

HIV/AIDS – What Role for our Schools?

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We, in Trinidad and Tobago, have in the last few decades virtually eliminated the childhood diseases that accounted for high morbidity and mortality rates among children. Improved hygienic practices and access to better nutrition and education also increased life expectancy and the quality of life of young persons. The HIV/AIDS epidemic now facing Trinidad and Tobago and the rest of the Caribbean has the potential to wipe out all the gains made in the past. Recent figures for CAREC member countries reveal that AIDS is the leading cause of death in the 25-44 age group. HIV/AIDS is not only a serious health issue; it has the potential to seriously dismantle the social structures. For instance, a World Bank report, published in 2000, revealed that at the end of 1999, the number of Caribbean children estimated to have been orphaned by AIDS at age 14 or younger was 83,000. This has implications for the quality of life these children will experience. In addition, if the epidemic is not curbed, there are implications for economic development through decreased availability of human resources and impoverished households.

The overall HIV/AIDS statistics, collated by CAREC, are alarming. The estimated number of people living with HIV/AIDS in the Caribbean in 2000 was 572,730. CAREC member countries accounted for 137,000. The age-group distribution shows 10% of this figure to be in the 15-24 age group, 35% in the 25-34 age group, and 28% in the 35-44 age group. (It should be noted that these figures are conservative, since they represent reported cases. UNAIDS estimates that under-reporting could vary between 30% and 75%.) These figures show that HIV/AIDS is concentrated among young people. Since the HIV virus can have an incubation period of up to 10 years, it is quite possible that many of those persons diagnosed with AIDS in the 25-34 age group may have become infected during adolescence. In Trinidad and Tobago, the adolescent age group (15-19) is the fastest growing group to test positive for HIV. Within this group, there is a sharp difference between male and female adolescents in terms of rates of infection. It appears that females in this group are seven times more likely than males to become infected with HIV. This trend is significant and is related to the increasing number of children who test positive for HIV at birth. While figures in the 0-4 age group are still relatively low, we must be concerned about the quality of life of these children. The statistics also reveal that the incidence rates for HIV/AIDS infection are lowest in the 5-14 age group. It is imperative, therefore, that efforts are made to ensure that this group becomes relatively virus-free. A WHO/PAHO report, published in 2000, speaks to the need for advocacy for investment in youth, but cautions that strategies must be built upon a framework that recognises the links between healthy behaviour and the broader contexts of family, community, society, and culture. The setting up of a Multi-Sectorial Task Force to develop a National Strategic Plan on HIV/AIDS is timely. The role of education, however, and in particular the role of the school must be clearly articulated in this plan, and it must reflect the government's commitment to Health and Family Life Education (HFLE) in the school curriculum, as an intervention to empower young people to engage in the kinds of positive behaviours that will promote a healthy lifestyle.

A case has already been made for a whole school approach to health education in Trinidad and Tobago. A whole school approach to HFLE is compatible with the *Health Promoting School* concept. A health promoting school (HPS) has been defined as a school that has an organised set of policies, procedures, activities, and structures designed to protect and promote the health and well-being of students, staff, and members of the wider community. The concept has been applied as a core framework to a range of issues in schools in different parts of the world, and it has proven to be supportive of, and compatible with, other frameworks, and adaptable to different cultures. Some of the advantages of the HPS framework include the following: the integration of vertical programmes on single issues (e.g., HIV/AIDS) into a planned comprehensive approach, which is economical in terms of curricular time and deployment of human resources; an increase in students' action competence through life skills acquisition; and the provision of a coherent framework for school improvement, such as a school policy on health promotion and education. HPS encourages a critical analysis of values, behaviours, social conditions, and lifestyles, and strengthens those that favour and promote healthy practices.

How, then, does the school respond to the challenges of HIV/AIDS? The answer lies in an ongoing life skills-based comprehensive HFLE programme that uses an HPS approach to understanding human sexual development and sexual health. Such a programme should be age appropriate, culturally relevant, and developmentally based, and should target students at all levels of the educational system. The programme must involve all members of the school community, including parents. There are three critical groups that must be catered for within any overall thrust to educate/empower children and youth about HIV/AIDS and reverse the present trends. This may require national/school policies on education to be enforced or revisited, and attitudinal changes on the part of all stakeholders.

The first group includes those children who contracted the virus from HIV-positive mothers. If we take into consideration the length of the incubation period, and new policies with respect to access to drugs, it is likely that quality of life and life expectancy would improve for these children. They will need to be placed in schools. Are they to be excluded from mainstream education? It is not easy to remove deep-seated fears with respect to infection from casual encounters with persons with HIV/AIDS, or to overcome the negative attitudes to such persons. On the other hand, children living with HIV/AIDS cannot be denied equality of educational opportunities through discriminatory practices. Programmes, therefore, cannot target children alone. They must include the reorientation and retraining of teachers, administrators, and parents about HIV/AIDS, including its safe management. Similarly, early education of children about HIV/AIDS, and life skills training in key areas such as interpersonal skills, empathy skills, and communication skills should also encourage greater acceptance of these children by their peers.

The second group is the 5-14 age group. Although the incidence rate is lowest in this group, an alarming trend is the increasing number of infected young persons in the 13-14 age range. This is a vulnerable group, which is prone to exploitation by unscrupulous adults. It is obvious that some children in this age group are already sexually active. The

HFLE curriculum must address the full range of pre-adolescent and adolescent development needs. It must also fully explore all issues related to sexual health. Emphasis in this group must be placed on abstinence as the only way to prevent HIV and other sexually transmitted diseases (STDs). Education goes beyond teaching to say “no.” It must include training and practice in the necessary life skills such as interpersonal, decision-making, resistance, and refusal skills, to be able to support this decision.

The third group is the at-risk 15-19 age group, which is really a very complex group. This group consists of many students who are sexually active. Some may have already experienced childbirth, abortion, STDs, and some may be HIV positive. It is also likely that those who are HIV positive may be unaware of their status. There are, therefore, a number of issues that must be addressed at this level with respect to sexual health. There are also a number of complex social issues related to sexual health that form part of the school environment, which adolescents need to understand and cope with, for example, the social construction of sexuality and gender, and power relations. We must also be aware that sexual activity is clearly related to what is normative for one’s peer group. The emphasis here, therefore, must be on the development of personal health skills through the formal and informal curriculum, so that students gain the appropriate knowledge, attitudes, and competence to enable them to be responsible in matters related to their sexual health. Emphasis must still be on abstinence and delaying the initiation of sexual activity until the development of the emotional, psychological, and financial capability to deal with its impact. All students, however, need to be aware of how to protect themselves against HIV infection and other STDs. We need to acknowledge that there are those who may be unwilling or unable to change behaviours, and they too must have the tools to be able to say “yes” to life.

AIDS is a killer and there is no cure. The Junior Finance Minister, at the recently concluded National Consultation for the Preparation of the National Strategic Plan on HIV/AIDS, spoke to the need to devise strategies that could effect behavioural changes among high-risk and vulnerable groups. Our young people clearly fall into these categories. There is enough evidence that knowledge alone does not bring about behaviour change. Promoting behavioural change requires empowering young people in a variety of areas--life skills, values, attitudes, and knowledge--and giving them the opportunity to practise new behaviours. Young people are the “window of hope” for the future. The majority of them are HIV free, and education is the key to ensuring that they remain so.

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