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Abstract

There is potential evidence of the link between Education and behaviour change in HIV/AIDS prevention efforts. Provision of clear information about the sources of HIV/AIDS infection and, indeed, improved general levels of literacy, will allow those at risk to understand and judge their options better. The education sector in Uganda has taken long strides to utilise education as a ‘social vaccine’ in the prevention of HIV/AIDS. Knowledge and risk reducing skills are provided through a complex network of formal, informal and non-formal channels of education. But a lot of gaps still exist in these efforts. Nevertheless, the cognitive skills required for informed choices in respect of HIV/AIDS risk – and for behavioural change – appear to be substantively dependent on the ability to understand and apply the messages, quality and competence of teachers, community support as well as recognition of socio-economic and demographic diversities in which HIV/AIDS education programs are implemented and should Uganda realise this, the spread of the epidemic will be significantly reduced.

1.0 Introduction

This paper examines the implementation of HIV/AIDS Education in Uganda. Education has been referred to as a ‘social vaccine’ against HIV/AIDS because of its role in providing information and knowledge that lead to behaviour change in the continued efforts to reduce the spread of the virus that causes AIDS. Two theories: the Social Learning theory and the Health Belief Model are used to examine and analyse the effectiveness of HIV/AIDS education programs implemented by the government, private sector and Non-Governmental Organisations in making education work as a social vaccine against the epidemic. A wide range of social science and medical research literature is used to point out that there are gaps existing in the prevention efforts through education. I argue that failure to put in place mechanisms that will reduce these gaps render the social vaccine paradigm remain a fallacy.

1.1 Definition and role of education

It is rather impossible to define education separate from its role to individuals and the society whether defined from a sociological, philosophical or psychological point of view. According to Whitehead (1951), education is the acquisition of the art of the utilisation of knowledge. Defined from an African perspective, education is ‘the process of cultural transmission and renewal’, the process whereby the adult members of a society carefully guide the development of infants and young children, initiating them into the culture of the society (Adeyemi & Adeyinka 2003). Education as a process of bringing up or guiding is not limited to children since it is a life-long process that begins at the time of birth and ends with death (Kenyatta 1961). It also means more than what the school can offer since it takes place within and outside the school and this
emphasizes the involvement of the community at large where every member of the community has a stake.

1.2 Formal, Non-formal and Informal Education

Formal education is used to refer to regular schooling that follows a normal pattern – admission of students, promotion from grade to grade on a yearly basis, and use of a curriculum that covers a wide range of knowledge, skills, values and attitudes (UNESCO/IIEP 2006). A formal education system comprises primary, secondary, tertiary and vocational education. In Health Education matters, the school system is seen as a very strategic and effective institution to improve the health of children, prolong the time that students can engage in risky behaviours as well as giving students aspirations to become successful (Balikana et al. 2005). Non-formal education refers to educational activities delivered to targeted social groups, where there is a possibility to provide attention to individual learners. However, some of the issues addressed here may also be addressed in the formal school setting. Informal education which targets large groups of people differs from the above. It involves the use of learning channels such as mass media and mass publicity campaigns to reach the masses where the possibilities of reaching individuals are minimal. Whatever the type of education, the individual and social benefits from it depend on whether it addresses the core issues, whether the knowledge and ideas learnt are applied in the practical life of the learners (Whitehead 1951) and the extent to which key stakeholders are involved in the formulation and delivery of what it taught. It is on the basis of this argument that this paper tries to examine how each of these categories has been applied to bring about positive changes in behaviour aimed at encouraging HIV/AIDS prevention in Uganda.

2.1 Behaviour change theories and the role of education

My point of departure in examining whether the ‘social vaccine’ paradigm has been applicable in the fight against HIV/AIDS in Uganda through behaviour change is taking a look at the two important theories that help to explain behaviour change: the Social Learning Theory (Bandura 1977) and the Health Belief Model (HBM) by Rosenstock I., Strecher, V., and Becker, M. (1974). These two theories are selected because apart from providing explanation to enact and maintain behaviour change, (FHI 2004) they are commonly recommended in HIV/AIDS prevention literature.

2.1.1 The Social Learning theory

According to the Social Learning theory, human behaviour is not simply determined by motivational forces in form of needs, drives and impulses that are within the individual. Instead,
these inner forces can be induced, eliminated and reinstated by varying external influences. Thus, the determinants of behaviour reside not within the individual or organism but in the environmental forces. Although this theory has been criticized for reducing human beings to mere respondents of whatever influence comes upon them, it points out that through a process of reciprocal determinism, behavioural, environmental and other personal factors interact interdependently. The theory further points out that individuals have self-regulatory capacities with the ability to exercise some measure of control over their own behaviour by arranging environmental inducements, generating cognitive support and producing consequences for their own actions. This theory has a lot of implications for HIV/AIDS prevention programs that focus on behaviour change as will be discussed later in this paper for it will help in the deeper understanding of several factors that influence various approaches used in behaviour change communication in HIV/AIDS education.

