

The HIV and AIDS Epidemic and the Challenge Posed to University Education Excellence in Sub-Saharan Africa

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ABSTRACT The HIV and AIDS epidemic definitely impacts on the provision of quality education in universities in Sub-Saharan Africa. For the intellectual capacity and human resource development efforts of the sub-continent are being reduced in effects and value. Both staff and students are dying, and the previous aspirations and expectations that hitherto accompanied investments in higher education are almost dashed and some have gone to the extent of even questioning the wisdom of continuing to invest in the sub-sector when no one is sure if the recipients of such investment would live much longer than expected. Fortunately, hope is rising again because of the advent of determined political will, concerted efforts, new treatment strategies, advocacy and reduction in stigmatization. In the light of the new hope that is emerging, this paper steps back a bit in reflecting on how the epidemic has impacted university education and what needs to be done in order to ensure that strategies adopted are firmer and more rewarding to the region.

INTRODUCTION

Excellence in university education in Sub-Saharan Africa is at major a crossroad partly because of the pervading effect of the HIV and AIDS epidemic. Its true significant progress is being made in combating the epidemic in recent times. It has been widely reported that between 2001 and 2011, the incidence of HIV infection has declined in 33 countries, 22 of which are in Sub-Saharan Africa (Grant 2010; UNAIDS 2012; van Rooyen 2013; Cooper and Dickinson 2013). As a matter of fact, Sub-Saharan Africa should have good reason to celebrate its efforts to combat the epidemic. For it has been reported that in 2011, it was estimated that there were 1.8 (1.6 million - 2 million) new HIV infections as compared to the 2.4 million (2.2 million – 2.5 million) new infections in 2001 representing a 25% decline for the region (UNAIDS 2012a, 2012b). However, scant scholarship exists on the possible dangers the epidemic poses to the pursuit of and investment in excellence in university education in the sub-region (Resch et al. 2011). This discussion is an attempt to contribute some ideas that might help scholars, practitioners, policy makers and political pundits who are in hot pursuit of how education could help in accelerating the rate and degree of success of all HIV programming in Sub-Saharan Africa (UNESCO 2013;

Kunnuji et al. 2013; Lesi et al. 2014). This discussion becomes even more compelling and urgent partly because most African universities are seemingly not making remarkable entry into the Ivy League of universities that are excelling in academic excellence in the world today.

The literature on Sub-Saharan Africa's HIV and AIDS as a disturbing phenomenon is building up rapidly over the last three decades. Almost all aspects of the epidemic have been addressed (Dawson 2013). Even at that, not much quality information is available on how HIV and AIDS have negatively impacted excellence in education in the sub-continent. This paper is therefore intended to fill the gap in terms of exploring how the HIV and AIDS epidemic has impacted excellence in education with particular reference to university education in Sub-Saharan Africa. Unfortunately, the more intense scholarship and discourse on how the epidemic has impacted on university education has not been too impressive thus far. This is one reason why this paper is needed at a time that public universities in Sub-Saharan Africa are struggling to be counted among the most excellent educational edifices in the world even as they battle with declining financial outlays by governments in the era of slow growth in the global economy. The paper confirms the common assumption among practitioners that in every community HIV

and AIDS poses a significant challenge to investment in human capital including the education sector. To achieve this purpose, the paper begins with a conceptual framework, runs through contextualizing HIV and AIDS, educational excellence, briefly highlights how the epidemic has negatively impacted on excellence in education, in particular, university education, the universities' response, constraints and challenges, what might be done to ensure a reversal of the phenomenon and then reaches a conclusion. This might sound over-ambitious and even tantamount to painting on a rather large canvass, but it is worthy and urgent because the challenge posed requires the need to match propositions with positive action.

Conceptual Clarification

There is as yet no consensus as to what really constitutes excellence in university education per se. In many instances, scholars are apt to introduce the related concepts of originality, significance, currency of ideas, integrity, quality of research, quality and quantity of inventions, discoveries, objective peer evaluations of research and scholarship, the funding of academics, faculty development, student academic achievements, and the efficiency and effectiveness in academic service provisions that is available, amongst other considerations as possible indicators of academic excellence (Daggett 2005; Lavoie 2009). Generally, what appears to be a consensus in defining excellence in education is that whatever indicators that are considered as core would vary from discipline to discipline and from one geographic space to another. In that case, what is taken as excellence in philosophy might differ from the connotation in economics or sociology or education or science and technology. Its agreed meaning may differ between Europe and Africa. Even at that, there could be elements in the definition that one could identify among scholars.

