FROM POLICY TO PRACTICE

An HIV and AIDS training kit for education sector professionals

DRAFT

This draft training kit has been prepared with support from the UNESCO Nairobi Office.
It is being reviewed by the UNESCO National Commissions in
Burundi, Eritrea, Kenya, Rwanda, Uganda.

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- The Government of the Republic of Uganda; Ministry of Education and Sport
- The Government of the Republic of Rwanda; Ministry of Education, Science, Technology and Scientific Research
- The Mobile Task Team on the impact of HIV/AIDS on education – www.mttaids.com
- The International Finance Corporation – www.ifc.org/ifcagainstaids
- The Joint United Nations Programme on HIV/AIDS (UNAIDS) – www.unaids.org
- The United Nations Educational, Scientific and Cultural Organisation (UNESCO) – http://hivaids.nairobi-unesco.org
- International Planned Parenthood Federation – www.ippfwhr.org/publications

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FOREWORD

The HIV/AIDS epidemic represents one of the greatest challenges to Africa; jeopardising many international and national development goals. In countries in East and Central Africa, Ministries of Education, with UNESCO and other partners, have initiated sector-wide programmes to prevent new HIV infections and to mitigate the impact of the epidemic on the demand, supply and quality of education.

In many of these countries, an important part of this process has been the development of an **education sector policy on HIV and AIDS**, linked to an education sector HIV/AIDS implementation plan, to give effect to the policy goals. Typically these goals are in four strategic areas:

- **Prevention** – which strives to achieve an environment in which all learners are free and safe from HIV infection;
- **Care and support** – which aims to create an education sector in which care and support is available for all, particularly orphans and vulnerable children and those with special needs;
- **HIV and AIDS and the workplace** – which establishes a comprehensive workplace HIV/AIDS programme for educators and other staff and emphasises non-discriminatory labour practices and terms and conditions of service that are sensitive and responsive to the impact of HIV and AIDS; and
- **Management of the response** – which provides for management structures at all levels of the education sector, and a wide range of management interventions in order to ensure and sustain quality education in the context of HIV and AIDS.

After the successful adoption of an e**ducation sector policy on HIV and AIDS**, it is necessary to recognise and address the multiple challenges inherent in translating policy into practice. To support this process a product for education sector professionals has been developed. Referred to as **From policy to practice: An HIV and AIDS training kit for education sector professionals**, the kit can be used to train teams of education sector trainers to enhance the capacity of those responsible for implementing their country's **education sector policy on HIV and AIDS**.

The development of the training kit took the following course:

- Development of a draft kit;
- Pilot testing at the 4th UNESCO Nairobi Cluster Consultation on HIV/AIDS and Education that took place in Mombasa, Kenya from 21 to 23 June 2005;
- Distribution to the UNESCO National Commissions (Burundi, Eritrea, Kenya, Rwanda, Uganda) to solicit their comments; and
- Final revision of the kit.

ABBREVIATIONS AND ACRONYMS

ACU	AIDS Control Unit (Kenya)
AIDS	Acquired immune deficiency syndrome
ARV	Antiretroviral (drugs or treatment)
CEDAW	Convention on the elimination of all forms of discrimination against women
DEMMIS	District education monitoring and management information system
EAP	Employee Assistance Programme
ECD	Early childhood development
ECOWAS	Economic Community of West African States
EFA	Education For All (Goals)
EMIS	Education Management Information System
ESC	Education Service Commission
HAART	Highly active antiretroviral therapy/treatment
HIV	Human immunodeficiency virus
HR	Human resources
ILO	International Labour Organisation
LTSM	Learning and teaching support materials
M&E	Monitoring and evaluation
MDG	Millennium Development Goals
MoE	Ministry of Education
MoES	Ministry of Education and Sport (Uganda)
MoEST	Ministry of Education, Science and Technology (Kenya)
MoEST& SR	Ministry of Education, Science, Technology and Scientific Research (Rwanda)
MTT	Mobile Task Team on the impact of HIV/AIDS on education
NGO	Non-governmental organisation
OH	Overhead (projector)
OVC	Orphans and other vulnerable children/learners
PLWHA	Person/people living with HIV/AIDS
PMTCT	Prevention of mother to child transmission (of HIV)
PPT	Power point presentation
PTA	Parent Teacher Association
SGB	School Governing Board
SMT	School Management Team
STI	Sexually transmitted infection
TB	Tuberculosis
TSC	Teacher Service Commission

UN CRC	United Nations Convention on the Rights of the Child
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UPE	Universal primary education
VCT	Voluntary counselling and testing

SECTION ONE GETTING STARTED

USER GUIDE

What is the HIV and AIDS training kit for education sector professionals?

The HIV and AIDS training kit is a user-friendly guide to build capacity in education sector professionals who have responsibility for the implementation of their country's **education sector policy on HIV and AIDS**.

Why was the training kit developed?

It is always a challenge to translate policy provisions into practice and the training kit was developed to meet the need for implementation support. The primary objective of the kit, therefore, is as a training and capacity building resource to support the operationalisation of a country's **education sector policy on HIV and AIDS**.

How was the training kit developed?

Guided by UNESCO, a draft training kit was compiled and then piloted at the 4th UNESCO Nairobi Cluster Consultation on HIV/AIDS and Education that took place in Mombasa, Kenya, from 21 to 23 June 2005. The **education sector policies on HIV and AIDS** from Kenya, Rwanda and Uganda served as the foundation documents, together with selected training manuals from some of these countries and supplemented by information from a wide range of HIV/AIDS and education resources.

Who will use the training kit?

Education sector trainers will use the training kit in any initiatives to build capacity to implement an **education sector policy on HIV and AIDS**.

What is in the training kit?

The kit consists of three sections.

- **Section One** contains information on getting started – such as a training curriculum, generic workshop programme and tips for training in the era of HIV and AIDS.
- **Section Two** contains tools to assess HIV/AIDS competency, in both the participants and the trainers. It then sets the scene with information on legal and policy frameworks within which implementation should take place; and the policy principles that should guide implementation. There are also background facts on the impact of the HIV/AIDS epidemic on education; and a "Goldstar" scenario response, which describes an optimal or ideal response.
- **Section Three** explores each of the policy themes in turn:
    - Prevention
    - Care and support
    - HIV and AIDS and the workplace
    - Management of the response

with information, examples and exercises to build knowledge and skills for implementation.

- **Section Four** contains fact sheets on basic HIV/AIDS information, in Appendix One, important references in Appendix Two and a glossary of terms in Appendix Three.

In Sections Two and Three, each sub-section follows the same format. You will find **information for trainers,** often with examples or extracts from actual education sector policies or strategies; as well as **training exercises,** which can be used in workshop situations.

Customising the training kit

The kit is generic, although it draws extensively from Kenyan, Ugandan and Rwandan policies. To be of optimal use, it should be customised so that it most accurately reflects its user's situations. Clearly, in the case of French-speaking countries, this also implies translation into French.

Use the following checklist to guide the adaptations that need to be made:

SECTION	ADAPTATIONS TO BE MADE		COMMENTS/ DETAILS OF REQUIRED ADAPTATIONS
	YES	NO	
SECTION ONE User guide Curriculum Generic programme Training tips			
SECTION TWO Assessing basic HIV/AIDS competency Impact of HIV/AIDS on education Legal and policy framework Policy principles A "Goldstar" response			
SECTION THREE Prevention Care and support HIV and AIDS and the workplace Management of the response			
APPENDICES Fact sheets on HIV/AIDS Important references Glossary of terms			

CURRICULUM

The following details can be used as a basis for designing a training curriculum using the kit.

Overall aim

To operationalise an **education sector policy on HIV and AIDS** through a training and capacity building programme.

Learning outcomes

By the end of the course participants will be able to:

- Explain the impact of the HIV/AIDS epidemic on the education sector;
- Describe the key themes of their country's **education sector policy on HIV and AIDS**;
- Demonstrate commitment and skills to operationalise the policy; and
- Provide guidance and information to others on the prevention, mitigation and management of HIV/AIDS.

Participant profile, competencies and previous learning

A wide range of participants will benefit from training using the kit, however the priority groups of participants will be:

- Education sector professionals with a policy implementation mandate; and
- Stakeholders, like members of School Management Teams (SMTs), School Governing Boards (SGBs) and Parent Teacher Associations (PTAs), who also have policy implementation responsibilities.

The participants should have an understanding of the basics of HIV/AIDS[1] and should, ideally, have been involved in their country's policy development process. For reference purposes, fact sheets on basic HIV/AIDS information are provided in Appendix One. If participants have not received basic HIV/AIDS training, provision for this should be made, by adding at least five additional hours to the programme.

[1] The optimal use of the training kit assumes that users will have basic HIV/AIDS competence.

GENERIC PROGRAMME

The following three-day generic programme can be adapted and used, with the kit, when designing a training programme.

DAY ONE

Session One
Introductions and expectations
Questionnaire to assess HIV/AIDS competency
Legal and policy framework

Session Two
Policy principles
Group exercise

Session Three
Impact of HIV/AIDS on education
Group exercise

Session Four
"Goldstar" (illustrative) response
Group exercise

DAY TWO

Session One
Policy Theme One – prevention
Presentation and discussion

Session Two
Policy Theme One – prevention (cont.)
Group exercise

Session Three
Policy Theme Two – care and support
Presentation and discussion

Session Four
Policy Theme Two – care and support (cont.)
Group exercise

DAY THREE

Session One
Policy Theme Three – HIV and AIDS and the workplace
Presentation and discussion

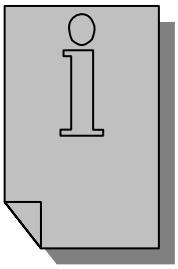
Session Two
Policy Theme Three – HIV and AIDS and the workplace (cont.)
Group exercise

Session Three
Policy Theme Four – managing the response

Presentation and discussion

Session Four
Policy Theme Four – managing the response (cont.)
Group exercise
Evaluation, thanks and closure

TRAINING TIPS



Information for trainers

Even if you are an experienced teacher, there are some important things to consider before embarking on the task of training groups to implement their country's **education sector policy on HIV and AIDS**.

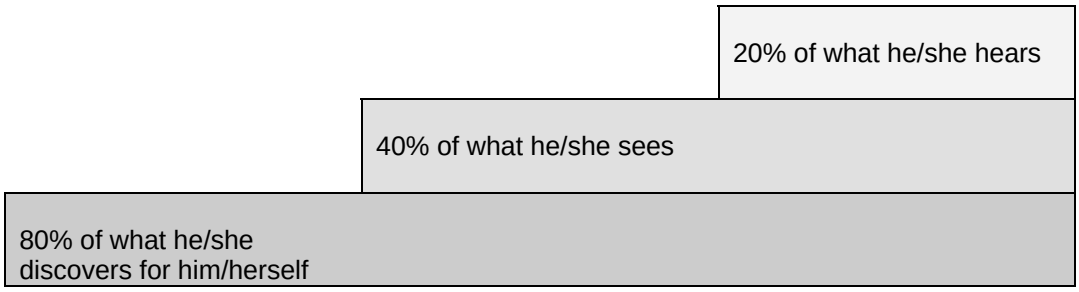
The challenge of training in the era of HIV/AIDS[2]

Across the globe, the HIV/AIDS epidemic is demanding new, creative responses and innovative ways of doing things. To be effective, facilitators and trainers will need to:

- Acquire a comprehensive knowledge of HIV/AIDS and constantly update this.
- Critically confront attitudes and prejudices, in themselves and others.
- Internalise and use terminology that is supportive and not offensive to infected and affected persons, families and communities.
- Develop new skills and embrace alternative methodologies to ensure that participants' learning experiences are optimal.
- Practice discussing sensitive subjects, such as sexuality, different sexual practices, drug use and other risk behaviours.
- Always remember that there will be people in the sessions who are infected and affected and the session must not compromise or threaten them in any way.