2.1.2 The Health Belief Model (HBM)

The Health Belief Model (HBM) was developed in the 1950s in the United States as a result of widespread failure of people to accept disease preventives although they were provided at low cost or sometimes for free. According to this theory, an individual exists in a life space composed of regions categorized as positively valued (positive valence), negatively valued (negative valence) and relatively neutral regions. Negative valence is undesirable thereby forcing people to move away from it while being pulled by positive forces. Taking the disease as an example of a negative valence, in order for an individual to avoid the disease, one needs to believe that he/she is personally susceptible to it (perceived susceptibility), that the occurrence of the disease would have at least moderate severity or serious consequences on some components of his life (perceived severity) and that taking a particular action would in fact be beneficial by reducing his susceptibility to the condition or if the disease occurred, by reducing its severity. Also, the individual has to believe that taking such action would not entail overcoming important psychological barriers such as costs, pain, convenience or embarrassment, etc. hence perceived benefits. The theory further argues that a person’s beliefs about the availability and effectiveness of an action determine what course he/she will take. But this is not the case in all situations since according to Bandura (1977), beliefs are also influenced by the norms and pressures of that individual’s social group or external influences.

Even then, the individual does not take action immediately according to this theory. The combined levels of susceptibility, severity and less barriers do not guarantee an overt action. An instigating event (Cue to action) must occur to set the process in motion and such event may be
internal (like perception of bodily state) or external (like interpersonal interactions, the impact of media and communication, etc). Further than that, the theory further points out that these cues to action must be intense and the levels of susceptibility and the severity must be adequate.

2.2 Relevance of the theories to HIV/AIDS Education

The above theories put emphasis on what should be considered when planning the delivery of HIV/AIDS education aimed at influencing positive change of behaviours and attitudes. It shows what it takes to effect behaviour change, seemingly to suggest that different approaches are required to reach different people while using appropriate means at different stages in the process. The theories help to explain what motivates behaviour change and this helps me to analyse whether the programs in the implementation of HIV/AIDS education in Uganda consider this as an important component. The environmental and social settings, the media of communication used, the economic, social and demographic characteristics of the individuals receiving HIV/AIDS education need to be considered and these theories provide a framework for analysis.

HIV/AIDS education that adopts a behaviour change approach is among other components of Health Education based on the recognition that individual behaviour plays a pivotal role in the development and maintenance of proper health. Positive change in behaviours has a major preventive and health enhancing value (Hornik 2002; Koelen and Anne 2004). I claim that HIV/AIDS education in Uganda is based on this paradigm. Using the Behaviour Change Communication education, it is widely believed that provision of knowledge is important as it is expected to eventually lead to change in behaviour. But increased knowledge does not often lead to expected behaviour effects and if an effect is found, it is usually of small magnitude (Koelen and Anne 2004). Thus motivation, skills and perceived self-efficacy are important conditions to enhance behaviour change (Bandura, 1977). After all, much of the health-related behaviour whether positive or negative, occurs or is learnt in a social context.

3.1 Education ‘a social vaccine’, where is the evidence?

An inverse association between the disease burden and the level of education exists for most infectious diseases (Vandemoortele 2000) based on the assumption that with increased information, knowledge and awareness, the behaviour of the educated people changes faster than that of illiterate and poor people. This concurs with the view that the level of education goes hand in hand with a person’s socio-economic status (World Bank 1995). This hypothesis implies that in the absence an immediate cure of HIV/AIDS, education is the best available protection against
the infection because it provides information and knowledge necessary for behaviour change. In Uganda, the decline in infection rates in 1990s is also credited to education where increased general knowledge about how the disease should be prevented is said to have led to risk-avoidance behaviour as shown in the graph below;

**Figure 1: HIV prevalence in rural Uganda (%) by education category, 1990-2001 (individuals aged 18-29)**

During the 1990s, the decline in infection rates in Uganda is attributed to increased knowledge about how the disease should be prevented, leading to risk-avoidance behaviour.