In Africa, it could be that by excellence in education, we mean the degree of the efficiency and effectiveness of the education sector in meeting the needs of and responding to challenges facing Africans using maximally the available resources in a sustainable way (ADEA 2004a). This conceptualization might take into consideration providing enabling learning environment, the ability of the education system to

resolve issues surrounding access and equity, the preparation of learners to handle life, citizenship and the world of work, and the debilitating effects of HIV and AIDS and other equally dangerous epidemics (ADEA 2004a; Daggett 2005). It also takes into consideration key issues in the aspects of responsive and relevant training that can meet social, economic and political development, enhancement of the performance and status of the teaching profession and cost-effectiveness and cost-benefit and the pursuit of the ideals of excellence within the education system.

Excellence in education may be typified by the concern for quality. Towards meeting that need, the Association for the Development of Education in Africa (ADEA 2004:1) had in 2002 initiated a study that involved 22 case studies, 3 reviews of development agency experiences, 15 background papers, 4 thematic syntheses and a discussion paper. That study identified seven fundamental pillars of quality to include:

- ♦ Creating learning opportunities;
- ♦ Improving instructional practices;
- ♦ Managing the challenge of equity;
- ♦ Increasing school autonomy and flexibility;
- ♦ Nurturing community support;
- ♦ Ensuring a realistic financial framework; and
- ♦ Responding to the HIV and AIDS epidemic and to conflict situations.

(Association for the Development of Education in Africa (ADEA 2004b).

These pillars indicate the need for deep reflections, research and action on how they can be harnessed through the professional development of human resources in the education sector. They also call for reforms in all sectors of education, decentralization and diversification of provisions and participation by everyone in the community, development of contextual and relevant curricula, and the monitoring and evaluation of efforts geared toward the achievement of access, equality, equity and quality.

It is this same concern for excellence in education even as the region confronts HIV and AIDS that probably informed the proposal that recently retired British teachers be made to serve a two-year term in former colonies as a way of helping to reduce the workload of the present teaching workforce, and provide quality inputs to students (Patel et al. 2003).

African countries must continue to embrace excellence for several reasons. For excellence

helps one to develop individual and community self-confidence and self-esteem in highly competitive and globalizing world. For as the South African former Minister of Education, Kader Asmal (2003) once put it:

Realities of global competitiveness may threaten us negatively or challenge us positively. If we take the negative view, we are more likely to develop a parochial vision and avoid the major issues and challenges confronting us.

The realities of the times suggest that Africans can never sit down and be oblivious of the race for the global cup. The region must take the bulls by the horns and move on to confront the challenge of contributing its quota to global development, competitiveness, efficiency and effectiveness.

The major concern in this paper will be limited to how the education system, especially the university education sub-sector, has been gravely affected by HIV and AIDS, and then, how the sector has tried to respond to the challenge. Wherever possible, we will attempt to take sample cases to illustrate the major developments within the frameworks of existing national policies. Before doing so, it might be expedient to examine first of all, the context of the HIV and AIDS epidemic in Sub-Saharan Africa.

CONTEXT OF SUB-SAHARAN AFRICA HIV AND AIDS EPIDEMIC

“No child should be born with HIV; no child should be an orphan because of HIV; no child should die due to lack of access to treatment,” urged Ebube Sylvia Taylor, an eleven year old born free of HIV, to world leaders gathered in New York to share progress made towards achieving the Millennium Development Goals by 2015 (UNAIDS 2010). It is has been widely reported in research that we have halted and begun to reverse the epidemic, that fewer people are becoming infected with HIV and that fewer people are dying from AIDS (UNAIDS 2010; Shabazz-El 2010). Indeed, it has been reported that 2011 UN Political Declaration on HIV/AIDS is seemingly having effect on the region. According to UNAIDS (2013), that Declaration sets the targets and elimination commitments towards reaching the goal of Zero infection by 2015 as follows:

1. Reduce sexual transmission by 50% by 2015
2. Reduce transmission of HIV among people who inject drugs by 50% by 2015
3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths
4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015
5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015
6. Close the global AIDS resource gap by 2015 and reach annual global investment of US\$ 22-24 billion in low- and middle-income countries
7. Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV
8. Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms
9. Eliminate HIV-related restrictions on entry, stay and residence
10. Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts

So then, what we can say at this stage is that new infections and AIDS related deaths are on the decline, and we have been learnt that between 2009 and 2011, the number of children newly infected with HIV in Sub-Saharan Africa fell by 24% with Burundi, Kenya, Namibia, South Africa, Togo and Zambia recording between 40% and 59% decline (UNAIDS 2013). Not only that it has been reported that HIV testing and treatment in the region has increased among adults in 14 countries between 2004 and 2011 with Lesotho recording 42%, for example, and this should be good news, even to the most unimpressed observer (UNAIDS 2013).

UNAIDS (2010, 2011a, 2011b, 2011c) has continued to encourage us to be proud of these successes, especially as the potential of our shared future—breakthroughs in a prevention revolution are at hand with a new microbicide gel holding promise for a generation of women who will be able to initiate usage and take control of their ability to stop HIV (Cohen et al. 2011). It has been suggested that Political break-

throughs would be achieved as more countries abolish discriminatory practices led by voices of a new law commission, and Treatment 2.0—a breakthrough that could save an additional 10 million lives (Grant 2010; UNAIDS 2010; Karim 2010; Schwartländer 2011; Hirnschall and Schwartländer 2011). But sadly, we are not yet in a position to say “mission accomplished”.

The protracted push against HIV and AIDS in Sub-Saharan Africa (hereinafter, referred to as SSA) remains mission unaccomplished. This position has been confirmed by President Jacob Zuma (2013), President of the Republic of South Africa who also noted that the continent has continued to bear a significant burden because of the disease. He could not have been wrong because UNAIDS has been fair enough to remind all that Sub-Saharan Africa remains the most heavily affected region in the global HIV epidemic with an estimated 23.4 million people living with HIV, and that this represents 69% of the global HIV burden (UNAIDS 2013; Zuma 2013). The reasons advanced by UNAIDS (2013), amongst others, include the fact that growth in investment for AIDS response has flattened for the first time in 2009 whilst demand for effective medication is outstripping supply. At the same time, stigma, discrimination, and bad laws and inaccurate statistics, continue to remain roadblocks for most people living with HIV and people on the margins (UNAIDS 2010, 2013). This is painfully the case, and that is one of the issues that remains unresolved not just in the wider community but in the universities.

When one expected that the epidemic should be on the decrease because of the combination of approaches and vigorous campaigns seemingly backed by political will that had been directed at it, the sub-continent did not get any signs of complete freedom from HIV and AIDS. The situation seemingly remains grim.

The devastating effects of HIV and AIDS in the SSA are very much indicated in shorter healthy life expectancy at birth. And we know that HIV and AIDS epidemic is deepening and spreading poverty, reversing human development, worsening gender inequalities and rapidly and uncontrollably eroding the capacity of governments to avail even the most basic essential social services. The HIV and AIDS in Sub-Saharan Africa epidemic have almost completely changed the demography and focus of educational excellence in the region.

DOWNSTREAM IMPLICATIONS FOR UNIVERSITY EDUCATION EXCELLENCE

It is true that no continent can ever hope to achieve sustained socio-economic and political development without firstly investing in human capital. Nevertheless, we also know that education alone does not guarantee successful and sustainable development as history has demonstrated in the former Soviet Union, Sri-Lanka, and the Philippines amongst others. Indeed, for education to bring about high payoffs, it probably requires healthy human capital. Unfortunately, that is the crucial reality that has evaded Africa since HIV and AIDS was first discovered on the continent almost 30 years ago.

