

***'Modernism' in Higher Learning Institutions (HLIs):
An overview of Students' Vulnerability to HIV/AIDS***

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Abstract

For the last twenty years, HIV/AIDS has been found to be the most devastating disease ever in the history of mankind. It is now the leading cause of death in Sub-Saharan Africa (WHO, 2005). Tens of millions of children and young people are at the front line of the epidemics advance, bearing the burden of its impact. In a world where more than 11.7 million children and young people are living with HIV/AIDS protecting young productive people against the epidemic is requisite.

According to UNAIDS (2004), an estimated 10.3 million people aged 15-24 (where the highest infection rate in Ethiopia is also concentrated in the 15 –24 age groups) are living with HIV/AIDS, and half of all new infections—over 7000 daily- are occurring among young people. It is also believed that most HIV infections in Ethiopia occur among young people in their teens and 20s, and young women are particularly vulnerable. They are vulnerable to HIV because of risky sexual behaviour, substance abuse and their lack of access to HIV information and prevention services.

With the aforementioned realities, in Ethiopia, most of the students of Higher learning Institutions (HLIs) are young; usually within the ages between 15-24. Most of them are adolescents and join the institutions at times of active sexual ages when no close relatives, no parents as it was in the high school, no brothers and sisters to stay together, no cultural boundaries which bounded the individual to be limited, etc. Students, therefore, join new social and academic environments that can either positively or negatively affect their behaviour, attitude, etc and feel 'free' to do things which were not practiced before.

In HLIs of Ethiopia, the notion of having boy friends for girls and girlfriends for boys has been common phenomena among youth and regarded as the characteristics of modernism^{}. The nighttime sex films, the mannerless clothing styles of girls, the feeling of chauvinism of young boys by having sex with a beautiful girl, etc are fertile situations to realize unsafe sex and get vulnerable to HIV/AIDS. This paper, therefore, assesses to what extent the feeling of 'modernism' and facing new social environment made students of HLIs vulnerable to HIV infection. To this effect, and to best explore the issue; this study utilized the triangle of human health ecology model. It also tried to suggest appropriate strategies to fight HIV/AIDS in HLIs and ways on how to equip students with better information about the issue under discussion.*

1. Introduction

1.1. Operational Definitions

Modernism refers something characteristics and practices of modern as distinguished from former and common. Modernism reflects a sense of cultural crisis which was both exciting and disquieting, ... as putting into question any previously accepted means of grounding and evaluating new ideas. **(Modified from Encarta, 2004)**

Freedom is the right of individuals to act as they choose.

Adolescence is a time when young people naturally explore and take risks in many aspects of their living, including sexual relationships.

1.2. Facts of HIV/AIDS and Youth

Due to AIDS 8000 people die everyday. Everything on earth has its own natural boundary. Nature has given us boundaries to protect us as we lead our lives here on earth.

^{*} Modernism in this paper refers to something characteristics of modern as distinguished from former and common.

While sexual boundaries can seem out-dated in the 21st century, sexual activity outside the bonds of marriage is becoming common. HIV is a silent virus that can reside quietly in its victim for years before any symptoms of the disease appear. During this time, the carrier of the virus can spread it to many others through sexual activity, continuing the progression of the disease across a city, a state, a nation and the world. By the year 2010, it is estimated that between 70 and 100 million people worldwide will be infected with the virus that causes AIDS. These will be young men, women, and children who represent not only the future, but the prime years of productivity for their nations. There are countries right now in Africa where 40% of people within age 15-49 have HIV (AIDS Advocacy Network, 2006).

Of the 15 million new cases of STDs (sexually transmitted diseases) diagnosed in the U.S. each year, 25% are in young people ages 15-19, some who will live with the disease or its side effects for the rest of their lives. Fifty percent of all new HIV/AIDS cases in the world are between 15-25 years old (WHO, 2006). In Ethiopia, this age group directly matches to the ages of students who join HLIs.

The earliest evidence of HIV infection in Ethiopia was found in 1984, with the first case reported in 1986. Since 1984, a cumulative total of 107,575 AIDS cases were reported to the Ministry of Health. The prevalence of HIV was low in 1980's but increased rapidly in the 1990's (MOH, 2002).

In Ethiopia, the highest prevalence of HIV is seen in the group 15 to 24 years of age, representing "recent infections". The age and sex distribution of reported AIDS cases shows that about 91 percent of infections occur among adults between 15 and 49 years. The USAIDS data also show that the number of females infected between 15 and 19 years is much higher than the number of males in the same age group. This discrepancy is attributable to earlier sexual activity among young females with older male partners (USAIDS, 2002).

Although the government has made progress in the areas of education, access to health care and economic development, the AIDS epidemic is eroding those gains. The limited empirical data that is available shows that hospital bed occupancy rates for HIV/AIDS cases are increasing. The health care sector, military and the mobile work force are likely to be significantly affected (MOH, 2002). To me one of the mobile workforce is the youth who are currently flocking to HLIs that do not know what will happen and what to do in the destination.

