

# **Problematic Recipe: Alternatives to Public Health Education to Reduce the HIV Pandemic**

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## **ABSTRACT**

This paper problematizes the manner in which health education messages, especially HIV/AIDS messages in sub-Saharan Africa, are transmitted to the population. It challenges the top-down method of disseminating health education information and suggests a culturally sensitive and relevant bottom-up approach. Culture consideration in message construction and cultural context decoding is supported by Airhihenbuwa (1995); Dutta-Bergman (2004, 2005). Complicating the situation further is the hegemonic masculinity that characterizes most cultures in the sub-region. Thus we contend that alternatives to health education should bring men on board in partnership with women as agents of change to reduce the spread of HIV/AIDS. The article adopts an approach of a critical literature review augmented by interview data from eight media practitioners. Some pragmatic solutions are put forth.

**Keywords:** *Health education communication, HIV/AIDS, Culture, Counter-hegemonic masculinity, Bottom-up/top-down.*

## **INTRODUCTION**

In a new report released on the occasion of the 20th anniversary of the first observance of World AIDS Day the United Nations Programme on HIV/AIDS (UNAIDS) indicated that an estimated 33 million people worldwide are living with HIV. In the year 2007, 2.7 million people were newly infected while two million died of AIDS (UNAIDS 2008). This is against the backdrop of extensive effort invested by different organizations and governments to promote awareness to reduce the rate of HIV infection especially in Sub-Saharan Africa, yet the problem is getting out of control. The UNAIDS (2007: 15) report on the AIDS epidemic update confirmed that:

Sub-Saharan Africa remains the most affected region in the global AIDS epidemic. More than two-thirds (68%) of all HIV-positive people live in this region where more than three-quarters (76%) of all AIDS deaths in 2007 occurred. It is estimated that 1.7 million people were newly infected with HIV in 2007. Unlike other regions, the majority of people living with HIV in sub-



effective communication and health promotion and then discusses the sub-regional context in which health education is carried out. This situational analysis makes it clear why we cannot continue “business as usual” health education in the region. We explore further the need for a change in communication strategy. Finally alternative strategies for carrying out health education and promotion are discussed.

## 1. EFFECTIVE COMMUNICATION AND HEALTH PROMOTION

According to Chetley (2004), effective communication concerns not what, but how. This means that what effective health communication has been is not what is done that matters, but how it is done. Who is involved in the communication process? What role do they play? Who drives the agenda? Chetley (2004) further stresses that understanding the how comes about through practice; analyses, dialogue, reflection and new practices, and, we will add, what is embedded within the specific dynamics of the target culture.

In the first place it is important for countries to see health education as an integral part of health promotion. Donatelle (2009) defines health education as the principle by which individuals and groups of people learn to behave in a manner conducive to the promotion, maintenance and restoration of health. He also views it as a combination of several planned learning experiences based on sound theories that provide individuals, groups and communities the opportunity to acquire information and the skills needed to make quality health decisions. Based on this definition, health education aims at bringing about behavior change.

Health education focuses on acquainting people in explicit, identifiable and even measurable terms with facts of what health is, for example, teaching people how to look after their teeth, information about nutrition, or anything connected with mortality. This narrow view makes health education unidirectional and implies that the individual is the victim who must change. This unidirectional characteristic of health education has been applied to the HIV pandemic in Africa. What gets left out is that participation and communication go hand in hand. You cannot have one without the other. Indeed, the Latin root of the word communicate, “*communicare*,” means to share in common or to participate in (Gumucio-Dagron 2001).

On the other hand, if one views health education as an integral part of health promotion then the purview becomes much wider. The term “health promotion” has been in existence in its current usage since 1973 and can be traced to the document “A New Perspective on the Health of Canadians.” In this document, the Canadian Minister of Health and Welfare Marc Lalonde forcefully elaborated the point that all causes of ill-health could be attributed basically to non-medical origins (Lalonde 1974; Bunton & MacDonand 1992). He identified four causes:

1. Inadequacy in actual primary health care provision;
2. Behavioral factors – both corporate and individual;
3. Pollution of the environment;
4. Bio-physical characteristics.