HIV and AIDS have affected and continues to affect the productive age of African nations. It has reduced the productive capacity and productivity, in general, of SSA. Its impacts are felt seriously at individual, community and national levels. In fact, its impacts can be discussed at the macro and micro-economic levels, but in this discussion, our interest is education, and, in particular, teacher mortality and how the epidemic has negatively impacted excellence in education.

HIV AND AIDS AND TEACHER MORTALITY

Globally, the first survey that was directed at measuring the readiness of the education sector to respond to AIDS was in 2004 and it covered 71 high-, medium-, and low- prevalence countries (UNESCO 2013). The survey revealed that most Education Ministries and civil society had made considerable efforts to institutionize effective responses. However, a recent search of the literature has not yielded the kind of recent data that should inform our discussion. The 2011-2013 Education Sector HIV and AIDS Global Progress Survey (UNESSO 2013) did not yield current data on AIDS-related teachers and learners mortality for reasons not known as yet. That is why this discussion unfortunately had to rely on the update provided by Bennell (2004).

So then we continue to propose that whatever quality information we require on the number of teachers who have been killed by AIDS is circumscribed by the dearth of good quality information that pervades much of the health system in Sub-Saharan African countries. This is so

because in many of these countries, vital statistics on death are hard to come by for some reasons. Among such reasons are the absence of weak databases and the chronic inability on the part of many African nations to provide well-resourced health statistics as they are pre-occupied with the debates about how to provide the basic necessities of life. The point that is being made here has been well illustrated by Bennell (2004) as follows:

No country in Africa has good quality national population-based survey data over a number of years. Primary reliance has instead been placed on anonymous testing of samples of pregnant women attending antenatal clinics. While these antenatal clinic (ANC) senile surveys are reliable in monitoring trends in HIV prevalence, they are not an accurate method for measuring HIV prevalence levels among both women and men. This is especially the case for young people.

What Bennell (2004) has pointed out above holds true for many African nations. Nevertheless, it is commonly agreed that the HIV and AIDS epidemic has decimated the population of teachers. Katjavivi and Otaala (2003) had drawn attention to the fact that in the Central African Republic, 85 per cent of teachers who died between 1996 and 1998 were HIV-positive, dying on the average 10 years before their due retirement year.

Schneider and Moodie (2002) have drawn attention to the fact that across Sub-Saharan Africa, more than 860,000 teachers died of AIDS in 1999 alone. Attention has also been drawn to the ravaging impacts of HIV and AIDS in Zambia, Kenya and Malawi. Katjavivi and Otaala (2003) quoting Michael Kelly (2001) have opined that:

- ♦ In Zambia, more teachers died of HIV and AIDS in 1996 than were produced by the country's colleges of education that year, and that 1300 teachers died of AIDS in the first ten months of 1998 compared with the 680 teachers who died of AIDS in 1996. In Kenya, teacher deaths rose from 450 in 1995 to 1,500 in 1999. HIV-positive teachers are estimated at over 30 per cent in parts of Malawi and Uganda, 20 per cent in Zambia and 12 per cent in South Africa.

Again, Bennell (2004) has quoted the BBC World Report of November 2002 to the effect that:

"...One in seven teachers in Malawi were likely to die (of AIDS) during this year alone."

If that can hold true of Malawi, one can only imagine what the case could be for high HIV prevalence countries like South Africa, Botswana and Zambia to mention just but a few. Bennell (2004) has attempted an analysis of teacher HIV and AIDS mortality rates in Sub-Saharan Africa since the mid-late 1990s in selected high HIV prevalence countries located in Eastern and Southern Africa, and the report is disturbing as it reflects very closely what is happening in the wider community in SSA.

Even though the data reported by Bennell (2004) covered teachers' deaths from all causes, they clearly suggest that we can infer correctly that the number of teachers who have been killed by AIDS related illnesses is tragically disturbing. Even though the rates for some of the countries have not exceeded 1.0 per cent, Zambia featured 2.0 in 2000 and 2001. In the case of Zambia, 2.0 per cent might have meant that over 2000 teachers died every year from AIDS-related causes, and that should be disturbing. In Zimbabwe, it would be observed that one percent of all teachers died in 2001. In Botswana, which has the highest HIV prevalence rates in the world, death among teachers occurring from AIDS was 0.55 per cent in 2002. This might appear small to others when viewed against the projected figure of 3.0 percent for that same year.