One of the areas of manifestations of the picture of the outside world is in the higher learning institutions, and many teens are feeling the pressures of the outside world: peers at school, television, movies, music, and advertising all aimed at their sexuality. They need direction as they weigh the choices of abstinence versus intercourse, with or without contraception. Currently, many parents in urban areas are facing problems on raising sexually pure teenagers. They have brought into the myth that today's youth spend the majority of their time with other influences, drowning out the voices of their parents. Outside homes, the school system, or friends, or the media must play a larger role in the development of teenage moral behavior than the parents (AFLA (Amharic), 2005; WHO, 2006).

In a University of Utah study that compared the age teens began dating with the age they became sexually active, 91% of those who began dating at age 12 were sexually active by graduation from high school. Over fifty percent who began dating at age 14 were sexual active over the same period. Only 20% of those teens who waited to begin steady dating until age 16 had lost their virginity by graduation. In a culture where the average age to marry is after 18 for both women and men, it is in the best interest of the children/youth to stay with friendships and mixed group activities instead of engaging in the prolonged cycle of dating/breakup/dating, with all of the physical and hormonal pressures that come with it (John Hagee Ministries, 2005). Researchers at the University of Minnesota found that teenage girls who had a close relationship with their mothers were more likely to remain virgins.

They also discovered that it is unlikely for teenage boys to have sex while living with their parents in close relationship and have straightforward discussions about sex and related activities (WHO, 2005; AIDS Advocacy Network, 2006).

The devastating effects of HIV/AIDS on the well-being of millions of people and the grim prospects for its rapid expansion in parts of Africa have serious implications for future human development. Imagine how difficult and painful is to lose productive and educated youth who have been sent to HLIs and expected to help both their parents and their country after graduation. While HIV/AIDS has historically been viewed as adults' problem, it is spreading rapidly among young people. But the attention given to HIV/AIDS and health care expenditures seem scarce and inadequate in HLIs. For example, the 2005/06-activity report of Debu University showed that one of the least done activities in the University is the HIV/AIDS issue (Debu University, Annual Activity Report, 2006).

This study therefore:

- Shows youth's vulnerability to HIV/AIDS in HLIs.
- Assesses to what extent the feeling of 'modernism' and facing new social environment made students of HLIs vulnerable HIV infection.
- Explores the issue of HIV/AIDS in HLIs by using the triangle of human health ecology model.
- Suggests appropriate strategies to fight HIV/AIDS in HLIs and ways to equip students with better information about the issue under discussion.

The data sources to analyze this paper include: Literature, Experiences and personal Observation

1.3. HIV/AIDS and Youth in Sub Saharan Africa

Sub-Saharan Africa has been more devastated by the HIV/AIDS epidemic than any other region of the world. As of 2004, 2.3 million people in the region had died of AIDS-related illness, and almost 27 million were estimated to be living with HIV/AIDS.

The epidemic is taking an enormous toll on the region's youth: Nearly 10 million women and men aged 15-24 roughly one in 14 young adults- are living with HIV/AIDS.

Half of the 3-4 million new cases of HIV infection in this region in the aforementioned time occurred among this age group. In addition, youth have suffered indirectly from the epidemic: Millions of children and teenagers in sub-Saharan Africa have lost at least one parent to AIDS.

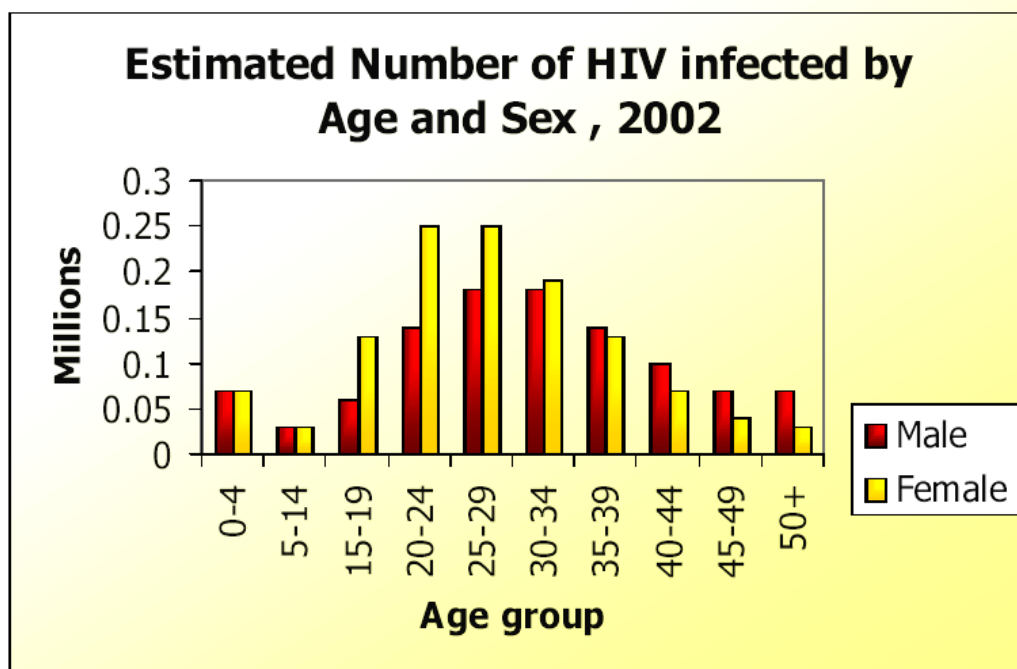
Compared with adults, adolescents are at greater risk of acquiring HIV than adults. Behavioral, psychological and socio-cultural factors make young people more vulnerable than adults to HIV infection. Adolescence is a time when young people naturally explore and take risks in many aspects of their living, including sexual relationships. Those who have sex may change partners frequently, have more than one partner in the same time period or engage into unprotected sex. All of these behaviors increase young people's risk of contracting HIV. In addition, young people who are HIV positive probably become infected quite recently and are therefore likely to be highly infectious; as a result, they pose a very high risk to their sexual partners (Population options, 2005)

