the last four years between 1997 and 2001 most of the decline has occurred among the younger age groups. You can see a significant drop in the last two lines that are in the solid lines the 15 to 19 years old and the 20 to 24 age group. With no change really seen in the older age groups. So it appears that the younger persons are getting the message and modifying their behaviour. We have had successive reproductive health surveys since 1989 and when we look at whether or not women reported or not that the last pregnancies were planned we see an increased prevalence of planned pregnancies over the duration of the epidemic suggesting that there is more deliberate reproductive behaviour than in the previous years. One thing for certain is that the epidemic continues to increase in Jamaica but what would appear is that the number of deaths is slowing down. When you look at the new AIDS cases by age and this is on a logarithmic scale and it is smooth so you can get a better feel for the changes over time you can see the lines between the men and women are converging suggesting that the epidemic is now a general epidemic in the heterosexual population. As you would expect no sex difference are seen among the pediatric cases and the number of cases seem to be slower over the last few years. And when we look at pediatric mortality for 1998 there were 61 deaths due to AIDS among children under ten years of age. It has gone up in importance it is now in the 1 to 4 years age group as the leading cause of death in that age group.

So what can we conclude from all of this information. There is no evidence that HIV deaths are occurring among Jamaican teachers. The leading cause of premature mortality among our teachers is cancer cardiovascular disease, accidents and violence. Teachers represent a potential low risk group. If we look at who they say are the high risk groups: persons who have occupations that

take them up and down that are mobile, person in lower socio-economic groups - those are the persons who are seen at risk. For the most part teachers have stable jobs and they are usually married even though many of them are in the reproductive age population. Even in Southern Africa whereas the HIV prevalence in the antenatal population is 35%, among teachers it is one-third of that. And we see that AIDS mortality rate in Malawi is lower among secondary school teachers and primary school teachers than the general population. So it would appear that teachers as change agents for the AIDS education seem to be also getting the message.

While there was under notification of HIV deaths to the Ministry of Health and this was more often occurring among the very poor and this is suggesting that maybe their lack of resources is also limiting their access to services. The deaths that were more likely to be misclassified occurred among the middle class groups. However some of the causes of death that were registered were valid and as the epidemic becomes more generalised and the anti- retro-viral therapy becomes more widely available persons who are living with HIV and AIDS will succumb to other illnesses other than AIDS.

Decrease fertility possibly due to positive behaviour change is reducing the school age cohort. One of the areas we have to investigate is the readiness of the school system to accept the HIV positive child. What are the attitudes of teachers, classmates and auxiliary staff to the child in the school environment who has HIV? Are there going to be caring and sharing or is there going to be shunning and ostracization of these children? Are there are social supports in the facility for these children? They are going to need more tutoring, health staff in the school need to be aware of universal precautions. A cut or a nosebleed can potentially put a member of staff at risk.

We cannot ask teachers to disclose their HIV status. However if we monitor their attendance, if we look whether there is an increase in the demand for sick leave

so much so that there is a need for substitute teachers then we have some idea whether or not we are having increased ill teachers that we have to deal with. The system also need to insure that health insurance provides for surveillance and testing and with anti-retro-viral treatment for teachers who are HIV positive. And there needs to be social support for them as well. For the children we need to develop training programmes so that the school environment is HIV friendly. That teachers, auxilliary staff and students have the correct attitudes in terms of sharing their environment with these children. And we of course need to teach universal precautions regarding first aid to protect those person who are healthy. Thank you.

**Philip Finlay MD: General Hospital, St. George's  
SGU Director of Medical Education  
Director, National Infectious Disease Control Unit  
Country Model and Lessons Learnt - Case of Grenada**

Madam Chairperson, Distinguished members of UNICA, other distinguished guests. I am here to present the situation in Grenada. How big is the problem? There are many ways to look at how big is the problem in the country. One of them is by looking at ceroprevalent studies. You can never get a general population sample or at least it is an extremely very difficult thing to do but we do look at a sentinel population which are the antenatal women. These people are of course characterized by being people in the age group where you get your AIDS infections and deaths predominantly. They are also by definition having sex that is unprotected sex. We had an antenatal seroprevalence study done by a Masters student from St. Georges University and I was on his supervisory panel. I remember that there were 0 out of 538 women. This was a voluntary one. We repeated last year in the NIBCU a study that was anonymous and unlinked using consecutive sampling and got 0 out of 570 women positive. What it means is that the rate is quite low. It does not mean that it is zero. We have been getting recently in the region of 1800 pregnancies a year. The fertility rate is dropping. We have had two positive mothers this year and this gives you an idea what you can expect in a year in Grenada just about two positive mothers. But one is was

a visitor who had just come to the island and went back to her country even before the result was available. Once it was available we got the message down to her country. The other one was a recent immigrant. About 40 people are known to be living with HIV in Grenada. One of the things you will see is statistics from Grenada which says there are two hundred and something people since the epidemic began in 1984 and that so many have died and so many are living but it is not quite true. First the figures of those who have died/ had not been updated and as you update them you realise that there have been more deaths and second there are cases on our roster that do not necessarily represent people because what they were doing was checking the labs for positives. Some of these positives we could prove were duplicates of people who were already on the list. Many could not accept such a serious diagnosis and repeat it. And others we just don't know who they are or whether they represented real people. To give you an example of what goes on in terms of deaths, we have 12 deaths this year - this is the first year we have been tracking deaths very carefully because we have a bigger idea. I should say the other groups are groups that have migrated and in fact are no longer living in Grenada. Or groups for which there is a name and an address but the names and addresses seem mythical because we can find no such person and people don't know about them.

We have had about 227 cases accumulated since the epidemic started in 1984. That's another way. That's those which are reported to us . I have seen what the size of the epidemic is, keep in mind a population of 100,000. Now there are 148 males and 79 females. I think this puts in clear focus the fact that it is not true that we love to say that in the Caribbean- no we are a heterosexual epidemic etc. We know that the virus is transmitted more efficiently from males to females and therefore the results won't support it. Most of all even this late in the epidemic we are getting more men than women but look at this next line which I have highlighted it shows you just what you will find in other places in the Caribbean. In the younger age groups it is the females who are getting preferentially infected - there is 0.62 males to females ratio. UNAID said that it should be something like

1.2 if the epidemic was really heterosexual. The highest recorded was 23. In 1993 and 1995 we had 23 cases we have never had so many cases reported since then. So another way of looking at it is the last three years we have had 18, 15 and 15 cases reported. So far we have had 9 cases this year and three that are pending confirmation but if most of those turn out to be positive we will be at 12 and we are pretty close to the end of the year. It is becoming more and more apparent that our epidemic may have peaked.

The strongest associations are with stay in another country, intercourse, poverty, work on a ship, or multiple sexual partners. But I must warn you that these are casual observations rather than statistical evaluations. Let's talk about care. Antiretroviral treatment has been launched in Grenada with help from the WJ Clinton Foundation and we have a group of first line drug and a group of second line drugs. We are going to be monitoring people, you know looking at things like side-effects, intolerance to the drugs etc. And going up to the levels for changing therapy or stopping therapy we come on to changes in immune status. We are not able yet to look at changes in virologic status. we have actually been caring for HIV people since about March even though we have just started within the last few weeks the programme of HEART - Highly Effective Anti Retro-viral Therapy but we have been treating people in clinics and we have been going to see them in their homes and it has made a very big difference - the friendships that have built up between the doctor who is in general myself and the nurses and the patients - we are friends. We go to funerals. We deliver it at an infectious disease clinic and it is centralized delivery of care. At the moment you can imagine with such a small population of HIV people and with very few people who know much about anti-retrovirals and HIV care. We have a Doctor, a nurse, a counselor, and a pharmacist in the clinic each week and we do the personalized care in the home visits.

Now our strategy in fact involves more things than are written on this page but the page is already becoming quite busy. But Abstinence (where appropriate)

and I will tell that abstinence is exceeding appropriate for school children, it is very appropriate for persons whose spouses are away studying for six months etc. We, instead of just saying be faithful which we promote monogamy and of course and it is a moral choice whether you have serious monogamy but we promote monogamy. We say that you test yourself before you get in to a monogamous relationship. We have several examples of people who have knowingly infected their partners and really had a good relationship and was faithful but they were infected long ago and they ended up infecting their partners. And we say couples test together and that is a part of a strategy we want to have - the couples challenge. Challenge couples to come forward and get tested together. That is part of voluntary coupling and testing which is a wider thing not otherwise referred to on this page. Then condoms - promotion and distribution. We promote and distribute a lot of condoms. We let people know in that abstinence is in fact a much, much more effective way . Abstinence is an absolute - so I would not even say a practice properly - is a 100 percent effective. You go to the CDC website and you will see it tucked away somewhere. We know about condoms 85 -90% maybe. So we talked about that.

I will say one thing about this. I get worked up about this. I was in Japan and there was this representative from an Eastern European country and she was - most of them were saying no that was a waste of time. It is impossible. Then I said we are promoting abstinence to a school children until about age 18 and they said, "Is this your idea or is this your Ministry's idea?" They wanted to know if I was just a deviant. What happened was that I said could you do something for me please. Go find out what percentage of your students at age 18 sexually experienced - have had sex. They came back and said 65%, you see you see. But I said but you see that 35% percent of people without you promoting have been abstaining. It is a fallacy that abstinence will not work and that young people will not - you know we can be cynical in medicine we used to say the difference between herpes and true love is that herpes last forever. And we can be cynical with youth instead of promoting some ideals by telling them that it is



impossible for them to get through secondary school without having sex. Let me not get worked up.

Prevention of mother to child transmission is of course is a big thing with us and that has been instituted. We have a contact treating programme that is only suffering from the lack of bodies to do the job. We have been doing surveillance studies and you will see of course that we are doing a hospital seroprevalence study now but we have done that other one the one for the antenatal and we expect to do other surveillance studies maybe in the prisons.