*Note: Primary means having attended any or all of grades 1–7; and Secondary, any or all of grades 8–13 or above.*


Education has been called a ‘social vaccine’ against HIV/AIDS because through provision of information about the epidemic, it empowers individuals with appropriate skills to receive and act on knowledge of protection against infection (Kelly 2000a; Balikana, *et al* 2005; Rispel, Letlape and Metcalf 2006; World Bank 2002). Apart from providing information on prevention, education prolongs the time young people can engage in risky sexual behaviours. Schools also give students hope and aspirations to become successful which in most cases discourage them from indulging in risky behaviours. In the long term, education is said to play a key role in establishing conditions that render the transmission of HIV/AIDS less likely through empowering individuals, reducing poverty and ensuring gender equity (Kelly 2000a). Thus, in absence of curative drugs for HIV/AIDS, the only option available is to develop appropriate standards of behaviour with information being translated into action (Kelly 2000a; Hornik 2002; Breckon, *et*
and this can only be done through education. To this end, education is perceived to provide a multi-pronged approach to the fight against the epidemic (Bastien 2005). However, translation of information into action is determined by a number of factors, which seem to receive little attention in planning and delivery of behaviour change programs through education. There must be cues to action which actually lack in many behaviour change education programs in Uganda.

3.1 Rationale for HIV/AIDS Education

HIV/AIDS Education refers to giving people information about HIV/AIDS, such as how the disease is transmitted and how people can protect themselves from infection. It also involves giving people the knowledge of how to put this information to use and act on it practically. The Dakar Framework for Action stressed that Education is now a human right that is key to sustainable development. It also noted that HIV/AIDS is an enormous challenge to education but also noted ‘the enormous potential that the education system offers as a vehicle to help reduce the incidence of HIV/AIDS and to alleviate its impact on society’ (Dakar Framework for Action, UNESCO 2000:23). The rationale for HIV/AIDS education revolves around prevention of occurrence of new infections, improvement of quality of life for People Living with HIV/AIDS (PLHAs) and to reduce stigma and discrimination among the people who are infected and actually affected by the disease.

The majority of young people, who are at high risk, can be found at school. Further than that, the school system brings together students, teachers, parents and the community. Thus if AIDS information and sex education is provided at school, it captures a bigger audience. In addition, it is argued that education equips and empowers people especially young women to understand and internalise relevant information and to translate knowledge into behavioural change (Vandemoortele 2000). Education also helps to change the family and community environment and attitudes whereby it enables open and frank discussions about HIV transmission in areas still surrounded by a wall of silence on which the virus thrives. Thus, with the enemies of illiteracy and ignorance defeated, AIDS information is more easily absorbed and the allies of silence, shame, stigma and superstition which AIDS thrives upon will be defeated. In this way, education provides enabling conditions for behaviour change.

HIV/AIDS Education is also based on the fact that for now, when the curative drug has not been discovered, hope for the defeat of the epidemic only lies in education. Kelly, a prominent HIV/AIDS education researcher noted that ‘the long, arduous and costly search for the HIV Vaccine must continue, but in the meantime every one of our communities is equipped with a
structure that can boost society’s immune system, the structure of education’ (Kelly 2000b:7). Like the parents expect the school to transform a child into an adult, the education sector can reduce the spread of HIV/AIDS. Education equips optimistic and hopeful young people with affection, morale and intellect to make sound and healthy decisions concerning their own lives, deal with pressure and keep themselves free of HIV infection (World Bank 2002).

But far from the above preventive-focused reasons, HIV/AIDS education should not be targeted at only people who are not infected. Even the People Living with HIV/AIDS (PLHAs) need information that enables and empowers them to improve their quality of life. Apart from that, the great deal of fear and stigma accompanied by resentment and anger of people who are diagnosed HIV positive can only be dealt with through provision of information about Positive Living components of coping with positive results, nutrition and drug adherence. Ignorance about such issues leads to hopelessness and emotional stress which are known to shorten the lives of PLHAs.

4.0 Multi-sectoral Approach and HIV/AIDS Education in Uganda

Uganda adopted a Multi-sectoral AIDS Control Approach (MACA) after realizing that the impact of the epidemic went beyond the domains of health and cut across all aspects of individual, family, community and national life (Uganda AIDS Commission 1993). A multi-sectoral approach refers to responses to the impact of HIV/AIDS by different functional or sectoral ministries or agencies (Husein & Bery 2003). The Ministry of Education and Sports in Uganda formulated it first draft of its sector policy on HIV/AIDS in 2004 with the main goal of prevention and alleviation through Behaviour Change Communication (BCC). This was to ensure that age appropriate prevention messages are adequately and systematically passed on to the young people at all levels of education through curricular and co-curricular activities (ESAPR 2006). The discussion to follow examines gaps that exist in the implementation of HIV/AIDS education activities at different levels with attempts being made to link the discussion to the ‘social vaccine’ paradigm.