The increase in young people's greater vulnerability to HIV from behavioral and Psychological factors is due to the fact that in sub-Saharan Africa many young people do not know where to get the right information or are unable to pay for it. Thus, most young women and men have to overcome significant obstacles to obtain the information and care they need to have safe sexual relationships. It is this fact that made important to focus on young people to the most effective approach to confronting the epidemic, particularly in high prevalence countries and fertile situations like HLIs.

A focus on youth and the place where youths are frequently met has ever far-reaching implications. The contributions that young people make to the society are crucial to the survival and well-being of the institution. Therefore, curbing the HIV/AIDS epidemic by focusing on the needs of youth and coincident conditions is an urgent priority.

The place where people distinguish as learning environment should have not to be a front of death environment because of mismanaging the situation.

Most HIV infections in Ethiopia occur among young people in their tens and 20s, and young women are particularly vulnerable. The number of HIV-positive women in the 15- to 19-year-old age group is much higher than the number of HIV-positive men in the same age group.



Source: MOH, 2002

Data on age-specific HIV prevalence rates reported that highest infection rates are concentrated among the group 15 to 24 years and to a slightly lesser extent among the group 25 to 34 years. The median age at first sexual intercourse among men is 20.3 years, three years lower than their median age at first marriage (23.3 years) (Garbus, 2003). Yet, in terms of absolute numbers, the highest concentration of HIV-infected persons is found in the groups 20 to 24 years and 25 to 29 years, particularly in the case of females. The highest concentration of infected males is found among in both age groups 0 to 24 years and 25 to 29 years. The HIV prevalence rates as well as the number of infected persons seem to decline with age. The implication is quite clear. It is the population in the most productive age group that is primarily affected by HIV.

1.4. Why and how Young people in Higher Learning Institutions (HLIs) are Vulnerable to HIV/AIDS

Most of the research works indicate that young people are at the forefront of the risk. Following are some of the factors showing why young people in HLIs are vulnerable to HIV/AIDS.

1. **Misinformation and Misunderstanding.** Researchers indicate that many young people do not believe or not aware that HIV/AIDS is a threat to them. Almost two thirds of sexually active youths in Sub-Saharan Africa either do not believe they run the risk of HIV/AIDS infection or do not know that their age plays a significant role for vulnerability (UNAIDS, 2001). Additionally youth frequently use incorrect information from their peers which may give them the false sense that they are invulnerable or already protected. Thus risky behaviors among youth persist and frequently young people, even with the information they need, lack the practical skills to affect a change in their lives (Population Option, 2005).

A 1995 study by the National Progressive Primary Health Care Network (NPPHCN) found that, customarily, young people receive conflicting messages about sex and sexuality; that non-penetrative sex is not considered to be proper sex; that widely believed myths reinforce negative attitudes about safer sex and contraceptive use; and that most adolescents make decisions about sex in the absence of accurate information and access to support and services. The study concluded that these young people lack the confidence and skills to discuss sexual issues, contraception and prevention of infection.

2. **Early sexual activity.** Some adolescents become sexually active early, without the benefit of the necessary information, skills and services to protect themselves from HIV. This is very true in HLIs where students join it without either prior knowledge about HIV/AIDS or having adequate information on the onset of their entry in the Institutions, etc.

Programs targeting young people often fail to acknowledge such early sexual activity. Most of the anti AIDS clubs like 'Yebruhtesfa' at Dilla Campus and 'Dewel' at Awasa and some others almost in all HLIs are unable to go further to strengthen themselves and reach the young and therefore remain only as 'CLUBS'.

