Standing Education on its Head:
Aspects of Schooling in a World with HIV/AIDS

Michael J. Kelly
School of Education, University of Zambia

Introduction

HIV/AIDS has radically transformed the world, including the world of education. The content, structures and programs that responded to the needs of a world without AIDS no longer suffice in a world with AIDS. This appears in the way school participation can enhance the risk of HIV infection. It also surfaces in the way school efforts to deal with HIV/AIDS in a traditional way, as part of the school curriculum, have failed to meet their objectives. These and other factors necessitate a radical re-thinking of educational provision. An initial step in this direction would be for the formal school system to incorporate some of the participatory features of non-formal education, with emphasis on the involvement of young people at all stages.

When society encounters a problem affecting the young, it tends to turn to its schools, and ask what they are doing about it. For example, many say that schools should teach more practical skills, so that young people will be more employable upon completion of their school programs. It is further apparent in the way many societies require schools to give more attention to the teaching of values with a view to arresting the decline in moral standards.

In relation to HIV/AIDS, the same tendency appears with schools expected to communicate knowledge, instill values and promote behaviors that will enable students to protect themselves against HIV infection. These expectations are legitimate given that, in the absence of a vaccine, other preventions involve some learning and some relatively permanent change in behavior arising from a communication process. What is common among messages about abstinence, safe sex, fidelity to one partner, reducing the number of sexual partners, protecting against vertical (mother to child) HIV transmission and using clean needles is that they must be communicated to and incorporated by the individual if they are to be acted upon. In other words, there must be some teaching and learning.

This being so, it seems reasonable to expect that the school as society's most formal teaching-learning institution should play a very active role in the communication of messages about HIV/AIDS. Yet there are reasons for caution. First, schools are not idyllic HIV-free institutions. They have their own problems with the disease. Second, they manifest such inadequacies in incorporating it realistically into the curriculum that one might ask whether they should even try to do so.

Addressing the role of schools with respect to this disease is simply one component of the difficult question of education in an HIV/AIDS dominated society. The world has not been the same since HIV/AIDS made its first appearance in the late 1970s and early 1980s. Neither can education be the same. Yet there has been very little recognition of this change. Existing responses to the way the epidemic interacts with education,

especially through the schooling system, have been piecemeal. Although there has been considerable tinkering around the edges, this has not been accompanied by great efforts to re-examine education in its entirety, or to ask whether, as currently conceived and provided, education can meet expectations that it be a potent force for gaining control over HIV/AIDS. In some settings, the education system may have undergone the equivalent of a somewhat botched varicose veins operation. In none has it been given the heart transplant that it really needs.

This paper argues that HIV/AIDS stands education on its head. Education in a world with AIDS must be different from education in an AIDS free world. The content, process, methodology, role and organization of school education in a world with HIV/AIDS must be radically altered. The entire educational edifice must be dismantled. Every brick must be examined, and where necessary, re-shaped before it is used in a new structure that has not yet been designed. The new structure will almost certainly incorporate a number of aspects of non-formal education provision. It seems likely that it will also be more community-based, with the traditional school replaced by a community-based service organization which will provide not only education but other services as well.

Recognizing that the very structures of current educational provision may enhance the risks of HIV infection for school students and teachers in a country with high levels of HIV prevalence points clearly to the need for some such radical restructuring of education. The difficulties in using the current education paradigm to induce behavior that ensures that the learner remains HIV free underscores the same need for change.

There are other pointers--the AIDS mortality and morbidity of teachers who work in a person-intensive industry that is dominated by a virtually unchanging methodology of one teacher before a class of twenty to fifty students; the erosion of managerial staff and the consequent loss of the experience on which their management was built; the AIDS-related incapacity of the traditional education system to accommodate the poor; the entrenchment by educational systems, as socializing organs of society, of the very disempowerment that renders girls and women highly vulnerable to HIV infection; the inability of education as traditionally provided to respond to the special conditions of an unimaginably large number of orphans and vulnerable children; the divorce between schools primly going about their customary teaching business and the AIDS-related horrors, violence and destitution in communities--all of these social dilemmas demand the restructuring of education.