From available data, we now know that whether or not there is a discrepancy between projected and actual figures, the loss of human life in the education sector is a tragedy for SSA, for the teaching profession, for the dead teachers and their families. The frequent death of teachers due to AIDS leaves a sad memory of people who were once treasured by the young ones as builders of their hopes for tomorrow. Their deaths can provoke despair and hopelessness in the psyche of the young ones, and this cannot help the case for the pursuit of excellence.

The statistics on personnel AIDS mortality in the education sector, according to Bennell (2004), have revealed the following:

1. On the whole, the mortality rates for teachers compared with other skilled professions were considerably lower than expected, especially in Malawi.
2. In Botswana, teacher mortality rates were well under half the mortality rates of semi-unskilled public sector worker in 2000.

3. At the national universities in Botswana and Malawi, it has been discovered that the mortality rates among junior support staff (consisting of cleaners, cooks, maintenance personnel, gardeners, etc.) have been reportedly much higher than has been the case for senior administrative staff and academics.
4. AIDS mortality rates are reportedly typically higher among primary than secondary school teachers who are in many instances better educated and who usually receive higher salaries.
5. The Al-Samarrai S and P.S. Bennell 2003 tracer survey of about 5,000 university and secondary school leavers in four African countries comprising of Malawi, Tanzania, Uganda and Zimbabwe has revealed that the cumulative mortality rates for Form Four leavers were two-three times higher than for university graduates of about the same age.

When one looks critically at the situation we just described above, some questions come readily to mind:

1. Why are teachers in Sub-Saharan Africa particularly prone to HIV infection?
2. What must have been responsible for the stability or decline in the mortality rates?

For the first question, we must note that the teaching profession in Sub-Saharan Africa is relatively young. That means that teachers belong to the highest HIV prevalence age cohorts. Again, in many countries, the teaching profession is dominated by female citizens and we are aware that these female persons are exploited when it comes to expressing and asserting their rights to make a choice of the frequency of sexual activity and partners or to insist on their rights to protected sex. It is more of a cultural issue than anything else.

It has been suggested that teachers are more likely to engage in high-risk sexual behavior compared to the rest of the adult population (Bennell 2004). It is also alleged that a sizeable number of male teachers have sexual relations with their students (Bennell 2004). You can now better appreciate why the education sector is at great risk.

For the second question, it can be argued that teacher mortality is stabilizing or actually declining fortunately because of changes that have occurred in the sexual behavior of teach-

ers. No one knows if this change is the result of the intensive behavior change campaigns mounted by the governments of Sub-Saharan African countries. What one can say, for sure, is that mortality rates among teachers and lecturers are declining also mainly because of the increasing availability of anti-retroviral drugs. For example, Bennell (2004) has reported that in Botswana alone, the number of teachers taking anti-retroviral drugs increased from 62 in 1999 to 474 (that is 2 per cent of the total number of teachers in post) in April 2002.

HIV AND AIDS IN SUB-SAHARAN AFRICAN UNIVERSITIES

We know that the estimates of AIDS death in a sample of the universities are informative and disturbing. Kelly (2005) has opined that at the University of Nairobi, it is believed that an average of two members of the immediate university community die of AIDS every week, and that in Zambia, the crude death rate for staff at the University of Zambia is higher than the national rate. When you consider the fact that there has been a tendency on the part of relations not to disclose the cause of death of students and staff of our universities who die in recent times, the picture looks dimmer than can be imagined. For example, Kelly (2005) has quoted Jones (2001) as having suggested that 30 per cent of the nurses graduating from the University of Natal in South Africa are dying within three years of completing their program. Everything put together, we are sure that Africa stands at the shore of sorrow as far as AIDS death is concerned.

Quoting the 2001 Michael Kelly's synthesis of the ADEA sponsored case studies of how HIV and AIDS affect some universities in Africa, Katjavivi and Otaala (2003) have noted that:

1. The picture of HIV and AIDS in African universities is disquieting.
2. There is a thick cloak of ignorance surrounding the presence of the disease in our universities
3. There is profound amount of secrecy, silence, denial and fear of stigmatization and discrimination surrounding the HIV and AIDS dilemma in our universities.
4. HIV and AIDS are increasing the operating costs of universities while reducing productivity (mostly arising from high absenteeism).