3. **Unplanned sexual relations and emotionality.** Sexual relations are often unplanned. The big trees and dense forests (probably planted by nature clubs) are becoming night time leisure places in the campuses. Don't ask me how do I know? This is testified by high condom demands and consumption and the morning shift cleaners murmur while collecting basket of condoms from the roadsides and out of sight places. But how many of the students are aware of HIV infection and utilization of condoms? How many of the students know that putting condoms in the out of sight places is not a legal permission for 'Kiseta'⁴⁷. In general, both substance use and emotional unpreparedness for sexual intimacy can impair judgment in risky situation, putting youth at increased risk for unplanned pregnancy and infection with HIV and other sexually transmitted diseases (STDs) (Center for Population Options, 2005).
4. **Inadequate health services and lack of trust.** Many factors discourage young people from using counselling and health services: lack of privacy and confidentiality, insensitive staff, threatening environments, inability to afford services, etc. Because of these and related factors young people in HLIs are less likely to protect themselves from HIV infection and go to counsellor pre-test or post test reactions.
5. **Frequent interactions.** There is also evidence that a large share of new cases of HIV infection is in homes, schools, workplaces and other social spheres where people can interact frequently. HLIs are places where people of different cultures and experiences interact to share both bad and good experiences.

⁴⁷ Kiseta is a commonly used Amharic word in most HLIs especially in Debub University indicating having sex with girls/boys.

6. **Feeling of being modern.** It is most likely assumed that because of feeling of being modern, many of drug users, sex film attendants, chat chewers, alcohol users, etc are young. These experiences are more common in the senior class students than freshmen. The use of alcohol and drugs are factors forcing students for 'Kiseta'. These complementary and supplementary experiences are associated with unsafe sexual behaviour.
7. **Ability of fast socialization.** Young people are active for socialization process. Most of the time young people are victims of the influence of the outside world's culture. Honestly speaking, sex films, immoral sexual relationships, drug usage, etc are the results of modernism in the western world (Bahamas Faith Ministry, 2005). The directly adopted superficial modernism among the youth in Ethiopia is becoming a factor for the spread of HIV. The style of dressing, unique hair cut, exchange of sex stimulant words, etc are common in the senior classes after being socialized during their stay in the campus. These are fertile grounds for vulnerability and infection of youth by HIV.

2. HLIs, Youth and HIV/AIDS

2.1. Modernism and Youths Vulnerability to HIV/AIDS in HLIs

As stated above, the highest prevalence of HIV is seen in the group 15 to 24 years of age, representing "Recent infections". The mean age at which people become infected is probably 15 to 24 years for females and 25 to 34 years for male (USAIDS, 2006).

Adolescence is traditionally a time of growth, as young men and women seek to stretch beyond the protective shelter of family and begin to create an independent vision and life. Developmentally this time of frantic self-definition is full of experimentation, spontaneity and limit testing, frequently in the arenas of sexual activity and drug use (population options, 2005).

Young people's and particularly young women's, highlighted vulnerability to HIV infection has root not only in their sexual and marital behaviour, but also in the broader social, cultural, and economic conditions they face in their lives.

The virus spreads fast and furthest in conditions of scarcity, powerlessness and lack of information-conditions in which many young people live and interact. HLIs are best examples regarding this.

As far as the place of origin of students is concerned, Adolescents in rural Ethiopia face rural underdevelopment, widespread poverty, poor educational opportunities and limited access to radio, television and newspapers.

When these youth join a university /HLIs no one is responsible to orient them about HIV, sound friendship, (ab) normal opposite sex interactions, etc. In the name of studying together, supporting each other, ethnic connection, religious affiliation, etc coupled with boundless freedom, many young boys and girls enter into abnormal and unplanned sexual relationships. Cornerly available condom boxes with very nice but misused word- 'Use It' undoubtedly fuel this and expose students to HIV infection.

Hoping that some thing can be obtained out of the nicely decorated word, the misinformed young start to think about with whom to try to. It seems a legal obligation to use it and sign of modernity to have intercourse in the campus with an opposite sex.

Educational Systems and HIV/AIDS

Evidence shows that African education systems are being impacted by the HIV/AIDS epidemic. The impact of the epidemic could be far reaching in view of the distinctive nature of the educational sector in terms of its organization; the numbers and kinds of people involved, the degree of vulnerability, and the matchless role that education plays in fighting HIV/AIDS (Debub University- 'AFLA', 2006).

At the panel discussion in students' day of Dilla College, students confirmed that although many young women report delaying their sexual debut, once women do have unprotected sex, the odds of acquiring HIV are dauntingly high. The students added that, unlike girls, most of the boys usually start sexual activities in the HLIs.

Given that HIV/AIDS is already having an effect on education systems, educational planners and managers at various levels need to recognize the nature and extent of the impact, as well as equipping themselves and the academic community with the necessary conceptual and analytical tools to capture and monitor the impact, and design strategies and programs for prevention, care and impact mitigation (Busech, 2004). At present many educational managers think that activities related to HIV/AIDS are the responsibility of specialized agencies, such as the HIV/AIDS Secretariat, rather than being part and parcel of the responsibilities of each and every actor. Until now responses to HIV/AIDS within the education sector have been momentary, but this condition is neither effective nor sustainable. The present situation especially in HLIs is largely a function of the lack of capacity to properly conceive and analyze the impact of the epidemic on the system particularly on the youth, and to design cogent intervention programmes as part of institutional strategic planning.

