CHAPTER 1

HIV/AIDS, sub-Saharan Africa and education

Questions have long been asked about children and sex education: what do they know? What do they need to know? What is the best way to teach them? Who should teach them? And how did the advent of HIV and AIDS change some of the answers to these questions? This book is a study of children’s sexual knowledge and its interaction with formal schooling and local community contexts. The enquiry was undertaken in three African countries – Kenya, Tanzania and South Africa. This chapter provides the background to and overall framework for the research study.

AIDS in sub-Saharan Africa

It is over 30 years since cases of AIDS were first reported in sub-Saharan Africa. Since then much has happened. In its latest update on the epidemic, UNAIDS/WHO (2010) asserts that the spread of AIDS peaked in 1996, when 3.5 million new infections occurred. This report shows that ‘the world has turned the corner – it has halted and begun to reverse the spread of HIV’ (UNAIDS/WHO 2010: 7). New infections are declining in 33 countries, 22 of which are in sub-Saharan Africa. This is due to ‘the impact of HIV prevention efforts plus the natural course of HIV epidemics’ (UNAIDS/WHO 2010: 16). The incidence of HIV infection fell by more than 25 per cent in these 22 countries. The trend is most apparent among young people. ‘The sharpest declines have showed a significant decline in HIV prevalence among young men or women in national surveys’ (UNAIDS/WHO 2010: 19). In the three countries in this present study, rates either fell or stabilised between 2001 and 2009. The prevalence in Kenya fell from about 14 per cent in the mid-1990s to 5 per cent in 2006; Tanzania’s rates have slowed to about 3.4 per 1 000 persons; South Africa’s annual incidence among 18-year-olds declined from 1.8 per cent in 2005 to 0.8 per cent in 2008. Despite these falling rates, in South Africa the prevalence of the epidemic remains the largest in the world, and about 40 per cent of all adult women with HIV live in southern Africa (UNAIDS/WHO 2010: 28).

Sub-Saharan Africa is more severely affected by HIV/AIDS than any other region in the world. It is estimated that 1.3 million people died of HIV-related illnesses in sub-Saharan Africa in 2009, or 72 per cent of the global total of 1.8 million (UNAIDS/WHO 2010). Of all people living with HIV in 2009, 34 per cent resided in the 10 countries comprising southern Africa and 31 per cent of all new HIV infections occurred in these same countries, as did 33 per cent of all AIDS-related deaths (UNAIDS/WHO 2010: 28). Many new infections were among young people aged 15 and over, although there was a reduction in new infections among children younger than 15. In 2009 there were 32 per cent fewer newly infected children and 26 per cent fewer AIDS-related deaths among children in 2009 compared with 2004 (UNAIDS/WHO 2010: 29). To date it is estimated that 14 million children have been orphaned in sub-Saharan Africa. This is a large-scale human tragedy with children and young people at the centre of it.
The risk of becoming infected is especially disproportionate for girls and young women. UNAIDS/WHO (2010) reports that slightly more than half of all people living with HIV are women and girls. In sub-Saharan Africa, more women than men are living with HIV, and young women aged 15–24 are as much as eight times more likely than men to be HIV-positive. These rates are linked to gender-based violence and women’s economic dependence on older men. In Kenya, young women between 15 and 19 are three times more likely than males to be infected, while 20- to 24-year-old women are 5.5 times more likely to be living with HIV than men in the same age cohort (KNACC 2009). Among people aged 15 to 24 in Tanzania, females are four times more likely than males to be living with HIV (Tanzanian Commission for AIDS 2008). The high prevalence of intergenerational sexual partnerships may also play an important role in young women’s disproportionate risk of HIV infection (Leclerc-Madlala 2008).

Heterosexual intercourse remains the primary mode of HIV transmission in sub-Saharan Africa, with extensive ongoing transmission to newborns and breastfed babies (Leclerc-Madlala 2008.) In a number of African countries, there is evidence of increasing transmission of the virus through needle sharing among drug users and among men who have sex with men (UNAIDS/WHO 2010). These recent data show that AIDS remains a major health priority, that there is geographic variation between and within countries, that it is an evolving epidemic, that there is evidence of success in HIV prevention and that improved treatment is having an impact.