These issues deserve thought. Though raised here, they are not considered any further in this article. Our concerns, rather, are with the HIV risks of schooling and with some of the underlying reasons for the problems related to the inclusion of HIV/AIDS in the curriculum. Studies recently undertaken on behalf of the Economic Commission for Africa on the impact of the epidemic on education in a number of African countries have highlighted many of these risks and problems. These issues were also raised at the "Education For All 2000" Conference held in Johannesburg in December 1999 and subsequently at the World Education Forum in Dakar in April 2000 (UNECA, 2000; Kelly, 2000). The problems schools experience are also frequently alluded to in program evaluations that seek to incorporate HIV/AIDS and reproductive health into school

curricula (Macintyre et al., 2000), but these allusions should be combined to see that they constitute a formidable problem. An appreciation of the extent of this problem will make it possible to be realistic about what schools can and cannot accomplish in the field of HIV prevention.

The Vulnerability of School Children to HIV Infection

Age-related data in various African countries regularly show AIDS cases at their lowest for boys and girls between the ages of five and 14. Because of mother-to-child transmission they are higher in children below the age of five, and after the age of 14 they increase very rapidly, especially for girls. Because of the low occurrence of AIDS among those aged 5-14 many regard these children as a "window of hope." Programs targeted at this group are thought to provide a special opportunity to prevent infections and reduce transmission of the disease (UNAIDS, June, 2000).

However, a number of circumstances relating to the way schools are organized and managed increase the risk of HIV infection for students, teachers and the community in which the school is embedded. First, school participation for children aged 5-14 is not risk-free. Indeed, as the following considerations show, in many cases it may increase the risk. If there are many more AIDS and AIDS-related cases among those aged 15-19 than among those aged 5-14, this can only be because in many cases the HIV infection which must precede has occurred well before the individual reached age 15. In much of the developing world (where the AIDS crisis strikes hardest), those attending primary school are of mixed ages. Because many children begin school late, they are older than they should be for their grade. This situation is compounded by the common practice of repeating one or more grades. In many countries it can be expected that at least half of those in primary school will have repeated at least one year, thereby extending the within-class age range (Nkamba & Kanyika, 1998). This management and organizational feature means that the same class may contain pupils ranging from the sexually naive and innocent to the knowledgeable and experienced. Being at school did not provide any protection.

Compounding the problem of mixed ages, many primary and junior secondary school children are already sexually active. Somewhere between ages ten and thirteen, the majority of boys and girls reach puberty, but there are indications from various parts of the world that the age of initial sexual awareness and experience has fallen considerably and that it continues to do so. Reports abound of pregnancies in pre-teenage girls. Almost half the primary school children in Malawi are reported to be sexually active (Domatob & Tabifor, 2000). There is evidence from Zambia of considerable sexual activity among street children, boys and girls, aged eight or less (UNECA, 2000). Additionally, children in primary schools and adolescents receive very little help from their parents or other adults about sexual and reproductive health issues. There is almost no communication about these matters in the homes of children in Africa and Asia. Left to grapple with them on their own, young people turn to one another both in and out of school for information, standards and some modicum of guidance. This aspect of the peer culture replaces the support that otherwise responsible adults fail to provide.

Furthermore, the lack of adult communication about sexual and reproductive health issues is of particular concern when one considers that many school children are in danger of sexual harassment. Reports are escalating about the extent of sexual abuse of children, especially girls, in the 5-14 age group (Smart, 1999). The abusers are rarely complete strangers to the child--in many cases the abusers are members of the child's family. In the process of the abuse, many children become infected with HIV and potential transmitters of infection to their schoolmates or teachers.

School circumstances may aggravate such dangers. The need to pay school fees may lead young girls from poor families into the sale of sexual favors. Intense competition for academic success and progression to the next higher educational level may lead to sexual relationships (heterosexual or homosexual) with teachers or brighter fellow-students. Long walking distances to and from a school that is located far from one's home, and traveling always by the same route, contribute to the risk of sexual harassment from school-mates or from strangers. Yet, providing term-time boarding or hostel accommodation for young, sexually active students who receive almost no guidance or support in a form that speaks to them can increase the risk that they will engage in sexual activity with one another or with individuals from the surrounding community.

