HIV/AIDS and Development in the Education Sector

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Introduction

In 1997 the Development Assistance Committee (DAC) of the OECD articulated the bilateral donor priorities and goals for development, stating that these were achievable by 2015. Its emphasis was, and is, on attacking poverty, its overarching economic goal "a reduction by one-half in the proportion of people living in extreme poverty by 2015." Under social development targets, the first goal is "universal primary education in all countries by 2015", the second "demonstrated progress towards gender inequality and the empowerment of women by eliminating disparity in primary and secondary education by 2005", and the third "a reduction by two-thirds in the mortality rates for infants and children under age 5".

Over time the goals might be achievable perhaps, but not in the 'ambitious but realistic' time frames envisaged. The reason - HIV/AIDS, an issue not considered in these well intentioned declarations. That HIV/AIDS has not been adequately considered in such development thinking is perhaps not surprising; by its very nature, the disease has been largely invisible to planners and is attended by such insufficient data that its dismissal was all too easy. However its grim reality is now becoming apparent. Not only will it mean development goals are unattainable, but in fact that there may be a real reversal in the development status of many nations, and "development" can not be business as usual. Nowhere is this more the case than in the education sector, which by its very nature is engaged in producing human capital. What makes this even more crucial is that Africa has the majority of the world's infections and Southern Africa the highest levels of HIV infection in Africa.

The objective of this paper is to describe the underlying problem of HIV/AIDS in the context of education development, and also to identify opportunities for remedial action and positive enablement. Given the importance of education as a transformative force in social and economic terms, there can be little doubt that the education sectors of these countries constitute a primary site for containment or disaster, or both.

The spread of HIV in the region is now being matched by the increase in illness and death. The consequences for education are considerable. All other things being equal, the provision and growth of quality education is directly linked to positive economic development, emancipation and health dividends. These dividends may also include a demonstrable relationship between high rates of participation in the education system (especially of female children) and reduced levels of HIV/AIDS infection. The dysfunction and even collapse of such education systems, together with related social instability, may eventually prove to be directly associated with the explosion of the pandemic in these areas. For the purpose of this paper, the education sector is deemed to include the complete cycle of pre-employment learning from the preparatory or pre-primary phase through primary and secondary schooling, to both formal and semi-formal post-school and tertiary activity. In terms of social impact,

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the inclusion of children of school age who are either not in the education system or who drop in and out of it on an irregular basis is important. Given the extent of orphaning in the region, and the collapse of extended family structures and support systems, this last point has added significance.

Trends in the education sector

During the 1970s and 80s many developing countries experienced explosive growth in their education systems, reflecting increases in both population and school participation rates. This rapid growth placed considerable stress on national budgets, against which education makes sizeable claims, at a time when the escalating debt burdens and declining economic growth rates conspired to disadvantage and destabilise education. This led to a sharp decline in access and quality and placed less well-qualified teachers in front of larger classes, in increasingly cramped and under-provisioned conditions.

The net result of these trends, has been reduced parental confidence in the value of education or preparedness to share its cost and a consequent real decline in enrolments, with predictable gender discrimination. This pattern of the 1970s and 1980s - uncontrolled education expansion, followed by qualitative and even quantitative decline – is significant in terms of reduced social exposure to AIDS awareness and education and reduced access to the intellectual and systemic resources required to stem its expansion.

The implication is that while education and its delivery systems, if properly harnessed and employed, have the rare potential to reverse runaway infection rates over time, their effect is being dissipated and squandered in precisely those regions where the problem is greatest. This paper urges remedial steps in this regard, but cautions that for these to stand any chance of success, education planners, their political masters and development agency partners must assert their collective will to change

HIV/AIDS and the Education Sector

Impact on Labour

HIV/AIDS has long been understood to threaten the supply of educators. In Zambia for example, the mortality rate amongst educators in 1998 was 39 per 1000, 70% higher than that of the 15-49 age group in the general population. Deaths of educators in service were equivalent to the loss of about two-thirds of the total annual output of the country's educator training colleges.[3]

Less well recognised (or researched) is its potential impact on the provision of system managers who are, in real terms, in much shorter supply and are in the main drawn from the ranks of experienced, senior educators. For example, a 30% erosion of the educator stock may indeed be critical, but a similar erosion of more limited management stock would be catastrophic. The comparatively high incomes, often remote postings and social mobility of both educators and system managers has long suggested that they may be at far greater risk than the population they serve, a fact now confirmed by Zambia's comparative mortality rates. But in the case of managers, attrition in their ranks poses a threat to the structure and system in which educators function. As a consequence, the system may be impacted on at least five levels:

- The management, administration and financial control of education systems are likely to deteriorate further, off an already limited and stressed human-resource base.

[3] M J Kelly, The Impact of HIV/AIDS on Schooling in Zambia, Paper for presentation at the XIth International Conference on AIDS and STDs in Africa, Lusaka 12th September 1999.