There has been much progress both in preventative efforts and in treatment programmes. Behaviour, especially that of young people, has begun to change and behaviour change is the most important factor accounting for the recent declines in new HIV infections: ‘Amongst young people in 15 of the most severely affected countries, HIV prevalence has fallen by more than 25 percent as these young people have adopted safer sexual practices.’ Such practices include condom use, a reduction in engaging in sexual activity with multiple partners and delaying the onset of sexual activity (UNAIDS/WHO 2010: 9). Condom availability has increased in places of need and since ‘correct and consistent condom use has been found to be greater than 90 percent effective in preventing transmission of HIV and other sexually transmitted infections’, this is significant progress (UNAIDS/WHO 2010: 64). The combination of preventive efforts is having an impact and is important. In Namibia, for example, improvements across key knowledge and behaviour indicators, such as comprehensive knowledge, age of sexual engagement in higher-risk sex and condom use among male and females aged 15 to 24, have been linked to declines in HIV prevalence among young people from more than 10 per cent in 2007 to 5 per cent in 2009 (UNAIDS/WHO 2010: 65).

An interesting element, and one that is important for this study, is knowledge. Comprehensive and correct knowledge about HIV has increased slightly since 2003, but at 34 per cent the number of young people with sufficient knowledge is only a third of the target of 95 per cent. Ten countries in the world have achieved 60 per cent, but Namibia is the only southern African country to have done so. All three countries in our study are among those countries where less than half of young people can correctly answer five basic questions about HIV and its transmission (UNAIDS/WHO 2010: 68). Knowledge about HIV is important and a central feature of educational interventions.
The role of education

There are two main aspects that are considered here: the general role of schooling and the specific role of HIV prevention education. The impact of HIV upon those in education is also referred to in this section.

Education in general and specific HIV-related education for young people both in and out of school are seen as among the primary means for prevention in the absence of a cure or vaccine. Recent research has shown that education is having an impact in reducing the number of new infections and that the role of formal schooling is increasingly being shown to prevent HIV (Acedo 2009; UNAIDS/WHO 2010). However, HIV/AIDS is Janus-faced: it impacts upon those in education and those in education have at the same time to turn their faces to engage in preventative work. The syndrome is a major problem for both young people and teachers in sub-Saharan African countries (Bennell et al. 2002). Young people are particularly vulnerable, and those living in poverty even more so. Teachers and teacher trainees are also vulnerable to HIV/AIDS and the pandemic has had a big impact on the teacher workforce. Teacher mortality rates are rising and Acedo (2009) notes that teachers are dying faster than they can be replaced. Schools are increasingly facing the challenge of dealing with young people who have been orphaned and whose families have been affected by HIV. High school dropout rates and low enrolment rates are especially prevalent among children who have lost one or both parents to HIV/AIDS.

Education in general

Formal education, or schooling, appears to play a protective role with regard to HIV. Bennell et al. (2002, citing Gregson et al. 2001) highlight an interesting study in Zimbabwe that showed that HIV prevalence rates were much lower among 15- to 19-year-olds who were attending school than those who were not. This is especially important for girls, since rates of infection among teenage girls are five times higher than those among boys (Baker et al. 2009). Initially, however, research showed that education was in reality a risk factor and not a protective factor – contrary to the positive relationship between increased education and improved health-related behaviours. Baker et al. give a vivid account of the slowness of sub-Saharan countries to respond to the onset of HIV. It was in 1981 that HIV was first identified in the US, and it was not until the late 1980s that it was recognised as present and problematic in African countries. In these early stages, studies noted that the virus was more prevalent among the wealthy and more educated. This was due to increased mobility and wealth. Educated men especially, were frequently more socially and sexually active. They had greater leisure time than others, more time for sexual relationships, and greater status given their wealth and leisure. Baker et al. (2009) show that this conception of education as a risk factor for HIV infection has changed over the past decade and that education is now firmly seen to be a protective factor and hence deserving of its label as a ‘social vaccine’ (see also Kelly 2000; World Bank 2003). There is now a wealth of evidence to show that formal education ‘has a social vaccine effect even after controlling for confounding factors such as relative social status and wealth, and access to health care’ (Baker et al. 2009: 473). Education, conclude Mirowski and Ross (2003), has an ‘enduring, consistent and growing effect on health’. Therefore, in general, education is very powerful in helping to reduce rates of HIV, although we are not necessarily sure of the nature of the relationship, with information and knowledge transfer not being seen as a complete explanation (Baker et al. 2009). Baker et al. (2009: 481) conclude that ‘there is growing evidence that resulting enhanced everyday reasoning and decision-making skills lead to healthier behaviour and avoidance of unhealthy behaviour’. However, more work needs to be done to fully understand the relationship between formal schooling and rates of HIV infection.
HIV prevention education: Policy and practice

Although HIV prevention education has become widely known as the ‘social vaccine’, educational responses in sub-Saharan Africa have not been speedy. This has been due to the initial conception that HIV is a condition contracted by homosexual men, the long latency period of the infection, embedded practices of transactional sex and the reluctance to act shown by a number of African governments. For example, in Kenya an effective national response was not adopted until 2000, and in South Africa, Thabo Mbeki’s support of scientists who denied the existence of the virus was infamous. Some countries were quicker to respond, however, and currently all of the countries in this study and many other sub-Saharan countries have adopted HIV-related preventative education programmes and have national policies in place. These national efforts included preventative programmes in formal schooling, as well as community education programmes (Kirby 2008). Uganda was the first country in the region to run a campaign to reduce its HIV/AIDS prevalence, and has been extraordinarily successful in reducing rates from 18 per cent in 1992 to 6 per cent in 2002 (Uganda AIDS Commission 2008).