An introduction to adult education

A person remembers:



Most adults learn best by being actively involved in the learning process. The following factors are important for learning to take place. The learner must:

- Be motivated, want to learn and feel the need to know.
- Learn in a situation as close to real life as possible.
- Feel safe to admit when they do not understand something, and be able to seek additional teaching, learning and support.
- Receive feedback about the learned behaviour.
- Repeat and practice new skills.
- Receive guidance – so that the minimum number of mistakes is made.
- Be rewarded – praise (positive reward) is more effective than threats or penalties (negative reward).
- Learn to discriminate; when to behave in one way and when in another.

[2] For additional information, trainers and participants are referred to the Ministry of Education, Science and Technology (Kenya); HIV/AIDS education: secondary school teacher's toolkit (undated)

- Unlearn certain behaviours, which are no longer appropriate.

Adult education techniques

Different people learn through different educational strategies; consequently, no single learning methodology should be used in all situations. Techniques that can work well with adults include:

1. Group discussions – This method is useful if group members feel comfortable with one another and individuals are not hesitant to speak. Group discussion exposes the members of the group to the beliefs, values and practices of others.

2. Visual aids – Posters, photographs, pictures, overhead projections, slide presentations and videos can be powerful educational tools. Discussion should always follow the use of such visual aids.

3. Learning aids – Flip charts, fact sheets, handouts, flash cards, wall charts, drawings done by the group or others, diagrams, tables and graphs provide clear and easy access to information. These visual aids can also be used to promote group discussion.

4. Role play and simulation – Participants often find it beneficial to practice new learning by acting in, or observing, a role play or simulated exercise. They are then more able and confident to transfer this learning to their world.

5. Story telling and sharing experiences – People like to hear about the experiences of others, and often find they can relate to these experiences better than trying to grasp facts that seem to have little relevance for themselves. Fictional stories are also helpful in sharing important messages.

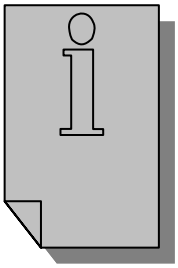
SECTION TWO SETTING THE SCENE

ASSESSING BASIC HIV/AIDS COMPETENCY

Adapted from the IIEP publication: HIV/AIDS and education: a strategic approach

Education for prevention means addressing six issues:

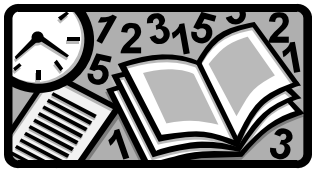
- Understanding the nature of infection;
- Knowing what behaviours to avoid;
- Knowing how to reduce risk;
- Adopting attitudes of respect for human rights;
- Understanding the nature and dynamics of human relationships; and
- Skills development to put into practice understanding and knowledge.



Information for trainers

For the training to be optimal, participants require an understanding of basic HIV/AIDS facts. In addition, it is not simply knowledge that is important, but also the participant's attitudes towards people living with HIV/AIDS (PLWHAs).

The chances are that as participants arrive for training there will be variable competencies in this area. So an assessment is appropriate, with an opportunity thereafter to build on the results to bring all the participants to a common level of understanding.



Training exercises

1. Use the following questionnaire to assess the HIV/AIDS knowledge and attitudes of the participants.
2. After collecting the completed questionnaires, refer the participants to the fact sheets in Appendix One.
3. The consolidated results for the group can be presented and used as an opportunity to fill in the gaps, correct misinformation and reinforce key messages.
4. The model answers are provided below.
5. The second instrument or tool can be used to assess the HIV/AIDS competency of the trainers themselves, as they will need an in-depth knowledge of basic HIV/AIDS information, as well the skills to be able to communicate the facts effectively to others.

MODEL ANSWERS	YES	NO	DON'T KNOW
1. Did AIDS come from the polio vaccine?		X	
2. Can you get infected with HIV from donating blood?		X	
3. Can you get infected with HIV by having oral sex with an infected person?	X		
4. If you have only one sexual partner can you get infected with HIV?	X		
5. Is it safe to share an apple with someone who is HIV positive?	X		
6. Can the HIV test tell when a person was infected?		X	
7. Are all babies born to HIV infected mothers also infected?		X	

8. Is there treatment to prevent you from getting TB if you are HIV positive?	X		
9. Would you eat at your favourite restaurant if you knew that the cook was infected with HIV?	X		
10. Would you be willing to take care of a family member with HIV/AIDS?	X		
11. Should people with HIV/AIDS be allowed to have communion at church?	X		
12. Do you support virginity testing as a way to keep the youth free of HIV?		X	
13. Should people who are HIV positive have sex?	X		
14. Do you believe that the HIV/AIDS epidemic will sort out the world's overpopulation problems?		X	
15. Should infected people be forced to disclose to their families?		X	
16. Would you support AIDS being made a notifiable disease, like TB is?		X	

ANONYMOUS PRE-WORKSHOP QUESTIONNAIRE – WORKSHEET

INSTRUCTIONS

Read each question carefully; then place a cross (X) in the block that corresponds with your answer – "Yes", or "No", or "Don't Know".

	YES	NO	DON'T KNOW
1. Did AIDS come from the polio vaccine?			
2. Can you get infected with HIV from donating blood?			
3. Can you get infected with HIV by having oral sex with an infected person?			
4. If you have only one sexual partner can you get infected with HIV?			
5. Is it safe to share an apple with someone who is HIV positive?			
6. Can the HIV test tell when a person was infected?			
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8. Is there treatment to prevent you from getting TB if you are HIV positive?			
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16. Would you support AIDS being made a notifiable disease, like TB is?			

CHECKLIST – FOR CONDUCTING A TRAINER HIV/AIDS COMPETENCY ASSESSMENT

INSTRUCTIONS

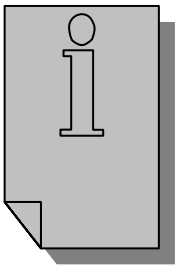
A person with extensive HIV/AIDS knowledge should be nominated to administer the checklist to establish the trainer's strong and weak areas.

Use the results to define and then meet the trainer's capacity building needs. This will ensure that the subsequent training is optimal.

COMPETENCY	QUESTIONS TO ASSESS COMPETENCY	RATING		
		VERY GOOD	AVERAGE	POOR
Basic knowledge of HIV/AIDS and other STIs	What is the different between HIV and AIDS? What is the "window period"? What is the relationship between HIV infection and other STIs?			
In-depth knowledge about selected aspects, like VCT, PMTCT, HAART	What does a voluntary counselling and testing (VCT) programme consist of? What intervention/s is/are available to prevent mother to child transmission of HIV? How does highly active antiretroviral therapy (HAART) prevent the progression of HIV disease?			
In-depth knowledge of legal and human rights issues	What is meant by the right to privacy and bodily integrity? What is the difference between confidentiality and secrecy? What is the difference between stigma and discrimination?			

Ability to talk openly and comfortably about sex, sexuality, relationships and HIV/AIDS and STIs	What words would you use for “penis” and “vagina” when talking to young people about sex? What qualities are important in an educator who is working with young people? What advice would you give parents wishing to talk to their children about sex?			
Attitudes towards PLWHAs, homosexuality, sex work, etc.	Would you share a cigarette/apple with a person living with HIV/AIDS? What do you think about gay couples adopting children? Should sex workers who are HIV infected be allowed to continue working as sex workers?			
Communication skills	How would you explain the effect of HIV on the immune system to a primary school child/fellow colleague? How would you describe how to use a condom to a blind person?			
Counselling skills	How would you define counselling? What are the qualities of a good counsellor? What information should be given to a client during pre-test counselling?			

IMPACT OF HIV/AIDS ON EDUCATION



Information for trainers

It is useful to understand the impact of HIV/AIDS on an education sector in three spheres – the impact on the **demand** for education; on the **supply** of education; and on the **quality** of education[3]. The impact of HIV/AIDS in each of these spheres is summarised below.

1. Demand for education

Because of HIV/AIDS, the size of learner populations will decrease as:

- Many children of school-going age are not enrolled in school.
- Affected children attend school intermittently and more children drop out of school – as a result of competing demands on their time, cost constraints, or parental loss.
- Birth-rates (of HIV infected women) drop and more children (who are themselves infected) die in infancy.

2. Supply of education

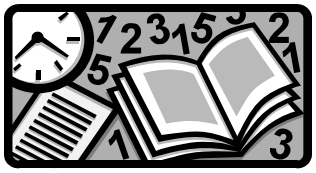
Because of HIV/AIDS, optimal teaching contact time will change negatively as:

- Shortages of qualified educators escalate and the numbers of students coming into and staying in the system drop (because they are infected).
- Educator absenteeism increases – due to illness or care-related commitments at home.
- Educator attrition and mortality increase – as those who are infected die of AIDS or leave the profession, while others move to areas of employment that offer better remuneration.

3. Quality of education

Because of HIV/AIDS, the quality of education will suffer as:

- Skills, especially specialist skills, are lost and there is increased reliance on less qualified educators.
- Resources are diverted from education to cover increased health and other benefit costs, recruitment and related replacement costs, etc.
- Morale – amongst learners, educators and other staff – is affected and trauma and stress levels escalate.
- Management at systemic and institutional level is compromised.



Training exercise

1. Materials: butcher's paper, felt tipped pens, scenario handout.

2. Divide the participants into four groups.

3. Hand out butcher's paper to each group, with a couple of coloured felt tipped pens.

[3] PPT presentations on the impact of the HIV/AIDS epidemic on education are available on the MTT website – www.mttaids.com

4. Instruct the groups to create a time line on their paper with three points on it:

   - When the person is infected;
   - When the person becomes symptomatic; and
   - When the person dies or leaves the education system.

5. Then allocate one of the following scenarios to each group. You can do this by making a copy and cutting out one scenario for each group of participants.

IMPACT OF HIV/AIDS ON EDUCATION – GROUP WORK

Scenario #1
A female primary school teacher, who became infected during her last year at teacher training college.

Scenario #2
A secondary school mathematics teacher, who is HIV infected and who works far away from his home and family.

Scenario #3
A school inspector, who is HIV infected, who is a married woman and whose husband and last-born child are also infected.

Scenario #4
A learner, boy or girl, at a secondary boarding school, who is infected.

6. Instruct the groups to discuss and record on their time lines or graph the situations that will commonly arise at each point, focusing not only on the person in their case study, but also on those that he/she routinely interacts with – colleagues, friends, family, etc.

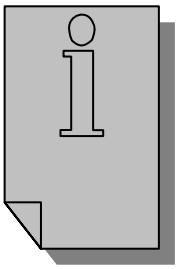
   NOTE: An important point to bear in mind is that the scenarios that the groups develop may change with the availability of antiretroviral (ARV) treatment. Perhaps the exercise can be extended to develop alternative scenarios where the persons concerned access treatment.

7. Put up the group's butcher papers around the room. Have one person per group remain at the group's report. Instruct the other participants, in their groups, to move around, to the other three group stations, one station at a time. At each station, that group's representative will explain to them their scenario and time line.

