NUMBERS AND THE AIDS EFFECT
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The silence of the academics can only frustrate the layperson. There is something in us, or at least something in some of us, that urgently seeks to make sense out of disconnected data and unassimilated experience... The urgency increases when the subject at hand, like war or disease, involves life and death, including the potential death of all people on earth. We need to know, and we need to know something more than piles of unrelated observations. (Blood Rites, Barbara Ehrenreich, Virago 1997, p2)

The gains of EFA are being undone by the AIDS pandemic. Nevertheless, most countries do riot factor the influence of AIDS into education planning. What must we do to understand how to live with AIDS, as individuals, communities, and civil societies? How can we mitigate the pandemic's consequences? Does education's planning and management paradigm need to change? This note addresses the first question, in an attempt to find practical answers to the other two.

What do we know about AIDS in Southern Africa?

Our education systems are vulnerable to AIDS because of political, economic and social instability. They are characterised by high attrition, repetition and drop-out rates and over-age enrolments which are related to viral transmission. Large numbers of traumatised, malnourished and stunted AIDS orphans live outside community control and are lost to schooling. Rising STD infections among scholars and teachers make them more vulnerable to HIV, while old killers like TB, malaria and cholera take advantage of depleted immune systems. Morbidity and mortality rates among children, teachers, administrators and parents are rising inexorably. In Africa, post-infection life expectancy is 6-8 years.

- In *Southern Africa,* life expectancy rose from 44 (1950s) to 59 (1990s), but will fall to 45 by 2010. 20% of 15-19 year olds are HIV+. About 10% of school children are infected.

- In *Mozambique,* there will be more than 250,000 AIDS orphans by the end of 2000, and onequarter of all children will be living in a family where HIV is present.

- *Namibian* school enrolments in 2010 will be 8% lower than in 1998. About 3,500 serving teachers will die by 2010; AIDS-related teacher attrition is likely to be about 3% pa over ten years.

- In South *Africa,* perhaps 3.6m South Africans (8.6% of the population) are infected. Prevalence in girls 15-19 has risen from 12.7% to 21% in 1999.

- In *Swaziland* about one in five Swazis over 14 are HIV+. The population is already 7% below expected levels and by 2016 it will be 42% lower than projected without AIDS. There are currently 35,000 AIDS orphans; by 2016, there may be 120,000.

- *Zambia:* Mortality among educators in 1998 was 70% higher than that of the 15-49 age group, and equals two-thirds of annual TTC output; by 2005 losses will exceed output. This year, there will be 1.66m AIDS orphans, and 7% of Zambia's households will be child-headed, without adults.

What we can predict about the impact ofAIDS on education in the region?

Fewer children will enrol in school because HIV+ mothers die young, with fewer progeny; children die of AIDS complications; and children who are ill, impoverished, orphaned, or carers for younger children, or those who are earners or producers, are out of school.. Qualified teachers and officials will be lost to education. They are particularly vulnerable to infection because of their comparatively high incomes, often remote postings, and social mobility. Other teachers will be lost as they leave education for better jobs elsewhere. TTCs' capacity to keep up with educator attrition will be undermined by their own staff losses. There are likely anyway to be fewer tertiary students as secondary school output and quality goes down, and as higher education itself declines due to staff attrition. In some countries, management, administration and financial control is already deteriorating. Under these circumstances, ministries will find it difficult to provide formal education of the scope and quality envisioned after Jomtien. Sick and death benefit costs are rising, along with additional costs for teacher training. Governments will come under increasing pressure to finance other social sectors. Contributions from parents and communities are declining, and many households are no longer willing or able to keep children in school. Thus the cost of schooling is shifted back to governments. What is ultimately incalculable is the trauma which overwhelms individuals and communities. At the very least, in pragmatic rather than humanitarian terms, school effectiveness will decline where 30-40% of teachers, officials and children are ill, lacking morale, and unable to concentrate on learning, teaching and professional matters. All of this means that we must anticipate a real reversal of development gains, that further development will be more difficult, and that current development goals will be unattainable.

What initial steps can we take to address the impact of AIDS on education quality and provision?

Ideally, policy makers planning to mitigate the impact of AIDS would base their plans on a complete picture of the current shape of the epidemic, derived from full information about levels of infection, determinants of spread, and factors affecting vulnerability of various population groups. Nowhere in the world is this possible; we have no models or previous experience. We cannot wait

for detailed data, perfected statistics, and painstaking analysis before acting. We need to rely on whatever we have, or can get, if we are to maintain and consolidate gains in education quality and provision.

Collective dedication: Education planners, their political masters, and development agency partners must assert their collective will to understand and mitigate AIDS impact.

Intelligent planning: Common agreement is required now about the necessity to factor in the influence of the pandemic in educational and cross-sectoral planning.

Information collection: Minimum information requirements might be: the numbers of people likely to fall ill, the duration of illness, and age distributions; the numbers of people dying,, analysed by age; and impact on population size and distribution. We need to know about teacher and child illness, death and attrition rates so as to project teacher requirements, enrolment shifts, geographical and age shifts etc. The paucity of hard data must be supplemented by indicative figures for key groups, to help focus and target interventions, and to establish benchmarks for risk categories. Clearly, ethical and human rights issues related to testing are involved here, and need to be addressed.

Understanding and using the data: Whatever information is available needs to be translated into useable form so as to create education sector models and projections which take account AIDS.

Analysing impact: Ministries need to clarify their understanding of the influence of the pandem is on the education service in terms of staff and capacity losses and projected replacement costs, and to determine how this will affect the delivery of services at all levels. They need to have and use estimates of changing demand for services, according to geographic area, and projections of student populations. They need to consider the psycho-social effects of AIDS on the school community, and how it will affect morale and performance of educators, children and parents.

Appropriate intervention: It may be possible to slow the spread of the epidemic, to reduce its impact, or to circumvent its worst consequences. At the very least, it should be possible to target resources where they are most needed (by making provision to replace teachers lost to AIDS for example), to avoid wastage (by building fewer schools where populations are decimated, or for which there are no teachers for example), to identify at-risk student populations (in hostels for example, in countries where secondary school expansion will require hostel facilities), and to consider the precarious state of procedures and management capacity when creating sector plans.

We have tried for 20 years to stem this pandemic. We have failed. We must now learn to live with AIDS in our schools and communities. We can start by being aware, analysing available information, and planning pragmatically. The EFA paradigm must confront this reality.

Selected Readings

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