In a number of African countries such as Tanzania, Kenya, Malawi and Zambia, the practice of "weekly boarding" aggravates the boarding risk. Weekly boarders arrive at a school on a Sunday evening or Monday morning, bringing with them food supplies for the following five days. They make their own accommodation arrangements, do their own cooking, and supervise themselves. On Friday evenings they return to their homes to replenish their food supplies. The need for food, accommodation, security, recreation, pleasure and exploration or experimentation makes the weekly boarders susceptible to sexual activities with members of the local community or with one another.

The increased risks and teaching problems cited above are likely to be more severe in countries that already experience high rates of HIV prevalence. In other words, where the challenges are greatest, school risks are highest and the capacity to deliver prevention messages is weakest.

The Vulnerability of Teachers to HIV Infection

If schools expose children to the possibility of increased sexual activity, and consequently, to HIV infection, they may be organized in such a way that they also expose teachers to similar risks. It is well known that those who are highly mobile, such as truck-drivers, or those who are part of a migratory labor force, such as farm, plantation and mine workers in many parts of the world, are more vulnerable than others to HIV infection. Although those who work in education are not usually regarded as mobile or migratory, teachers and other education personnel may share some of the HIV infection risks of more mobile workers. Two factors accentuate the risk of casual sexual encounters and hence of HIV infection: distance away from home and family, and access to income, albeit small sums. In each of the following situations, teachers or education officials may experience increased vulnerability to HIV infection.

In almost all African countries trainee teachers posted to a school for practice teaching usually have to make their own temporary accommodation arrangements. Many teachers, finding themselves posted to schools with little by way of institutional accommodation, must search for suitable housing. Until they have found accommodations, their families cannot join them. These circumstances are much the same for education officials who are transferred from one location to another without adequate provision made for their families to accompany them from the outset (this is not unique to education but happens in most areas of public sector employment in many African countries). Teachers in rural schools in many parts of Asia and Africa often have to travel long distances, for a considerable length of time away from home, to pick up their monthly pay-checks. Education personnel are sent frequently on training courses that last from a few weeks to a few years. In the majority of cases, spouses may accompany them on a program that lasts for more than one year. However, they are separated generally from their spouses and families if the program lasts for less than a year. The absence of family, loneliness, and the availability of some money combine to make them vulnerable to casual sex (or quasi-steady temporary relationships) and HIV infection.

Difficulties in Including HIV/AIDS Education in the Curriculum

In the southern African countries discussed above few schools come to grips with issues of sexuality. They tend to displace to more superficial concerns the attention that would be more profitably devoted to this area. In practice this means that in many high-risk developing countries, schools do little to help their pupils increase their understanding and change their behavior in order to manage their emerging sexuality responsibly. That said, several countries among those hardest hit by the AIDS pandemic have adapted their school curriculum to include HIV/AIDS education, or are in the process of doing so, in the expectation that this will help stem the tide of HIV transmission. In some cases, family life or sex education programs have promoted positive adolescent reproductive health benefits and behaviors (Gachuhi, 1999, p. 12). The information and skills acquired by young people in these cases helped them to delay the initiation of sexual activity. Yet at their present level of development, the UNECA 2000 studies suggest that programs such as life skills, family life, reproductive health, sexual, or HIV/AIDS education encounter a number of problems related to design and implementation, and raise certain questions.

First, the design of these programs may be faulty. Programs appear to have been developed from the top, with minimal participation of classroom teachers, parents, and young people themselves. In addition, program delivery is almost exclusively in the hands of teachers, again with minimal involvement of parents and young people. This approach has the effect of assimilating the life skills programs into other curriculum areas that too often have little relevance or reality outside the classroom. Thus, although the programs seem to provide young people with better factual information, this does not lead to the necessary changes in behavior. Also, Uganda, Zambia and other African countries report that both teachers and students express a strong desire to have life skills and HIV/AIDS education as examinable subjects. This suggests that much may be going into the head, but little into the heart. Finally, the majority of the programs target older children, those aged nine and upwards. In light of what has already been said about the

enhanced HIV risks of school children, this is too late. Programs should target children at an early age, from the day they enter school.