LEGAL AND POLICY FRAMEWORK

Extract from UNAIDS publication; "Accelerating action against AIDS in Africa" (2003)

Good quality education is a powerful weapon against HIV/AIDS. Yet, across sub-Saharan Africa, only 57% of children are enrolled in primary school. The added impact of the HIV/AIDS epidemic on the education system is undermining the fundamental right of every child to education, increasing the number of HIV/AIDS-related school drop-outs and raising young people's vulnerability to HIV infection. In high prevalence countries, substantial numbers of teachers are ill, dying, or caring for sick family members. Management of the education system is also threatened by illness and death of qualified persons.



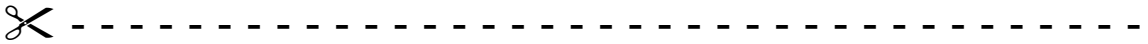
Information for trainers

Any policy implementation must take place in accordance with the framework defined by international and national legal and policy instruments.

In respect of an **education sector policy on HIV and AIDS**, the framework that applies relates to provisions that are contained in legal and policy instruments that focus on:

- Children and youth;
- Education;
- Gender;
- HIV/AIDS; and
- The workplace.

The main ones are listed below, with relevant extracts or examples.



LEGAL AND POLICY FRAMEWORK – HANDOUT

1. International conventions and agreements

1.1 The United Nations Convention on the Rights of the Child (UN CRC) (1989)

The four principles of the CRC, namely:
- Non-discrimination;
- The best interests of the child;
- The right to life, survival and development; and
- Respect for the rights of the child

are given effect in terms of children's education rights as the right to at least free and compulsory primary education; and the right to leisure and play and to participate in cultural and artistic activities.

1.2 The Millennium Development Goals (MDG) (2000)

These goals form the basis for a global development plan with the broad aim of halving the number of people living in absolute poverty by the year 2015. Specific to education and HIV/AIDS are the following goals:

- MDG # 2: Achieve universal primary education
  Target for 2015: Ensure that all boys and girls complete primary school.
- MDG # 3: Promote gender equality and empower women
  Targets for 2005 and 2015: Eliminate gender disparities in primary and secondary education preferably by 2005, and at all levels by 2015.
- MDG # 6: Combat HIV/AIDS, malaria and other diseases
  Target for 2015: Halt and begin to reverse the spread of HIV/AIDS and the incidence of malaria and other major diseases.

1.3 Education For All (EFA) (2000)

This initiative aims to ensure that by 2015 all children, particularly girls, children in difficult circumstances and those belonging to ethnic minorities, have access to and complete free and compulsory education of good quality. Specifically within the Dakar Framework is a commitment to ensuring that *the learning needs of all young people and adults are met through equitable access to appropriate learning and life skills programmes.*

Education For All goals

- Expanding and improving comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children.
- Ensuring that by 2015 all children, particularly girls, children in difficult circumstances and those belonging to ethnic minorities, have access to and complete free and compulsory education of good quality.
- Ensuring that the learning needs of all young children and adults are met through equitable access to appropriate learning and life skills.
- Achieving a 50 per cent improvement in levels of adult literacy by 2015, especially for women, an equitable access to basic and continuing education for all adults.
- Eliminating gender disparities in primary and secondary education by 2005, and achieving gender equality in education by 2015 with focus on ensuring girls' full and equal access to and achievement in basic education of good quality.
- Improving every aspect of the quality of education, and ensuring their excellence so that recognized and measurable learning outcomes are achieved by all, especially in literacy, numeracy and essential life skills.

1.4 United Nations General Assembly Special Session on HIV/AIDS (UNGASS) (2001)

This meeting secured a global commitment to address the HIV/AIDS epidemic. Relevant goals include:

- UNGASS # 2: Prevention
  Target: By 2005, reduce HIV prevalence amongst young men and women aged 15-24 by 25% in most affected countries, and by 25% globally by 2010.
- UNGASS # 6: Children orphaned and made vulnerable by HIV/AIDS
  Target: By 2003 develop and by 2005, implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS including by providing appropriate counselling and psycho-social support, ensuring their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children; and

protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance.

1.5 Convention on the elimination of all forms of discrimination against women (CEDAW) (1979)

The convention, which is often described as an international bill of rights for women (and girls), defines what constitutes discrimination against women and girls. It sets an agenda for National action to end such discrimination. Signatories are required to:

- Incorporate the principle of equality of men and women in their legal system, abolish all discriminatory laws and adopt appropriate ones prohibiting discrimination against women;
- Establish tribunals and other public institutions to ensure the effective protection of women against discrimination; and
- Ensure elimination of all acts of discrimination against women by persons, organisations or enterprises.

1.6 International Labour Organisation (ILO); Code of practice on HIV/AIDS and the world of work (2001)

The Code provides guidance to Governments, employers and workers, as well as other stakeholders, on National action plans and workplace policies and programmes to combat HIV/AIDS. It sets out 10 key principles that provide the basis for workplace policy and interventions – principles such as non-discrimination, no HIV screening, confidentiality, and the continuation of the employment relationship.

1.7 Significant African events

At the African Summit on HIV/AIDS, Tuberculosis and other related infectious diseases in Abuja, Nigeria (April 2001), African Heads of State agreed to devote 15% of all National budgets to spending on health including HIV/AIDS campaigns.

And, at the Elmina Conference on HIV/AIDS and Education (March 2001), strategies for Government, educational institutions and civil society agencies in the Economic Community of West African States (ECOWAS) were identified.

2. National laws and policies

2.1 On education

- Constitutions and Bills of Rights typically contain a range of rights and protections for citizens such as the:
  - Right to life
  - Right to bodily integrity and security of person
  - Right to privacy
  - Right to the benefits of scientific progress
  - Right to seek, receive and impart information
  - Right to education
  - Right to health
  - Right to work and to fair labour practices
  - Non-discrimination

- Education Acts provide substance to the right to education. They detail issues related to access, admission and attendance, non-discrimination, language and religious policy, fees versus free education (such as universal primary education or

UPE), education for learners with special needs, school governance and disciplinary measures.

- In some countries, Teacher Service Commission (TSC) legislation, codes and regulations focus on the working conditions of educators.

2.2 On HIV/AIDS

- National HIV/AIDS strategic and implementation plans define the priorities for the National response, as well as for sectoral responses.

- Sectoral policies and plans, in turn, detail sectoral commitments, within their respective areas of comparative advantage, but also within the National framework.

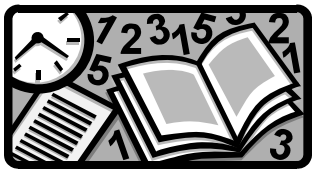
2.3 On children

- Children's Acts or statutes define a child, an orphan and frequently also a child in need of special protection. They also contain provisions on children's rights and protections.

- National policies (and guidelines) on orphans and other children made vulnerable by HIV/AIDS and other causes (OVC) seek to strengthen responses at all levels and to reduce OVC vulnerability. For example, through enrolling and retaining OVC in educational institutions by mobilising resources for tuition fee waivers, accessible bursary facilities, educational supplies, feeding programmes, etc.

2.4 On the workplace

- Labour laws and codes provide for basic conditions of employment, health and safety, workers' compensation, equity and non-discrimination, and disciplinary and dismissal procedures.



Training exercise

1. Materials: butcher's paper, felt tipped pens, legal and policy handout.

2. Brainstorm in plenary, and record on butcher's paper, all of the:

- International; and
- National legal and policy instruments that collectively constitute the framework for implementation of your country's ***education sector policy on HIV and AIDS***.

3. Fill in the gaps, from the notes provided above. These can be given to the participants as a handout, if necessary.

4. Then divide the participants into four groups and allocate one of the following themes to each group:

- Children and youth
- Education
- Gender
- The workplace

5. Focusing on their theme, instruct the groups to discuss and develop arguments in response to the following statement (which can be written up on butcher's paper):

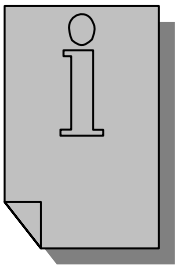
   Why should universally recognised human rights standards guide policy-makers in formulating the direction and content of HIV and AIDS policy development and implementation?

6. Have a rapporteur from each group report back to the plenary and record the main points on butcher's paper. Keep this to refer to in the next session on **Policy Principles**.

POLICY PRINCIPLES

In the longer term, it will be community development and wealth creation, literacy programmes, promotion of equality between men and women, and the protection of human rights which will address the underlying conditions and consequences (of the epidemic).

Nelson Mandela



Information for trainers

Principles are an important part of any policy. Stating the principles describes the ethos of the education sector on HIV/AIDS-related issues, sets the parameters of the policy and guides its implementation.

Bear in mind that the principles apply to the entire education sector, which usually includes learners, educators, employees, managers, employers and other providers of education and training in all public and private, formal and non-formal learning institutions at all levels of the education system.

POLICY PRINCIPLES – HANDOUT

Extract from Republic of Kenya's *education sector policy on HIV and AIDS*

The principles that guide this policy are in accordance with international conventions, national laws, policies, guidelines and regulations. In particular, the principles take into consideration gender issues, learners with special needs and recognise the universality of human rights.

These principles are:

Access to education
Every person has the right to education. No learner will be denied access to education on the basis of his or her actual or perceived HIV status. In particular, access to education will be facilitated for orphans and vulnerable learners.

Access to information
Every person has the right to relevant and factual HIV and AIDS information, knowledge and skills that are appropriate to their age, gender, culture, language and context.

Equality
Every person has the same rights, opportunities and responsibilities and will be protected from all forms of discrimination, including discrimination based on actual, known or perceived HIV status.

Privacy and confidentiality
Every person has the right to privacy and confidentiality regarding their health, including information related to their HIV status.

No institution or workplace is permitted to require a learner or employee to undergo an HIV test.

No person may disclose information relating to the HIV status of another person, without his or her consent. In the case of a minor the best interest of the child shall guide decisions concerning disclosure.

Every person has a moral responsibility to protect themselves and others from HIV infection.

Every person has the right to know their HIV status and openness and disclosure are encouraged within a safe, supportive and accepting environment.

Access to care, treatment and support
All infected and affected learners, educators and other personnel in the education sector have the right to access holistic care, treatment and support in line with available resources. The education sector will work in partnership with agencies offering support and care including institutions, communities and private and public health care systems.

Safety in workplace and learning institutions
All workplace and learning institutions have a responsibility to minimise the risk of HIV transmission by taking the appropriate first aid and universal infection control precautions.

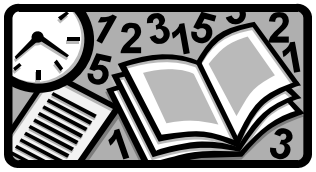
Safe workplace and learning institutions
There will be zero tolerance for sexual harassment, abuse and exploitation.

Fair labour practices
Every person, whether infected or affected, has the right to fair labour practices in terms of recruitment, appointment and continued enjoyment of employment, promotion, training and benefits. HIV testing as a requirement for any of the above is prohibited.

Gender responsiveness
HIV and AIDS affect and impact on women and men differently due to their biological, socio-cultural and economic circumstances. Application of all aspects of this policy should be responsive to the different needs of men and women, boys and girls.

Involvement of people living with AIDS (PLWHA)
The involvement of PLWHA to educate and inform will be promoted at all levels of the education sector.

Partnerships
While the education sector will be responsible and accountable for implementation of this policy it will at all times seek to develop effective partnerships to enhance the success of its implementation.



Training exercise

1. Materials: computer and projector for Kenya example PPT or handout and case study handout.

2. The Kenya example (above) can be projected as a power point presentation (PPT) or copied and given to participants as a handout. It can be replaced, if desired, by the policy principles from the specific country's ***education sector policy on HIV and AIDS***.