4.1 The Uganda Education Sector response to HIV/AIDS

Efforts to integrate HIV/AIDS in the education sector in Uganda date as early as 1985 (Carl-Hill et al 2002). Based on ABC approach,¹ HIV/AIDS education in Uganda mainly focuses on bringing about positive behaviour change among the people through intensive Information Education and Communication (IEC)². The sector policy on HIV/AIDS prevention in Uganda

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¹ ABC strategy refers to A-Abstinence, B-Being faithful to one partner and C-Using a Condom. The main idea is that individuals should abstain or if they cannot, they should be faithful to their partners or if they fail both, they use a condom to protect themselves from HIV/AIDS.

² This is according to the National Health Policy, a policy document that guides all health programs in the Ministry of Health.
was drafted in 2004 and among the underlying principles was to mainstream HIV/AIDS into every policy, procedure, practice and program in the education sector.\textsuperscript{3} The Sector response also includes the development of the sector policy that guides all HIV intervention, workplace intervention, prevention, education through schools and institutions, capacity building, provision of evidence based facts on the impact of HIV/AIDS on the sector and finally managing the response through strong coordination mechanisms within the education sector both at national and district levels.

A number of Non-Governmental Organisations (NGOs) are also involved in HIV/AIDS education in Uganda. Straight Talk Foundation whose primary aim was to safeguard youth from AIDS through communication was among the first NGOs to get involved, Family Planning Association of Uganda (FPAU) also carries out sensitization programs in schools and Uganda Program for Human and Holistic Development (UPHOLD) which is involved in training pre-service and in-service teachers in the implementation of PIASCY in some districts in the country. Other international NGOs like ActionAid and Save the Children have worked with other organizations and line ministries in the effort to fight the epidemic among young people in the country.

The Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY) program was launched in Uganda in 2001 with the purpose of educating youth about HIV/AIDS, sex and how to protect themselves. This program targeted young people mainly in schools especially at Primary level. PIASCY handbooks were supplied to schools but teachers received no training to diffuse the knowledge in them and this compromised the success of the program. Most intervention strategies in the handbook and in HIV/AIDS education in general are focused on learners only and teachers are not well equipped and this challenge, first faced in 2001, was still evident in 2004 and worse has persisted through until this day\textsuperscript{4}. This calls for more investment in time and resources to HIV/AIDS in pre- and in-service training so as to prepare teachers for the challenge.

The PIASCY program has received a lot of credit for its contribution in protecting young people against HIV/AIDS (MoES/ESAPR 2006; UPHOLD 2005; Buonocore\textsuperscript{5} 2006). At first, it was based on the pillars of ABC strategy which have been perceived to be the core of Uganda’s

\textsuperscript{3} The Ministry of Education and Sports policy was drafted in February 2004. Its scope was to include learners, employees, employers, managers and administrators, and other providers of education in all public and private, formal and non-formal learning institutions at all levels of the education system in the Republic of Uganda.

\textsuperscript{4} Training for Life: An Education International Report on Teacher Training on HIV/AIDS/www.ei-ie.org

‘success story’ in the early 1990s (Okware, et al 2005; Bounocore 2006; Allen and Heald 2004; Green, et al 2006; Cohen 2003). According to the guidelines for implementation, each school was supposed to talk about HIV/AIDS at least once a week on general assemblies addressed by the headteacher. Abstinence is mainly emphasized during these addresses especially at the lower primary levels of Peers 1-5. One important thing to note here is that general school assemblies are held for the whole school and it means that the message for abstinence will be even for the already sexually active adolescents of Peer 5-7 and being faithful and using condoms messages will be conveyed to 1-3 peers. More so, teaching about condoms that adolescents cannot access in school may not create an impact. Conflicting messages about condom use are noted in many research findings in the study of ABC approach in Uganda (Cohen, 2005; Okware, et al 2005; Mugabirwe 2005; Bounocore 2006). Whereas the male condom is effective for reduction sexual transmission of HIV/AIDS when used correctly and consistently, other people believe that marketing it encourages promiscuity (Okware, et al 2005) especially in religious circles that emphasize abstinence and being faithful to one partner. Moreover, the traditional anti-AIDS message which received a lot of emphasis for many years in Uganda was ‘Love faithfully’. Thus, condom promotion seems to tell people that use of condoms reduces the risk of getting the virus and hence encouraging people to engage in sexual activities or use it with other partners. This is the reason why many parents are against teaching about condom use in schools.

4.1.1 Teaching HIV/AIDS Education and the Curriculum

The catch word often used by national governments and international organizations is that ‘the classroom situation is the key to change’. This seems to put emphasis on the role of a teacher who is the manager of the classroom. However, what is happening in classrooms in Uganda is different. Although teachers demonstrate staunch commitment to the fight against HIV/AIDS, reports indicate that they feel hopelessly incompetent when confronted with questions regarding the epidemic (EI Report 2006). This is due to piecemeal teacher training and support in HIV/AIDS competence (UNAIDS/IA TT 2006). Teachers do not only lack training but also the corresponding materials to be used in teaching about AIDS. It is no wonder that they were ranked fifth by male students and second by female students as sources of information regarding HIV/AIDS (Benell, et al 2002), reinforcing the view that teachers are not necessarily the principal source of information about HIV/AIDS yet they are presumed to be the key ‘administrators’ of the vaccine against the epidemic.

