6. Socio Economic Burden of HIV/AIDS in Developing Countries: Education Sector Response

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Background

- Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS) continue its course.
- HIV and AIDS are reversing decades of development gains, increasing poverty especially among the poor countries and undermining the very foundations of progress and security.
- The pandemic demands a response that confronts the infection in every sector but education has a particularly important role to play.

Sub-Saharan Africa (SSA)

- SSA, bears the global burden and remains the worst-affected region, with the highest prevalence in Southern-African (between 15-35%)
- At the end of 2009, 68% of all people living with HIV, or 22.5 million individuals lived in Sub-Saharan Africa.
- In 2009, an estimated 1.8 million people in the region became newly infected with HIV and 1.3 million adults and children died of AIDS
- In 2009, 14.8 million children in the region have lost one or more parents to AIDS. Almost 90% of the total number of children living with HIV lives in Sub-Saharan Africa and fewer than one in ten of these children are being reached by basic support services.

Factors that aid the progression of the Epidemic in Sub-Saharan Africa

- Physiological factors
- Poverty
- Lack of information/ignorance
- Discrimination and stigmatization, denial

- There is increasingly awareness of the female face of the AIDS epidemic (Feminization of HIV and AIDS)
- Women are more vulnerable to HIV infection on social and economic grounds which are clearly related to gender, cultural norms, expectations and harmful traditional practices e.g. Wife inheritance, FGC etc.

Impact on household & individuals

Increase in number of female headed households, exuberating poverty

South Africa

- Study in South Africa showed affected households have less monthly income than non affected households and funeral costs were four times the monthly income of households.
- The purchasing power of the market is affected because there is lower income to rising prices.

Nigeria

- In Benue state Nigeria. Affected households took an advance on future earnings by reducing their investment in farming (19% reduced expenses on hired labor), 12% stopped the payment of school fees while 8% started working as casual laborers at the expense of their own farms or sold their land (Hilhorst et al, 2006)

Impact on Agriculture

- Reduction in Agriculture labor force: It is estimated that by 2020 the pandemic will have claimed 26% lives in Namibia, 23% in Botswana and Zimbabwe, 20% in Mozambique and South Africa, and 17% in Kenya.
- Decrease in range of crops being cultivated and output by 50% (FAO). A study in Thailand showed a shift away from labor-demanding crops like rice and chili to crops that need less labor.
- 85% of the women farmers interviewed in a study at Enugu, Nigeria stated that HIV and AIDS caused reduction in their family income.

Impact on the Health Sector

- Reduction in health care work force e.g. in Botswana 17% died between 1999 to 2005
- Increased infrastructure modifications, spending and cost on government.

- More demand for services and care due to long hospitalization.
- A significant increase in time spent by all household members in caring for the ill. Women spent on average of 14 hours per week, Men 12 hours, and boys and girls 10 and 11 hours per week respectively.

Orphans and other special at risk populations

- Largest impact of the AIDS pandemic, with an estimated 15 million children who have lost one or both parents to AIDS.
- Due to death of parents or to take care of other family needs, OVC withdraw from schooling.
- Initially estimated at 2% but has now risen to as high as 15 to 20 percent in some African countries.
- Children orphaned by AIDS often exhibit cognitive deficits when compared with their uninfected peers (Martin et al 2006). These deficits can adversely affect learning and earning ability later in life.

Impact on Education

1. Access to Education – Children may be denied access to school due to fears and stigmatization in the community
2. Demand for education – decline in the number seeking education
3. Supply of education – reduced number of teachers
4. Quality and management – decreased human and material resources.

The Impact and devastating effect of HIV/AIDS to the education system has not been calculated or determined in SSA.

- Deaths of children born with HIV and the removal of AIDS orphans and other children affected by the epidermis from school, result in smaller numbers of children needing education. In Swaziland, it is projected that by 2016, there will be a 30% reduction in the size of the primary school population for each grade.
- In South Africa, 21% of teachers aged 25-34 and 13% of those aged 25-44 are estimated to be infected; even with decline in teacher's resources, there are reports that the number of teachers being trained is not enough to fill the gaps.

- In Zambia, 60% of teachers are absent in schools because of personal illness or taking care of family members. Also a survey carried out among teachers found a five percent increase in a teacher's rate of absence, there by reduced students' average gains in learning by four to eight percent per year.
- Tanzania estimated that 45,000 additional teachers are needed to make up for those who have died or left the system because of AIDS.
- The average age, and therefore the level of training of teachers, is also expected to fail, which will mean that teachers may be less experienced.

Why does education matter?

'Education is the most powerful weapon you can use to change the world' (Nelson Mandela, Global Campaign for Education (GCE), 2004), and 'is a basic instrument for eradicating poverty'

- HIV/AIDS has significantly reduced average years of schooling or enrolment rates.
- Investment in education is vital: It promotes achievement of six of the eight MDGs.
- Better educated women are more likely, in comparison with their peers to adopt and sustain behaviors that will reduce the spread of the virus.
- Data in the late 1980s and early 1990s mostly showed a positive correlation between level of education and rates of infection. E.g. a study in Zambia found a marked decline in HIV prevalence rates in 15-to 19-years-old boys and girls with a medium to higher level education, but an increase among those with lower educational levels (Kelly, 2000c).
- Countries' education sectors have a strong potential to make a difference in the response against HIV/AIDS. In terms of monetary impact. HIV/AIDS is estimated to add between US$450 million and $550 million per year (US dollar values for 2000) to the cost of achieving the mandate set out in "*Education For All*" (UNESCO.) in 33 African countries.