Targeted HIV prevention programmes are also having an impact on sexual behaviours in some African countries. In southern Africa, a trend towards safer sexual behaviour was observed among both young men and young women (15- to 24-year-olds) between 2000 and 2007 (Gouws et al. 2008). Shisana et al. (2009) reported a decline in new infections among teenagers aged 15 to 19 in South Africa and an increase in the proportion of adults (including teenage males) reporting condom use during their most recent episode of sexual intercourse (from 31.3 per cent in 2002 to 64.8 per cent in 2008). Nevertheless, condom use remains low in many parts of sub-Saharan Africa (Shisana et al. 2009). The latest UNAIDS/WHO (2010) update on the epidemic has confirmed this trend, namely that young people are adopting safer sexual practices, including increased usage of condoms. Therefore, this report argues that prevention programmes are having an impact among young people. A more detailed picture of HIV and AIDS prevalence rates and policies in each of the three countries that are the focus of this book is provided in Chapter 3.

However, education for HIV prevention and education in the context of high AIDS prevalence are highly challenging endeavours. Education as a central response to this medical condition comes at a price. As early as 2002, the World Bank (2002) estimated that HIV/AIDS would add between $450 and $550 million to the cost of achieving the Education For All goals in 33 African countries. In addition to this financial cost, teaching on HIV-related matters is highly contentious and problematic both for teachers and teacher educators (Mugimu & Nabadda 2009; Oluga et al. 2010). Following the initial educational response, there is now an acceptance that much more nuanced, contextual research and understanding is needed.

The nature of the response

Governments have responded to the HIV/AIDS crisis by introducing HIV-related educational programmes. The initial response to the recognised need for action was to introduce a range of programmes, including life skills, sex education, reproductive health programmes and other health interventions in schools (Aikman et al. 2008). The introduction of sexuality education in schools is justified and has been confirmed by recent trends in the decline of infection as well as by research on sex education. For example, Kirby et al. (2007) reviewed 83 studies that measured the impact of curriculum-based sex and HIV education programmes on sexual behaviour, and mediating factors among youth under 25 worldwide. Two-thirds of the programmes significantly improved one or more sexual behaviours. The evidence is strong that programmes do not hasten or increase sexual behaviour but, instead, that some programmes delay or decrease sexual behaviours or increase condom or contraceptive use.
The management and implementation of such programmes is complex and there are different degrees of progress and success. For example, Coombe and Kelly (2002) report that many programmes lacked connections to the social pressures experienced by young people or to their decision-making and social experiences. Other researchers have argued strongly for the need to understand more about how young people contextualise their knowledge (Allen 2005; Brown et al. 2001). Although there have been evaluations of young people’s knowledge about HIV/AIDS, there is a need for in-depth, small-scale qualitative studies that focus on ‘the perspectives and experiences of youth in different settings’ (Brown et al. 2001: 46). This way, we will gain a better understanding of the social dynamics that contribute to the impact and conduct of sexuality education in schools (Campbell et al. 2005; Esat 2003).

Approaches are not necessarily driven by evidence-based understandings. For example, Boler and Aggleton (2005) critique the introduction of life skills into school curricula and suggest there is a lack of evidence regarding its effectiveness, despite being adopted by UN programmes and national educational ministries. They identify two key approaches to HIV prevention education. One set of approaches is underpinned by the belief that individuals have substantial control over their actions, an approach followed by a group of academics whom they label as rationalists, or bounded rationalists. The other group, the structuralists, view human action as ‘influenced more by underlying economic, social and cultural structures’ (Boler & Aggleton 2005: 1). Although these characterisations are polarised, they argue that most attempts to date have been in the rationalist camp, with an emphasis on rational choice and individual agency. This present study leans towards a structuralist approach to prevention education, with the emphasis on social context and structure. A fuller exploration of HIV-related education and sex education is undertaken in Chapter 3. However, as can be seen from this discussion, there is much debate to be had about the nature of HIV-related education and much research is still needed.