HIV/AIDS education in Uganda is integrated in some of the traditional subjects taught in school such as Biology, Christian Religious Education and Health Science (Mirembe 2002) although
more recent reports refute this claim (Benell 2002; EI Report, 2006) and this offers piecemeal content considering the complexity of HIV/AIDS. Other programs like PIASCY which mainly operate at the primary school level are not visible in the school curriculum as it requires teachers to pass on information about HIV/AIDS to pupils on weekly assemblies (Mirembe 2002; EI Report 2006; Bounocore, 2006; Karin A., et al 2004). Worth noting also is that teachers fear to talk about it because pupils may ask difficult questions. But there is a lot more than this as seen below;

There are a number of missed opportunities; for example the curriculum discusses hygiene in the context of caring for the sick and elderly and other ‘weak’ community members but there is no direct reference to HIV/AIDS… Similarly breast-feeding and nutrition is also to be presented, again without reference to mother-child transmission or the role that good nutrition can play in living positively with AIDS. (Karin A. et al 2004:32)

It is also important to note that teaching for good grades, most common in schools in Uganda, has a lot of implications for HIV/AIDS education. There is a lot of pressure to cover the syllabus content (UNAIDS/IATT 2006; Benell, et al 2002) and therefore little time, if any in some schools, is dedicated to HIV/AIDS education which is seen to be part of extra-curricular activities in school. AIDS education does not contribute significantly to the grade and therefore is seen to be a waste of time by teachers and pupils (Mirembe 2002). If at all HIV/AIDS is taught, it takes ‘selective teaching’ in which messages are either not communicated at all, or restricted to overly-scientific discussions without direct reference to sex or sexual relationships (Boler 2003) or if sex is discussed, it is restricted within the ‘acceptable’ boundaries of abstinence.

The above point indicates that the knowledge offered in HIV/AIDS education is fragmented and hence does not provide opportunities to make linkages between knowledge and reality. This is what Macedo (1993) calls ‘the pedagogy of big lies’ because apart from being offered in bits, it lacks core issues of the subject. The situation is worse at the secondary school level where many adolescents who are trying to explore the potentials of their bodies as observed below;

At the secondary level, cognisance must be taken …that students are probably wrestling with the personal decision-making about sexual activity and may need more detailed information and opportunities for discussion about their bodies, their hormonal levels and HIV/AIDS than was necessary in primary school…the total absence of HIV/AIDS issues (on the school curriculum) is unfortunate…The inclusion of discussion of a disease that has been eradicated, namely smallpox, and the omission of conditions like HIV/AIDS or lung cancer that pose serious contemporary threats is puzzling (Karin, et al 2004:73).

Even at primary school level where HIV/AIDS education seem to have taken root because of PIASCY program, the inclusion of AIDS content seems to be implicit. In the primary school curriculum, what seems to be relevant to HIV/AIDS education is in the subject of Integrated Science that has themes of Human Health, the Human Body, Community Population and Family
Life. However, the coverage of HIV/AIDS is sparse and it is covered during the second term of Primary Seven, just before the student leaves primary school. At secondary school level, there is no reference to HIV/AIDS in the whole syllabus (Benell 2002) and this is evident from the teachers themselves;

“HIV/AIDS information in secondary schools is almost non-existent. In the curriculum, there is something on definitions. But this lack of information is a big problem because by secondary school, children are already adolescents” (Teacher interview: EI Report, 2006:19)

Instead, teachers use their initiatives to refer to HIV/AIDS in examples they give in class while teaching. Yet, although HIV/AIDS is seen as a major area for policy reform in Uganda, integrating such policy in schools is said to be difficult where financial and supervisory resources are insufficient. Even teacher training colleges ignore it (EI Report 2006). This is a potential setback in the country’s efforts to mitigate the AIDS epidemic through provision of education because a system that lacks such capacity will not be able to serve as a vehicle for reducing the incidence of the disease.