We have been protecting the blood supply from HIV for a very long time and we have had no - the last time we had somebody infected was before the era of protecting the blood supply by testing every unit of blood.

We want to reach covert or high risk groups and we have already seen that we can bring out some people who could not have been brought out before. Now we are offering treating so we have had some people come out of the woodwork and we have at least one person who is promising in terms of being a link to that covert MSN.

What about Law Reform. We are cooperating and we have sent people overseas to a kind of Caribbean initiative with some training etc. and some discussion but we have some ideas that we are thinking about and I will just mention them:

- Partner notification - you have to know who can be really called a partner.
- Criminalizing willfully exposing the naïve - which in some U.S. jurisdictions you can be and possibly on the existing law if an HIV person willfully exposes - naïve means that the person does not know what is going on and does not realize that they are exposing themselves to infection.
- Requiring evidence of HIV testing before granting of marriage licenses - a good way and in fact I thought that New York state used to do that but somebody said no, no there is still a law in New York.

- Protection against loss of job on basis of infection
- Protection of rights to occupy rented home
- Requiring continuing medical education credits in HIV for maintaining licensure. I have to do that in Florida and I think Medical authorities should think about doing that.

Who is involved in Grenada? The Red Cross, NGOs like ART - The Agency for Rural Transformation. we have two main Theatre groups which have both produced plays and one of them have invited us to sit down and work with us in the message in the play to see if they are getting it right. The Young leaders programme in the schools etc. They are involved. We are involved in the Calypso association. I have never had a problem with churches and the condom in Grenada and the Catholic Church is the biggest church in Grenada. Service organizations like Rotary and Rotaract. PLWHA and we have an AIDS foundation and HOPE Pals which is in fact all people living with HIV Aids.. Then there is St. George's University, PAHO, CAREC, UNAIDS - very important. William J Clinton Foundation they held us to negotiate good prices for our drugs but we bought the drugs and of course we have a World Bank loan. To give you an idea what the University has gotten involved in. Just recently Dr. Smythe and I were involved in a public lecture where the University brought in the Minister of Health in Guyana to give a lecture dealing with AIDS. Two lectures and the other one was given by a Catholic priest.

We have changed our management so that we have founded an Aids Directorate right now a chief cook but no bottle washers. And really the National Infectious Disease Control Unit that I am involved in has been pretty much been doing everything but this is what we should be doing in the future taking care of the care and seroprevalence studies.

And the challenges of not enough money, youth who think they are immortal or their parents who just don't want them to have sex that is why they are making

such a fuss about HIV. Transactional sex and prostitution, especially transactional sex, reaching men who have sex with men, conquering stigma in health workers, limited ability to monitor and adjust HEART and a limited ability to investigate and treat opportunistic infections.

I leave you with some images from our new General Hospital. The view from there. Thank you.

### **HIV in Grenada 2003: How big is the problem**

- Antenatal seroprevalence study (anonymous unlinked) showed 0/570 women positive
- 1800 pregnancies/year. Two positive mothers this year (one in a visitor) other in recent immigrant
- About 40 people known living with HIV here
- 12 deaths so far this year
- About 227 cases cumulative since epidemic start 1984

### **HIV in Grenada: Demographics**

- Cumulative to 2002: 227
- 148 males 79 females M:F = 1.87: 1
- 15-24 age group 21 females 13 males for M:F= 0.62
- Highest reported 23 in 1995 and 1993
- Last 3 years 18, 15, and 15 cases reported
- Strongest associations are with stay in another country, anal intercourse, poverty, work on a ship, multiple sexual partners. Casual observations

### **HIV in Grenada: Care**

- Antiretroviral treatment being launched with help from the WJ Clinton Foundation
- AZT 3TC NVP will be first line
- NFV d4T DDI second line
- Monitor immune status(CD4), clinical status (OIs) but not virologic status
- Delivery at ID clinic: centralized
- Doctor, nurse, counselor, pharmacist
- Personalized care: home visits

### **HIV in Grenada: Other major programmes**

- Public education
  - Abstinence (where appropriate)
  - Be tested and faithful (couples test together)
  - Condoms (promotion and distribution)

- Prevention of mother to child transmission
- Contact tracing
- Surveillance studies
- Protecting blood supply
- Reaching covert high risk groups

#### **HIV in Grenada: law reform**

- Partner notification
- Criminalizing willfully exposing the naïve
- Requiring evidence of HIV testing before granting of marriage licenses
- Protection against loss of job on basis of infection
- Protection of rights to occupy rented home
- Requiring continuing medical education credits in HIV for maintaining licensure

#### **HIV in Grenada: who is involved**

- Red cross
- NGOs like ART
- Theatre groups
- Young leaders
- Calypso association
- Churches
- Service organizations: Rotaract
- PLWHA (AIDS foundation, HOPE Pals)
- St. George's University
- PAHO, CAREC, UNAIDS, WJCF, World Bank

#### **SGU activities**

- Research
- Sponsoring public lectures
- Sponsoring of town meetings
- Participating in planning

#### **HIV in Grenada: Management**

- Aids Directorate
  - Manages the overall program
  - Contracts out tasks
- National Infectious Disease Control Unit
  - Care: Treatment and counseling
  - Serological and other surveillance studies
  - Keeping database
  - Contact tracing
  - PMTCT program. Preventing perinatal transmission

### **HIV in Grenada: challenges**

- Money: never enough
- 'Immortal' youth
- Transactional sex and prostitution
- Reaching men who have sex with men
- Conquering stigma in health workers
- Conquering stigma overall
- Limited ability to monitor and adjust HAART
- Limited ability to investigate and treat OIs

#### **Dr. Marlene Cox, Deputy Vice-Chancellor, University of Guyana:**

Good afternoon everyone. Can I say how happy the University of Guyana is to be present here this afternoon for which I thank UNESCO and the organizers of this conference for allowing us at the last moment to make this presentation. It is actually going to be in two parts. The first part will be given by Dr. Max Cunningham - the Director of our School of Medicine who will give the background aspect to HIV/AIDS in Guyana and I will deal with the education aspect.

#### **Dr. Max Cunningham, Director of School of Medicine, Guyana:**

Good afternoon. I happy to be here because I am starting from the time I left Guyana yesterday afternoon, I arrived at the airport and arrived at immigration and the immigration officer asked, "What is your business in Trinidad?" I said, "Well I am here for an HIV/AIDS education conference." She said, "What, do you have a return ticket?" I said, "Madame I am not here to stay, I am only here to be educated." This morning I was really educated.

I am from Guyana, a beautiful country covering 83,000 square miles - the concept of the Caribbean as an island you have to really visit Guyana to understand it. Huge country -small population 700,000 people. You might ask the question - Why is Guyana having this problem of HIV/AIDS as compared to Thailand which is really beating the problem. Our first case of HIV/AIDS was diagnosed in 1987- a homosexual. But we never took measures to really arrest

the disease. We waited and it crept up on us. It was a monster and now the monster is ready to engulf us.

In 1992 we started the AIDS Secretariat, I was on that committee but what happens when you start committees human rights people get involved - can you take blood from individuals? Can't you do this - the rights of the individual? We were stomped. Let us look at the Caribbean and see what is happening in Guyana.

This morning I heard that the epidemic affect the economy. There are many factors that cause HIV/AIDS but let's look at the Caribbean - Guyana and Haiti the countries with the highest number of HIV/AIDS infected individuals per capita. What about our economy? If the economy is bad HIV is on the increase. We have to look at the economy of these countries as a means of addressing the disease. If we do not look at the economy the disease will take us over. Love thy neighbour as thyself but love thy neighbour even though he is affected with HIV/AIDS. Because soon my neighbour will have HIV/AIDS.

It is estimated in Guyana that one in fourteen persons have the virus - we have noticed that more males than females are infected. And if you look at our chart, over the years the AIDS Surveillance by year - it follows the pattern in each and every country. The affected group will be more so the 20 to 39 age group. That has shown an increase over the years. If you look by 20 to 39 age group, even if the numbers increase the percentage remains the same. This goes on. What happens is that Guyana is a large country we have divided it into 10 regions. What is particular about this chart is that if you look at region four which includes Georgetown, Region 6 New Amsterdam, these are small cities and towns, you will find the number of HIV infected patients higher. That is because in those communities you will have the commercial sex worker. The number of commercial sex workers will increase depending on the economic status of that community. If you question individuals they will say, "Look I am hungry, I am

going to die anyhow so if I get HIV the end result is the same." We have to address through education the problem for these people. We have to train them and give them alternatives methods of employment.

We get our data from blood donors because as you know the blood is screened and we find out the percentage of prevalence in HIV. From blood donors we have one percent. From pregnant women at the anti-natal clinics in Region 4 and 6 with the big hospitals you find that there is an increase over the years. What should be noted from the chart is the increase in the percentage of HIV prevalence from 1992 to 1997 in the commercial sex workers. In 1992 it was 25% whereas in 1997 it went all the way to 47%. The percentage of gold miners - this is a migrant population - even though they have six years. There are certain areas within the city that gold miners come from so that figure even within the interior - these gold miners are subject to prostitution because there is a honeymoon to their enjoyment. If you know Guyana it is isolated and that is what happens.

Now let us look at the result with the cause of death. In previous years our highest incidence of cause of death would be cardio-vascular disease, heart disease but from 1998 to 2000 HIV/AIDS have been climbing uphill. And 2000 to 2003 it is the number one killer in Guyana. Now to summarize that we know that the infection rate in Guyana is the highest in the Caribbean and it just slightly lower than that of Haiti.