Lalonde's initiative prompted the World Health Organization (WHO) to mount the "Alma-Ata Conference on Health Promotion," resulting in the Alma-Ata Declaration of 1978. The core of the declaration that concerned the International Conference on Primary Health Care meeting in Alma-Ata in Kazakhstan, expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world (WHO 1978).

Health promotion is thus seen as multifaceted. It implies an ongoing process involving both education about health and elaboration of strategies which enhance the effect of such education. It is this aspect that informs us that health promotion involves a collective response (transcending the activities and decisions of the individual), and, largely for that reason, is likely to seek (and find) expression through political structures and channels.

Whereas the narrow meaning of health education made it possible for governments to shed the brunt of the load of ensuring a healthy populace, health promotion seeks to call governments to order. It is as much the responsibility of the individual to cultivate healthy habits as it is the government's duty to ensure a conducive and enabling environment for the cultivation of healthy habits. African governments in the sub-Saharan region, therefore, can no longer relegate health promotion issues to the health agencies and other public-spirited organizations but must face up to the challenge and responsibility, just as they handle all national disasters. For example, in May, 2001, in Ghana a fight at a soccer match between the Kumasi Asante Kotoko team and the Accra Hearts of Oak resulted in the deaths of 120 people, with over 300 wounded. The issue was not left in the hands of the soccer teams or the Ministry of Sports, but assumed national dimensions whereby the government shouldered a sizeable portion of the cost of the morgue and burial of the victims. Unclaimed bodies were buried by the government. Yet, though the statistics of its devastating effects are more alarming and shocking, many African governments have not elevated HIV/AIDS to the level of attention and commitment commensurate with its impact.

The sub-Saharan region which is the context for our paper has a high incidence of patriarchal practices. According to Bryceson (2002), the colonial and postcolonial policies shaped agrarian systems that integrated family subsistence production and commodity production in many parts of Africa. The formation of patriarchal family structures in which senior males as heads of households were accorded the role of liaising with government and co-opted into cash-crop production was encouraged. The male cash crop and female subsistence spheres date back to this hierarchical arrangement for agricultural production which is the mainstay of the majority of the economies of the sub-

region. Thus the produce from men's work yielded cash while that of women went to feed the family and higher value was associated with the endeavor that produced cash.

Following similar trends of privileging the male we argue that HIV/AIDS messages in the sub-Saharan region are gender-biased because they seem to leave men out of the fight against the pandemic. Therefore hegemonic patriarchal factors have tended to dominate most cultural and regional responses to HIV/AIDS, thereby rendering HIV programs ineffective and impotent. In addition, Stones (2001: 245) argues that "many of the current HIV/AIDS interventions serve to reinforce traditional, hegemonic notions of masculinity." Consequently, we fear that this style of communication has the possibility of worsening the pandemic situation in Africa in the near future because it affects not only the HIV messages, content and style of communication but the receivers' decoding strategies as well. Therefore, we strongly suggest a change from using a patriarchal context which is hegemonic in nature to using counter-hegemonic strategies which could communicate HIV messages in a more effective manner. Thus, for health messages to be effective, they must be culturally sensitive to enable a target audience to relate to them. In doing so, the communicators must recognize the hierarchy of relationship, i.e., who is perceived to "own" knowledge, the hidden codes to use, the privileged "voice," the invisible but powerful coercive forces that ensure compliance, among others.

Creators of health promotion messages should also be cognizant of the social construction of reality that underpins discourses within different cultures which makes transposing systems or packages from one culture to another problematic. How we create agency within a specific society should tie into the peculiarity of target cultures and intended consumers of health promotion. Dutta-Bergman (2004) referred to the pivotal role culture plays in health communication as the culture-centered approach. He argues that communication theorizing ought to locate culture at the center of the communication process so that the theories are contextually embedded and co-constructed.