HIV/AIDS education takes a traditional authoritarian teacher-centred approach in which the learners simply listen and are expected to understand and act on what they have learnt. However, this is known to reduce learners to objects of the directives teachers give, whether right or wrong (Freire & Macedo 1995). This is what takes place in bureaucratic schools on assemblies and even, in classrooms. This is the use of expert-led approach in HIV/AIDS Education that is based on the assumption that through an increase in knowledge, there will be attitude change which may lead to change in behaviour (Koelen & Anne 2004). Individuals are provided with knowledge and advice to enable them behave in a healthier manner. Yet research indicates that young people’s involvement in formulation, delivery and individual choice of subject content influences their response to the HIV/AIDS education (Mirembe 2002). Further more, human beings are not static objects; they are carriers and producers of information in their own right. Information does not fall in empty minds but it is integrated into what people already know and do and into what they like and dislike and this may help to explain why people do not necessarily practice what they learn (Hornik 2002). This makes it important for HIV/AIDS education in Uganda to take a participatory approach that gives individuals opportunity to seek answers to their questions. The supportive environment that enables free interaction is important in motivating change in behaviour (Bandura 1977). Therefore, interventions for prevention through HIV/AIDS Education that do not take this into consideration will not effectively change behaviour and thus will not build the social immunity against HIV/AIDS pandemic.

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6 Based on the Uganda Primary School Curriculum introduced in 2000 cited by Paul Benell, et al, 2002 p.33
7 This is a personal experience. As a teacher of Old Testament Bible, I compared the social perception of lepers with stigma associated with AIDS today.
Even outside the school setting, the expert-led approach is common, aimed at persuading people to adopt certain behaviours. This is common through the media and print materials that promote behaviour change for HIV/AIDS prevention. But once again, this approach ignores the constraints that socio-demographic and economic factors place on voluntary behaviour change (Mirembe 2002; Koelen & Anne 2004). In a society still characterized by gender inequality with male dominance, you can tell women how to use a condom but you cannot make men listen to them. Similarly, you cannot tell someone to abstain if she knows that sex is the only source of income for feeding the family, taking children to school and livelihood (Buonocore 2006). It means that HIV/AIDS education aimed at providing social immunity is more than just ABC as experts seem to assume. If it ignores the socio-economic, demographic and political factors that facilitate the adoption of desired behaviours, the success will be counted on fingers and the ‘social vaccine’ role will remain a fallacy. People should be helped to identify their own concerns and to gain skills and confidence to act upon them.

Alternative approach to teach HIV/AIDS in schools takes the form of teaching life skills. This has been adopted partly due to perceived limitations of information-based HIV/AIDS education (Boler & Aggleton 2005). The assumption underlying life skills education is that young people somehow lack skills such as assertiveness or abilities to say ‘no’ and for coping with social pressures. That if taught and learned, such skills would be applied in different situations thereby reducing the risk of HIV infection. Skills-based health education enables the development of interpersonal and other skills, such as critical and creative thinking, decision making and self-awareness (World Bank 2002). It is also argued that life skills approach does not explicitly discuss sex and sexuality directly and thus appropriate in situations where discussing sexual matters is a cultural taboo (Boler and Aggleton 2005). It is probably based on this argument that Uganda embraced this approach.

Life skills approach to HIV/AIDS education presents a number of questions regarding applicability, acceptability and cultural sensitivity in different situations. In the first instance, not everything that is learned is applied or acted upon unless important motivating conditions such as self-efficacy are in place (Bandura 1977). Secondly, they are taught in a generalized way in disregard of individual differences and heterogeneous socio-demographic and economic backgrounds of the learners. There are also claims that life skills education has less impact on sexual behaviours in developing countries and that this is a donor-driven approach imposed on schools that rarely puts local needs into consideration (Boler and Aggleton 2005). It further goes to the previously raised issue as to whether teachers are trained to teach life skills as they find it
difficult to introduce it in the pre-existing system which is not even conducive. Many students are known to learn from their peers and school matrons or senior women (Komunda 2005) who are in most cases not trained. Thus if life skills education is not properly grounded with clear methodology of teaching by trained personnel, it risks leaving young people in more confused situations and the vaccination role of education will fail.

4.1.2 Communicating HIV/AIDS Education

Koelen and Anne (2004) argue that the success of any Health Education program depends on accessibility and the level of understanding of the information provided. These are enabled by peoples’ participation in the designing of these programs. I agree with them but add that this participation should consider the importance of indigenous knowledge and experience of those involved. This will not only ensure the sense of ownership but also, it will make it possible for what is learnt to be applied and reinforced in real life and hence well-sustained because if individuals find that what they learn cannot be reinforced in their real life, they will abandon it (J. A. Kelly 1995). The HIV/AIDS education policy stresses the importance of all learners, employees and employers to have access to information on HIV/AIDS that is accurate, current, complete, appropriate and scientifically factual...in a manner that does not alienate any group (Draft Education Sector HIV/AIDS Policy 2004:8). In practice however, HIV/AIDS education programs in Uganda seem to ignore the role of involvement of the teachers, learners and communities and it possibly explains the covertsness of the impact of behaviour change programs in education.