Who is affected? The young people, the sexually active people. 20 -39 age group, multiple partners -there of course you will find the highest incidence rate. Transmission is primarily heterosexual but 80%. With 80% of the cases transmitted homosexually or bisexually and a small percent being the consequence of IV transmission could be cocaine. Now 60% of the persons who are affected are unaware that they have the condition.

Now the National AIDS Programme that is how we are approaching this started in 1992. Of course I told you the difficulties they had and so effectively they became the really effective medium in 1996 and 1997 after they cross the hurdles. The mission statement - ***the Eradication of STI/HIV/AIDS in Guyana*** and their motto - ***Bridging the links, building bridges and forging partnerships***. What are the goals of NAPS - National AIDS Programme Secretariat.?

- The promotion of informed and responsible behaviour and healthier lifestyles.
- Reduction of morbidity and mortality due to HIV/AIDS/STI.
- Reduction of psycho-social economic impact due to HIV/AIDS/STI.

Now what strategies do we want to go ahead with:

- Strengthening, Development, Effective management of the **NAP**.
- Providing awareness, education and training through governmental and non-governmental collaboration.
- Prevention and effective management of STI/HIV transmission .
- Strengthen epidemiological surveillance, collection, analysis and dissemination of information on HIV/AIDS/STI.
- Strengthen health care and support service.
- Facilitate and support a network of governmental and non-governmental agencies to achieve eradication.

It must be noted that in Guyana I think within the Caribbean we are the first people that packaged HIV. It is available in the hospital free of cost to HIV infected patients. It is not widespread because the cost per patient per year runs up to about U.S.\$500.00. I think there is a hope by the end of 2004 that the anti-retrovirals will be available to all the practitioners to be dispensed to individuals.

Thank you.



**Dr. Marlene Cox, Deputy Vice-Chancellor, University of Guyana:**

Now Guyana has developed a National Strategic Plan 2002 -2006. The overall objective is to reduce the social and economic impact of HIV and AIDS on individuals and communities. --- **break in taping** ----The implementation strategies are largely left to NGOs. There are 21 NGOs dedicated to HIV and AIDS. 13 are based in region 4 which Dr. Cunningham said is the largest populated area in the country. However the numbers are growing and outreaching into other parts of the country. The longest serving NGO is Lifeline Counselling Services - it is seven years old. Its mission is to provide quality service to persons living with and affected by HIV/AIDS, increase individual sensitivity to the disease and reduce youth vulnerability to AIDS by 2010.

I am going to rush through because of time but I would like to let you know that we are particularly proud of this longer serving NGO because it is basically composed of young people. It has a staff of three persons, over fifty volunteers and just two weeks ago the Executive Director just 25 years old was awarded UNDP's Poverty Eradication Award 2003 for Latin America and the Caribbean for work that the organization was doing in HIV/AIDS.

The activities of the NGO's focus mainly on workshops, plays, visits to secondary schools, discussions on radio and TV. They also focus on the ABC and we do have a D. Our D is not die but say free of drugs and alcohol. We did bring a number of brochures and flyers displaying what the ads say. Lifeline counselling works through all the regions of Guyana and to ensure that the training is uniform they have produced this manual which all the regions follow. I can leave this for anybody who is interested. Now Education in the schools, it is an interesting situation, the National AIDS Secretariat advises that schools will not go to the Ministry seeking their help in giving information on HIV/AIDS and prevention. They prefer for NGOs to go to the schools. NGOs will go to the schools, the schools will not go to the Ministry. I don't know why but essentially that activity takes place in secondary schools. However the Ministry of Education will shortly

embark on a Health and Family Life Education Programme and one aspect is HIV/AIDS. The University has only recently, I must admit, become active in education in HIV/AIDS, three of our staff members, one is right here - the Director of the School of Medicine, one from the Faculty of Education and one from the Faculty of Social Sciences, attended the Train the Trainer Programme as part of U.W.I.'s and UNESCO's and CARICOM's XXXXSURE HARPxxx project. And we have become good friends with Professor Bain, Neisha Ghany, Roger Mc Clean and Dr. Brathwaite. As a result of this training, many lecturers are now including HIV/AIDS aspects in their courses wherever they can. In addition at the Turkin Campus, I should tell you we have two campuses - the oldest one it is Turkin and it is celebrating its 40<sup>th</sup> anniversary this year, we have established in the library an AIDS Awareness Centre. When it was first established last Academic year it was permanently displayed in the foyer of the library now it has been moved to one of the other floors but still in a prominent position to attract the attention of anyone. In addition to that, on campus we have in some of the washrooms -male and female - condom vending machines and we also have them in the Halls of Residence.

**AIDS in the workplace.** The National AIDS Secretariat in collaboration with the Occupational Health and Safety Department of the Ministry of Labour, Human Services and Social Security have conducted programmes so that over 500 public and private enterprises now have awareness and education sessions and a number of organizations also have their policy manuals. We have just gotten a grant from USAID to further work in AIDS education in the workplace. In addition to which one of our private hospitals has recently, I am saying recently since everything is very recent, has decided to offer free AIDS testing to women and to do whatever follow up is necessary all under a confidentiality basis. Our major funders are listed there:

We are a small country and an under-developed country so we are financially strapped and depend a lot on assistance.

**Conclusion:** We have just basically joined in the race to fight the HIV/AIDS issue. I know that we are not doing enough but we have begun essentially promoting healthy life styles. We would look forward to the session tomorrow which deals with strategies towards dealing with HIV/AIDS particularly in tertiary education institutions. Thank you very much.

**Mr. Carole Keller, St. Augustine Campus, Trinidad, U.W.I.:**

Thank you very much Madam chair. I was asked to speak on the issue of Education versus Behaviour Change and I thought about that for some time preparing this because I don't think that they are opposed to each other but certainly there are some issues that have arisen over the years. Let me say very briefly how I have organized this. There are two major points that I want to make. One of them is that the state of our society today presents us with certain kinds of problems that make it difficult for us to treat with additional public health issues. That is one of the first points I want to make. The second point that I wish to make is that we have learnt a lot about behaviour change from looking at what has happened in very small confined communities particularly for example we have learnt some lessons from the Gay community. And one of the things that we try to do very often is see how we can transfer some of those lessons to the heterosexual community. The third point that I would like to make is that there is a sense in which some of the issues -so let me just back up.

We face today and in nearly all societies, societies that are fragmented in which there is a lot of politics of difference, in which the whole idea of what citizenship means - whether it is a cultural issue, whether it is a more political issue is very much on the cards. And more and more what is happening is that we are seeing with a globalized world that identities are becoming in a sense privatised. There is a certain kind of localisation that is taking place at the same time. And the very much gaunted information and communication technology has created for us more of a virtual than a real world where a number of images have been created and have had tremendous effects globally. All of this I mention just a s preface to

suggesting the culture of policy making in such a world needs to be studied carefully and I do in the paper examine what that means. In other words the kinds of language, the values underpinning policy making and the policy process much be understood if we are to understand in a sense education policy, understand its contradictions, assess the extent to which it is really treated with the problems that we face. At the same time however some progress is being made.

Let me go to the second point I was asked to talk about which is behaviour change. What the evidence points to as far as the gay community is concerned there have been some successes with the reduction of risky behaviours. But it indicates that is because in those communities the individuals are socially engaged. They are really members of a community that in fact sets norms and standards for them and those communities norms and standards are actually recognised and people act according to them. The lesson there perhaps for us is that community based, and communal or communitarian type organizations have a greater effect in terms of behaviour change than where we are trying to do this through mandates or through individual information and so on. Now what we have tried to do over time is to try to transfer this to the heterosexual community. If we look at the heterosexual community and ask - How can we then use that information to actually carry out programmes in the heterosexual community? Several things arise. The first thing that complicates it is that you have a different kind of the politics of gender. A lot of the writings about HIV/AIDS have shown that marriage for example is a very legal obviously kind of arrangement. Women in terms of HIV, women often find themselves subordinated, not powerful, and their fidelity very often is not a protective factor because of course the behaviours of their partners. So we really don't have the kind of binding communal norms that you would find a closer, tighter gay community. I am not by any means recommending that the entire society become a gay one. I just trying to point out how the plurality that we face in societies today actually pose some problems for us. There are a number of cases in which this happens in normal circumstances.

You have heard of stories of young children who go home to their parents in tears because the schools that they attend the other children get two gifts on their birthdays but those children who belong to monogamous, nuclear families only get one and they feel quite disadvantaged. So it poses some questions for us as to how to establish community standards in the heterosexual community. How do we establish community standards of behaviour - that is one of the big challenges. How do we get established? Norms to which people feel bound with which they feel identified, and for which they will be motivated to reduce risky behaviour. So the whole business of mobilizing loyalty still faces us. Of course quite apart from that how do we ensure realistic and sustainable choices are offered to people in our community. Now this leads to a lot of questions about schooling and the role of schooling. Whether in fact schooling shouldn't be about preparing people, young people, for or to deal with these problems that we face? In other words whether schooling shouldn't be preparing young people to think about a more collective identity. And of course to develop the sort of norms and values that are democratic, communitarian values. In addition the idea of horizontal education not vertical education is something that we people tend to want to borrow from closed, organized communities meaning that you have in those circumstances are education that really speaks to the reality that these people experience because the education does not come from experts from above. But they come from people in the community who share the experiences with the people to whom they are talking. And this is an important and significant thing for us to start to think about and how we might actually adopt it. Some of the situations in which we find ourselves.

One of the things that has happened is that the idea that we now face a major health problem. It is a public health problem with HIV/AIDS. It is something that is accepted globally and locally. Some people point out that there is some doubt as to whether there is full awareness of the nature of the problem everywhere and because of that they suggest that what we need to do is stress information to begin with and awareness to begin with. And to begin to see that in other places

where the epidemic has been on the march for a longer time there are some phases that we should recognize and which we might think about short-circuiting, Those phases as they turn up and are written about are the initial phase of denial, second phase in which you blame foreigners, a third phase in which you identify and target groups that are at risk, and four of course we come to a stage where the epidemic is recognized as a public health problem.