## 2. SITUATIONAL ANALYSIS OF HIV/AIDS IN SUB-SAHARAN AFRICA

HIV in sub-Saharan Africa is now deadlier than war. For example in 1998, 200,000 Africans died in war but more than two million died of AIDS (UNAIDS 2001). Sub-Saharan Africa remains the region most affected in the global AIDS pandemic estimated at affecting 22.5 million (UNAIDS 2007; African Action 2007). However, it should be noted that the magnitude of the pandemic is not the same in all parts of the sub-region.

In southern Africa, the scale and trends of the pandemic vary considerably, with South Africa most severely affected. This region accounted for 35% of all people living with HIV and almost one third (32%) of all new HIV infections

and AIDS deaths globally in 2007. In 2005 national adult HIV prevalence exceeded 15% in eight countries (Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe). While there is evidence of a significant decline in the national HIV prevalence in Zimbabwe, the pandemic in most of the rest of sub-Saharan Africa has either reached or is approaching a plateau. This may be because each year the number of deaths exceeds the number of new infections. However, the total number of people living with HIV is still rising because of overall population growth (UNAIDS 2007).

In western Africa, studies show that countries have responded differently in using the education sector as a means of combating the pandemic. For instance, Ghana has made concerted efforts to better equip teachers as transmitters of HIV messages in schools. Harmsworth (2007) asserts that teachers represent tremendous potential as allies in the fight against AIDS despite their being highly vulnerable to HIV infection. The Ministry of Education in Ghana has fully incorporated HIV/AIDS prevention into the national pre-service training curriculum at each of Ghana's 41 initial Teacher Training Colleges for K-9 teachers. This move aims at tapping into teachers' strengths as well as their positions as educated and respected community members. The new HIV/AIDS curriculum's goal is to prepare new teachers for the challenge of teaching, creating safe learning environments for students, protecting teachers' own health by adopting safe behaviors, and ultimately engendering the respect that they deserve as community role models.

A focus on teachers, both in their capacity as agents of HIV/AIDS education and as part of the population identified as vulnerable to the epidemic, is important. If teachers are to be effective in transmitting HIV messages to their learners, they need to have what it takes to avoid the pandemic in the first place. However, this is sadly not the case in many parts of the sub-region. According to UNICEF (2000), there is a disproportionately high incidence of HIV/AIDS among teachers in sub-Saharan Africa although no one seems to have a good explanation. The illness or death of teachers is especially devastating in rural areas with schools depending heavily on one or two teachers. Skilled teachers are not easily replaced. Tanzania has estimated that it needs around 45,000 additional teachers to make up for those who have died or left work because of HIV/AIDS. The greatest proportion of staff loss according to the Tanzania Teacher's Union, were experienced teachers between the ages of 41-50 (UNAIDS 2006). PHNFlash (1995), doing a study on the economic impact of AIDS in Tanzania, estimates that it will cost the country US \$40 million to replace the 15,000 teachers who are estimated to die from AIDS through the year 2010.

Quite apart from the direct death toll, the HIV/AIDS pandemic, according to Boler, Adoss, Ibrahim and Shaw (2003), will have a traumatic impact on all educators and learners unless there are appropriate interventions. Thus, HIV/AIDS will seriously affect the quality of learning outcomes. At any one time, 30-40% of HIV-positive teachers will have developed full-blown AIDS (Boler et al. 2003). The effect of the virus on teachers presents another challenge

to health promotion. Many governments are turning to the educational system and introducing educational programs into the school curriculum in an effort to create awareness of the AIDS pandemic. The irony here is that the educating agents themselves are dying from the scourge, so who will be left to educate the children about the pandemic? What is the level of awareness among teachers? If they have become victims themselves can they educate others about how to avoid contracting HIV/AIDS?

Mureu Kamau, an executive member of the Federation in the Kenya National Union of Teachers, was asked about the impact of AIDS on teachers. He flipped through a ledger containing the names of teachers who had died and said, “Generally, these are teachers dying of illnesses, not accidents. Most of our members who die are dying of AIDS.” Asked when the last Nairobi teacher had died, Kamau gave a sad response; “Yesterday, just yesterday. It was someone I knew well, someone I went through teacher training with” (Crawley 2000: 5-7).