5. University health record-keeping system is not smart enough to seriously track the numbers of staff and students affected.
6. African universities are a high-risk institution for the transmission of HIV because of the activities of what is commonly known as “sugar daddies” (meaning rich and well-to-do men who go to the campuses to lure young beautiful female students into sexual intercourse knowing fully well that they are HIV positive).
7. African universities remain one of the most visible high risks institution for the transmission of HIV also because of such practices as sexual experimentation, prostitution on campus, unprotected casual sex, gender violence and multiple sexual partners.
8. The extreme vulnerability of female students and workers who are mostly from the lower-rung of the socio-economic status and who out of economic desperation yield to or are unable to negotiate no sex or safer sexual practices.
9. There is the prevalence in our universities of what is commonly known as “consensual rape”. This is a practice whereby a female student or lower cadre university worker yield to sex under duress because of her lack of empowerment or in order to preserve a relationship or to avoid being beaten up or even killed or to ensure financial support, or repay favors.

HIV AND AIDS IMPACTS ON EXCELLENCE IN UNIVERSITY EDUCATION

AIDS impacts excellence in university education in several ways, and this it does both in the short-terms and long-terms. First, in the short-term, the epidemic does not discriminate between poorly prepared and high quality teachers, educational managers and support staff. Yet, these are the kinds of people who should have been the drivers and pillars of excellence in education in the continent. They are being wiped out by the epidemic, and this means that we also do not have around those who can pass on the culture of excellence that we very much cherished and needed in our struggle to make our presence felt in this world. In the long-term, those who are dying now ought to be the ones we can rely upon for the future development of the ed-

ucational personnel. If they are all wiped out, it will be an illusion to expect that there will be some other people who understand our culture, challenges and vision so well to be valuable replacement for dying beloved personnel.

AIDS increases the costs of maintaining educational services. This is so because of the costs involved in replacing educational personnel in all sectors of the education system (Jackson 2002). The reality of this situation is better imagined against the background of the ever-rising costs of educating and training those who serve our community needs in the education sector. If, for example, it costs you, on the average, a thousand US dollars per year to educate a science teacher today, that cost may increase to a thousand, five hundred US dollars in the next few years. Yet, many of our African countries remain among the poorest nations, and this does not give much room for comfort.

Jackson (2002) puts the message simply in this way:

The return on investment in education and training declines as more and more trainee and newly qualified teachers acquire HIV infection and die.

There is waste and decline in value of investments in education as more and more teachers, managers and support staffs die from HIV. From the point of view of learners, the story is not in any way different. The death of learners at all levels and sectors of the education systems would reduce the plan for sustainability of whatever gains we might have secured in education.

HIV reduces the elasticity in the supply of personnel that should have been used in pursuing excellence in education. For example, when teachers and learners fall sick because of HIV, the quality of education is directly affected. This is because of the long hours they should be spending in hospital or on their sick (death?) beds. Moreover, HIV has helped in increasing the number of hours spent in hospital visitation, caring and in funeral attendance. Jackson (2002) has quoted Mukuka and Kalikiti (1995) as having reported that in Zambia alone, there has been a 25% increase in public expenditure needed to maintain recruitment and staffing levels.

HIV is capable of increasing classroom stress that is related to longer teaching hours as teachers who have not been afflicted yet are made to stand in for their sick or “fallen” colleagues (Jack-

son, 2002). There is a way in which drives fears of the unknown, pity and hopelessness into staff and learners. The usual conviviality that has been typical of interactions in our classrooms and the universally acknowledged African warmth have been reduced into feats of sighing, knowing fully well that, sooner or later, one may soon pay the “usual” supreme price of living in a continent that has been unable to put in effective check the ravaging assault of HIV.