Now in the face of these kinds of difficulties we have had some recommendations from people who have done some fairly careful studies of the HIV/AIDS epidemic worldwide. What I list here are some injunctions that come from Professor Kelly's book on Planning Education in the context of HIV/AIDS. First of all what he recommends is that we mobilize everybody. I have just pointed out that that is important and significant not easy given the social circumstances that we have just spoken about. And we have to think very carefully about how we will mobilize, on what basis we will mobilize and of course how loyalty and motivation are to be not only in a sense triggered but sustained.

Secondly what he suggests is flexibility. Now flexibility makes sense in the context of an understanding of what it means to ignoring alternatives that make sense. In other words flexibility calls for breath of understanding, it is not something while we can mandate it really grows out of a particular kind of education that people must get.

So is openness to change. These might be behaviours that we see but I want to suggest that they come out of a certain kind of connection with communities, a kind of learning about the importance and significance of diversity. And of course these are things that do not come overnight, they take some time.

Sensitivity to the needs of the infected and those who are affected. Infection was another thing that Professor Kelly spoke to. If we look at all of these they have an assumption about a particular kind of sense of the collective. A very important

issue about a sense of the collective. And I want to suggest that one of the things that we need to be looking at in our education systems is how we promote that sense of the collective. For all the talk of globalization as I said in my initial statement one of the things that we are seeing is that there is much greater fragmentation than any kind of collectiveness, a certain kind of competition and individualization that has accompanied that and so we have to be very conscious of this.

Now the third point that I want to mention is that in the face of all of this the role given to education needs very careful consideration and reconsideration. Just let me say that one of the things that people in education have to accept and understand fully is that education cannot do it alone. But that does not mean that what we have to do is to depend on other sectors. We need to develop mutually reinforcing partnerships and I do set out very carefully how we have to go about doing that. It really means that schooling has to be organized quite differently and a deeper understanding of the culture of schools and how we have to reorganize them so that they start to focus on the promotion of those values that underpin a collective kind of orientation. A democratic, communitarian orientation. Rather than one that just has to deal with utility and rights of individuals. How we do that becomes very important.

And in the last minute, the whole set of conditions and complimentary inputs that are necessary for schooling to give the pay-off that it can give when it is reorganized need to be identified. That is a very serious task. It is one of the most important and significant tasks if in fact what is to happen is that we are to actually sustain the behaviour changes that are schooling, the new type of schooling can promote. What I am trying to say in summing up, what I have tried to say very briefly -is that there are lots of people who would argue that schooling provides a kind of mis-education and therefore the whole problem of behaviour change is a result of this mis-education. I want to suggest that one of the things that we want to do is not to dismiss this but certainly to look to see how we can

make schooling much more educational. And if we are thinking about that and thinking about the HIV/AIDS pandemic then we need to start to see what success factors there are and I have identified one here which is the notion of a collective identity -one of promoting a democratic, communitarian kind of society through a kind of humanistic experience in schools that becomes a critical and important thing. Of course unless we address that what is going to happen is that more and more there is going to be quite a lot of misunderstanding of the role that education can play, the purposes it should serve and of course there is going to be much more expenditure of time, resources and money on the business of behaviour changes when in fact we all know that behaviours do not change very easily, they do not change very suddenly but they change in the context of a particular kind of orientation and understanding and connection, social connection. Thank you very much.

## **QUESTIONS**

### **Halim Porters representing UWI Medical Students Association:**

Education has been stressed here a lot this morning but I would like to share some information with you that I have. A Research was done by our Medical Students Association about the knowledge and attitudes of HiV/AIDS that medical students have and how they view this . And the results show that a lot of medical students knew a lot about AIDS, medical students were involved in the management of HIV patients, they are still having unprotected sex. What I want to know is - is there any specific research that links education with behavioural practices because these are students who know a lot, see it everyday but yet still there is no improvement.

### **Philip Finlay MD:**

I could make one comment which is that I listened to a researcher who was speaking about that and he had done research in Armenia. It is funny that you say medical students because they checked different people for their knowledge and the found that medical students were among the highest in knowledge of



ways it spread etc. and that they were also the highest in terms of behaviour that is risk-taking behaviour. We used to say in the 1960s as a social scientist you know, "What XXX is education when people know they will behave differently." When that didn't turn out to be the case they said, "Well you know that education doesn't really mean knowledge." So we are really redefining knowledge in order to protect ourselves. We should understand that changing human behaviour is a very complex thing. First you have to know how people behave, then you have to find out why they behave as they behave but even then nobody knows enough about how you persuade people to change. It is arguable that people like preachers that preach and get people to make big changes in their lifestyles and so on . Of course they will say that it is God's work know far more about it than the scientists in this place.

**Horace Williams, University of Technology, Jamaica:**

There appears to be a fair amount of progress in targeting the formal education sector. As the university tries to impact on public policy, this is for Dr. Findlay, what are your thoughts on are some thoughts on the licensing of sex workers, targeting the young unemployed males in depressed communities and thirdly targeting the prison population.

**Philip Finlay MD:**

With the licensing of sex workers, there are some places in which commercial sex or prostitution whichever you like is legal. The State of Nevada in the United States. Indeed if you have legalised sex but not only that have strict rules about the conditions under which sex can take place barrier methods and frequent testing etc. - you can decrease the spread of HIV among that particular group of people. That is probable the group of people that you won't get very much by preaching abstinence. So it is true and another thing apropos of that is that I was talking to somebody from Trinidad and he was mentioning them getting into testing about 200 sex workers and finding maybe one or two people compared to with the study they did in Guyana where they had alarming rates which went up

to over 45%. And the idea is that you are asking questions and this particular Madam had connections and if you were positive you did come to work with her you were tested frequently to see and if somebody came to the establishment and didn't use a condom I heard that they went into the street first and then their clothes would follow them. But you could understand that there could be wide disparity according to these practices and that practice might work. In prison when I first started talking about doing something about prisons people started talking about human rights. I don't want to say very much more about that but right to life is one of the most fundamental human rights and they know that people get raped in prisons and theoretically if you are in prison you are supposed to be under the protection of the state. I don't want to go much into that.

The third thing was targeting young males. Targeting young males can help but I have a fundamental problem with what I have heard a lot of in the Caribbean. What goes on in the Caribbean is something like this. Males start sexual intercourse before females, males have more partners and more episodes of sexual intercourse than females, males target younger women and girls - older men younger girls but older women hardly interfere with young boys. And they do these surveys and somehow the brain doesn't come up and say wait this data is not consistent. Who are these young boys having sex with? I saw it from the thing Israel and I have challenged people with black marbles and white marbles and said okay let us have sex. Mathematically unless these people are having sex with goats or something like that, mathematically especially in a population in which there are equal numbers of males and females despite the 7 to 1 ratio that we all know in the Caribbean. We all know that when we do the census it turns out in Grenada for instance in the 1991 census there were slightly more males than females in the 25 to 44 age group. If there are approximately equal numbers then it is impossible for one group to be having more sex than the other, for one group to have a higher ratio of partners and I have challenged many people to show me this. But if we have these stereotypes, in fact the only thing that seems

to be true about this is that indeed it seems that older males are targeting younger females and that is reflected I think in their own age 15 to 24 age group and all through the Caribbean we are seeing it where the females are outnumbering the males. This is the one part that is true. It remains, that we must conclude that boys boast more even in anonymous 'so to speak' interviews about sexual exploits some of which they never had and girls conceal. We know that there are too many of these that are done by interviews in which the person records rather than the subject. Therefore you are never sure if people are doing ---- and I am making the case therefore to you that although there had a program called 'Males matter', that right now we probably should be getting alarmed especially because of their reproductive capacity. We should be getting alarmed that the young women we are seeing are increasingly getting infected. And we should be thinking more about targeting them. I usually say in Grenada that there are too many girls who don't have to pay for the bus. And there are too many girls who will tell you that they have to get a cell phone and they know exactly how they are going to get it . Transactional sex we are seeing a lot of in Grenada. We are now seeing that people arrange for sex on the internet from New York. So when they get there they have instructions to just talk to a driver and to go to whatever. I think that we can't leave out anybody but if I had to have a target I would be more inclined to go towards young females. There a lot I couldn't say but we have the Home and Family Life education in the schools so we integrated our abstinence programme into this. I don't believe that you are very successful by preaching abstinence just as I believe that you can be very unsuccessful in getting people family planning. But if you want Family Planning instead of preaching family planning you start improving the economic status of women, education etc. all of a sudden women will tell you they cannot afford to have another child. It is increasing or training the overall thing, giving the boy a purpose in life, the girl a purpose in life let them see how society is structured, and let them develop themselves. Of course you bring the specific messages too and then within that comes AIDS. Not just AIDS only.

**Brendon Bain, U.W.I.:**

I didn't come to ask Dr. Findlay but since he said about targeting the young girls I wonder whether he would include the older men as well.

**Philip Finlay MD:**

Let me make it succinct and say yes.

**Brendon Bain, U.W.I.:**

My question is to Mrs. Ali. What improvements will you like to see in the action approach taken by Faith based Organizations and how can the links with the education sector, between Faith based Organizations and the education sector, be strengthened.