This means that AIDS has become a full-blown development crisis. Its social and economic effects are being felt not only in health circles but also in education, industry, agriculture, transport, human resources and the economic sectors in general (UNAIDS 2001).

In Zambia, increasing numbers of teachers are dying of AIDS and for many their teaching input is decreasing because they are sick. Swaziland estimates that it has to train more than twice as many teachers over the next 17 years just to keep the services at their 1997 level (Crawley 2000). Teacher shortages have been looming in many African countries, with 30-45% of secondary school teachers in Botswana infected with the HIV virus. Zimbabwe, South Africa, Swaziland, Malawi, and Zambia are said to have worryingly high teacher death rates and if nothing is done in the next 10 years, this group will be completely depleted according to AIDS specialists (Crawley 2000). Crawley quoting Pitso Mosothoane, a representative of the Lesotho Association of Teachers, points out that AIDS is causing teacher shortages in that country. The analyses above drive home the urgency to turn the situation around through effective health promotion strategies to ensure that this human capital wastage is stemmed.

Given these stark statistics, we explored ways to understand how health education is carried out in the communities of eight African media practitioners – two each from Botswana, Swaziland, Zambia, and Zimbabwe –, who work mainly in radio. Using Skype, computer software that enables free worldwide audio communication, we interviewed these media professionals for their views. In response when we asked how health messages were framed for consumption by the populace, they all indicated that the majority of health promotion messages are framed and sent to the media houses by the appropriate government agencies and all the media practitioners do is transmit. Interviewees indicated that in a few cases, NGOs or other organizations working in the area of HIV frame their messages in the form of advertisements for transmission through radio and other media outlets.

Responding to how they gauge the success or failure of health propaganda messages, the media practitioners said they do not do evaluation but leave that in

the hands of the originating agencies. Thus, the media functioned merely as transmitters of health messages rather than originators and managers. The respondents were also asked to describe the processes they used to ensure that the target audience felt some sense of ownership of the health messages. They said that with general health propaganda they sometimes had call-in sessions to involve the public, but the sensitivity and negative stigma attached to HIV/AIDS made such public involvement less likely. Thus, it was more difficult to gauge the audience involvement with or attention to specific HIV/AIDS propaganda programs.

Responding to whether there were any health propaganda messages particularly targeting HIV/AIDS initiated at the grassroots level, they indicated that there were few such programs, and those, mostly aired during public service slots, were few and far between. Considering the devastating impact of HIV/AIDS on communities, one would have expected more of such initiatives, but in the media practitioners' view, there appears to be an expectation for government and other outside bodies to assume leadership in combating the pandemic. They also felt that there wasn't enough education on the issue and some communities still viewed the pandemic as being caused by supernatural forces. In this regard, the interviewees argued that what is needed is more public education that targets grassroot organizations, opinion leaders and other well-meaning citizens who in turn can galvanize local groups and individuals into becoming active in educating about HIV/AIDS.

### 3. NEED FOR CHANGE IN COMMUNICATION STRATEGIES

Changing the communication strategy to a counter-hegemonic style can put men at the center of the fight against HIV/AIDS. According to Stones (2001: 241), "It is men who drive the AIDS pandemic, and if there is to be any major change in the HIV/AIDS infection rate, it is men, rather than women, who need to change their behavior." Therefore, in order for such change to take place, there is need for radical behavior modifications. Stones (2001) suggests a reconstruction of masculinity and a dismantling of hegemonic masculinity is necessary since masculinity has always been reinforced through culture in Africa and other parts of the world.

A move away from hegemonic masculinity has occurred in other parts of the world. For instance, in the past two decades, pro-feminist men in the United States (U.S.) and Britain have become concerned with new, nonoppressive, life-affirming ways of being men and in the process have challenged many of the contradictions surrounding the very construction of masculinity (Connell 1995). Generally, such men have discovered that the main enemy to be fought is the rigid, conventional, hegemonic construction of masculinity. Another reason why such a shift is important is because HIV is spread through sex and there is a need to understand it in relation to masculinity. According to Foreman (1999),

convincing ten men with several partners to use condoms will have a greater impact on the spread of HIV than will intervening with a thousand women. Though it has been realized that HIV/AIDS is a gendered disease that has a dramatic impact on the lives of women (Stones, 2001), Stones (2001: 231) points out that if “there is to be any major change in the current HIV/AIDS pandemic, it is the behavior of men rather than women that must undergo dramatic change.”