Why Education sector response

- The largely uninfected age group (0-14) is found in the sector and represents a window of hope for prevention of new infections
- School not only offer an organized and efficient way to reach large numbers of school-age youth but the students are particularly receptive to learning new information.
- Schools provide a base for reaching out to the wider community
- The sector provides tools for behavior change and provides comparative advantage with an existing framework – the curriculum.
- Education sector is now unanimously recognized as having a key role to play in HIV prevention and mitigation of the impact of AIDS; not only in its capacity to reach large numbers of the most at risk group (the youth) but also in its ability to change the negative attitudes, behaviors and practices that put staff and learners at all tiers at risk.

Response

The Darkar Framework for Action during the World Education Forum drew attention to the urgent need to combat HIV/AIDS, if Education for all (EFA) goals is to be achieved. It called on governments to ensure that by 2015 all children particularly girls, children in difficult circumstances and ethnic minorities have access to complete free and compulsory primary education of good quality.

- Millennium Development Goals for Education which seeks to "ensure that by 2015. Children everywhere, boys and girls alike, will be able to complete a full course of primary schooling", cannot be achieved without urgent attention to HIV/AIDS.
- UNGASS targets and the MDG for HIV/AIDS, malaria and other diseases cannot be achieved without the active contribution of the education sector.

Response of Sub-Saharan African Countries

- At national level, some countries in SSA have taken steps to address the impact of HIV and AIDS on the education sector and to adapt systems to respond to the epidemic.
- Mass media campaigns have been conducted, but many have not been formally evaluated.

- Life skill program have been introduced within the education sector as part of the school curriculum.
- Less attention to teachers' programs on HIV and AIDS.
- Comprehensive programs on OVC only available in 29% of countries.
- Implementation tends to be weak, with geographical disparity within countries; it is mostly focused on schoolchildren and is only just beginning to focus on teachers.

Response Nigeria

- Faced with controlling HIV/AIDS in its 36 states and the Federal Capital Territory (FCT), Nigeria's response until 1999 was coordinated by the Federal Ministry of Health
- Stages in response to the epidemic included: an initial period of denial; a largely medical response; a public health response; and now a multi-sectoral response that focuses on prevention, treatment and impact mitigation interventions.
- In 2000, National Action Committee on AIDS (NACA) was inaugurated and a-3-year HIV strategic plan. HIV/AIDS Emergency Action Plan was formulated in 2001 (HEAP 2001-2004)
- In 2001 provision of subsidized ART was announced by the President through the Abuja Declaration
- In 2003 the first national workshop on accelerating the education sector response to HIV/AIDS organized by the FME, supported by the UNAIDS and other development partners, helped set the stage.
- In 2004 National Policy on HIV/AIDS for the Education Sector was developed and finalized in 2005. This helped to inform the National Education Sector HIV/AIDS Strategic Plan (NESP) 2006-2010.
- Acceleration of education sector response is in four main areas namely:
- Policy and Strategies with five main strategic areas for response
- Planning and mitigation
- Prevention
- Orphans and Vulnerable Children

- 26 out of the 36 states and the FCT had developed state level strategic plans based on NESP, with technical support from development partners. This led to following responses;
- Increased capacity for program management, leading to establishment of critical mass within FME, States and mobilization of funds.
- Development of culturally appropriate national HIV prevention curriculum – Family Life and HIV Education (FLHE) between 2003 and 2004
- In 2006, 26 states reported that they had initiated teachers training on FLHE. In 13 states, the FLHE was already being taught in secondary schools, while nine states reported teaching the FLHE in primary schools.
- E-learning methods for delivering the FLHE were also being piloted in three states.
- Co-curricular methods (peer education, anti-AIDS clubs, Drama, Music, comic books, posters etc.) were widely promoted in all states.
- UNICEF supported Co-curriculum program for NYSC member in school.
- *Support to orphans and vulnerable children: In 2007*. The FME proposed holistic scholarship support to OVC children working with the Federal Ministry of Women Affairs to identify and respond to the educational needs of these children.

FLHE Implementation

- States were asked to implement under culturally acceptable standards
- Global Health Awareness Research Foundation (GHARF) a non-governmental, non-profit making and humanitarian organization based in Enugu State, South East Nigeria facilitated the process in the state
- GHARF facilitated the integration of Family Life and HIV Education into the curriculum of all the 286 Public Junior secondary schools in Enugu State with support from the John T. and Catherine D. MacArthur Foundation
- Integration was in two subjects Social Studies and Integrated Science
- FLHE was implemented in three phases:

- Phase 1:PRE IMPLEMENTATION
- Phase 2:IMPLEMENTATION
- Phase 3:POST IMPLEMENTATION