3. Ask individual participants to read aloud one principle at a time from the Kenya example and then to give their opinion on whether the principle is, or is not, in line with the international and National laws and policies discussed in the previous session. They can make reference to the notes recorded on the butcher's papers if necessary. Continue until all the principles have been read. Most, if not all, should affirm that the principles are, in fact, consistent with international and National laws and policies.

4. Then hand out the following case studies from the workplace and from school. You can do this by making a copy and cutting out one case study for each group of participants.

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POLICY PRINCIPLES – GROUP WORK

Case study #1
Some people suggested we test everyone and put them into separate vehicles when we travel so that if there is an accident the "innocent negative" staff won't be put at risk.

Case study #2
Thabang faced a lot of complications. After his father died, I told his teacher that I was HIV positive. All the teachers at the school said, *"Don't touch this child, his mother has AIDS".*

Case study #3
A few months after I tested HIV positive I tried to inform one of my colleagues. After a couple of months, it spread all over the office and I decided to leave.

Case study #4
Sometimes they'll chase us back home if we don't have exercises (books). Then we try our luck again at school, maybe today they don't want what you don't have and you stay at school and go home with all the other children.

5. Instruct the groups to identify which principle or principles are compromised in their case study and what can be done (a) to prevent such situations from occurring and (b) to respond appropriately, if they do occur.

6. Each group should report back to the plenary by providing a summary of their discussions.

A "GOLDSTAR" (Illustrative) RESPONSE

Information for trainers

Describing an optimal or illustrative education sector response to HIV/AIDS can be useful to develop the participants' understandings of what is possible, before they tackle the four themes in the policy. This is referred to as a "Goldstar" response, but this name can be changed to be locally relevant.

The "Goldstar" education sector HIV/AIDS response consists of ten components, which are listed below, with a brief explanation of each. This session can be presented as a power point (PPT)[4], followed by the exercise suggested below.

"GOLDSTAR" (Illustrative) RESPONSE – HANDOUT

1. HIV/AIDS structures established and functional

   At the National level the following structures exist:

   - A senior Strategic HIV/AIDS Task Team, with representation from all key role players and with well-defined functions (policy, norms and standards, resource mobilisation).
   - An Operational HIV/AIDS Management Unit, headed by a senior official (dedicated position), plus representatives from policy and planning, curriculum development, finance, etc. (with the mandate to develop, implement and monitor internal and external responses).

   At the District level there are HIV/AIDS sub-committees of District Management Committees, chaired by District Managers (with co-ordination, communication, regulatory, resourcing, information gathering and monitoring functions).

   At school level there are HIV/AIDS Working Groups, with the mandate to deal with all institution level external and internal HIV/AIDS-related matters.

2. Enabling legal and policy framework in place

   - A National Schools Act has been promulgated which regulates schools in terms of admissions, fees, etc. and provides for exemption from school fees for children from poor families;
   - A policy for the education sector has been adopted that binds the sector, and all institutions and role players, to a common vision, a set of principles, minimum standards and commitments related to HIV/AIDS;
   - A generic workplace policy was developed in consultation with the unions, and other role players; in line with public sector conditions of service. It is binding on all institutions; and
   - Institutional level policies have been developed by each school, in line with other policies, and defining the school's position on HIV/AIDS.
   - The National Policy Unit has conducted a review of all laws, regulations, policies, procedures, codes of conduct and collective agreements (current and planned) to

[4] The PPT is available on the MTT website at www.mttaids.com

ensure that HIV/AIDS is appropriately addressed (e.g. non-discrimination, confidentiality, zero tolerance for sexual abuse, etc.); and
- Implications and amendments have been communicated to Districts and to all institutions.

3. HIV/AIDS mainstreamed into all planning and budgeting

- At National level, as part of routine planning activities, an HIV/AIDS plan/strategy for the sector – narrative and financial – has been developed, linked to the policy, to education management information system (EMIS) data and to the budget. The plan is reviewed annually; and
- Sector-wide HIV/AIDS indicators have been developed, field tested and institutionalised.
- EMIS data and processes have been reviewed and amended to include HIV/AIDS sensitive indicators – including, but not limited to:
    - Pupil enrolment (disaggregated by gender);
    - Planning for school and District staff supply and attrition;
    - Learner/educator ratios;
    - Decline in school fees;
    - Primary/secondary transition rates;
    - Matriculation rates; and
    - Specialist subject pass rates.
- Orientation training for officials responsible for EMIS has been conducted.
- Resource mobilisation has taken place, with costed plans being presented to development partners at an annual resource mobilisation summit; and
- A proposal for support for 100 rural primary schools (youth prevention activities and OVC support) was submitted to the Global Fund (and approved).
- A base-line impact assessment was commissioned and conducted; a validation workshop was held, and the executive summary was disseminated widely for use as an advocacy and reference document.
- There is a commitment to repeat the impact assessment at 5-yearly intervals.
- At District level, an HIV/AIDS action plan/strategy for the District has been developed – based on District level information, National policy, budget, etc. – and disseminated to all schools.
- At each school, DEMMIS (District education management and monitoring information system) is in place, monthly reports are received from schools, and feedback processes are functional; and
- Training has been conducted for all District and school level staff involved.
- HIV/AIDS is included in every school plan.

4. HIV/AIDS mainstreamed into all human resource management functions

- HR policies have been examined and amended to minimise vulnerability and susceptibility to HIV/AIDS (e.g. policies that permit the deployment of educators away from their families). In addition, they have been examined and amended to pro-actively address educator attrition (e.g. by amendments that allow educators to continue teaching beyond normal retirement age).
- Succession planning is in place, based upon a review of demand and supply, and with special emphasis on specialist educators.
- HR data (e.g. EMIS data) have been analysed and used to establish an human resources (HR) preparedness system; and
- Orientation sessions have been held for the staff responsible for the HR preparedness system.
- HIV/AIDS and education guidelines for (i) education sector managers and (ii)

educators have been developed, field tested, and distributed.
- A code of conduct has been adopted and signed by all educators committing them to zero tolerance for violence, abuse – sexual and other – and harassment of learners);
- The code is displayed in every school; and
- Information on disciplinary procedures has been disseminated to all staff.
- A system has been established and implemented to track education quality, with an early warning system and systems to implement remedial procedures.

5. Workplace HIV/AIDS programme developed, implemented and monitored

- Conditions of service have been reviewed and amended to accommodate HIV/AIDS (e.g. reasonable accommodation for infected staff, time off for family duties, etc.). The revised conditions of service have been disseminated to every staff member.

At National level the following programme takes place:

- An awareness programme for National staff (that is sensitive to language, culture, age, gender, etc.);
- A peer education programme with on-going sessions that are held during working hours;
- An HIV/AIDS counselling service, which is available as part of the Employee Assistance Programme (EAP);
- Referrals for staff for (i) VCT, (ii) treatment and (iii) social support; and
- An infection control programme, based on guidelines (including guidelines for compensation for HIV infection following occupational exposure). The guidelines have been disseminated, first aiders have been trained, resources (e.g. gloves) have been purchased and distributed, and a reporting system has been established.

Similarly, at District level, there are programmes of:

- Awareness for district staff (that are sensitive to language, culture, age, gender, etc.);
- Peer education with on-going sessions held during working hours;
- HIV/AIDS counselling for infected and affected staff;
- Referrals for (i) VCT, (ii) treatment and (iii) social support; and
- Infection control.

This is replicated at school level, with programmes of:

- Prevention for all staff (managers, educators and support staff), conducted during working hours;
- Referrals for (i) VCT and on-going counselling, (ii) treatment and (iii) social support; and
- Infection control.

6. HIV/AIDS mainstreamed into life orientation and other curricula

At the National level:

- The curriculum policy has been amended to include HIV/AIDS within the life skills module of the life orientation curriculum, as well as, as a component of all other subjects.
- Teaching materials have been reviewed and amended for (i) different levels (primary, secondary and tertiary), (ii) local use and (ii) to conform to outcomes-based methodologies.

At District level:

- Resource centres have been established; and
- Information and materials are disseminated to support implementation.

- Mentoring and monitoring systems have been established to ensure compliance with the curriculum.

At school level:

- Life skills and HIV/AIDS lessons are held as per timetable; and
- HIV/AIDS-focused lessons are conducted in all subjects.
- Youth peer educators have been recruited and trained and are supported to conduct group activities.
- Systems have been established to monitor the life skills and HIV/AIDS programme.

7. Holistic support for infected and affected staff and learners

- A system has been developed, implemented and is regularly monitored for the identification, support and monitoring of OVC.
- The school feeding scheme provides one meal per day to all learners at primary school level.
- Educators have attended briefing sessions on the signs, symptoms and management of HIV disease in young people.
- Special arrangements are in place for infected and affected children (e.g. provision to supervise medication, home learning for infected learners, shorter hours for children caring for parents and/or siblings, etc.); and
- A counselling service has been established for crisis counselling, bereavement counselling, etc.
- For infected and affected educators, systems are in place to provide care and support for educators – such as reasonable accommodation.
- A resource directory for local referrals has been developed and disseminated.

8. Training and capacity building to meet the challenge of HIV/AIDS

At pre-service level:

- In line with the predicted demand for additional educators, the annual quota of educator trainees admitted to training institutions has been increased; and
- Specialist educators have been trained, in line with National demands for these skills.

At in-service level:

- Life orientation educators have been trained in HIV/AIDS;
- Selected educators have been trained as counsellors; and
- A system of mentoring and support for educators and counsellors has been institutionalised.

To support all the training and capacity building activities:

- A database of resources has been developed and disseminated; and
- Resources and materials have been commissioned or developed to fill the identified gaps.

9. Partnerships to enhance HIV/AIDS responses

At national level:

- A database of National partners has been established;
- An education sector mobilisation strategy has been defined and implemented; and
- HIV/AIDS is prominent in the bi-annual education conference.

At district level:

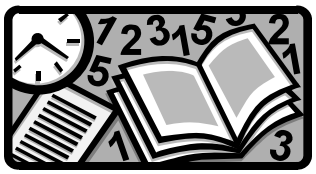
- A database of district partners has been established;
- Roles, responsibilities and commitments have been defined; and
- Consultations are regularly held with these partners.

At school level:

- Orientation sessions on life skills and HIV/AIDS have been held for parents; and
- Briefing sessions on HIV/AIDS for PTAs and School Governing Boards (SGBs) are conducted on a routine basis.

10. Research guided programmes

- A research agenda has been defined, based on the research already conducted and the gaps that have been identified; and
- Studies have been commissioned to answer priority questions.



Training exercise

1. Materials: computer and projector for "Goldstar" presentation; handouts x 2:
   - A copy for each participant of the "Goldstar" response; and
   - One for the group work on the "Goldstar" response areas.

2. Present the "Goldstar" response as a PowerPoint.

3. Divide the group into 10 small groups and allocate to each group one of the "Goldstar" response areas. You can do this by making a copy and cutting out one response area for each group of participants. It may also be useful to provide each group with a handout of the "Goldstar" presentation, as a reference.

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"GOLDSTAR" RESPONSE – SMALL GROUP WORK

1. HIV/AIDS structures established and functional	2. Enabling legal and policy framework in place

3. HIV/AIDS mainstreamed into all planning and budgeting	4. HIV/AIDS mainstreamed into all human resource management functions
5. Workplace HIV/AIDS programme developed, implemented and monitored	6. HIV/AIDS mainstreamed into life orientation and other curricula
7. Holistic support for infected and affected staff and pupils	8. Training and capacity building to meet the challenge of HIV/AIDS
9. Partnerships to enhance HIV/AIDS responses	10. Research guided programmes

4. Instruct the groups to discuss their particular response area and decide how well, or poorly, their Ministry, education unit, Department or institution compares with the "Goldstar" response.