In many countries, responsibility for the program and its components appears to rest almost entirely with the education ministry. There is very little evidence of collaboration with other partners (except in some cases with ministries of health), with non-governmental organizations (NGOs) or community based organizations (CBOs), or with the private sector. The much-vaunted multi-sectoral approach as a crucial component in a comprehensive HIV/AIDS response is conspicuously absent. None of the programs seeks to contextualize messages about HIV/AIDS within the cultural discourse of traditional ideas and perceived traditions. Hence, they do not acknowledge and build on the understanding and beliefs of those they seek to influence (Kippax, Smith & Aggleton, 2000). Although there is some evidence that programs may lead to delays in the onset of sexual activities, the extent to which they lead to a reduction in HIV transmission, sexually transmitted diseases (STDs), rape or coerced sex has not been evaluated. Very few programs go so far as to include in the design a reduction in HIV/AIDS incidence among learners as one of their performance indicators. In the current AIDS crisis, this is the bottom line.

Second, there are many problems with program implementation. As mentioned, at first sight some programs appear to be successful. But where they should really count, they are less effectual. Most often bio-medical topics and barrier methods of HIV prevention appear to be presented in their own right, without a corresponding effort made to promote an understanding of relationships, respect for the other, and rights. This has led to a tendency to equate prevention with the proper use of condoms. Presenting the bio-medical and mechanistic aspects outside the context of the learner's developing sexuality runs the risk of focusing attention on these aspects, and the factual knowledge involved, as if these provided the complete answer to HIV transmission. At the same time, many programs seem to downplay the potential of abstinence as a means for preventing HIV transmission. By doing so, they not only fail to challenge their students, but they also adopt a defeatist attitude towards what they regard as the inevitability of sexual activity among young people.

Among teachers, there is a widespread problem relating to teacher knowledge, understanding and commitment. This is further complicated by the lengthy cascade model[2] for training serving teachers, by legitimate concerns about the dilution and even misrepresentation of content, and by the teacher's dubious status as a role model when she or he may be known to be HIV infected.

Teachers question their role in this form of education. They have "anxiety concerns" and "resistance concerns." Anxiety concerns refer to fears of violating taboos, giving offence to parents, being accused of encouraging promiscuity and loose moral practices in the young, or being regarded as using their teaching in this area as a form of personal sexual outlet. Resistance concerns relate to doubts whether sex education, the formation of appropriate sexual attitudes, and the transmission of very specific behavioral guidelines really belong to their work as teachers when their whole training and orientation were directed towards what are essentially academic areas.

HIV/AIDS Education and the Cultural Context

Programs that include HIV/AIDS in the curriculum face the problem that their listeners hear messages at different levels. First they hear the educational program itself with its scientific messages about the cause of HIV/AIDS and how it is transmitted. This tends to be an academic, notional level, where messages are received and stored for subsequent action within the context of the scientific, academic, modern, western world. As it relates to personal behavior, this may be quite a superficial level.

Much deeper and more influential is the traditional view that interprets the disease and its causes in terms of the cultural world of taboos, obligations, and sorcery. Sickness and disease are almost invariably considered to have external causes other than the viruses, germs and microbes identified by medical science. Very often, the external cause is thought to be an ill-willed, malevolent human agent who uses the powers and forces that are at the disposal of a witch or sorcerer. The external cause can also lie with ancestral spirits who are offended by the violation of certain taboos. This can include having intercourse with a woman before she has been "cleansed," and/or with a woman who has had a miscarriage, or failing to observe certain rituals (such as the "cleansing" by a man of his brother's widow).

In the case of HIV/AIDS, this traditional interpretation of a sickness and its causes draws strength from the inability of western science to produce a complete cure. The deep-rooted view that sorcery and witchcraft are the root causes of HIV/AIDS manifests itself not just among rural people, but also among those from urban and well-to-do settings. The educated are no strangers to it. Neither are those who adhere to the major world religious traditions. Individuals from all classes and categories seek to discover the source of the ill-will that brought them their sickness, in the belief that once this cause has been identified appropriate remedial action can be taken.

None of the educational programs takes this cultural perspective into account. None of them seeks to interpret HIV infection in terms "not of the malevolence of external witches but rather the witchcraft ('evil') that is within each one (…) for in African belief, all persons, inasmuch as they have propensity to wrongdoing, are potentially witches" (Magesa, 2000, p.82). No educational program is known in Eastern and Southern Africa that takes sorcery/witchcraft seriously and uses this world-view in strengthening school children to protect themselves against HIV infection. No attempt appears to have been made to take account of the positive role that traditional healers can play in the fight against HIV/AIDS. In consequence there is a lamentable lack of headway, with the frequent complaint that wide diffusion of knowledge about HIV/AIDS is not leading to any correspondingly wide change in behavior.