The possible Costs and Consequences of HIV/AIDS in HLIs and Educational Systems

According to Kelly (2002) the educational system at all levels is interconnected and the higher level is affected by the lower level and vice-versa. Either in the short or long run the impact of HIV/AIDS on education in general can be manifested in several ways.

1. HIV/AIDS affects the demand for education because gradually

- ❖ Fewer youth/children to educate; An increasing number of drop-outs many of whom are reduced to inefficient and poor academic performance.
- ❖ Fewer children/youth want to be educated;
- ❖ Fewer youth/children able to afford education;
- ❖ Fewer youth/children able to complete their schooling and study.

2. HIV/AIDS affects the supply of education because of the loss through mortality of trained teachers

- ❖ The reduced productivity of sick teachers;
- ❖ The reduction in the system's ability to match supply with demand because of the loss, through mortality or sickness, of education officers, inspectors, finance officers, building officers, planning officers, management personnel;
- ❖ The closure of classes or schools because of population decline in catchment areas and the consequent decline in enrolments.

3. HIV/AIDS affects the availability of resources for education because of

- ❖ The reduced availability of private resources, owing to AIDS-related reductions in family incomes and/or the diversion of family resources to medical care;
- ❖ Reduced public funds for the system, owing to the AIDS- related decline in national income and pre-emptive allocations to health and AIDS-related interventions;
- ❖ The funds that are tied down by salaries for sick but inactive teachers;
- ❖ Reduced community ability to contribute labour for school developments because of AIDS-related debilitation and/or increasing claims on time and work capacity because of loss of active community members.

4. HIV/AIDS affects the potential customers for education because of

- ❖ The rapid growth in the number of orphans;
- ❖ The massive strain which the orphans phenomenon is placing on the extended family and the public welfare services;
- ❖ The need for youth/children who are heading households, orphans, the poor, girls, and street children to undertake income-generating activities.

5. HIV/AIDS affects the process of education because of

- ❖ The new social interactions that arise from the presence of AIDS-affected individuals in schools;
- ❖ Community views of teachers as those who have brought the sickness into their midst;

- ❖ The erratic school attendance of pupils from AIDS-affected families;
- ❖ The erratic teaching activities of teachers, who are personally infected, or whose immediate families are infected, by the disease;
- ❖ The increased risk that young girls experience of sexual harassment because they are regarded as 'safe' and free from **HIV**infection.

6. HIV/AIDS affects the content of education because of

- ❖ The need to incorporate HIV/AIDS education into the curriculum, with a view to imparting the knowledge, attitudes and skills that may help to promote safer Sexual behaviour;
- ❖ The need to develop life-skills which equip pupils for positive social behaviour and for coping with negative social pressures;
- ❖ The need for earlier inclusion in the curriculum of work-related training and skills, so as to prepare those compelled to leave school early (because of orphan hood or other reasons) to care for themselves, their siblings, and their families.

7. HIV/AIDS affects the role of education because of

- ❖ New counseling roles that teachers and the system must adopt;
- ❖ The need for a new image of the school as a centre for the dissemination of messages about HIV/AIDS to its own pupils and staff, to the entire education community, and to the community it serves;
- ❖ The need for the school to be envisaged as a multi-purpose development and welfare institution, delivering more than formal school education as traditionally understood.

8. HIV/AIDS affects the organization of schools because of the need to

- ❖ Adopt a flexible timetable or calendar that will be more responsive to the income-generating burdens that many youth/pupils must shoulder;
- ❖ Provide for schools that are closer to youth/children's homes;

- ❖ Provide for orphans and children from infected families, for whom normal school attendance is impossible, by bringing the school out to them instead of requiring them to come in to some central location;
- ❖ Examine assumptions about schooling, such as the age at which children/youth should commence the desirability of making boarding provision for girls, the advisability of bringing together large numbers of young people in relatively high-risk circumstances.

9. HIV/AIDS affects the planning and management of the education system because of

- ❖ The imperative of managing the system for the prevention of **HIV** transmission;
- ❖ The loss through mortality and sickness of various education officials charged with responsibility for planning, implementing, and managing policies, programmes and projects;
- ❖ The need for all capacity-building and human resource planning to provide for
 - (a) Potential personnel losses, (b) developing new approaches, knowledge, skills and attitudes that will enable the system to cope with the impacts epidemic and monitoring how it is doing so, and (c) establishing intra-sectoral epidemic-related information systems;
- ❖ The need for more accountable and cost-effective financial management at all levels in response to reduced national, community and private resources for education;
- ❖ The need for sensitive care in dealing with personnel and human rights issues of AIDS-affected employees and their dependants.