**Mrs. Ali:**

I believe there is so much that we have in common that we can help to support. Number one I find when we try to teach abstinence rather than getting an acceptance about that abstinence aspect or programme you end up getting into debates and saying that it is not possible. So I will like to see where it can be readily accepted as Faith based Organizations let us be free to the abstinence and show our youths how they can do it. Not just saying no to drugs and no to sex but empowering them through various programmes and developing them to accept something like that. Also in terms of marriage relationships, fidelity, stressing that aspect. The connection between the education sector and what can be done, I know that one problem that we face is lack of resources in terms of finances. I mean we are involved in a lot of things I mean there are young people who want to do drama, pursue skills in different things like right now we are working on producing some public service announcements on AIDS but it needs to be funded. It needs large sums of money. We have people who are willing but it is the funding. Also identifying our young people, getting our young people involved in using their talents and abilities and you will be amazed how much we can tap into. Sometimes as adults we feel we have the ideas and we

are really not consulting our youths in the programmes that we have. So I can believe that having dialogue with the youths, also working closely with NGOs and this has been one of my complaints that many things are happening and I would hear about them after the fact. And I am very passionate about everything concerning HIV/AIDS yet many times as churches we don't know what is happening and we are not really involved or invited. I would like to know that we are on mailing lists and that we are consulted since I believe we have so much to offer.

**Adele Jones, Social Work Unit, Faculty of Behavioural Sciences, U.W.I.:**

I really just want to make a point to respond to Carole Keller's request that we approach this in a multi-disciplinary way. This is a conference of educators and I am here with a contingent of graduate social work students. I know that there are a lot of people in this audience who are very committed to the psycho-social effects of the epidemic and perhaps one of the things that we can offer among many things is perhaps some more understanding around behaviour and the way in which exclude and include certain groups. This really talks to Dr. Kelly's comment about the use of language. I like to make a plea that when we talk about high risk people we have to remember that it isn't people that are high-risk it is behaviours. And when we set people up as having high-risk behaviours we then very conveniently create a separate exclusive group that we are not part of. The child who is the new born infant does not indulge in high-risk behaviour by breastfeeding, however if the child's mother is HIV positive the child is at high-risk of contracting the virus. I think the dangers of thinking of risks in terms of high and low risks is one of the ways in which we very conveniently create a language in which some people are excluded and some people are included. And those people who are having sex within the context of their marriage are not indulging in high-risks behaviours. So if we want to have an inclusive approach we really do need to take on board the issues around language and how language creates exclusion and inclusion. Thank you.

**Ruby Greene, Keane University, Staffordshire, United Kingdom:**

I just wanted to comment on the fact that throughout the conference so far we have been hearing about education but I don't think it has been dealt with in a holistic way given Caribbean culture. We need to understand that the Caribbean is a patriarchal society, very patriarchal. Women are very high-risk. We are not taking into consideration the cultural factors which put women at risk. Gender violence - it is no point giving education and women are being beaten everyday and nobody is talking about it. It is not the things we are saying in education it is the things we are not saying. We have things like the power of women - how powerful are women given the fact that it is not uncommon in the Caribbean to have multiple sexual partners and for it to be a norm. It is accepted. In the case of women - if a woman has multiple sexual partners it is frowned on. It is not so frowned on - remember, I don't know if there are some of you who are old enough can remember in 1981 we had a road march called the 'Deputy is Essential' and everybody was prancing to that road march. Nobody saw anything wrong with it but that was prior to AIDS. However, we have gender violence, we have things like women not being able to control the exposure to risk, we have things like gender and sexuality in terms of culture - women under some kind of social pressure to have children and when I say social pressure is that we don't have something called voluntary childlessness in the Caribbean. If a woman says I have chosen not to have a child everybody in the Caribbean says, "Don't worry about her it is because she can't have." If you are to have a child you have to have unprotected sex and you are at risk and it is the things that we do not say within our culture and when we are talking about education we need to talk about it. in a holistic way. We also have been talking a lot about men who have sex with men and we haven't spoken about the homophobia which we have in the Caribbean. We are a very homophobic society and because we are homophobic we have many men who are potentially or who are probably closet homosexuals who have sex with men and because they are suspected of being homosexual they have sex with women. And even if the rumour persists that he is still a homosexual the only way to prove that he is not homosexual he has a child with

this women thereby putting her at risk. These are the things we don't talk about so when we are talking about education we need to be a bit more holistic in our approach to it. Thank you.

**Dr. Zulaika Ali, Faculty of Medical Sciences, Coordinator of HARP:**

Good afternoon ladies and gentlemen. Unfortunately your chairman is not here as yet so I am deputising.

**Mrs. Catherine Williams, Activities Coordinator for the Community Action Resource Group:**

Good afternoon everyone. Members of the head table and distinguished guests. Before I start I want to let you know a little about Community Action Resource because sometimes people even in Trinidad don't know about this organization. It is an organization formed in 1989 to support persons infected and affected by HIV/AIDS. It incorporates HIV positive persons in the work of the organization. We target most of the people in Trinidad and Tobago, most of the HIV population in Trinidad and Tobago. Recently we have seen two groups started but we are still seeing patients/clients from San Fernando and Tobago.

Today I am asked to talk about HIV and the power of education. We live in a society where the acquisition of wealth and material things have become the reason for living for many persons. Parents encourage their children to choose careers that will bring large monetary returns and not necessarily something that they like or enjoy doing. The workplace sometimes become a competitive war zone. In such an environment persons living with HIV/AIDS are seen as dispensable commodities, liabilities, not human beings. Many employers when informed about their employees' HIV status either by mischievous accident or when informed by the employee themselves panic. Not much consideration is given as to how the company can assist those employees to work and maintain productivity even in companies that have medical and pension plans. In most cases the prevailing concept is how can I get rid of this liability. This is so sad.

productive employees with so much to give are discarded because of their HIV status. What thought is given to the impact that these heartless decisions cause? Take for example the case of a widowed mother already devastated by the lost of her partner now she losses her job. How can she continue to pay the mortgage? She will have to sell her car and what about the children's lesson fees and where is the grocery money going to come from? And the money to buy all the expensive medications? Forget about dancing and swimming classes? This is the reality of quite a few middle and working class families here in trinidad and Tobago. Silencing suffering because of the stigma and discrimination associated with HIV/AIDS. Living on the brink of poverty, isolated, frustrated, suicidal. In desperation many have called the AIDS hotline and have been referred to CARE and we have provided counselling and medicine and help to stabilize them. Some of them have been fortunate to have relatives abroad who have assisted them to go to the United States and helped them to get into clinics. Some see stay abroad unable to face the stigma and discrimination while others return home when they have put back on weight. They manage to find lesser paying jobs. They also have the lesser burden of going to New York every six months for their chck-up and medication. But what about the persons who have no help? Wee they simply die alone without dignity and their orphaned children they become street children, vagrants, dug addicts, criminals, haters. What will you do if after completing your degree programme and acquiring your prestigious job, you found out you were HIV positive? How can education help to reverse this vicious cycle people are living with right now in Trinidad and Tobago. We at CARE we have provided information on the disease and counselling for our clients and we have seen that through information and through education these persons have become empowered. We are seeing behaviour change and we are seeing people going back to work , people going back to school and now since the anti-retro viral therapy has been reduced in Trinidad people are more healthy and even getting married and their life has been extended. And so because we have used education as a tool at that intervention we have seen an improvement in the lives of persons living with HIV and AIDS. Education can be used to



change the messages of HIV and AIDS. Many of the messages which we presently see have a negative impact and encourage discrimination by suggesting particular groups of persons who are infected with HIV/AIDS. An example of one of these ads is: "Get high, get stupid, get AIDS." Education can help change the images. People still think of people with HIV/AIDS as emasculated skeletons just waiting to die and develop a false sense of the reality that HIV positive people are beautiful people, good looking people just like you and me and they can pass the virus on to other persons even though they are looking good. Education can be used to restore the identity of persons living with HIV and AIDS. When a person becomes HIV positive he or she automatically loses his identity - he is no longer Mr. John, he is the man with AIDS. I notice even at CARE when organizations send invitations to us many times on their letter and on their agenda they have 'a person with AIDS', not a representative of Community Action Resource. Sometimes some of them don't even try to find out the name of the person who is coming and they don't understand when you look at the agenda when you see everybody with Mr. John -their names and designations - then you look and see a person living with HIV/AIDS. You have no identity, you have no name and a lot of organizations do this. They need to be reeducated so they can understand that people living with HIV are persons. Education can be used to empower persons living with HIV/AIDS to advocate for themselves and demand their basic human rights. One of the things we have found in CARE is that a lot of persons living in Trinidad and Tobago, in the population there are many people who don't know their basic human rights. This is why a lot of them leave their jobs and accept discrimination at the hospitals because they don't know that they can stand up for themselves. We find that after we give them this information and they understand that this is my right . So whenever another incident happens they come back and say you know this happened at the hospital today and I was able to defend myself - I was able to demand service and this is because they now know their right. When they don't know their rights they accept everything that is given to them.

Education can be used to promote self-esteem and self-awareness among the youths and even older persons through family life education, and peer counselling programmes. One of the programmes that Community Action has been involved with is the School Programme and we started it through our World Aid's Day Project by asking the schools to sell ribbons for us and then we found that we needed to give back something to the schools and so the HIV positive clients who have become empowered we train them and they join the coordinators and go to the schools to provide information. We find that there is a lack of information, family life education, information on HIV, STDs, even one school I went to - a SERVOL school, some of the students didn't know anything about monthly cycles and that is basic thing. So that if we provide education on family life and all these things it will help the young people to understand what is happening around them. It will help them to change their behaviour, if they feel good about themselves then they would not do some of the things that they are doing presently.

Education can be used to provide persons with correct information on HIV/AIDS, and this will help them to make informed choices and practise safe sex and change their behaviours.

Education can be used to help to improve delivery of service to persons living with HIV/AIDS and to improve confidentiality especially in the Health sector and in the education sectors.