HIV, whether on the part of the teacher or learner, has been notorious for increasing the rate of absenteeism. Jackson (2002) has reported that teachers and learners are now frequently absent from learning and teaching exchanges. For HIV increases the likelihood of anxiety about health, depression, despair and hopelessness. It also compels sufferers and carers, as well, to begin to develop poorer attitudes to work while reducing the ability of almost everyone affected or afflicted to perform to standard, knowing fully well that it would just be a matter of time before one takes a bow out of this world. For many of our teachers and learners, life, as Shakespeare puts in his play titled *Macbeth*:

Life is but a walking shadow; a poor player that struts its foot upon the stage, and is heard no more.

There is no research yet that measures the amount of despair that learners experience when their teachers die. Yet we know that frequent “confrontation” with the deaths of relatives and teachers can even immobilize stoics to some extent. Thus, Jackson (2002) has reported the possibility of a decline in the demand for education in Sub-Saharan Africa. Specifically, Jackson (2002), quoting Webb (1996), has advised that the decline will arise from:

- ♦ Increasing opportunity costs of education in the form of higher of higher fees charged to meet rising educational costs;
- ♦ More impoverishment of families as breadwinners die from AIDS;
- ♦ Withdrawal of learners from learning so that they can contribute to family income instead of the family incurring more debts as a result of the increasing costs of learning;
- ♦ Withdrawal of children, especially girls, to care for sick and dying members of the family and younger siblings; and
- ♦ Decrease in fertility rates and hence fewer children needing to enroll in school or learning programs.

The list is far from being exhaustive, but one is constrained by space limitations.

CLINICAL EFFECT AND THE PURSUIT OF ACADEMIC EXCELLENCE

Although there are no clinical evidences at the moment, we know that HIV may have a serious impact on excellence and academic ability of sufferers. HIV is clinical capable of inducing *Cryptococcus meningitis* which is a form of inflammation of the brain membrane that is caused by a fungus that is common in full-blown AIDS. In addition, closely related to *Cryptococcus meningitis* is *encephalitis* is another form of brain inflammation common in full blown AIDS. The literature is rife with accounts of the clinical manifestation of AIDS dementia (Jackson 2002). AIDS dementia is known to cause the total loss of control of thoughts, emotions, personality and behavior through progressive brain damage. When this happens no will expect the sufferer to get involved in the pursuit of academic excellence.

University Response to the HIV and AIDS Epidemic

In response to the challenges posed by HIV and AIDS to investment in and sustenance of excellence in education, many universities in the Sub-Saharan Africa have come up with some innovative practices that are most likely to help in mitigating the problem.

The UNESCO (2013) survey has revealed that about 100% of students globally now has access to HIV information and prevention materials. The case is also true of SSA nations for which have been reported some major practices in the prevention and care strategy, including the fact that:

1. Many universities in Africa have developed HIV and AIDS policies to prevent, care for the affected and mitigate the epidemic (for example, Kenyatta University, Kenya, the University of Namibia, the University of Botswana and a number of universities in South Africa).
2. Some African universities have also developed sexual harassment policies as one direct approach to checkmating the spread of HIV on campus. For example, the University of Botswana has come up with a sexual harassment policy that is being monitored and implemented by an established committee.

3. Many African universities are integrating HIV and AIDS in their teaching, research and community service. This practice requires academic to include in their courses items that are very closely related to HIV and AIDS and gender.
4. Some African universities have initiated preventive, care and support services as well. This ensures that all efforts are made to prevent the spread of the epidemic while taking steps to care for the afflicted.
5. Some African universities like the University of Botswana, Kenyatta University and the University of Cape Town, have established HIV and AIDS units or centers for the study of AIDS in Africa.
6. Developing partnerships that can help in confronting the epidemic.
7. Sharing experiences on effective strategies and practices for reducing and mitigating the impact of HIV and AIDS on university education.

Nevertheless, there are still a number of daunting problems or barriers or challenges that have reduced the impacts of the initial efforts that the universities have made to mitigate the problem of HIV and AIDS on the campuses.

CONSTRAINTS AND CHALLENGES TO THE UNIVERSITY RESPONSE

The Association of African Universities (2013) has identified the following barriers to change:

- ♦ Lack of high level commitment
- ♦ Lack of necessary structures for implementation
- ♦ Lack of empirical evidence of the scope and scale of the problem
- ♦ Lack of resources (human and financial)
- ♦ Lack of buy-in from the campus community
- ♦ Limited access into academic curriculum

Even in the midst of these challenges, one can propose a number of things that the Universities can do in order to mitigate the negative impacts of HIV and AIDS on excellence in education.