5. They must then allocate a percentage to their response area and prepare a motivation for why they have scored it as they have. Guidance in doing this is as follows:

   - 0-33% Long way to go
   - 33-66% More-or-less average
   - 66-100% Doing well

6. Then get the groups, one by one, to paste/stick their card at the appropriate point along a continuum that has been created (e.g. on a wall of the venue) from 0% to 100%. As this is done, the group spokesperson motivates the score allocated to their response area, highlighting the strengths and weaknesses of the education sector's current response.

7. Then facilitate a plenary discussion on what the composite display indicates in terms of strengths and weaknesses, to allow everyone to "own" the collective "picture" of the education sector response.

8. Finally, in plenary, summarise the discussions that have taken place in accordance with the four policy themes – which are the areas of greatest strength or weakness:

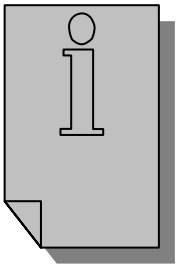
   - Prevention;
   - Care and support;
   - HIV and AIDS and the workplace; and
   - Management of the response.

SECTION THREE POLICY THEMES

PREVENTION

Extract from the "World declaration on the survival, protection and development of children" (30 September 1990)

The children of the world are innocent, vulnerable and dependent. They are also curious, active and full of hope. Their time should be one of joy and peace, of playing, learning and growing. Their future should be shaped in harmony and co-operation. Their lives should mature, as they broaden their perspectives and gain new experiences.



Information for trainers

Prevention is the core of the education sector's HIV and AIDS responsibility. It can take many forms, such as life skills, peer education and the integration of HIV and AIDS into all aspects of the curriculum, complemented by appropriate learning and teaching support materials (LTSM).

The goal is to provide learners with the knowledge and skills to protect them from HIV infection, within a safe learning environment. The emphasis in this theme area is on **learners**.

Typically this goal is achieved through interventions in four main areas:

- Education on HIV and AIDS:
  - For learners – life skills, living values and HIV education curriculum development, procurement of appropriate learning and teaching support materials and mainstreaming HIV and AIDS into existing curricula and co-curricular activities.
- Access to information on HIV and AIDS:
  - Provision of materials and programmes for all in the sector – where appropriate in partnership with relevant organisations or sectors (like the sports sector, or religious organisations).
- Peer education:
  - Development of peer education and guidance skills; and implementation, with relevant partners, of peer education programmes.
- Safe learning and teaching environment:
  - Universal infection control precautions – to minimise any risk of HIV transmission in the learning or teaching environment.

Notes on key prevention issues

1. Life skills and HIV/AIDS education

1.1 Life skills refer to a group of psychosocial and interpersonal skills which assist a person to make informed decisions, to communicate effectively and to develop coping and self-management strategies to help them lead a healthy and productive life[5].

[5] UNICEF; Life skills with a focus on HIV/AIDS (2002)

1.2 The importance of life skills education in the prevention of HIV infection in children and young people cannot be overemphasised. Life skills develop skills for decision making, communication, negotiation, critical thinking, stress management and conflict resolution. Life skills build self-esteem and confidence and help boys and girls learn how to relate to each other.

1.3 It is appropriate to include HIV/AIDS into a broad-based life skills programme for learners, whereas for adults it is possible to provide HIV/AIDS information and education in isolation.

2. Peer education

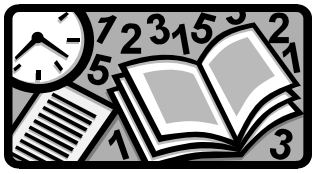
2.1 Peer education, in its broadest sense, refers to training select members of any group of equals, (school, office, church, etc.) to effect positive behaviour change among members of that same group. Peer education is a means whereby the effectiveness of a single trained educator can be multiplied.

2.2 In general, peer education is based on behavioural theory which asserts that people make changes not because of scientific evidence or testimony but because of the subjective judgement of close, trusted peers who have adopted changes and who act as persuasive role models for change.

3. School-based HIV and AIDS programmes

School HIV and AIDS programmes should:

- Be interactive and learner-centred;
- aimed at life, not death;
- Minimise fear and eliminate discrimination;
- Provide accurate and frank information;
- Support abstinence as a positive choice;
- Take place both in schools and in recreational activities;
- Be developmentally appropriate for the targeted age group;
- Use multiple channels to convey consistent messages and employ a variety of teaching strategies; and
- Utilise the creativity of learners.



Training exercise

1. Materials: butcher's paper and felt tipped pens or blank overhead (OH) transparency film and overhead transparency pens.

2. Allocate one of the following situations to each group:

- A national/provincial/regional[6] curriculum unit or special subjects unit
- A district with primary and secondary schools
- A non-formal learning institution
- A higher education institution, such as a teacher training college

3. Instruct the groups to create an HIV and AIDS prevention implementation plan for learners that is based on their country's ***education sector policy on HIV and AIDS*** for

[6] Select the level which is most appropriate for the participants

their allocated situation. They should firstly define the objectives and then the strategies to achieve each objective.

To assist the participants, provide them with a handout of the four examples below, as well as any relevant extract from the current education sector strategic plan (where this exists).

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PREVENTION – HANDOUT

EXAMPLE #1

OBJECTIVES	STRATEGIES
HIV and AIDS life skills integrated into and across the curriculum	Identify and then train educators to cover all learning institutions Establish a mentoring and updating programme for existing and then new trained educators Conduct orientation sessions and workshops at all levels for stakeholders on the life skills programme Promote a safe and healthy learning environment free of the risk of HIV infection for all learners Set up systems to track and manage the life skills programme at Provincial, District and school level Identify, document and distribute lessons learned and best practices in the programme
Learning and teaching support materials (LTSM) for life skills that are age, learner and language appropriate	Build capacity to develop local and context appropriate LTSM Mainstream the procurement and distribution of HIV/AIDS-related LTSM into the Ministry LTSM processes Develop support materials for all stakeholder groups
Safe learning environment	Ensure that educators and learners in every school are trained in the use of first aid kits (universal infection control precautions) Maintain a clean and hygienic environment Maintain stocked first aids kits in every school and learning institution Take appropriate measures to ensure the safety of learners Strengthen systems to monitor and evaluate this programme annually and take remedial action, as appropriate
Enhanced parenting skills for HIV and AIDS prevention	Facilitate, with relevant partners, information sessions for all parents and care givers Identify, adapt and procure relevant support materials Establish a mechanism for on-going information dissemination and

	support to parents and care givers
Functional peer education programmes in all secondary schools	Identify and train peer educators to ensure complete coverage (e.g. 10 learners per secondary school) Establish peer support teams (at school and District levels) Implement school-based programmes of peer activities Identify and train Master Trainers and maintain a core training team Establish a mentoring programme to maintain and monitor the quality of the Master Trainers' training
School-based HIV and AIDS activities	Collaborate with organisations and agencies conducting HIV and AIDS activities Establish and observe HIV and AIDS calendar days at all schools Encourage and support schools to initiate their own HIV and AIDS activities (prevention and care and support) Where this applies, support initiatives for safe cultural practices (such as circumcision practices) – in partnership with relevant stakeholders
Referral systems for prevention services for learners (VCT, PMTCT, STI management, etc.)	Establish partnerships to facilitate access to youth-friendly services for prevention, care and support – where applicable

EXAMPLE #2

Extract from Kenya's MoEST: Education sector strategic plan (2003-2007)

Objective/output 39: Effective strategies for behaviour change in learning institutions developed

Strategies/activities:

- Carry out survey on factors that inhibit behaviour change.
- Targeted dissemination and sensitisation on survey findings.
- Draw guidelines on voluntary HIV testing before admission in learning institutions starting from secondary levels.
- Promote life skills education in schools.
- Promote education and health clubs – education for HIV/AIDS advocacy and prevention in education institutions.

EXAMPLE #3

Extract from Kenya's MoEST; Education sector HIV and AIDS policy implementation plan (2004-2007) (draft)	
OBJECTIVES	**STRATEGIES**
To create an enabling environment in which managers and relevant stakeholders take an active role in preventing HIV infection amongst learners	Organise and conduct a package of education and training workshops for students, learners, peer educators, educators, managers and other education sector partners, at National, Provincial, District and institutional level, on the HIV and AIDS prevention strategy; care and support skills (especially for educators responsible for OVC); prevention of abuse, stigma and discrimination; and community networking
To put in place appropriate systems, structures and methodologies for the HIV and AIDS prevention strategy, including the life skills and living values programmes	Develop and strengthen the means to provide accurate and relevant information on the HIV and AIDS prevention strategy, including the life skills and living values programmes Strengthen linkages with relevant Ministries and other partners Mobilise funds to develop, strengthen and implement the HIV and AIDS prevention curriculum across all levels of education
To protect learners from stigma and discrimination, sexual harassment, abuse, exploitation or assault	Strengthen and/or develop appropriate curricula on HIV and AIDS prevention, life skills and living values (incl. developing guidelines and programmes to increase flexibility of learning process); and build capacity to mainstream and implement HIV and AIDS curricula Strengthen and/or develop appropriate learning, teaching and IEC materials at all levels Distribute relevant HIV and AIDS curriculum materials at all levels Establish and support peer education, through partnerships, at all levels Strengthen and support HIV and AIDS co-curricular activities across all levels (athletics, drama, music and ball game competitions) Develop and implement a strategy for on-going mobilisation of resources and activities, within institutions and communities

EXAMPLE #4

Extract from Republic of Uganda's *education sector policy on HIV and AIDS*

Goal:

An environment in which all persons within the sector are safe from HIV infection.

The core prevention interventions shall include, but not be limited to the following:

Provision of current, accurate, complete, appropriate and scientifically factual information to all persons presented in a manner that does not alienate any category of persons and that serves the purpose of reducing the risk of HIV infection.

Mainstreaming and integrating HIV/AIDS and life skills education into curricula of formal and non-formal education and training programmes at all levels.

4. Allow each group, in turn, to report back to the plenary, describing their implementation plan. At the end of each report, ask the plenary two questions:

   - Is the plan in line with your country's ***education sector policy on HIV and AIDS*** – if yes, why; and if no, why?
   - What barriers might be experienced in implementing the plan?

5. Finally, select three or four barriers and discuss and record, on butcher's paper, possible solutions to these barriers.

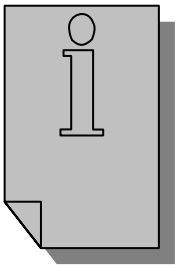
CARE AND SUPPORT

Extract from the UNGASS Declaration of Commitment (June 2001)

Nations must:

65. By 2003, develop and by 2005 implement National policies and strategies to build and strengthen Governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS including by providing appropriate counselling and psycho-social support, ensuring their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;

66. Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of destigmatisation of children orphaned and made vulnerable by HIV/AIDS;



Information for trainers

The focus for care and support has increasingly been on the needs of **affected** learners, such as orphans and vulnerable children or learners (OVC) and learners with special needs. Their numbers and vulnerability necessitate special efforts to ensure their access to education, counselling and psychosocial support, nutritional support, protection from the dire effects of poverty – particularly on child-headed households – access to social support and protection from stigma, abuse and exploitation.

For **infected** learners, treatment, care and support needs must be catered for, with due regard to the fact that this is primarily the responsibility of the health sector.

The overall **care and support** goal in the ***education sector policy on HIV and AIDS*** may be to ensure that care and support is available for all, particularly orphans and vulnerable children and those with special needs.