HIV/AIDS and Sexuality

In addition to the obstacles noted above, one of the most critical problems that HIV/AIDS education poses for schools is that educators, in common with the education systems to which they belong, tend to shy away from dealing with the basic, existential issues of child and adolescent sexuality. In so far as they broach this subject at all, they remain content for the greater part with an abstract presentation of themes and principles, a rigid presentation of true propositions, and an enumeration of biological and physiological facts. The perspective is that of genitality--the particularized, physical

consummation of the all-encompassing energy that lies within each human being--but not of a sexuality that involves the human drive for love, communion, community, friendship, family, self-perpetuation, joy, humor and self-transcendence.

In this process, many educators remain unaware that there is an enormous communication gap. They do not perceive that the young people they work with think differently from themselves. The educator can present much information on dangers and high-risks. Some may provide an authoritarian list of "do's and don'ts." Some may even try to use fear to motivate the young person to adopt sexually safe behavior. Yet these approaches, which are characteristic of methods in a traditional school setting, fail to speak to young people. Consequently, they do not share the potential of non-formal approaches to enter into dialogue with the underlying cultural imperatives which motivate young people from within more powerfully than anything the educator may propose from without.

These underlying cultural demands and expressions are contained in social pressures and cultural contradictions. Socially, they manifest themselves in the power of peer pressure and the group, and the need for young people to conform and belong. Moreover, parental failure to discuss sex with their children, teaches an implicit message: that sex is something which should not be discussed across ages, between adults and the young, but only between the young themselves, as equals. The usual socialization process teaches boys that they must be "physically strong, emotionally robust, daring and virile," and that they should not depend on others, worry about their health, or seek help when they face problems (UNAIDS, March 2000). For a girl, the socialization process teaches her that her principal role in life is to meet the physical, psychological, economic and sexual needs of a man, to be obedient to him and to show him unquestioning loyalty, to bear and rear his children, and to arrange for his comfort. Finally, abstinence is discouraged because of the widespread disbelief in the possibility of total sexual abstinence, particularly among boys (and there is even some suspicion and concern when there are signs of such abstinence).

Cultural contradictions abound. Among them, there is the veneer of "respectable," approved sexual behavior encountered in society, while it is common knowledge that large numbers of adults are following a different sexual code. More overtly, different standards exist for different genders. As a result, social expectations condone in men and boys what they condemn in women and girls. Society often condones or overlooks forced sex, at least as long as it does not exceed certain legally defined limits. There is widespread and more-or-less accepted violence against women and girls. Finally, an enormous mix of cultural values and counter-values send confusing messages. This is embodied in the weakening and progressive demise of traditional cultural systems, the simultaneous importing of systems in which immediate pleasurable gratification assumes a dominant role, and the entertainment industry's presentation of situations and role models which give prominence to temporary relationships and casual sex.

Alongside the dilemmas listed above, another is created because society has failed to inculcate the real value of human sexuality--contact with and surrender to the personality, not merely to the body of the partner. Society fails to appreciate that inadequate enculturation and socialization must be transformed into respect for the

other as a person whose rights must be respected and towards whom responsibility must be manifested.

The Way Forward

These observations point to the need for considerable re-thinking of education's curriculum response to HIV/AIDS. Weak links in the current response are at program design and delivery stages. Neither draws sufficiently on such demonstrated strengths of many non-formal education programs as the involvement of parents, significant community members, or community youth members. Both rely too heavily on a centralized approach and on the teacher as the provider of information and developer of attitudes. Yet because of a lack of expertise and training, because of personal sensitivities, and because of remoteness in age and mind-set from younger people, the teacher may not be the appropriate person for this role. In addition, little if any provision is made at the program design and delivery stages for the deeper aspects of human sexuality, traditional approaches, or youth culture.