What Should Universities Do to Confront the Challenge?

In addition to what the universities have been doing to mitigate the negative impacts of

HIV and AIDS in Sub-Saharan Africa, one may suggest that many more SSA nations need to consider the following set of actions:

- ♦ Assessing the real impacts of HIV and AIDS on the efficiency of the university education system and on the drive toward excellence on all fronts.
- ♦ Encouraging and cooperating in developing and implementing HIV and AIDS information systems that respond to the impact of HIV and AIDS.
- ♦ Strengthening existing HIV and AIDS policies and strategies as well as more vigorous monitoring.
- ♦ More extensive and expansive involvement of the communities in the development, implementation, review and modification of culturally appropriate prevention messages and teaching and learning materials.
- ♦ Tackling socio-economic factors, mostly poverty, that seems to be “luring” students into engaging in unprotected sex.
- ♦ Establishing more partnerships with UNESCO, Commonwealth of Learning, Forum for African Women Educators (FAWE), and Association for African universities (AAU) and Association of Commonwealth Universities (ACU) and civil societies than has hitherto been the case.
- ♦ Ensuring that all students take at least three General Education Courses on HIV and AIDS. And where such courses and modules are already in place, subjecting them to electronic access.
- ♦ Challenging the continuous and current evidence of denial and stigma on the campuses.
- ♦ Engaging with all communities HIV and AIDS prevention and care programs.
- ♦ Engaging more in vigorous scientific research to discover a cure.
- ♦ Researching more into nutritional health related to HIV.

Unless the universities are much more involved in confronting the epidemic, it will continue to have negative impacts on the cultivation, pursuit and sustenance of excellence in education (Elizabeth Gummerson 2013).

CONCLUSION

This discussion has highlighted the incidence of HIV and AIDS in the education system

of Sub-Saharan Africa. The discussion tried to position Africa in the context of the global manifestation of HIV and AIDS so that one gets a better picture of the epidemic. We noted that by killing large numbers of experienced workers and people in the prime of their lives and contribution to national development, the epidemic poses a fundamentally grave threat to the future of Africa. We were particularly interested in exploring summarily how the epidemic has negatively impacted the development of the education system, in general, and the cultivation and pursuit of excellence in university education.

RECOMMENDATIONS

Everything considered, we proposed that HIV and AIDS will continue to pose the most serious challenge to investment in university education in Sub-Saharan Africa. This is particularly so not only because of the tragic deaths of education staff in our universities but more so because of the way the epidemic has been draining human talent and weakening communities and increasing individual tragedies. The epidemic has negatively affected the traditional African liveliness and conviviality that used to be shared in classroom interactions in the universities. Even more worrisome is the fact that denial and stigmatization continue to complicate the problem, altogether ushering in an educational atmosphere that is characterized by suspicion, secrecy about ones HIV status, tears, sorrow and death.

We must now conclude by proposing the view that HIV poses a huge challenge to governance in Africa in the first place. For we have a situation whereby the capacity and capability of governments to care for the sick and govern the healthy is gradually declining in times when there are so many other challenges contending for almost stagnated financial invested in the era of sluggish economic growth in many parts of SSA. In addition, we know that when governments fail to or lose the capacity to govern, as the case is with many SSA countries, the governed may soon lose respect for the state, and the whole essence of political economy would soon be seriously questioned. However, even more importantly is the fact that huge expenditures on HIV will ostensibly reduce budgetary allocations to the education sector. That will in turn worsen the situation of university teacher

shortages, inability to pay salaries, reduced undergraduate allowances and eventually the introduction of school fees at all levels, where this has not been the case in some countries like Botswana, Nigeria (in Federal Government-owned universities) and South Africa, to mention a few. The possible consequence would be the reversal of all the years SSA countries have labored for in terms of widening access to education and higher education in particular in the context of this paper. When that happens, SSA universities may soon be grieving over not only the loss of staff and students but the decay of the foundations of excellence in education that has been the irreducible minimum for the developed world.

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