Education can be used to develop skills building and income generating projects especially for women because economics is a factor for women. We find that a lot of them are at risk and we find that if women are independent and can do something to provide an income for themselves they can say no if they feel that they are at risk. Right now at CARE we find a lot of the women are not employed and they come in looking for partners who would help them to survive and sometimes they accept any kind of relationship because they are not able to

survive on their own. We have tried some income generating projects and it has worked to some extent because of a lack of funding it is difficult to keep them going. I would like to see that in schools, in the school system, more skill building programmes like the HYPE programme which is now happening in Trinidad. We are attached to the schools so that people not only get academic education but they get skills because some people don't want to work in an office. They prefer to do something with their hands and this can help people to reduce their risks because if you are able to be in charge of your own situation - you know - you can say no you can think twice before you get into a relationship.

Today many people are dying right here in Trinidad and Tobago because of the lack of affordable treatment and care. But greater than the effect of the virus is the impact of the oppression and the discrimination faced by people living with HIV/AIDS everyday. This takes away our jobs, our homes, opportunities for self-determination and development, our purpose for living. It robs us our dignity and our will to live leaving many broken people and empty shells. Today as always I stand here to tell you that the people living with HIV and AIDS are not the problem. The problem is bigger than them. The spread and increase of HIV has greatly been influenced by the lack of information and the lifestyle of our society. People living with HIV and AIDS are part of the solution and working together we can use education as a tool to reduce the incidents of stigma and discrimination and create a better society for all of us to live in. Thank you.

**Mrs. Catherine Luyen, Special Advisor to UNDP:**

I am going to talk about UNDP's most recent programme in capacity building. It is a regional programme entitled, "Leadership development for results in HIV and AIDS." The programme as I mentioned is a regional one it was initiated this year for the first time in this region. It was actually started in 2002 in Sub-Saharan Africa and then extended this year to the Caribbean, Eastern Europe, Cambodia and Nepal. The whole concept of leadership development and the rationale

behind the development of leadership for UNDP came for many reasons one was the call from the **YUNGLASS** declaration that specified that in order to respond adequately to HIV and AIDS we needed innovative leadership at all levels. First at the highest levels of government and also from all sectors in collaboration with government. Another key reasoning for UNDP behind this programme was the UNDP's corporate strategy on HIV and AIDS which has capacity building at its core and the local ownership of capacity and solutions in response to AIDS. Also from the lessons learnt that we have gathered around the world re the global experience with HIV and AIDS many of the countries which have HIV and AIDS have noted highest level leadership at its core. Pivotal to positive responses we have noted that leadership is at the core of its response. The kind of leadership that drives sufficient allocation of resources, that drives proactive action, that drives facing up to the realities that HIV and AIDS bring. So because of this the UNDP decided that as its core programme in capacity development in response to HIV and AIDS we would implement what we call the LDP programme -the Leadership Development for Results in HIV/AIDS. As I mentioned that started this year in the Caribbean and involved five countries, Trinidad and Tobago, Barbados with some involvement from the OECS countries, Jamaica, Guyana and the Dominican Republic. The programme itself is based on the core concept of emotional intelligence and building emotional intelligence. It was termed coined through the organization management language by Daniel Beauman some ten years ago and then further developed by himself Robert xxx and Annie McKay in 2002 in their publication Primal leadership. Emotional Intelligence is one of the concepts, other concepts that were shared throughout the programme the LDP programme were dynamic inquiry and resonance of leadership. So at its core the LDP had emotional intelligence. So what is emotional intelligence? Well it is defined really as the capacity for an individual to be aware of ones self, ones emotion and moods. Control those emotions, manage those, be aware of ones strengths and weaknesses. And also manage those in relation to other people. Be aware of other people's reactions to your own moods, to your own strengths and your own weaknesses thereby controlling relationships with people and

also your own social relationships in other words your organizational relationships. We can take a look at some of the social competencies provided by emotional intelligence. E.I. provided competencies such as effective listening, empathy, initiative and creativity, adaptability, persuasion and motivation, optimism and team work. Now from what we know of HIV and AIDS work and for all of us who work in HIV and AIDS we know that it is often a draining, a challenging, a type of work that is is fraught with emotion and it is an often daunting task but also very, very rewarding. And so in everyday HIV work we call upon all of these competencies at one time or another. Work in HIV and AIDS also requires commitment and passion and therefore the programme sought to build upon this personal commitment and passion and harness it into individuals who are strategically placed and who can have influence over their peers and their organizations.

Just a little bit about the format and the methodology for rolling out the programme. It was and I use past tense even though there is one phase to go hopefully in December this year. I smile because one of my change agents is in the audience and she is smiling back at me. It was a one year roll out and the programme requires one year of intensive training. So you can imagine the commitment that is required at the beginning of the programme from persons who are called away from work and so on to be present at one year of workshops and training and repeated contact hours. The first phase of the programme requires the selection of what we call change agents. Change agents are really distinguished leaders identified within societies and in each one of these countries we choose ten change agents for each country. There were people who had the potential for leadership or displayed leadership qualities. They were people who were active in HIV and AIDS work or in related fields such as gender, stigma and discrimination. They were people who demonstrated a personal commitment to issues such as HIV and AIDS and other social qualities. These people were hand picked, carefully chosen in consultation with the country offices and with other national stakeholders. They were trained in a regional

workshop that took place here in Trinidad and Tobago. Ten change agents for each country as I mentioned this was followed by in-country workshops in each country that involves fifty to sixty persons training. At the second workshop the function of those change agents changed from recipients to facilitators and they took on this role very actively and very efficiently. They worked with the consulting team and also facilitated sessions themselves as they were identified to be coaches for the larger in-country teams.

The second phase of in-country workshops took place over a period of about two and a half months. What then followed was a three month period of implementation of what we call action learning projects. The in-country teams sat amongst themselves and developed, designed and budgeted projects that they chose to implement during the three month period. And this was particularly notable because we wanted some concrete outputs from the programme and we wanted to see what persons and some persons who were not usually exposed to HIV work would come up with. What resulted was a rich and vast array of programmes. Some quite ambitious, some more doable than others, some more successful than others but all attempted. And all participants returned in country for a third round of workshops to report on their action learning projects. Now I will go through some results of those action learning projects a little later. But just to take you through the foundation concepts of emotional intelligence. As I mentioned its core is self awareness, awareness of your moods, awareness of your strengths, awareness of your weaknesses. Self management, managing those weaknesses, those moods and it is more than putting on a brave face at the office every day. It is about making a conscious and executive decision to influence others by a positive attitude by your moods and so on. Particularly in an emotional charged issue and line of work as HIV and AIDS. That then of course contributes positively to social awareness to the management of relationship skills and therefore a positive impact on others and an action. You may how it is this was then delivered in a series of workshops themselves were extremely interactive and employed focus group discussions, one- on- one interviews,

dynamic inquires and even field visits and there was even a component where participants went out into the fields to practise their listening skills they were in St. James, in downtown Port of Spain and of course different location in different countries and many of them came back saying they never learnt how to listen and it was a revelation to them how little or how much information people had. And they had never quite had the opportunity to employ their listening skills in such a way.

A little bit on how these leadership competencies come from building emotional intelligence. The self awareness that I speak about demands emotional self awareness. Understanding that your very emotions and your inner life have just as much to do with your professional face and are just as important to what you project on your professional side. Self awareness also demands an accurate self assessment. Knowing your strengths and weaknesses is not an easy task and also the self confidence to project positively. Self management, self control, transparency, adaptability, achievement, initiative and optimism. These can feed into social awareness. Competencies here were empathy, organization awareness and commitment to service. And then feeds into management of your relationship positively, influence, developing others, acting as a catalyst, often conflict management, team work and collaboration. This was a critical component in what we noted particularly because the nature of the workshops and the representation was very, very vast. We had representation from Government sectors, NGOs, Faith based Organizations, and you had for example instances where Commercial Sex Workers Organizations met with the Catholic Church in one group and the dynamic that that created. The relationships and the interaction that that created was very, very interesting. So that this component was particularly interesting and how this emerged at the end of the workshops.

A little bit on resonance that we spoke about as one of the core components of the leadership programme. If we visualize some key leaders that we know and as Daniel Goldman puts it new leaders read the emotional landscape and respond

to it authentically. Again this is the difference between putting on a brave face and managing your emotions, managing your strengths and your weaknesses.

New leaders inspire people to actions through powerful, positive messages. Inspiration is one thing, inspiration into action is quite another. And being in control and being able to manage yourself and being able to project positively when you can move another individual from point A to point B into action is what we were targeting. New leaders act consistently with their values and they are not afraid to talk about them. It is this confidence that we spoke about earlier under that component on self management.

The programme unfolded based on this principle as well. But the fundamental role of the leader is to prime good feelings in those they lead. If they fail at this nothing else will work as well as it could or should work. The best leaders do this by creating reservoir positive energy by resonance this is from Primal Leadership from Daniel Beauman's publication. Great leaders move us, they unite our passion and they inspire the best in us.

The programme also recognize that resonance of dissonance is actually the leader's choice. The majority of what separates great leaders from others is emotional intelligence. While some leaders might be abrasive and might have short term success it is just that short-termed and short-lived. You will note that if you can look back to any leaders that you can think of whether in community or in organizations who have had long term success those are the ones who can really inspire people. So that based on concepts of self awareness, self management, social awareness and relationship skills leaders have the choice of resonance as distinct from dissonance which we consider the difference in peoples' ideas and principles that create obstacles in things working effectively. An example of this choice is how you look at obstacles. The good leader as oppose to dwelling on a breakdown or an obstacle views this obstacle as a breakthrough charts a different path, finds different options and solutions, and



different ways to respond to challenges. We took participants through this particular area in the programme specifically when they got feedback from the general public in their field interviews. We found that a lot of the projects emerged out of these field interviews simply because participants at this stage were so motivated to respond to those challenges that the projects were designed specifically on issues that they felt very strongly about which emerged from people that they spoke to on the street.