In the light of these issues, the way forward would seem to require close attention to the following points:

- Involving young people in program design and delivery, with a firm focus on promoting peer education.
- Involving community members, especially local and religious leaders, parents, and youths with standing among their peers, in content specification and delivery; drawing heavily on the resources of two different cultures-the quasi-modern youth culture and the traditional culture of as region or people.
- Using participatory methods and experiential learning techniques.
- Approaching sexual and reproductive health education from the broader perspective of human sexuality and accommodating the physiological details within this as part of a more comprehensive whole.
- Providing more of a challenge to the idealism of young people (including "making abstinence cool").
- Developing a learning climate that firmly and frequently re-affirms the principles of respect, responsibility and rights.

Those education programs that include these considerations stand a good chance of being successful in enabling young people to maintain or adopt behavior that will protect them against HIV infection. But if they are to do this they must deal with issues about which school programs are too often silent, and they must adopt design and delivery models which are foreign to school education as currently conceived. Yet, some of these considerations are integral to programs targeting out-of-school youth. These programs tend to be characterized by the prominent role they accord to young people as peer educators. Because the education is not coming from an outside body, but from contemporaries or the peers themselves, it is more readily assimilated into the peer culture and norms. In other words, the approach recognizes the powerful socializing influence that youth have over each other and seeks to win the potency of peer pressure over to its side.

The first tentative steps, therefore, in the radical transformation of school education could be to learn from and put in practice the positive lessons coming from HIV/AIDS education programs addressed to out-of-school youth in non-formal settings. It is approaches such as these that in-school HIV/AIDS education programs must adopt if they are to help reduce the risk situation inherent in educational institutions and equip their students to protect themselves against HIV infection when they leave school.

Notes

1. The Harvard AIDS Review (1995) dramatically highlights the vulnerability of mobile workers in India.

2. The cascade model refers to a training system that relies on the teaching of new material to trainers who train new trainers, who in turn, repeat the process, expanding skills in a 'cascade-like' fashion among the target population.

3. Dan Richey, Louisiana State Coordinator for Governor's Program on Abstinence, New Orleans Time Picayune, 31st August, 2000.

References

Domatob, A., & Tabifor, H. (2000). The impact of HIV/AIDS on the education sector in Malawi [Commissioned Country Report for United Nations Economic Commission for Africa]. (UNECA). Addis Ababa: UNECA.

Gachuhi, D. (1999). The impact of HIV/AIDS on education systems in the eastern & southern Africa region and the response of education systems to HIV/AIDS: Life skills programs. Paper presented to All Sub-Saharan Africa Conference on Education for All 2000, December 6-10, Johannesburg, South Africa.

Kelly, M. J. (2000). *The encounter between HIV/AIDS and education.* Harare: UNESCO Sub-Regional Office for Southern Africa (also available in French as L'éducation face au VIH/SIDA).

Kippax, S., Smith, G., & Aggleton, P. (2000). Schools, sex and HIV-prevention. Paper presented at the XIIIth International AIDS Conference, Durban, July 2000.

Magesa, L. (2000). Recognizing the reality of African religion in Tanzania. In J. F. Keenan. (Ed.) *Catholic ethicists on HIV/AIDS prevention* (pp. 76-84). New York: Continuum International Publishing Group.

Macintyre, K. et al. (2000). *Assessment of life skills programs. A study of secondary schools in Durban Metro and Mtunzini Magisterial districts.* Durban: Tulane University/Population Council/University of Natal.

Nkamba, M., & Kanyika, J. (1998). *The quality of education: Some policy suggestions based on a survey of schools* [SACMEQ Policy Research Report No. 5]. Paris: International Institute for Educational Planning.

Smart, R. (1999). *Children living with HIV/AIDS in South Africa: A rapid appraisal.* Pretoria: Department of Health and Save the Children (UK).

UNAIDS. (2000). *Men and AIDS - A gendered approach.* Geneva: UNAIDS

UNAIDS (June, 2000). Epifact sheets by country. [Online]. Available at: http://www.unaids.org/hivaidsinfo/statistics/june00/fact_sheets/index.html.

UNECA (United Nations Economic Commission for Africa) (2000). *HIV/AIDS and education in eastern and southern Africa: The leadership challenge and the way forward* [Paper Commissioned for the African Development Forum, December 2000]. Addis Ababa: UNECA.