School and community-based HIV/AIDS education in Uganda adopted a multi-channel approach that takes the form of use of drama, video shows, community educators and leaflets (Mitchell, et al., 2001). This IEC intervention approach is said to reach a wide range of the population, whether young or old, rural or urban based. However, the extent to which these channels reach the intended target population, the acceptability of the messages, whether the messages are understood and remembered need further analysis. An evaluation research to find answers to these questions found that drama shows and videos, for instance, are not attended by the majority of the community (Mitchell, et al 2001). This was attributed to inadequate mobilisation and other work commitments. Taken to a school scenario, young people are more

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8 A mini-study conducted in rural western Uganda confirms this. It was conducted to determine factors that affect access to Reproductive Health Services among in and out-of school adolescents.
9 Data about this approach in schools is not readily available because such programs take place informally out of NGO individual arrangements or drama groups which visit the schools. The explanation provided in this point focuses on the community.
interested in entertaining drama and videos than the messages in these shows\textsuperscript{10}, which may mean that their attention is less when it comes to more educative movies. These shows are also presented outside and open to everybody and it is not clear whether their messages are age-specific, yet there is inevitable attendance of young children. Thus, although the messages are understood, questions from young people are likely to remain unanswered because of the presence of their parents.

To further understand whether the messages in HIV/AIDS education are understood, it will be important to consider the language used. It should be realised that in Uganda, like in other African countries, oral cultures are still largely common where children learn from what their parents tell them through informal education. As Birgit (2000:49) points out, the normal way to learn is through the examples and oral information given by the family, elders and the teacher because these are listened to. They use the language that is well understood to everybody. The importance of the use of mother tongue is recognised by UNESCO contending that teaching in a mother tongue is a way to foster inclusion (EFA Report 2007). Ignoring this fact puts teaching HIV/IDS in schools at stake.

In the first instance, parents are rarely involved in teaching children about their gender roles and development to adulthood, yet they are the ones who use the language that their children understand. The reason given to ignore the role of parents is that due to cultural reasons, parents do not talk to their children directly about sex matters. At this point, I argue that as long as they are not involved in education efforts, most messages will not be understood. I find the idea of giving information to parents about HIV transmission and how it can be prevented, effects of stigma and discrimination among PLHAs and how appropriately these messages can be conveyed to their children more appealing. This is because, in predominantly day schools where children spend most of the time with their parents, a lot can be done while at home. Most materials used to teach HIV/AIDS education such as leaflets and posters are written in a foreign language, English. It is true that as they are distributed, many people receive them both in and out of school to as high as 80% (Mitchell, \textit{et al.}, 2001). Low literacy rates (UBOS Statistical Abstract 2006)\textsuperscript{11} in rural areas however, may help to explain whether the messages therein are understood or not which mainly depends on their ability to read them. Lack of reading culture also affects the understanding of messages in the leaflets. From this analysis, I argue that although IEC intervention is preferred in HIV/AIDS education because of the mere fact that it reaches the wide

\textsuperscript{10} I led a team of university students to sensitise in-school adolescents about reproductive health issues in February, 2001 supported by PEARL Project in the Ministry of Gender, Labour and Social Development. We used film shows but some students always asked for more entertaining videos with music or ‘action movies’.

\textsuperscript{11} According to Statistics report, literacy rate in rural areas is 67% compared to 87% in urban areas.
range of the population, its effectiveness is still low owing to nature of the population, age and gender diversities and other socio-demographic characteristics. These factors need to be considered when planning the delivery of HIV/AIDS education programs in culturally diverse settings of Uganda.

4.3 NGOs and government

As noted earlier in this paper, NGOs are involved in HIV/AIDS education in Uganda and their role cannot be underestimated. It is claimed that much of the reduction in the HIV/AIDS prevalence rates is credited to NGO efforts as earlier government interventions alone did not have an impact (Carl-Hill; Peart 2003). Straight Talk for example, is a health communication NGO that produces Behavioural Change Communication materials for adolescents and important adults in the lives of adolescents such as teachers and parents.12 These materials are aimed at educating and informing youth and concerned adults about adolescence, sexuality and health. UPHOLD aims to improve student learning through school-based quality reform, rooted in active partnerships among pupils, parents, teachers, and administrators to create effective learning environments.13 Unlike Straight Talk, this is a short-term project and so its programs run in only 20 districts. But their work has not gone without criticism. Most NGOs that respond to HIV/AIDS in the education sector have failed to integrate their work fully in national curriculum goals apart from not being institutionalized (EI 2006). Also, apart from being restricted to local initiatives, different NGOs pay visits to individual schools to hold short seminars with students and teachers and their approaches are not coordinated. This raises concerns of not only the failure of HIV/AIDS education to have impact but also that such programs may serve to confuse young people about the reality of HIV/AIDS (UNAIDS/IATT 2006). From my own experience, because of limited space on the already overcrowded school time table, some schools offer limited time to these talks and this makes their impact almost invisible.