As I mentioned another competency, another pivotal area of the programme was the systems perspective. And we know that HIV in its multisectoral response brings together many constituent groups often with overlapping goals and different ways of getting there, often with conflicts for resources and attention. The LDP facilitated an understanding of how those parts fit into the whole system. What role the church leader had to play, what role the NGO head had to play, what role the government sector personnel had to play and that communication and that collaboration that was built over the year long programme we believe and from the evaluations from participants did facilitate a greater understanding of how the system worked and this whole systems perspective. The understanding of the systems perspective therefore coupled with the leadership led to a greater achievement of the goals particularly in the learning projects. Diverse ranges of people came together to implement these projects.

Why is emotional intelligence important? Well emotions dictate our thinking, they motivate and mobilize us into action. Consequently our feelings direct us to what we want and or need, it determines our behaviour and actions, facilitates relationship forming, strengthens collaboration and influence how the leadership role is utilized or viewed by followers. It also influences how a team works together. This is often in an area that is not explored as much as the cognitive abilities but an area that is equally important because It drives our action, it

drives our passion to our work and for this reason was applied to the context of HIV and AIDS.

Some of the more noteworthy results of the Leadership Development Programme were:

1. The training in excess of more than 250 individuals in the Caribbean in leadership development, project management and networking.
2. A number of innovative action leading projects - there were an average of about 25 to 30 projects that were actually implemented over the course of the year.
  - One on HIV/AIDS awareness in correctional institutions in Jamaica.
  - HIV/AIDS sensitization of School Principals in Jamaica,
  - Project Hope which was a communication strategy that had positive imagery of HIV and AIDS and living with HIV in Trinidad and Tobago. That actually spawned a support group for People Living With HIV and AIDS in Trinidad and Tobago that I understand is still running.
  - HIV/AIDS sensitization and in rural areas of Trinidad and Tobago. Sensitization of Medical Personnel in Santo Domingo.

And this again came from the evaluation of the projects. Participants were provided with tools to sustain their personal development. So moved and so powerful was the programme that very early on we had a call from our change agents - these were our selected facilitators- to add on a final phase to debrief and for them to decide next steps. This came not from UNDP, it was initiated by the change agents and UNDP was challenged to find the resources to bring the regional change agents back together to regroup, to debrief, and to decide on next steps. I assure you at that session they will be telling us what is next for the region, they will be telling us what is next for the programme, and we will be hard pressed to find the resources to support that. Many participants also initiated workplace and community activities. In Trinidad and Tobago alone I have received five project proposals from participants at the workshop who have gone back, identified challenges and

opportunities particularly at the workplace and also in communities and developed proposals and submitted those proposals to us for funding and for support. Therefore it is not only the leadership skills that have obviously been built but the skills in project development, the identification of opportunities and so on. And the very confidence of individuals and leaders at community levels.

Another key output was the strengthening and often in some cases creating collaborative relationships among sectors in country. And sometimes non-traditional sectors. I mentioned the case of a particular working group that had head of a commercial sex worker NGO and a member of the Roman Catholic Clergy and we thought oh this would be an interesting dynamic and it was. And there are many such examples of that. And the type of relationships that were forged from it, the understanding of the role that each person plays was quite extraordinary.

Thank you very much.

**Professor Brendon Bain, DM, MPH, DipMedEd, Department of Community Health and Psychiatry, University of the west Indies, Mona:**

Thank you Professor Kochar, Sir George, and distinguished members of the audience. I want to take the same liberty that my colleague Roger Mc Clean took yesterday and use the first moments of my presentation for what I was not asked to do. I thought there were some memorable quotes yesterday on HIV/AIDS, some of them I will bring back to your attention by way of reinforcement. I heard our chancellor his words were very similar to those of Roger Mc Clean yesterday that HIV/AIDS is not inherently intractable. I am not multi-lingual so this is the best I can do in the way of translation.

Then I hurriedly wrote down word for word what Professor Kelly said to us in giving us an injunction from Africa. I listened carefully as different speakers changed the alphabet and Dr. Findlay emphasised that you must know your partner.

- Both be careful.
- 
- Abstain (where relevant)
- Condomize if uncertain.
- Don't do drugs.
- Educate.
- Abstain where relevant.

Professor Kelly especially said like this, "Educate, Educate, Educate."

Then in the discussion yesterday, he brought to our attention the four pillars of learning as outlined by UNESCO:

- Learning to know,
- Learning to love one another,
- Learning to be (self-awareness and development)
- Learning to do.

We also heard about:-

- Compassion
- Emotional Intelligence
- Institutional (school) Development not just Curriculum Development
- Spiritual Intelligence

I picked up very clearly from the President of the University of Aruba that we must just not focus on the Curriculum, our school systems need to be looked at outside of the context of HIV/AIDS. We need to look at and act on Institutional Development and then Mrs. Merle Ali brought to our attention the need for spiritual intelligence.

That was my quick review of Yesterday.

Now I was asked to speak on "**Structural Change to facilitate HIV/AIDS Education.**" I am very proud of our new logo that came out of a competition and was won by one of our students. These are some of the concepts of the UWI/HIV/AIDS Response Programme:

- Promoting awareness and appropriate action against HIV/AIDS,
- Neither over-emphasising nor under-emphasising.

I find it necessary in negotiating for change in the University to make clear that we do not want to flood the University with HIV/AIDS, I keep saying to people, yet we must not under-emphasise it and we are busy advocating not just for change but for effective and sustained change.

### **UWIHARP History: Beginnings**

**2000 - UWI Vice-Chancellor** approached three leaders to ask for increased UWI involvement in the response to HIV/AIDS.

The emphasis, the key role that the political leadership plays in every institution and in every country. I think that there are case examples that reinforce this principle to us, so that the presence of the President and the Prime Minister of Trinidad and Tobago at yesterday's session was just not symbolic, but a very practical gesture.

We began in March 2001 with a workshop and brain-storming session:

- August 2001 - Launch of 1<sup>st</sup> UWI HARP Committee coinciding with the first visit by Professor Kelly to this part of the world.
- February 2002 - Launch of UWI HARP committee in Barbados and Trinidad and Tobago.
- August 2002 - Strategic Planning workshop including campus and non-campus countries, Dr. Nancy George and a few persons from University of Technology were invited to this session.

We are very pleased that we have had a certain amount of financial support: In fact the first workshop was supported by grants from the Ford Foundation and the European Union.

- January 2001 - June 2004 - European Union Project for Strengthening Institutional Response to HIV/AIDS/STI in the Caribbean - Approximately \$2.5 million
- March 2001 - Ford Foundation - European Union - Approximately US \$12,000.

The Principal of Mona campus was able to provide salaries:

- February 2002 to Present - Mona campus salaries for two staff members.
- September 2003 - U.S. Centres for Disease Control start up funds for Caribbean HIV/AIDS Regional Training (CHART) Co-ordinating Unit

CHART centres to be located in Haiti, Bahamas, Trinidad and Tobago, and Guyana in the near future Jamaica.

**Our staffing at the moment:**

**Co-ordinating Unit:** One parttime director (Professor Bain) and one full time project officer.

**Three campuses:** One part time director (Professor Ali with Professor Carl Theodore), two full time lecturers (each campus) and one curriculum coordinator (each campus). All paid via EU project which is scheduled to finish June 2004.

**Our mission statement is similar to many agencies in the Caribbean that have engaged in HIV/AIDS:**

To build and harness capacity within the University in order to:

- Contribute maximally to the national, regional (Caribbean), and international effort to control the HIV/AIDS epidemic.
- To mitigate the impact of HIV/AIDS on the university itself and the wider society.

**Our aims are:**

To accelerate action by UWI in response to the growing HIV/AIDS epidemic through:

- Research
- Education and Training
- Strategic Engagement with the wider society
- To develop and monitor HIV/AIDS Policies -particularly within UWI.
- To generate attract/manage resources to sustain the response to HIV/AIDS.
- To serve as a clearing house for HIV/AIDS information, complementing national, regional and international agencies.

We naturally need to attract resources. we have pledged ourselves to manage them well. We want to join forces with CAREC to serve as a clearing house for HIV/AIDS information.

### **Our structure - UWI HARP Structure:**

- Coordinating unit reporting to Vice Chancellor
- Three campus committees report to campus principals and to coordinating unit.
- Sub-committee working on specific tasks. Relationships with non-campus centres via School of Continuing Studies
- UWI Bahamas School of Clinical Medicine

UWI HARP Membership is multi-disciplinary and we are covering just about every discipline on the three campuses.

I was talking just last night to a member of the Faculty of Engineering, St. Augustine and was encouraging him for his faculty to come on board, because engineers are not immune from HIV/AIDS and we would like them to be part of what is happening in this response on the campuses.

We have a cross-section of staff and students including:

- Trade Union Representatives and
- Government and other representatives (by invitation).

Our customers are:

- Our students and teachers
- Administrators
- Student Service Managers and Resident Advisors
- Trade Union Members
- Persons who graduated a long time ago, clerical and support staff.

Our tasks. We have discerned that our tasks is really one of social marketing. Those of us who have not had training in social marketing are relying on persons with expertise and trying to learn on the job ourselves. We are

- Marketing of attitude and behaviour change in the context of HIV/AIDS.



- Attempting to persuade all parties that HIV/AIDS requires an organized structured response - (Applies to Ministry of Education and High Schools)
- Establishing and maintaining appropriate structures for as long as is necessary to accomplish the task.

And in working with Professor Kelly, one of the things that impresses me is that we don't just need to focus on curriculum development we may well need to organize or re-organize some of our structures for the most effective response and this may apply to ministries of education and high schools as well. We need to maintain our structures. Historically they have been structures put in place for management leprosy and tuberculosis. And these structures have been dismantled appropriately in the course of time. One wonders if special structures need to be created for HIV even temporarily. And Professor Kelly tells me that in Africa they are digging in to a fifty year response to HIV/AIDS.