Since the age old top-down approach of passing out health education packages without input from the grassroots foot soldiers has been largely ineffective we strongly favor the use of constructive engagement in a bottom-up systematic strategic formulation of the whys, the whats and the hows of health promotion.

There is evidence that the bottom-up approach of communication has worked in other parts of the world. In Vietnam, for example, when the Save the Children Foundation (SCF) began to tackle child malnutrition the starting point was a concept described by SCF staff member Jerry Sternin as “positive deviance.” By identifying why some children from poor families did well, it became possible to identify some locally acceptable and relevant practices that could be used by others. But the key to the process was not to then teach others new knowledge, but to allow them to discover new behavior through encouraging dialogue and practice. A key part was letting those who had discovered the power of “positive deviant” behavior to tell others about it.

The ideas started in four villages, and then spread to 14 – all the time discovering new solutions, using new foods. The answers were never quite the same from one village to the next. Different solutions grew out of different situations. But the process remained the same: discover original local answers to a problem, and then give everyone access to the secrets. Over time, SCF used the 14 villages as “living laboratories,” inviting people who wanted to improve nutrition to visit the villages, learn from the villagers and go away and practice in their own locations. The program reached 2.2 million people in 265 villages. The positive deviance approach has been used by SCF in more than 20 countries (Chetley 2004). Therefore, to solve HIV and AIDs in Africa, there is need to “borrow a leaf” from organizations that have successfully used a different approach of communication. A high percentage of illiteracy, the multilingual composition, high cultural diversity, strong superstitious beliefs and certain unhelpful cultural practices make this grassroots bottom-up approach Africa’s most viable option in combating the HIV/AIDS pandemic.

Once the approach to health promotion has been successfully democratized, then strategizing to ensure that the audience attends to the content of health promotion packages is critical. Louis and Sutton (1991) put forward a model of “switching cognitive gears” that purports to motivate individuals to become actively cognitively engaged. They put forward three different criteria to achieve this:

- When presentation of content is unusual, unfamiliar or novel.
- When presentation of content represents a discrepancy between expectations and reality.
- When an external or internal request causes an individual to deliberately initiate an increased level of conscious attention.

If these criteria are met, the words of Mendelsohn (1968:136) would become true – that “[m]ass media can be extremely powerful in involving the audiences with the abstract matters of health in exciting personalized ways and in involving people they can become quite capable of affording insights that might produce ameliorative actions ultimately.” For instance, the message being transmitted should fit the situation and context of those targeted to adopt it. If radio and television messages or programs on HIV/AIDS do not seem to reflect real situation of the target group they will be treated as fiction since the audience cannot relate to them. The audience may not identify the real life threatening issue that warrants their attention and a change in their behavior. Messages and programs are required to model behavior change, show the benefits to the listeners of behavior change and raise their motivation to change within their own social-cultural context (Bandura 1997).

However, some radio and television programs in parts of Africa are not tailor-made for groups such as rural populations and if the programs are aired there, the messages are too unusual, too unfamiliar, too culturally irrelevant, or too novel for this population. For example, a character in an edutainment program who seems so smart that he or she never shows any human weakness, especially when it comes to issues of behavior change, could be less than attractive to the audience. Showing characters who struggle to change and finally succeed may have more impact in behavior-change messages.

Austin (1995) argues that to be effective, public communication campaigns must provide consistent messages from a variety of sources and over a long period of time. He further contends that mixed messages from parents, communities, and health officials may make adolescents skeptical of adult advice. He asserts that adolescents are more likely to imitate observed behavior than to do what they are told, especially when the two are in conflict. Thus, for example, campaigns that focus exclusively on deterring young persons from smoking without challenging the social acceptability of smoking itself (and aiming to reduce tobacco use among everyone, adults and children alike) are unlikely to be effective.