The potential impact of HIV/AIDS on education has been discussed and researched for many years.

Schaeffer (1994) showed how HIV/AIDS was likely to impact on educational systems analogous to its impact on the individual, weakening and disrupting the system, leaving it open to opportunistic problems, and the necessity for change and innovation.

10. HIV/AIDS affects donor support for education because of

- ❖ Donors' concern to promote capacity-building and develop a self-sustaining system, both of which are inhibited by the widespread incidence of HIV/AIDS;
- ❖ Donors' concern lest the effectiveness of their inputs be undermined by the impacts of the epidemic;

Donor uncertainty about supporting extended training abroad for persons from heavily infected countries (**adapted from Kelly, 2002**).

3. The Ecology of Human Health model: Analyzing tool of youth's vulnerability to HIV/AIDS

Our health is intimately intertwined with the environment in which we live. Air pollution, pesticides, drinking water, climate change, buildings, energy sources, etc are just a few of the factors that affect our well-being. As we learn about these issues we can begin to make changes in our daily lives, our communities, in our nation's policies, and at the international level. The human health is enclosed by the triangle of **Population** (gender, Age, Genetics,) **Habitat** (natural, social and built) and **Behaviour** (Belief, Social Organization, and technology).

This model suggested that health was the result of interactions between the three dimensions of population, environment, and culture. The population dimension includes such factors as genetics and nutritional status; concerns that were traditionally the domain of

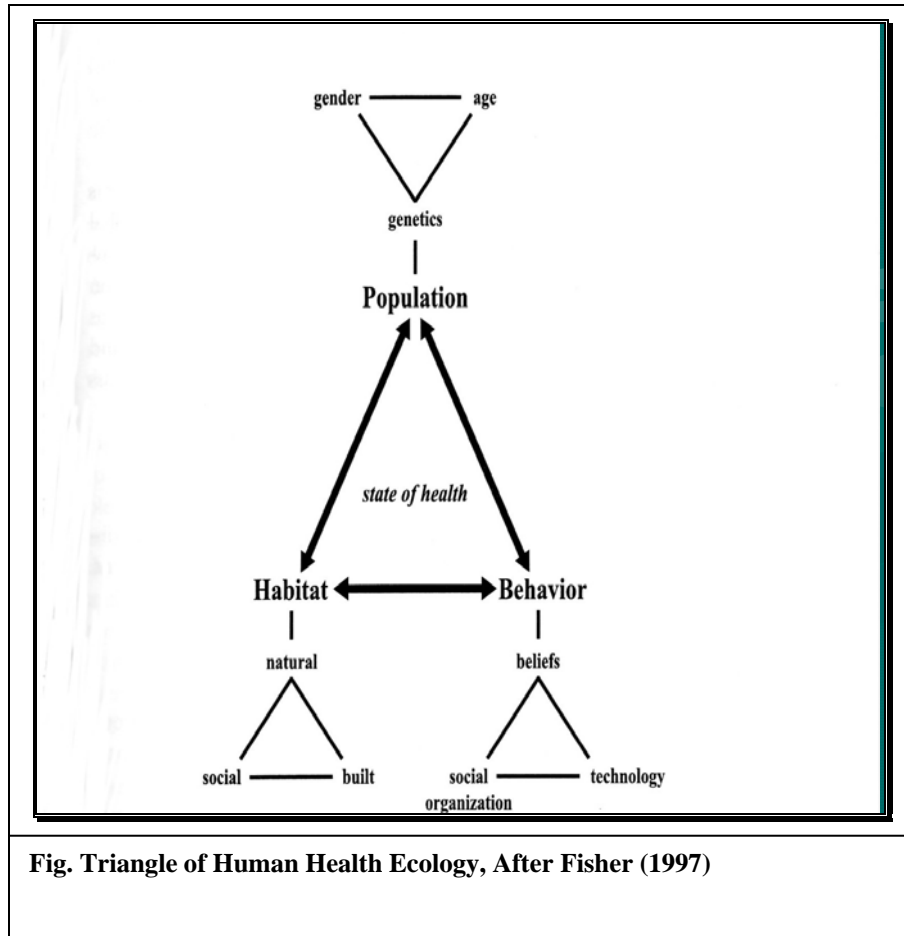


Fig. Triangle of Human Health Ecology, After Fisher (1997)

demographers. As was mentioned earlier, one of the factors that make students vulnerable to HIV infection is their age. Being male or female is also another factor for vulnerability and that is why one of the mechanisms of preventing HIV/AIDS is ensuring gender equality. Besides, due to nature and sexual behaviours women are more likely to be affected by HIV than men.

The environmental dimension includes physical, chemical, and psychological threats to health; factors usually measured by physicians, earth scientists, and ecologists. The cultural dimension is made up of the range of behaviors humans use to interact with the environment, friends, opposite sex, etc.