- In spite of the existence of quite large numbers of unemployed educators, theoretically available to replace educator fall-out, Student:Educator and other in-school service ratios are likely to worsen significantly as educators and support staff fall ill and die.
- The role model of the educator in the community will be devalued by the evidence of infection and will further erode the value of the education system in stemming the pandemic.
- The limited resources available to education will be reduced by the demands of the generous staff conditions and health benefits enjoyed by infected staff, the cost of replacement staff to cover sick-leave absences, the cost of educator training to replace those who die and the competing demands of other government ministries – notably Health.
- Educator training colleges will not be able to keep pace with the demand for new stock and may anyway have reduced numbers of lecturers, since this group too are at a similar level of risk.

Impact in the Learning Environment

Declining enrolment in many developing countries is already a fact of life. The lack of hard data in respect of infection rates for the school-going population makes it difficult to identify how far this decline has been accelerated by AIDS due to both reduced growth rates and inability to take up places. Further research is needed. In countries like Zambia, Swaziland and Zimbabwe, the number of children of primary school-going age will be more than 20% lower than pre-HIV/AIDS projections by 2010, and a high percentage of these will be orphans with very limited resources and incentives to enter the system. For example work being carried out for the Ministry of Education in Swaziland suggests that in 1999 the number of 6 year olds was 6% lower than it would have been in the absence of AIDS. By 2016 there will be 30% fewer 6 year olds and 17% fewer 18 year olds. The number of orphans will have risen from 35 000 in 1999 to 90 000 in 2005 and 120 000 in 2016.

On the face of it, there will be fewer students to educate, suggesting that pressures on currently over-taxed resources may reduce. However, the fact of the matter is that there will also be fewer educators, system managers as well as a reducing number of children motivated or able to attend school.

The education facility may also be a risk environment as high-risk sexual activity between students – or between students and others – may occur here (or at least relationships start). This may happen at all levels of education, not just higher levels. The point is that the age-profile of pupils in early years of education does not necessarily coincide with what might be expected in conditions in industrialised countries. An examination of the data suggests that over-aged students are a common feature of the school system from the first grade. There is evidence of pupils between the ages of puberty and their mid-twenties and more, enrolled with more appropriately aged cohorts, quite literally from the first grade.

The gravity of the situation may be illustrated by the rise in HIV seroprevalence reflected in the available regional data for young adults, 15 years and older. In round terms, over 20% of this age group are currently HIV positive. In South Africa for example, the measured infection rate amongst young women aged between 15 and 19 years, rose from 12,7% in 1997 to 21% in 1998, while the rate in women of 20 attending ante-natal clinics rose from 17% to 22% in the same period. In the SADC region of southern Africa, based on available age/grade data, these infection rates extrapolate *conservatively* to a probable 7% to 8% level over the total enrolment of the region's combined education systems, grades 1 through 12, although infections will be clustered at higher levels.

Making the situation even more complex are anecdotal reports of sexual relationships between (mainly male) educators and (usually female) students. These relationships not only conducive to the spread of STDs, but are damaging to the status and role of educators in the community. Some Ministries of Education may contribute to the climate for extra-marital sex by posting spouses away from each other.

At the secondary and tertiary levels, there is some research to confirm a chilling but unsurprising truth. Virtually every student not only knows about HIV/AIDS and their implications, but for the most part are unable or unwilling to take these messages seriously. Tertiary-level students are particularly vulnerable, but may in fact display the greatest disregard for the consequences. As for those who drop-out at every level of the system, or those who simply have no access for reasons of under-provision, gender-inequality, family-pressure or poverty, the picture is bleaker still. They are denied the potential the education system has for informing and guiding choice, and the life-skills it should offer and may be drawn to crime, prostitution and violence as a means of survival.

Further complicating this scenario is growing evidence that students and others, known – or assumed – to be infected, are being ostracised, and in extreme cases even attacked by families and communities. Whether occasioned by embarrassment, cultural conditioning, poverty or fear, this impacts AIDS orphans in particular, but may encompass anyone identified as being HIV positive or ill. This has a further adverse effect on the education environment.

Impact on Financial Resources

The education budgets will be adversely affected in a number of ways.

- Teaching and ministry staff will have to be carried as they experience increased periods of illness, and current sick leave and death benefits are generous. In addition they require time off to care for sick relatives and attend funerals. This is particularly an issue at the 'chalk face': an administrator can miss a few days or even weeks, but a class that is not taught losses that time forever.
- Government budget will be under increasing pressure from the other service ministries, in particular health and welfare.
- Contributions from the parents and community are likely to decline. Available income, already required to supplement education, health and other expenses is increasingly being diverted to AIDS-related care, funeral expenses and the assumption of responsibility for AIDS orphans and widows in an extended family context.
- Orphans may not be able to afford any expenditure for education, and there will be vast numbers of orphans. In Zambia alone, by 2000, there will be an estimated 1,66 million orphans. In practical terms, this means that more than 7% of Zambia's 1,9 million households will be without any adult member, but will be headed by children aged 14 or less. Quite apart from the societal issues, this points to the collapse of community capacity to play any part in funding and sustaining education.