Ormrod (1999) argues that many behaviors can be learned, at least partly, through modeling. For example, students can see parents read, students can watch demonstrations of math problems, or see someone acting bravely in a fearful situation. Social learning theory focuses on the learning that occurs within such a social context. Bandura (1977) believed that people learn from one another, including through such concepts as observational learning, imitation and modeling. In the same vein, giving teachers a higher edge on HIV

knowledge will make them better role models for their students. Team working or partnering is another concept, supported by Azmitia (1988) by stating that working in groups and having discussions about academic and social problems encourages more hours of engagement and clear focus on the issues at stake. Therefore, we suggest the use of teamwork between all stakeholders in solving HIV/AIDS-related crises in sub-Saharan Africa, which could increase the possibility of coming up with better and culturally relevant solutions.

#### 4. ALTERNATIVE ROUTES TO HEALTH EDUCATION AND PROMOTION

Schools have always been one of the vehicles for bringing about social change. For instance, all children need the skills to function as proactive citizens in society. According to Izadi (2003: 230), the concept of “world citizenship is no longer a mere expression of vague brotherhood; it has become a necessary aspect of learning to live as a competent inhabitant of the planet.” The words of Mohammad Khatami, President of the Islamic Republic of Iran, in a meeting with directors and staff of the Ministry of Education, January 27, 1998, are informative:

Our younger generation, which is the most vulnerable section of our population, the focus of our attention and our only hope for the future, is in the hands of our educational system in the most impressionable phase of its life. This goes to show the immense importance of the issue, especially if we consider the fact that it is the country’s human resources that shoulder its development. If scientific development exists, if research exists, if civil service exists and if technology exists, it is primarily because there is the manpower which runs and operates them. (Cited by Mehran, 2003: 311)

This view from Khatami emphasizes the central role of the schools in advancing national development issues. Health promotion can also utilize this vehicle. When the Sputnik event occurred and the Russians sent the dog Liaka into space, the education system in America was changed and emphasis was given to math and physics. This alteration enabled the Americans to land a human being on the moon within 10 years (Divine 1993). Additionally, Divine adds that dictators wanting to control the mind sets of their populace have used the educational system. Furthermore, the colonial legacy of psychological dominance was perpetuated through the educational system.

If the educational system has thus proven to be a tool for controlling social behavior why can’t we then galvanize this resource to serve health promotion? Other health-related social problems have been solved through school programs. For instance, a study in the U.S., conducted by the National Center for Education Statistics of the role of schools in preventing childhood obesity found

out that schools play an especially important role because over 95% of young people are enrolled in schools (National Center for Education Statistics 2005). Additionally, the promotion of physical activity and healthy eating in schools has long been a part of education, and research has shown that well-designed, well-implemented programs can effectively promote these behaviors (Robinson 1999).

UNESCO (2009) came up with a discussion forum or a blog where teachers share their views on how the HIV/AIDS curriculum is being implemented in their countries. This E-forum reports teachers' views in many countries of the sub-region supported by UNESCO and UNAIDS. It aims at promoting the exchange of views and experiences on the contribution of teachers to HIV prevention and mitigation efforts and the impact of the epidemic on teachers and students. The forum designed discussion questions on using teachers as HIV prevention channels. There were 54 responses drawn from 22 countries in sub-Saharan Africa to the blog.

The teachers raised concerns about why they are not as effective as they should be as agents of change. These can be categorized under the following issues:

- Teachers are embarrassed
- Lack of knowledge about the subject
- Overload for teachers
- Lack of compensation
- Lack of compensation for extra hours in teaching HIV/AIDS
- Lack of integration of HIV/AIDS curriculum in teacher training and schools

The views raised above are supported by other researchers. For example, according to a study conducted by Peltzer (2003) among high school teachers in South Africa, not only did teachers lack enough knowledge concerning HIV/AIDS, they also were embarrassed to share with their students topics related to safer sex. Tamukong (2004) complained that many education ministries in Central and Western Africa have not yet formalized HIV/AIDS education throughout their teacher training colleges and school systems. In our view, so long as a subject remains informal in the school system, it risks not being taken seriously by the students and has less chance of being funded. Tamukong adds to the above list of categories shared by the teachers' E-forum, stating that among the factors promoting the spread of the pandemic included: lack of higher disposable income, temporary separation from spouses while working in remote areas, frequent transfers from school to school and issues of multiple sex partners.