Extract from Republic of Rwanda's *education sector policy on HIV and AIDS*

S1. Provide counselling and care for learners and educators including psychosocial support.

S2. Improve nutritional, health, and medical services for orphans and other vulnerable children, young people and educators infected and affected by HIV/AIDS.

S3. Improve liaison among professionals in the social sector (educators, social workers and health workers) to help both educators and learners.

Notes on key care and support issues

1. Orphans and vulnerable children[7]

1.1 All children are affected by HIV/AIDS, but particularly children:

- Who live in a household in which someone has advanced HIV disease (sometimes referred to as "full-blown AIDS");
- Who are maternal, paternal or double orphans; and
- Who are co-resident with orphans – living with orphans – although they may not themselves be orphans.

1.2 The risks associated with orphanhood are many and include:

- Poverty;
- Lack of supervision and care;
- Mal/undernourishment, stunting and hunger;
- Educational failure;
- Lack of adequate medical care;
- Psychological problems;
- Disruption of normal childhood and adolescence;
- Exploitation;
- Early marriage;
- Discrimination;
- Poor housing;
- Child labour; and
- Sex for survival.

2. Stigma and discrimination

Children may experience stigma related to their own HIV infection or because they are from an HIV/AIDS affected household. The latter is very common, known as secondary stigmatisation, or stigma by association. These children may:

- Be perceived as "innocent victims";
- Be neglected/abused by their new "parents";
- Grow up without trust and love;
- Become street kids;
- Become introverted, or experience difficulty handling grief;
- Experience depression, or loss of hope and loss of any "sense of future";
- Be isolated by friends; or
- Effectively lose their childhood, as they are forced to accept adult responsibilities.

3. Psychosocial support

3.1 Within the broader context of counselling on career guidance, there is an acknowledgement that guidance and counselling personnel need additional skills to assist children and young people requiring psychosocial support.

3.2 The objectives of guidance and counselling in schools clearly cover HIV/AIDS-related aspects such as:

[7] A PPT on OVC is available on the MTT website at www.mttaids.com

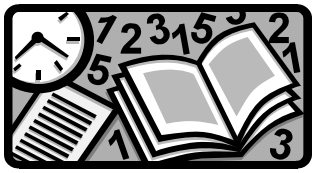
- Developing necessary life skills;
- Understanding sexuality and other family life issues;
- Coping with problems such as HIV/AIDS, teenage pregnancy and other social problems;
- Developing personal/self responsibility; and
- Knowing about rights, freedoms and responsibilities.

4. Nutritional support

School feeding schemes represent an excellent means to monitor the nutritional status of learners and to enhance both their health as well as their education.

Extract from the Republic of Rwanda's *education sector policy on HIV and AIDS*

School feeding scheme: Provide every secondary and primary school which is vulnerable or at high risk with a feeding scheme for all learners, irrespective of their individual socio-economic condition. In some cases a feeding scheme which covers all schools can be justified. Special provision must be made in school hostels to upgrade nutritional levels. School feeding schemes can be linked to home-based care and orphan supplementation schemes.



Training exercise

1. Materials: butcher's paper and felt tipped pens; as well as the handout of examples

2. For this exercise the participants will work in six groups. Allocate one of the following learning institutions to each group:
   i. An ECD institution
   ii. A primary school
   iii. A school for children with special needs
   iv. A secondary school, with boarding facilities
   v. A non-formal or skills building programme for out-of-school youth
   vi. A teacher training college

   NOTE: Participants should be reminded that vulnerability and orphaning are not only as a result of HIV/AIDS, but may be caused by many other factors, such as poverty, war, etc.

3. Instruct the groups to discuss what role their particular learning institution can play in (i) the identification, (ii) support and (iii) monitoring of OVC.

4. Have the groups report back on the identification of OVC first, getting the groups to build on what the other groups have reported, and capture the key points on butcher's paper. Repeat the process with support and then with monitoring.

5. Then join the groups, so that there are three groups, instead of six, and hand each group some butcher's paper – Group 1, will have IDENTIFICATION OF OVC; Group 2 will have SUPPORT OF OVC; and Group 3 will have MONITORING OF OVC.

6. Instruct the groups to design an implementation plan for their aspect – identification, support, monitoring – that would apply across all the listed learning institutions. The following examples can be handed out if necessary, to prompt the discussions.

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CARE AND SUPPORT – HANDOUT – PART ONE

INTERVENTION	ACTIVITIES
Identification	Create and institutionalise a system of OVC identification that includes the following: ▪ Agree on definitions and signs, for example: o Children who have lost a parent/primary care giver o Children with a sick parent/primary care giver o Children dropping out of school (or in and out of school) o School work deteriorating o Appearance that is changing/worsening o No school lunch o Teasing/targeting by peers o Psychological or behavioural problems ▪ Use school activities to collect information in a non threatening manner: o Set essay topics that provide learners with opportunities to talk about personal experiences o Establish a suggestion box at school where learners can post letters to educators about anything they want the school to know ▪ Establish ways of communicating with care givers: o Introduce “communication books” where caregivers and educators can communicate with each other about concerns regarding the child ▪ Keep and analyse records: o Of absenteeism o Of whether learners are repeatedly late for school o Of learners who struggle to complete their homework ▪ Respond to warning signs: o Hunger o Dirty, unkempt appearance o Falling asleep in class o Withdrawn

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CARE AND SUPPORT – HANDOUT – PART TWO

INTERVENTION	ACTIVITIES
Support	▪ Establish systems of support related to **direct** responsibilities, such as education, including alternative/flexible education, counselling and psychosocial support (PSS), after school supervision, protection from discrimination and recreation as well as support related to more **indirect** responsibilities, such as facilitating referrals for shelter, food, clothing, health care, access to social security, protection from exploitation and skills building and income generation. ▪ Provide material support with: o School fees and bursaries – such as providing information to learners and caregivers on how to access bursaries or fee exemptions o School uniforms – such as donations of old uniforms, collecting uniforms from learners who are leaving the school, etc. ▪ Create safe spaces for learners to: o Talk to teachers o Do homework o Access peer support ▪ Provide psychosocial support to: o Help learners who are caring for ill parents and/or siblings o Help bereaved learners deal with grief and loss ▪ Provide education support o Help learners catch up with school work, after any long absences o Create alternative learning situations for infected and affected learners who cannot participate in normal schooling (for whatever reason) ▪ Collaborate with agencies offering services and support to children o Find out about other organisations in the area that help vulnerable children and their families o Keep contact details of organisations easily accessible to learners o Invite organisations to deliver talks at the school, explaining what services they offer and how they can be reached ▪ Create educator support teams to support one another and to share lessons and experiences with colleagues

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CARE AND SUPPORT – HANDOUT – PART THREE

INTERVENTION	ACTIVITIES
Monitoring	Monitor OVC in the following ways: ▪ Follow up on referrals and find ways to work with other agencies and community child support structures ▪ Keep a register of OVCs and school records of learners' home circumstances, such as: o Who is caring for the child? o Where is the child living? o Is the child getting a meal every day? o Does the child feel safe with the current caregiver? o Did the child have a choice of who they will be living with? Who would they like to be living with? ▪ Identify specific needs (e.g. food) and have an action plan to address the needs ▪ Report on each learner on a regular basis

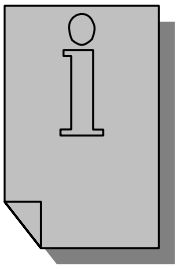
HIV AND AIDS AND THE WORKPLACE

AIDS has a devastating impact on the world of work. At the same time, the workplace has tremendous potential to help shape a unified and multisectoral response.

Juan Somavia, Director-General
International Labour Organisation

Extract from the Southern African Development Community: Code of good practice on HIV/AIDS and employment(1997)

An employee with HIV should be treated in the same way as any other employee. Employees with HIV-related illness, including AIDS, should be treated the same as any other employee with a life-threatening illness.



Information for trainers

The HIV/AIDS epidemic impacts on all spheres of life. One of the most significant features is its concentration in the working age population (aged 15-49) such that those with critical social and economic roles are disproportionately affected. In short, the epidemic is affecting the size, growth rate, and age and skill composition of both current and future workforces. At the same time, HIV/AIDS is raising the cost of labour in all African countries. This is summarised in the following diagram, which is adapted from *The response of African businesses to HIV/AIDS*.

Progression of HIV/AIDS in the Workforce	Economic Impact of Individual Case	Economic Impact of All Cases
1. Employee becomes infected with HIV	• No costs to the Ministry at this stage	• No costs to the Ministry at this stage
2. HIV/AIDS-related morbidity begins	• Sick leave and other absenteeism increase • Work performance declines due to employee illness • Overtime and contractors' wages increase to compensate for absenteeism • Use of health/medical aid benefits increases • Employee requires attention of human resource and employee assistance personnel	• Overall productivity of workforce declines • Overall labour costs increase • Additional use of medical aid benefits causes premiums to increase • Managers begin to spend time and resources on HIV-related issues • HIV/AIDS interventions are designed and implemented
3. Employee leaves workforce due to death, medical boarding, or voluntary resignation	• Payout from death benefit or life insurance scheme is claimed • Pension benefits are claimed by employee or dependants • Other employees are absent to attend funeral	• Payouts from pension fund cause employer and/or employee contributions to increase • Returns to training

	• Funeral expenses are incurred • Loans eg housing are not repaid • Co-workers are demoralised by loss of colleague	investments are reduced • Morale, discipline, and concentration of other employees are disrupted by frequent deaths of colleagues
4. Ministry recruits a replacement employee	• Ministry incurs costs of recruitment • Position is vacant until new employee is hired • Cost of overtime wages increases to compensate for vacant positions	• Additional recruiting staff and resources must be brought in • Wages for skilled (and possibly semi-skilled) employees increase as labour markets respond to the loss of workers
5. Ministry trains the new employee	• Ministry incurs costs of pre-employment training (induction etc.) • Ministry incurs costs of in-service training to bring new employee up to level of old one • Salary is paid to employee during training	• Additional training staff and resources must be brought in
6. New employee joins the workforce	• Performance is low while new employee comes up to speed • Other employees spend time providing on-the-job training	• There is an overall reduction in the experience, skill, institutional memory, and performance of the workforce • Work unit productivity is disrupted due to increased staff turnover

The **HIV and AIDS and the workplace** goal in an ***education sector policy on HIV and AIDS*** may be a comprehensive HIV/AIDS prevention, care and support programme in place, supported by non-discriminatory labour practices, terms and conditions of service. This theme typically covers educators and all other staff.

Notes on key HIV and AIDS and the workplace issues

1. Conditions of service

1.1 The HIV/AIDS epidemic demands that conditions of service be reviewed to protect employee rights, to minimise the impact of the epidemic on workplaces and to ensure compliance with international and National labour laws.

1.2 The conditions of service related to HIV/AIDS are likely to cover the following:

- Eliminating unfair discrimination and promoting a stigma-free workplace;
- Testing, confidentiality and disclosure;
- Ensuring a safe working environment and compensation for occupational infection with HIV;
- Providing equitable employee benefits; and
- Grievance procedures and dismissals.

1.3 The employment policies and practices to be reviewed include:

- Registration
- Recruitment and selection procedures;
- Appointments and appointment processes;
- Job classifications and grading;
- Remuneration and employee benefits;
- Job assignments;
- Training and development;
- Performance evaluation systems;
- Promotion, transfer and demotion procedures; and
- Disciplinary and dismissal procedures.