Traditionally the domain of anthropologists, these behaviors include dietary practice, types of housing, style of dressing, and the cultural and societal frameworks through which health and illness are perceived.

Habitat, population and behaviour form the vertices of a triangle, which encloses the state of human health. Habitat is that part of the environment within which people live, that which directly affects them. Houses and work places, settlement patterns, naturally occurring biotic and physical phenomena, health care services, transportation system, school environment, government, etc are parts of the habitat thus broadly conceived.

In our case habitat is the place or situation where students of HLIs learn and live. For most of non-commuting students in HLIs (Government HLIs) the habitat include dormitory where students of different cultures, ages, experiences, etc live; cafeterias: where many students interact at least three times a day; the structural arrangement of dormitories has enabled to hide oneself from others; the presence of forests and big trees in some campuses which in turn are places where boys and girls meet; school counseling services; school administration, etc. For commuting students (Private HLIs) habitat could be transportation, family, etc. In the HLIs the state of health of students is directly affected by the factors that conditioned the state of human health. Unless these elements are not working properly, students in **HLIs** are likely to be infected by HIV and in turn their state of health will be disturbed.

4. Conclusions and Recommendations

4.1. Conclusions

1. Young people's reproductive health in HLIs needs many changes somewhat depending on whether an adolescent has one sexual partner or several, and whether they have intercourse frequently or sporadically and whether they came from rural or urban areas, etc. However, all young people need information and services that will help them avoid contracting HIV and other STDs and enable them to get proper treatment for such infections. This is because young people especially at HLIs are at the forefront of the risk.

2. In HLIs adolescents' sexual needs have not been addressed on a variety of fronts but what have been seen in the HLIs are terrible sexual images say the mechanisms of fund raising by the graduation committee of the institution. The sex films are becoming common mostly in the last five months of the academic year. Students pay money to get stimulated and take further sexual actions.
3. To fight HIV /AIDS in HLIs require checking certain socio-cultural norms, values and practices that promote the knowledge, cause, and consequences of HIV/AIDS among youth. Addressing unusual behaviours, attitudes and practices among students will require openness, sensitivity and patience, change will not occur without strong support from and role modeling by community and leaders of HLIs.
4. Unlike other places, noncommercial sex in the name of ethnicity, place of origin, helping the low achievers, etc is relatively high in HLIs.
5. Misconceptions and misunderstanding about HIV/AIDS transmission remain high among HLIs students. These misconceptions about HIV/AIDS are high irrespective of the place of origin and family background, although access to information varies.
6. Despite a varied level of knowledge, a significant proportion of the population, particularly youth, is at high risk of HIV infection.
7. 'Superficial modernism'-imitating others' culture without knowing it, adopting others personality styles copied from audio-visual sources, etc are commonly observed elements among students, and hence are gradually changing their (sexual) behaviors. What has been seen so far in HLIs is that social and cultural norms are being increasingly liberalized.
8. If the state of health of students in HLIs is affected by HIV/AIDS, it is the result of the malfunctioning of the human health ecology model.

Recommendations

Greater and more effective prevention, treatment, and care efforts need to be brought to HLIs of Ethiopia. Clubs and all other concerned bodies should work together by getting stronger than before. A successful response to HIV/AIDS requires that essential public services, such as education and training, health, security, justice, good school administration, be maintained. The following recommendations are forwarded as strategic tools of fighting HIV/AIDS in HLIs of Ethiopia.

1. **Workable data.** To deal temporarily with the problem of inadequate sources of data for estimating HLIs HIV prevalence the sample size requirements can be met by collecting data from some institutions and aggregating them to meet the minimum sample size requirement.
2. **Strengthening the existing Anti-HIV/AIDS clubs and strategies.** Efforts need to be made to increase the capacity of existing information sources, HIV clubs, and health facilities and perform HIV tests. Since adolescents engage in activities, which increase the risk for HIV infection, school should provide HIV-related student support services. The Ministry of Education has yet to provide clear guidelines for a comprehensive HIV education curriculum. Although there are several hundred anti-HIV/AIDS clubs in high schools as well as in HLIs, their goals vary widely and they do not promote HIV prevention skills (Shin, 2001).
3. **Institutionalized strategies and guidelines.** HLI guidelines for HIV/AIDS and associated factors, like addiction, should be set and in turn promote students' AIDS/HIV knowledge and social growth. The Ethiopian Ministry of Youth, Sports, and Culture should stretch its hands to HLIs and follow youth-based participatory process to develop an HIV/AIDS and sexual health program. Effective programs equip young people with skills to interpret the conflicting messages that come from adult role models, television, advertisements and other media. Young people should develop a national youth character and take action for improved sexual health and HIV preventive behavior.