**Action for Attitude and Behaviour change:**

- Planning strategic and operational
  - Input
  - Process
  - Expected outputs / outcomes
- Getting into action
- Monitoring and evaluating activities
- Adjusting based on feedback
- Celebrating AND sustaining successes.

What action should we carry out. Planning this is not one of our forte. We just like to launch and do the work here in the Caribbean but strategic planning and working out your operational plan will help you to do your work more efficiently and effectively. These are just elements of strategic planning.

**Our aim is:**

- To ensure that each target group is aware of HARP.
- Perceive the programme accurately.

- Believes that the programme is valuable.
- Accepts their needs.
- Demonstrate appropriate action in response to the epidemic.

**Desired outcome:**

- Appropriate measurable action by Administrators and the University community attributable at least in part to UWI HARP.

**The Challenge:**

- To make our effort well coordinated and sustained.

**Our needs:**

- Continued strengthening of political will within the University
- Consolidation of organizational structures.
- Resources to build and sustain efforts.
- Excellent monitoring and evaluation.

Thank you

**Dr. Brader Brathwaite, Educational Specialist, Faculty of Medical sciences,  
UWI:**

## **CURRICULUM REFORM AT TERTIARY LEVEL**

### **Challenges for tertiary education in the face of HIV/AIDS**

- Correctly interpreting societal realities
- Understanding the structure, capacity and potential of the existing tertiary provisions
- Reconstructing the education provision to improve relevance
- Helping learners understand and adapt
- Achieving quality tertiary education in a culture of diversity and a climate of change
- Immediate response to staff and student concerns and their needs for resources
- Respond to the factors driving the epidemic.
- Immediate collaboration with stake holders.

### **Reported Aids cases in Carec Member CMC's 1982-2000**

Most tertiary students

15-24 ; 25-34; 35-44

### **Factors Driving the Epidemic Social cultural behavioral**

- Dysfunctional gender relations
- Limited life skills for sex education
- Cultural and religious taboos
- Insufficient condom use and monogamy
- Discriminatory policies and lack of equity
- Substance abuse : alcohol, crack and cocaine, risky behaviour

## **Economic Issues**

- Rapid urbanization
- Migration

## **Preliminary Enquiry Institution's mandate Policy and Management Systems Impacted by HIV/AIDS**

- High risks situations for students and staff
- Loss of human resources
- Care & support for persons affected by HIV/AIDS
- Mosaic in the Caribbean epidemic
- Tourism economies – higher incidences
- Mobile and migratory population
- Displaced persons
- Social sex networks
- Sex for survival, dis-empowered women
- Homosexuality & CSW are illicit

Curriculum Reform – Contents

Where is the voice of the most vulnerable

Informal, inter-sectoral contribution

What knowledge, attitude or skills must be delivered

We now have more female than males in the groups and need to look at patterns  
Male 15-19; students ; primary 5-9 ; 10-14

## **Curriculum Reform Classroom**

- Updated information from web sites
- Divergent view points
- Approaching sexual references in class room
- Student and Staff involved in action
- Student research on regional issues not esoteric studies

## **Issues of Confidentiality**

Service learning :

Send to community to learn by doing and bring back to classroom

Serious campaigning – SG West ; SG Central SG East. Why some people in certain area at risks

- Curriculum Reform : Quality
- New technologies and accommodations
  
- Curriculum relevance
  
- Infusion & Integration
  
- Monitory & Evaluation

Slide shown at this point –School of Education –Group called “Rapport”

END OF PRESENTATION.

**Dr. Nancy George, University of Technology, Jamaica:**

**“FOCUSING ON HIV/AIDS EDUCATION AT UTECH POLICY CHANGE AND PRACTICAL DEVELOPMENT”**

Good morning. It is really a pleasure to be here. UTECH can measure its involvement with HIV/AIDS with tUWI HARP and Professor Bain who has included us in so many of the endeavours that UWI HARP has undertaken. So basically just very quickly , originally we were a technical college and we were built on a Polytechnic model which was experientially based giving the students the experience in order to develop their skills. We were granted university status in 1995 and chartered in 1999. So we are very young as a university but we are growing and going through a transition in all sorts of different ways.

**BACKGROUND OF UNIVERSITY OF TECHNOLOGY**

- Originally technical college (CAST)
- Built on Polytechnic model (students learning to develop skills)
- First National Public University in Jamaica (we do not undermine UWI but are funded by the Government)
- Sole technical University in the English-speaking Caribbean (special regional responsibility).
- Granted University status in 1995
- Chartered 1999
- 7000 Students full time and part time

**HIV POLICY DEVELOPMENT AT UTECH**

Framework for Action

- Stimulus from UWI HIV/AIDS Response Programme (UWI HARP) and UNESCO - late 2002
- Established HIV/AIDS Steering Committee under Academic Board in December 2002
- HIV/AIDS strategies and milestones inserted in Strategic Plan 2003-07-February 2003.

- Policies (except HR) developed and approved September 2003

## **RESPONSE TO HIV/AIDS POLICY**

### Initiatives/Steering Committee

- All University Divisions and Faculties represented on HIV/AIDS Committee
- Indifferences among Student Body/Students Union
- Decision to initiate activities to generate student involvement/interest  
(Programme based on Action)

The steering committee was formed by putting the invitation to all of the units within the university to nominate a representative, someone who was interested in addressing the HIV/AIDS initiative to sit on the HIV/AIDS steering committee.

Everybody from the Unions to ever office, everybody from every unit in the university responded positively. Except the Student Body who said we will come to the next meeting, we will come to the next meeting but never turned up at any meeting. This was a great concern to the people in the university because after all if we are not targeting the most at risk group in our community and if they are not interested in being involved we have a real challenge on our hands. It doesn't matter what we do as a committee of people saying the students ought to if the students aren't involved in this. So this presented us with a real initial challenge. So we decide to initiative activities that would engage the students and get them interested and involved in issues related to HIV/AIDS. This was not by sending our papers saying you should come but we decided that wasn't going to work we had to do something more action oriented. So our programme this year has been based on action first. So the first thing we did which didn't have much to do with HIV/AIDS was a fund-raising car wash.

## **HIV/AIDS FUND-RAISING CAR WASH**

### Objective:

- Generate community interest and involvement in HIV/AIDS as priority issue in University.
- Raise funds for future HIV/AIDS education initiatives.

**OUTCOME:**

- Exceeded fund-raising objective by 17%
- Created cross-University community engaged with issue of HIV/AIDS
- Encouraged Steering Committee to attempt larger educational event
- Create cross-University community engaged with issue of HIV/AIDS
- Encouraged Steering Committee to attempt larger educational event

**HIV/AIDS AWARENESS DAY (HAAD) EXHIBITION:**

We came up with the idea of having a competition and inviting groups within the university not just students: the clubs, the faculties, and the divisions to put a graffiti message on this zinc fencing around the Sculpture Park. The graffiti wall turned out to be a whole initiative of itself - it was to be a backdrop for the exhibition but it became a whole energetic thing of itself. The objective was to engage the university community, as well as covering up the zinc fence, to develop positive messages related to three themes that were the foundation of the exhibition. UWI HARP also sent a team and also participated in the graffiti wall.

**First movement in this area was the installation of the Graffiti Wall. Check website : [www.utecgraffiti.cff.net](http://www.utecgraffiti.cff.net)**

**Objective:**

- Engage Utech Community in interactive educational exhibition related to HIV/AIDS around three themes: protection, abstention and respect for persons living with HIV/AIDS.

**FEATURES:**

- Classes suspended for students and staff to attend Exhibition.
- Support from eight Corporate Sponsors and MOTT/World Bank Project grant
- Minister of Health opened the Exhibition
- UNESCO conducted Caribbean launch of World Youth Debate



## **YOUNG PEOPLE'S THEATRE PERFORMANCE ON EXHIBITION THEMES:**

- 28 interactive exhibits by private sector, NGO's, Ministries, Universities
- Three faculty exhibits of curriculum strategies through which students are engaged with challenges of HIV/AIDS
- 20 Graffiti entries as backdrop to exhibits (purpose of Graffiti Wall)

## **OUTCOME:**

- Graffiti Wall stimulated University-wide interest for a week before event
- Community came to Exhibition and stayed through thunderstorm
- Exit interviews unanimously favoured further HIV/AIDS initiatives e.g. research, HIV/AIDS testing, peer counselling .

(Everybody was there)

## **OBSERVATIONS:**

- Students came before the start of the Exhibition to obtain materials on offer but stayed through rain to watch demonstrations and talk to Exhibitors.
- Visitors hungry for accurate information, enthusiastic about engaging with ways of stopping spread of HIV/AIDS
- Team members researched, planned and worked together so develop and display their messages
- Teams cooperated with each other and with their "Competitors" with extraordinary energy and enthusiasm.
- Competition stimulated increased knowledge about HIV/AIDS

## **HIV/AIDS AWARENESS DAY (HAAD) GRAFFITI WALL**

### Result:

Permanent record of 133 persons thoughtful of engagement with challenge of HIV/AIDS and its potential threat to their lives.

## **WHAT'S NEXT**

- Complete development/implementation of HIV/AIDS Human Resources policies (to be implemented this month.)
- Document development of Graffiti Wall (UNESCO PROJECT)
- Continue to expand incorporation/infusion of HIV/AIDS related activities into curricula .
- Install condom machine – Pilot Project with Ministry of Health in Jamaica
- Develop peer counselling initiative as part of Community Service Programme in University
- Develop on-line HIV/AIDS Portal on University intranet . This was tested on Awareness Day.
- Invite NGO's supporting seropositives to establish contact with Utech and in surrounding community.
- Make HIV/AIDS Awareness Day an annual event in which initiatives are featured for Utech Community.