Another resource at our disposal is utilization of the unique position occupied by chiefs, opinion leaders, churches, mosques and religious leaders in our societies. There is an urgent need for governments, civil society, and other bodies interested in health promotion to sit down with these identifiable power

brokers and design a bottom-up approach from the grassroots. For starters they need to determine the kind of messages needed, how those messages should be packaged, what dissemination strategies will be effective, what value systems have to be respected, what cultural practices can be harnessed, with what philosophical and traditional mental sets will they have to contend, and what types of personnel could be recruited as foot soldiers and agents of change.

Emphasizing further use of education, local knowledge, indigenous culture and community power structures could be helpful in this direction. UNAIDS (2006) indicates that maximum effectiveness requires partnerships among policy-makers, religious and community leaders, parents, and teachers in formulating sound policies on AIDS education. These policies involve training teachers and peer-educators to use curricula adapted to local culture and circumstances, focused on life skills rather than biomedical information. They would teach primary and secondary students to analyze and respond to social norms, including understanding which are potentially harmful and which protect their health and well-being. UNAIDS also recommends that HIV-prevention and health-promotion programs be started at the earliest possible age, and before the initiation of sexual activity—ideally with age appropriate programs at the primary school level. This approach will surely ensure the involvement of all the stakeholders in solving the HIV problem from an ownership point of view. When people take part in making decisions that affect them, they feel compelled to carry them through.

Individuals diagnosed as HIV positive should be given a supportive and enabling environment to join the crusade of passing on HIV messages. Supporting HIV-positive teachers in their work and in society has been viewed as an important aspect of using teachers as agents of change in stepping down the pandemic. In a UNESCO and EFAIDS's (2007) technical consultant report which drew participants from many countries in Africa, the Kenyan Network of Positive Teachers (KENEPOTE) chair Margaret Wambete strongly stated that, "HIV-positive teachers are part of the solution to fight HIV/AIDS in the education sectors and not a problem" (UNESCO & EFAIDS 2007: 13). Based on this background, teachers and education official encouraged formation of teacher networks and support mechanisms to retain the teachers in the job market.

## CONCLUSION

Boler, Adoss, Ibrahim and Shaw (2003) opine that if HIV/AIDS education is to succeed, it should be extended beyond the classroom and it must target all sectors of society including religious leaders, the media and families. Pre-existing systems of knowledge transfer should be utilized. Parents and the extended family should be targeted for adult learning programs that encourage them to communicate openly, positively and accurately on HIV/AIDS. The

education should be locally relevant since there needs to be a move away from an overly scientific approach to HIV/AIDS education. Learning materials should stimulate children to understand the human side of HIV so they can connect the issue to real life. Learning resources on HIV/AIDS should be locally driven – drawing upon local statistics of prevalence and local case studies.

In addition, according to Boler et al. (2003) social and power inequalities must be challenged in order to bring about education that leads to positive behavior or social change thus looking beyond skills in this particular context. HIV/AIDS education should focus on power and communication issues in wider human relationships, and in this way some of the power issues involved in sexual relationships can be addressed. If the education system is to be an effective vehicle for preventing further spread of HIV/AIDS, then improving the basic functioning of the system is a prerequisite. A massive injection of financial resources is needed at every level – internationally, nationally, in communities and in schools themselves – to provide good quality education. There is the need for partnerships between health administrations and media houses in countries to dialog, negotiate and adapt their messages to suit local needs. Such partnerships will help break the hegemonic top-down approach in favor of engagement, peer-review and consultations among others.

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