4. **HIV/AIDS Education, Awareness creation and Counseling.** 'AIDS; in most cases, is preventable. Until a cure is found, education is the best and for now the only defense against AIDS'. *Without education, AIDS will continue its rampant spread. With AIDS out of control, education will be out of reach*" Peter Piot, Director of UNAIDS). HIV student support services should provide prevention education, health-related services provided by school nurses and school psychologists, counseling service, HIV test counseling and support, referral and coordination services. Prevention education should encourage healthy sexual attitudes and practices. School nurses can provide medication administration and health counseling. School psychologists should observe cognitive functioning. Counseling services should be accessible to AIDS symptomatic and HIV-positive students. In general, vigorous prevention efforts are needed to equip young people with the knowledge and services (such as HIV/AIDS information, life-skill training, etc) they need to protect themselves against the virus.
5. **Integrated and partnership approach.** Establishing a coordinating mechanism for partnerships among government, NGOs and private sector to follow an integrated approach. Research, through the collaboration of the government, NGOs and civil society, should be conducted to determine the impact of HIV on educational system, worker productivity, on different educational levels, on the cost of health care, and so forth.
6. **Provision of adequate resources.** More efforts need to be made to involve public and civil society resources to provide care and support to drop outs from institutions because of HIV/AIDS. HLIs should also collaborate with agencies in the community to fight HIV/AIDS to find funds, health personnel, etc.
7. **Establishing independent culture clubs that can practically condemn immoral and unusual westernized cultures and values.** Limiting the influence of bad western cultures and in turn promoting local ones can build morally strong citizen in order to avoid superficial 'modernization' by students. Sex films, drug and alcohol use, unique dressing styles, haircut, etc should get limits. HLIs should help students develop skills which equip them for positive social behavior and for coping with negative cultural pressures.

REFERENCES

- Ainsworth, Martha, et al. *The Impact of Adult Mortality on Primary School Enrolment in Northwestern Tanzania*. UNAIDS. December 2000. <http://www.unaids.org/whatsnew/adf/files/schooling.pdf> (accessed June 19, 2002).
- _____ (2005.) Bahamas Faith Ministry. Informational Brochure. NASSU, BAHAMAS.
- _____ (2005). Center for population options. P.7, DC.
- David H. Shinn. (2001) "HIV/AIDS in Ethiopia: The Silence Is Broken; The Stigma Is Not." Africa Note no. 1. Washington, DC: Africa Program, Center for Strategic and International Studies, July 2001
- _____ Ethiopian Ministry of Health, Disease Prevention and Control Department. AIDS in Ethiopia. 4th edition. Addis Ababa: October 2002 <http://www.policyproject.com/pubs/countryreports/ETH_AIM_2002.pdf
- Fisher. (1997). Ecosystem, Health, Disease Ecology and beyond. Lecture Note, Center for Aging.
- Hepburn, Amy. *Primary Education in Eastern and Southern Africa: Increased Access for Orphans and Vulnerable Children in AIDS-affected Areas*. USAID. June 2001. http://www.usaid.gov/pop_health/dcofwvf/reports/edreps/hepburnfinal.doc (accessed June 5, 2002).
- IICBA-Newsletter. June 2001.
- _____ (2006). John Hagees Ministries. Informational Brochure. USA.
- Kelly, J.A., & Kalichman, S.C. (2000). Behavioral research in HIV/AIDS primary and secondary prevention: Recent advances and future directions. *Journal of Consulting and Clinical Psychology*, 44 pgs
- KIWAKKUKI.(2002). *Let's Fight AIDS Together*. Informational Brochure. 2002.
- Lisa Garbus (2003). HIV/AIDS in Ethiopia. AIDS Policy Research Center, University of California, San Francisco.
- MOH (2002). AIDS in Ethiopia, Disease Prevention and Control Department, AA, Ethiopia.
- NPPHCN (1995) National Progressive Primary Health Care Network

- _____ (2004) Risk and Protection: Youth and HIV/AIDS in sub Saharan Africa, the Alan Guttmacher Institute..
- **Schaeffer**, S., (1994). *The Impact of HIV/AIDS on Education: A Review of the Literature and Experience*. Background paper presented to an IIEP Seminar, Paris, 8th to 10th December 1993. Paris: International Institute for Educational Planning (IIEP).
- The European Union HIV/AIDS Programme in Developing Countries. *Expenditure on HIV/AIDs in Tanzania*. Confronting AIDS: Evidence from the Developing World. <http://europa.eu.int/comm/development/aids/limelette/html/lim12e/htm> (accessed June 20, 2002).
- UNAIDS (2001) (Joint United Nations Programme on HIV/AIDS). 2003. AIDS epidemic update: 2001. Geneva.
- UNAIDS/UNICEF/USAID. *Children on the Brink 2002: A Joint Report on Orphan Estimates and Program Strategies*. July 2002. <http://www.usaid.gov> (accessed October 7, 2002).
- UNAIDS/WHO. (2002) *Epidemiological Fact Sheets: United Republic of Tanzania*. 2000Update. http://www.unaids.org/hivaidsinfo/statistics/fact_sheets/pdfs/Tanzania_en.pdf (accessed June 19, 2002).