In terms of the financial implications of tertiary grants and bursaries, regardless of source, a number of important issues arise. First, the quality of students graduating the secondary and entering the tertiary system may reduce or at best become erratic. Second, the output of tertiary graduates will be reduced in number – and possibly in quality - as a result of reduced enrolments in a deteriorating basic education system. Third, the consequent injection of skills and professional capacity into the economies of the region may be short lived in *at least* 20% of cases, given the evidence in the region that life expectancy after infection is between six and eight years. And fourth, this implies that pay-back on investment, either through the provision of skills or the repayment of student loans and bursaries will be severely impacted.

Responding to the epidemic

In order to limit susceptibility and reduce potential impact, the present paucity of hard data must be supplemented with at least some dip-stick indicators in key groups, in order to help focus and target interventions. The alarming inclination to ignore the reality of the situation is exacerbated by the fact that it is eminently deniable. Once established as a benchmark for identified risk categories in education, this information must become the basis for accurate projection and action.

Several other enabling factors are required. It is imperative that the political and administrative heads of education systems declare policy and establish a principled position and implementable framework within which managers and educators can work. Moreover, this policy should be a matter of integrated national policy, binding at least Education, Finance, Health and Social Welfare together with development agency partners in a working alliance.

System managers and educators require retraining. The anecdotal evidence of many developing systems confirms that educators are at least as guilty of high-risk and indiscriminate behaviour, bias and, conversely, primly conservative reaction to the facts of the pandemic, as their peers outside the system. It is imperative that they – as a group – be retrained to act as role models and proactive, honest campaigners in HIV/AIDS education. This retraining must reinforce the prohibition of any sexual exploitation of students by educators.

Information programmes, counselling and the development of learning materials and teaching aids that effectively address issues that educators often find uncomfortable or difficult to communicate are a critical component. This activity should and must integrate basic sex education, in all its facets and from the *earliest* age, as a context for the limitation of the spread of HIV/AIDS.

Classroom and home environments must be integrated in a learning continuum, requiring that families be seen as an extension of the target group. The school through its principal and local management officers must extend learning programs in the first instance to the women of the community, to empower and enlist them as enlightened allies in the fight against the disease.

The risk of HIV infection is increased by up to 40 times by the presence of another sexually transmitted disease. This fact suggests that the prevention and treatment of *all* STDs should constitute a focus in such education, and is so significant in and of itself, that development agencies should consider involvement in a new generation of clinics for this purpose. While this involvement may seem distant from the primary goal of transforming education, it may in practice be fundamental to social reform in general, and education reform in particular, and provide a platform for HIV/AIDS counselling and related social programmes. School health programmes may provide a vehicle.

Departmental policy must ensure that educators are deployed within their home districts wherever possible and that any transfers and re-locations follow the same principle. Children *of school-going age*, whether HIV infected or not, must be assured access to the classroom. This may require platooning where classroom space is limited, or to compensate for the lifestyles of young people marginalised by agrarian responsibilities, or who have dropped out of urban society.

The phenomenon of an orphaned AIDS generation is in prospect, with consequent social implications. A care programme for AIDS orphans must be developed as a matter of urgency and its implementation

decentralised to appropriate levels. The financial and enrolment implications for education require research and projection and the integration of Health and Social Welfare support.

Finally, the proactive engagement of visible and vocal role models at all levels of society is necessary, to highlight positive lifestyle choices and open a transparent, national dialogue on this challenge.

Conclusion

African education programmes are both susceptible and vulnerable to HIV/AIDS. Reasons include a higher incidence of social instability, dysfunctional education systems, high attrition, repetition and drop-out rates and the common problem of over-aged enrolment. These factors create an environment in which limited and reducing numbers of system managers and under-qualified and under-resourced educators wrestle with still large numbers of disparately aged students. They also signal the emergence of an entire generation of AIDS orphans outside familial or societal influence or control, who must be cared for and directed into non-destructive roles and relationships.

Exacerbating these problems, the sector is characterised by the lack of hard data on seroprevalence, an absence of policy, limited management skills and depth, and often ill-disciplined and hence exposed educators. Add to this a disproportionately large number of over-age and sexually active students, already reflecting infection rates in the wider population of the same ages, and the system may be a high-risk environment for infection instead of being a pre-employment area of containment.

This said, the system is at once the most logical ground on which to engage and counter the spread of HIV/AIDS infection. Nowhere else in society is there such a concentration of impressionable minds assembled for so long in the control of educators, role models and information providers. Nowhere else does such an opportunity exist to counter the attitudinal and physical threat of the pandemic. It is an opportunity ignored or squandered through lack of knowledge or resources. This must change.