Findings from a study conducted in one district in Uganda in 2005 revealed that there is no official HIV/AIDS education policy from the Ministry of Education that provides guidelines for implementation of HIV/AIDS activities in schools (Mugabirwe 2005). Other studies indicate that whereas the strategic plans exist within the ministry, they are not being fully implemented because they are developed in isolation from other policy and budgetary processes (Boler & Jellema 2005). What schools do receive are circulars and directives from the ministry instructing them to start HIV/AIDS clubs in their schools (Mugabirwe 2005). Although the headteachers take HIV/AIDS education seriously, they lack practical guidelines. They are not aware of the existing

12 See http://www.straight-talk.or.ug/home/index.html
13 See http://uphold.jsi.com
guidelines like the National Strategic Framework and the Education Sector Policy although the official position from the ministry document is that ‘management structures, systems and programs are in place at all levels of the education sector to ensure and sustain quality education in the context of HIV/AIDS’ (Education Sector Policy on HIV/AIDS Final Draft 2004). In the face of teachers who are not equipped with appropriate skills to teach HIV/AIDS education, the issue will remain secondary and the ‘vaccine’ will not be properly administered.

Structural measures such as legal, environmental and regulatory ones are important in supporting behaviour change programs like HIV/AIDS education. This supportive environment backed by political commitment and openness has been a characteristic of Uganda’s HIV/AIDS Policy and has been perceived to be partly responsible for the country’s success story of 1990s (Uganda AIDS Commission, 2000; Okware, et al 2005; Bounocore 2006; Allen and Heald 2004; Green, et al 2006; Cohen 2003). Although there is not one adopted policy (statute) on the fight against HIV/AIDS (Mugabirwe 2005), various structures that guide the implementation of HIV/AIDS programs have been in place. For instance, the National Strategic Framework for HIV/AIDS Activities in Uganda (NSF) and the Uganda HIV/AIDS Partnership (UHAP) are the key structural frameworks that guide national response to the epidemic.14 However, not all HIV/AIDS activities refer to them as the NSF Mid-term review report states below;

‘The findings show that, partly as a result of lack of appropriate policy, ongoing HIV/AIDS interventions have not fully benefited from reference to a common national program of action. Both the small agencies involved in HIV/AIDS work and some of the centrally placed NGOs have not seen the NSF and consequently make little reference to the national targets therein’. (NSF MTR Report. December, 2003:1).

So lack of an appropriate policy is recognized as a setback. What about the legal framework? There are no legal frameworks to support HIV/AIDS education and some laws which exist are not adequately implemented. Structural and legal frameworks have proved to be important in supporting behaviour change in health education programs. Koelen and Anne (2004) illustrate this taking an example of the general decline in the number of smokers in industrialized countries since 1960s arguing that it was not attributed only to education about dangers of smoking but also legislative measures like prohibiting smoking in public places, increased tax on tobacco and warning smokers about health consequences. In Uganda, although the National Health Policy15 points out the need to promote campaigns against gender-related issues that lead to health problems such as rape, domestic violence, sexual harassment, defilement, prostitution and early

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14 The NSF is regularly reviewed to assess the progress and identify gaps in implementation of HIV/AIDS activities in the country. The UHAP is a body representing various stakeholders and groups active in national response. It holds annual forums for information sharing and dissemination as well as identifying emerging issues. See www.aidsuganda.org

15 The National Health Policy is the policy document that guides all health activities in the country. Its overall goal is the attainment of a good standard of health by all people in Uganda, in order to promote a healthy and productive life.
marriage among others, it seems this exists on paper. Reports of freed defilers and rapists as well as human rights violations are common in the local media. This means that the victims are not protected and the perpetuators are not threatened and this undermines HIV/AIDS prevention efforts.

5 Conclusion

It is true that in HIV/AIDS education, none of the categories of education (formal, informal and non-formal) can be ignored since learning takes place everywhere in the society. Hence the family, the teachers, the community, the government and all stakeholders must be involved in making the social vaccine against HIV/AIDS work. In this process however, it is very important that the messages are conveyed clearly to the learners by ready and well informed teachers. In this case, teachers are not those in formal schools only since everybody in the society is a teacher in his/her own way. The Social Learning theory helps us to realise that through reciprocal determinism, everybody learns from one another. The question remains of how to put into action the positive behaviours learnt in the society to promote prevention efforts. For the case of Uganda, and other countries looking into education as the only prevailing hope, the cues to action that the Health Belief Model prescribes call for further research if education is to fully provide social immunity in the efforts to defeat the HIV/AIDS scourge.
References