1.4 Reasonable accommodation

In order to ensure that employees living with HIV/AIDS are able to continue working, existing accommodation measures to be reviewed include:

- Job modifications;
- Flexible scheduling;
- Job sharing;
- Leaves of absence;
- Transfers;
- Computer terminals at home;
- Ease of access (e.g. wheelchair ramps); and
- Technological alternatives.

2. Workplace HIV/AIDS programme

2.1 Prevention programmes

- Even in situations where HIV prevalence is high, the majority of people are still uninfected and prevention efforts should always remain an important element of a workplace HIV/AIDS programme.
- However, a pre-condition for risk reduction is that a person must have the basic facts about HIV/AIDS, be taught a set of protective skills and offered access to appropriate services and products. He/she must also perceive their environment to be supportive of change and of safe sexual behaviours.
- Prevention programmes typically include:
  - Awareness raising and behaviour change activities, e.g. the ABC message[8];
  - Peer education sessions and activities;
  - Promoting safer sexual practices[9];
  - Sexually transmitted infection (STI) management;
  - Universal infection control practices to ensure a safe working environment;
  - Voluntary counselling and HIV testing;
  - A safe blood supply; and
  - Prevention of mother to child transmission of HIV.

2.2 Care and support programmes

[8] Many countries promote the message of making responsible choices – abstinence (A); being faithful to a faithful partners (B); and condom use (C).
[9] Safer sexual practices usually involves improving access to and acceptability of condom use.

- Ideally a workplace care and support programme should not be HIV/AIDS-specific, rather it should be broad-based covering a range of wellness initiatives, such as drug and alcohol avoidance, stress reduction, smoking cessation, counselling, and the management of chronic diseases (like hypertension and diabetes). Situating HIV/AIDS-related services within such a programme can enhance acceptability by employees and reduce possible stigma that may be associated with a dedicated HIV/AIDS programme.
- Typically a treatment, care and support programme includes[10]:
  - Nutritional advice and support;
  - Lifestyle education;
  - Psychosocial support and family support;
  - Treatment of minor ailments and STIs;
  - Reproductive health services for women;
  - Prevention and treatment of opportunistic infections;
  - Highly active antiretroviral therapy; and
  - Referral networks and partnerships.

Extract from the Republic of Uganda's MOES; HIV/AIDS strategic plan (April 2001)

Objective 7: To promote/build partnerships with NGOs/CBOs and other stakeholders for effective implementation of AIDS education, counselling/testing and health services in education institutions

Strategies

1. Initiate and foster partnerships with other stakeholders for effective implementation of AIDS education, counselling and care in educational institutions.
2. Establish a consortium composed of representatives from key organisations involved in AIDS education, counselling and care in the education sector.
3. Convene meetings and identify areas of collaboration and organisations with the capacity to implement such activities.
4. Develop an agreement for collaboration and partnerships with these organisations.

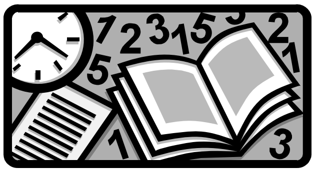
3. Gender dimensions

3.1 Appreciating the gender dimensions of the epidemic in general, and specifically in terms of the world of work is critical for an effective response.

- Gender inequality – linked to patterns of social, economic and cultural inequality – makes women more vulnerable to infection. The situation is worsened further by the biological differences between men and women.
- As the epidemic spreads, women are faced with the double burden of having to work and cope with the additional responsibilities of providing care and support for family and community members who fall ill.
- Most women are still confronted with limited access to secure livelihoods and socio-economic opportunities. This increases their dependence on male partners and their vulnerability in situations where there are risks of HIV infection.
- Men, too, are subject to social and cultural pressures that increase their susceptibility to infection and their likelihood of spreading it. Multiple partners and sexual infidelity are condoned for men in many societies.

[10] Refer to Appendix One for additional facts on treatment and care.

- Certain occupations tend to encourage risk-taking behaviour, especially those that involve men and women spending long periods away from their families. This in turn increases the risk of infection for their partners when they return home.



Training exercise

1. Materials: handouts x 2 for each participant.

This exercise has two parts.

Part One

2. In pairs, allocate one of the following questions to each pair of participants and instruct them to discuss their question and prepare a response to present to the plenary.

3. Give the set of questions to all participants as a reference.

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HIV AND AIDS AND THE WORKPLACE – PART ONE – SMALL GROUP WORK

i. Why is it important to have a workplace HIV/AIDS programme?

ii. Why is it necessary to include care and support as part of a workplace HIV/AIDS programme?

iii. What are the links between HIV/AIDS prevention on the one hand and care and support on the other?

iv. What are the care and support needs of education sector employees who are either HIV infected or affected?

v. What, if any, are the special needs for care and support of female employees who are HIV infected or affected?

vi. What is the minimum package of prevention that should be provided by any workplace?

vii. What is the minimum package of care and support that should be provided by any workplace?

viii. What workplace HIV/AIDS programmes can Ministries of Education and educational institutions (like schools) realistically provide for their educators and other staff?

ix. What are the likely implications (positive and negative) for Ministries of Education and educational institutions of providing workplace HIV/AIDS programmes for their educators and other staff?

x. What are the options for delivering a workplace HIV/AIDS programme (prevention as well as care and support)?

xi. What are the roles of trade unions and TSCs in formulating and delivering a workplace HIV/AIDS programme?

xii. What are the implications for education sectors in developing countries, and for their HIV/AIDS responses, of rapidly increasing access to antiretroviral therapy for staff who are infected with HIV?

Part Two

4. Now break into four groups. Groups One and Two will focus on prevention – Group One at the Ministry level and Group Two at the school level. Groups Three and Four will focus on care and support – Group Three at the Ministry level and Group Four at the school level.

5. Hand out the checklist (below) and instruct the groups to discuss, amend and add to the checklist to create a comprehensive checklist for their particular focus area.

HIV AND AIDS AND THE WORKPLACE – PART TWO – GROUP WORK

CHECKLIST OF ELEMENTS FOR AN EDUCATION SECTOR WORKPLACE HIV/AIDS PROGRAMME
Workplace HIV/AIDS programme promotes non-discrimination and openness around HIV/AIDS
Ministry has researched the needs of educators and other staff for HIV/AIDS-related information and education
Prevention programme is complemented by supportive services
Multiple complementary channels are used to convey HIV/AIDS prevention messages
Regular education is provided, for all staff, on healthy living and harm reduction
Employees (educators and other staff) participate in the development of the workplace HIV/AIDS programme
Workplace HIV/AIDS programme is popularised and promoted to staff
Training programme is in place to build capacity at all staff levels to support the workplace HIV/AIDS programme
Peer educators are appointed and trained from across the spectrum of employees and workplaces
Regular updates for peer educators are held, linked to a system of mentoring
PLWHAs are involved in planning and promoting the workplace HIV/AIDS programme
Protocol is in place for the safe disclosure of HIV status
Outreach on HIV/AIDS to the family members of educators and other staff takes place on a regular, scheduled basis
Condom distribution is researched with potential users and diverse distribution points established and regularly stocked
Records are kept of prevention activities, condom uptake, referrals, etc.
Infection control protocol is in place and operational; backed by a first aid programme
"Know your status" campaigns are conducted routinely, linked to referrals for confidential VCT

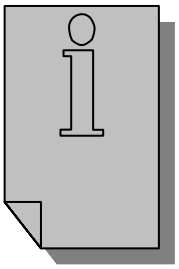
services; and management take HIV tests publicly
Access to VCT is easy (times and location); and services are acceptable to staff
Counselling services are available, linked to Employee Assistance Programmes, and are run by qualified counsellors
Structured support programme is in place for counsellors
Access is facilitated for infected staff to vitamin, mineral and other nutrient supplements
Access is facilitated to comprehensive STI treatment
Access is facilitated to prevent common opportunistic infections and to treat minor ailments
Pregnant staff have access to HIV testing and to PMTCT programmes
Surveillance for TB is encouraged and treatment for staff with TB is facilitated
TB and STI are encouraged to have HIV tests, with pre- and post-test counselling
HAART is available on cost-sharing basis for infected staff meeting treatment criteria
Support groups are established and meeting regularly
Legal assistance is available for succession planning and family support
Partnerships and referral processes are established with relevant NGOs and service providers
Staff with terminal HIV disease access home-based or hospice care
Reasonable accommodation is available for staff unable to fulfil normal duties
Budget and human resources are allocated to the workplace HIV/AIDS programme
M&E of workplace HIV/AIDS programme includes measurable prevention, care and support indicators
Monitoring of the workplace HIV/AIDS programme includes feedback from beneficiaries (e.g. PLWHAs)

MANAGEMENT OF THE RESPONSE

Extract from Republic of Kenya's *education sector policy on HIV and AIDS*

Role of the AIDS Control Units (ACUs)

- The education sector commits itself to establishing well-staffed, strong and sustainable ACUs at all levels of the education and training system.
- Other ACUs at all levels of the system need to be accountable and responsive to the needs of learners, employees, employers, stakeholders and other staff in the sector.



Information for trainers

HIV/AIDS should be a strategic priority as well as a significant risk to be managed in the same way as other strategic priorities and risks.

The **management of the response** goal in an ***education sector policy on HIV and AIDS*** may be management structures, systems and programmes in place at all levels of the education sector to ensure and sustain quality education in the context of HIV/AIDS. This theme is likely to cover:

- Advocacy to gain support for the programme;
- Management structures and programmes in place at all levels of the education sector;
- Mainstreaming HIV/AIDS into all planning and budgeting processes;
- Human resource management in order to provide the sector with the right people, with the right skills, in the right places and at the right times;
- Information systems to ensure and sustain quality education in the context of HIV and AIDS;
- Monitoring and evaluating the responses and programmes; and
- A research agenda to input quality information into the programme.

Extract from Republic of Uganda's MOES; HIV/AIDS strategic plan (April 2001)

Research: Promote research on areas related to HIV/AIDS and education as well as documentation and replication of good practice.

Notes on key issues related to management of the response

1. Management units[11]

1.1 There are opportunities to mainstream HIV/AIDS into the functions of existing education sector structures. However, because of the seriousness of the epidemic it is imperative to create dedicated HIV/AIDS management structures. It is optimal to have a structure within a Ministry of Education, consisting of diverse education sector officials and with a clear mandate to direct the Ministry's HIV/AIDS response.

[11] A PPT on management units/structures is available on the MTT website at www.mttaids.com

1.2 Another broader multisectoral consultative body should include other education sector stakeholders. This body may have more of a strategic than an operational role.

1.3 The structure, placement and functions of these units will largely determine their level of success. Key factors in this regard will be:

- Clearly defined mandates, roles, responsibilities and functions;
- The involvement of key role players;
- Clear lines of communication and accountability;
- A well-developed, disseminated and budgeted plan; and
- Active and visible involvement of leadership and management in a range of prevention, care and support, and rights activities.

1.4 The functions of a National education sector HIV/AIDS management unit could include:

- Policy development;
- Advocacy;
- Co-ordination;
- Fostering partnerships and linkages;
- Information dissemination and exchange;
- Communication, liaison and networking;
- Planning;
- Resource mobilisation;
- Facilitation and/or implementation of programme activities;
- Technical support (e.g. to the districts);
- Advisory;
- Reporting; and
- Monitoring.