This project and its aims

The theoretical frameworks that this study employs are the sociocultural influences on HIV-related education in schools (Campbell 2003), consulting pupils for school improvement (Rudduck & McIntyre 2007), and Basil Bernstein’s (1999) distinction between informal, everyday knowledge and formal, in-school knowledge. These frameworks also inform our use of the term ‘knowledges’, rather than only ‘knowledge’, to highlight the social context that informs how young people come to know what they know, rather than placing emphasis only on what they know. This section expands on these frameworks. They re-emerge and are further discussed throughout our analysis.

We know that young people are particularly at risk of HIV infection for a multiplicity of reasons, including youthful experimentation and risk taking in developing adult and sexual identity, and a lack of understanding of their vulnerability. This is exacerbated by poverty (Rivers & Aggleton 1999), a key feature of the three countries in which our study is conducted. De Waal (2002: 171) argues that HIV/AIDS is the ‘single greatest threat facing Africa’s young people today’. As has already been said, research into schooling and HIV is still in its infancy and efforts have focused largely on the evaluation of educational interventions in terms of behaviour change, with knowledge, attitude, belief practices and intentions of target audiences of such interventions being measured. Many have argued that the sort of educational programmes in existence do not meet the needs of young people and do not take sufficient account of the sociocultural aspects of their lives (Allen 2007; Campbell 2003). Some research has shown the importance of sociocultural, political and economic influences on the vulnerability of young people to HIV/AIDS (Campbell et al. 2005; Esat 2003; Rivers & Aggleton 1999). However, this is not yet sufficient to inform practice. Consequently, the first important idea in this study was to take into account the sociocultural context and processes that surround HIV-related education in schools.
The second important concept is that of consulting pupils. There has been a focus on consulting pupils about their education in the last decade and this has been linked to notions of rights and voice (Arnot et al. 2004; Nieto 1994; Rudduck & Flutter 2000). The United Nations Convention on the Rights of the Child has largely driven this agenda. There has also begun to be both consultation with young people about matters of sexuality and HIV/AIDS-related education and arguments for it (Allen 2007; Bhana 2007a; Campbell 2003; Pattman & Chege 2003). The practice of consulting pupils about their classroom experience is complex and challenging but highly profitable, in terms of what can be learnt about practices and perceptions (Rudduck & McIntyre 2007). There is a need to interrogate young people’s experiences and views on sex and AIDS-related education much more, and this has also been a key driver of this study.

However, the work of educational theorist Basil Bernstein drove us to go further than consultation. In thinking about schooling and the curriculum, Bernstein (1999) distinguished between horizontal and vertical knowledges and discourses. The horizontal is seen as everyday, oral, common-sense discourse, which has a group of features: local, segmental, context-dependent, tacit, multilayered, and often contradictory across contexts but not within contexts. Horizontal discourse is normally acquired from peers and significant others in the young person’s immediate context. The vertical is the formal discourse of schooling: codified, assessed and authoritative. We wanted to understand both of these and to explore the possibility of crossing these borders and of breaking these hard educational boundaries. We aimed to establish young people’s views on the ways in which sex and AIDS education is conducted, and how pedagogies and curricula on offer interact with their own social, cultural and individual contexts. Therefore, this study aimed to examine young people’s varying sexual knowledges and to go further by exploring how they are used and interact with AIDS education programmes in school.

We set ourselves two main research questions. The first asked where do children get their information about sex and AIDS and what do they know about these topics? We were especially eager to find out whether and in what way this information differs depending on where it was learnt. The second question asks how this informal information interacts with the formal sex and AIDS education received in the classroom. This second question was crucial to our overall research aim of finding out how young people’s sexual knowledges might be used to effect change in pedagogy and the curriculum.

We were, therefore, interested in teachers’ understandings and awareness of young people’s contexts and sexual knowledges, as well as the interactions during AIDS education in the classroom. The sociocultural aims that we believed to be crucial necessitated exploring community members’ views too. There have been some recent attempts to survey young people’s sources of knowledge (Bennell et al. 2002), but this has not received a detailed examination. We know little about the nature, sources and processes of the knowledges that young people bring into the classroom. Nor do we know how these knowledges are acquired, the importance young people attach to them, the ways in which poverty produces specific knowledges, or the way in which these knowledges interact with extant curricula and pedagogies.

In this study we begin to answer these questions. At the same time, we are already able to see how these understandings can be used to develop hybrid curricula – collaborations between teachers and pupils that ‘bridge[e]…school knowledge or public knowledge and the students’ own cultural knowledge, and thus encourag[e] students to analyse this interaction and then use the knowledge learned to take charge of their lives’ (Taylor 2000: 58). Therefore, this monograph highlights children’s sexual knowledges in three African countries, Tanzania, Kenya and South Africa, and explores the potential for a hybrid project with regard to sex and AIDS education among primary-aged children. Chapter 2 describes in some detail how we went about consulting children and key stakeholders’ voices through a multi-year research-and-development process.