2. Human resource (HR) management, training and development

2.1 Succession and skills planning

- It is critical to look at the sector's long-term workforce and succession needs, given that HIV/AIDS will result in high staff turnover, reduced skills levels, declining quality of available recruits and high competition for skilled staff.
- Plans should be drafted and implemented to ensure that the sector can fill positions with quality, skilled individuals; these should include hiring plans, systematic induction processes and skills development.
- It is also important to replicate skills and knowledge among multiple employees, so that the absence or loss of any individual can be more easily absorbed. This can be accomplished through co-operative and team-based work processes, multi-tasking, training and effective information exchange.
- Recording institutional knowledge and important processes in a formalised manner will ensure that this knowledge is not lost with the loss of an individual employee.

2.2 HR information systems

- To effectively manage the impact of HIV/AIDS on education requires the review and improvement of human resource information systems. Information can then be interpreted to:
  - Identify trends;
  - Show the extent of impact;
  - Predict or project trends and extent;

- Monitor and evaluate;
- Support advocacy; and
- Improve planning.

2.3 HR policies and practices

In addition, HR policies need to be reviewed, such as sick leave and incapacity policies to ensure that they adequately cater for HIV/AIDS; and systems and programmes need to be developed to manage:

- Increased absenteeism;
- Reduced productivity;
- Higher labour turnover; and
- Loss of skills.

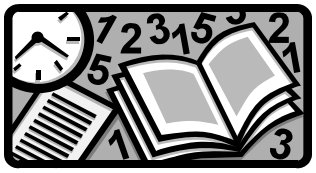
2.4 Benefits

- Review and, where necessary, remodel benefit and medical/health schemes; and
- Enhance the process for management of death benefit allocations and for managing ill health and early retirement cases.

2.5 Training

Develop an HIV/AIDS training plan that includes:

- Managers, supervisors and personnel officers;
- Educators;
- Employee representatives;
- Peer educators; and
- Health and safety officers.



Training exercise

1. Materials: computer and projector, if a presentation is made; paper and pens for the submissions.

2. Divide the participants into four groups.

3. Allocate one of the following to each group:

- The establishment of an HIV/AIDS management unit within the Ministry of Education;
- The establishment of a multisectoral HIV/AIDS committee at district level;
- Mainstreaming HIV/AIDS into the mandate and functions of the Teacher Service Commission
- Mainstreaming HIV/AIDS into the functions of School Governing Boards (SGBs) or Parent Teacher Associations (PTAs) at school level.

4. Instruct the groups to develop a submission to management using the following headings in the submission.

- Purpose (of the submission);
- Background;

- Motivation;
- Implications (policy, HR and financial); and
- Recommendation.

5. Hand each group's submission to another group to be reviewed and possibly approved (as if by management).

APPENDIX ONE FACT SHEETS ON HIV/AIDS

FACT SHEET: HIV/AIDS AND THE IMMUNE SYSTEM

HIV stands for the **H**uman **I**mmunodeficiency **V**irus.
AIDS stands for **A**cquired **I**mmune **D**eficiency **S**yndrome.

There are two types of HIV:

- HIV-1, the most common type; and
- HIV-2, found mostly in West Africa.

HIV affects the body by affecting the immune system. The immune system is the body's defence against infection by micro-organisms (bacteria and viruses) that cause disease.

Amongst the cells that make up the immune system is one called a CD4 lymphocyte. HIV is able, by attaching to the surface of the CD4 lymphocyte, to enter, infect and eventually destroy the cell. Over time this leads to a progressive and finally a profound impairment of the immune system, resulting in the infected person becoming susceptible to infections and diseases such as cancer.

In **adults**, the typical course from HIV infection to AIDS is as follows:

- About 6 weeks to 3 months after becoming infected a person will develop antibodies to HIV. At this time some people will experience a 'flu-like or glandular fever-like illness.
- There is usually thereafter a long 'silent' period - up to 8 years - during which the person may have no symptoms.
- Following that almost all (if not all) infected persons progress to HIV-related disease and AIDS. They may develop skin conditions, chronic diarrhoea, weight loss or they might develop one or more opportunistic infections such as tuberculosis, pneumonia, fungal infections, meningitis and certain cancers.

In **children** the typical course from HIV infection to AIDS is as follows:

- The majority of HIV infected infants develop disease during the first year of life and there is a high mortality rate.
- The common symptoms are:
  - An increased frequency of common childhood infections.
  - Symptoms such as fever, diarrhoea and dermatitis which tend to be more persistent and severe and do not respond as well to treatment.
  - Enlarged lymph nodes and liver.

Key points

🗝 HIV is a retrovirus. Retroviruses not only invade living cells, but take over and pervert their reproductive equipment.

🗝 HIV infection is ultimately fatal; in adults usually following a long asymptomatic period.

🗝 A person does not die of AIDS, but of one or more opportunistic infections that occur as a result of damage to the person's immune system.

FACT SHEET: TRANSMISSION AND PREVENTION

TRANSMISSION

HIV is a weak virus that cannot survive outside the human body. Although present in all body fluids, HIV is only present in sufficient concentrations to cause infection in:

- Blood;
- Sexual fluids (semen and vaginal secretions); and
- Breast milk.

HIV can only be transmitted from an infected person by the following routes:

- Sexual intercourse (vaginal, anal or oral). This is the most frequent mode of transmission.
- Contact with infected blood, semen, cervical or vaginal fluids – in situations where the infected body fluid is able to enter a person's body.
- From an infected mother to her child – during pregnancy or birth, or from breastfeeding.

In children and youth, sexual abuse and child prostitution are known causes of HIV transmission. The use of drugs and alcohol is also known to affect judgement and could be related to risky sexual behaviour.

Anybody who has unprotected sex is at risk regardless of race, religion or sexual orientation.

THERE IS NO RISK OF HIV TRANSMISSION FROM EVERYDAY CONTACT WITH AN INFECTED PERSON EITHER AT WORK OR SOCIALLY.

PREVENTION

The major route of HIV transmission is unprotected sex. The safest form of prevention is thus abstinence. However, in many instances, this is neither realistic nor desirable. Options such as remaining in a mutually faithful relationship with an uninfected partner, limiting the number of sexual partners and/or using barrier methods will reduce the risk. Barrier methods commonly include the male and female condom.

Key points

🗝 Transmission of HIV can only occur where there is an 'exit point' from an infected person and an 'entry point' into an uninfected person.

🗝 Prevention options include **A**bstinence, **B**eing faithful to your partner and **C**ondom use.

FACT SHEET: TESTING AND COUNSELLING

TESTING

HIV antibody testing is done for the following reasons:

- To screen donated blood and blood products, tissues, organs, sperm and ova.
- For epidemiological surveillance of HIV prevalence (usually anonymous and unlinked testing).
- To diagnose HIV infection.

The commonly used test for HIV infection tests for antibodies to HIV, it does not test directly for the presence of the virus. The period between infection with HIV and seroconversion (when the body develops antibodies) is called the 'window period'. During this time the HIV antibody test will not detect the infection, even though the person is infected and infectious.

Usually HIV antibody testing is done using an ELISA test (Enzyme Linked ImmunoSorbent Assay). The test can be done using a number of body fluids, but is usually done using blood. The ideal testing process involves two tests, if the first is positive. This re-testing, using a different test allows for the positive test to be confirmed and excludes the possibility that the first test was perhaps a false positive.

Pre- and post-test counselling are universally regarded as necessary accompaniments to all HIV testing where the person concerned will receive his or her test result. The 3 'C's' are the standards for ethical HIV antibody testing:

- Informed **C**onsent;
- **C**ounselling; and
- **C**onfidentiality.

COUNSELLING

HIV counselling is defined as a confidential dialogue between a client and a counsellor aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS.

Effective counselling requires:

- Self awareness of one's beliefs, values and assumptions.
- A respectful non-judgemental attitude.
- Active listening, including accurate reflection of issues and concerns.
- Asking supportive questions that raise important issues.
- Awareness of one's verbal and non-verbal behaviour.
- Providing practical support, advice and information.
- Discussing options for care, prevention and support.
- Encouraging the person counselled and his/her family to make their own decisions.
- A quiet, private environment.
- Ensured confidentiality.

Pre and post-test counselling

Counselling at the time of having an HIV antibody test has two main functions: prevention and support. It allows those tested to adopt preventive measures and, for those who are positive, to learn to live positively, accessing care and support at an early stage.

Counselling affected children and youth

Children and youth will react to crises in life, like the death of a family member, in different ways and will need different types of support. Bereavement counselling should be available to affected children and youth *before* the death of the family member and for as long afterwards as they may need it. Bereavement counselling should:

- Give children and youth an opportunity to talk about death, about events leading up to death, about the death itself (if it has occurred) and about the observances and rituals immediately after a death.
- Reassure them that feelings of disbelief, denial, sadness, pain and anger are normal.
- Allow them to express their feelings and concerns.
- Enable them to accept their loss or imminent loss and start looking to the future.

Key points

🗝 Voluntary counselling and testing (VCT) are encouraged in many countries to enable individuals or couples to learn their HIV status and to plan for their futures.

🗝 Good counselling assists people to make informed decisions, cope better with health conditions, lead more positive lives and prevent further transmission of HIV.

FACT SHEET: RELATED DISEASES - TB AND STIs

TUBERCULOSIS (TB)

Tuberculosis (TB) is a serious public health problem. TB kills more people every year than any other infectious disease - yet it is curable. Correct TB treatment not only cures TB and saves lives but also prevents the spread of infection and the development of drug-resistant TB.

TB is the most common opportunistic infection and the most frequent cause of death in people living with HIV in developing countries. In 1997, there were an estimated 2.2 billion people infected with *Mycobacterium tuberculosis* (the germ that causes TB) and 30.6 million people infected with HIV in the world. In 1996, there were an estimated 9.4 million people in the world infected with both HIV and TB.

How do HIV and TB interact?
In people with healthy immune systems, only 10% of those who are infected with TB ever become sick from TB. HIV, by destroying the immune system, increases the risk of progression from TB infection to TB disease from 10% per lifetime to 10% per year. This means that over 50% of people who are co-infected with TB and HIV will get sick with TB before they die. TB also accelerates HIV disease. It is important to realise that although HIV increases the risk of developing TB, not all HIV-positive people have TB and not all people with TB are HIV-positive.

People with TB or HIV face similar problems of stigmatisation, fear and discrimination and have shared needs for counselling, care and support. HIV/AIDS is common in socio-economically-stressed communities, and these same communities are also vulnerable to TB.

The symptoms of TB are the same in HIV-positive and HIV-negative people: cough for more than 3 weeks, loss of appetite and weight loss, night sweats, tiredness, chest pain and coughing blood.

TB is spread through coughing. A person who is sick with TB and is not on appropriate treatment coughs TB germs into the air and another person breathes them into their lungs. TB patients who are on appropriate treatment are not infectious and therefore it is safe to work with them, socialise with them and live near them.

The good news is that TB can be cured as effectively in HIV-positive as in HIV-negative people using the same drugs for the same amount of time.

The DOTS (Directly Observed Treatment, Short-course) strategy works. As part of DOTS, it is important that a treatment supporter encourages and observes the patient to complete their TB treatment. Treatment supporters can be health workers, employers, co-workers, shop keepers, traditional healers, teachers, and community or family members.

The risk of getting sick with TB can be decreased in people living with HIV/AIDS by taking TB preventive therapy for a period of 6 months using a TB drug called isoniazid.

SEXUALLY TRANSMITTED INFECTIONS (STIs)

STIs are very common. In Africa, as many as 1 in every 10 people will get an STI every year. Untreated STIs can cause serious health problems in both men and women. Fortunately most STIs can be cured.

The same behaviours that place people at risk for STI infection also place them at risk of HIV infection. Both are transmitted during unprotected sex.

STIs such as gonorrhoea, syphilis, chlamydia, chancroid and genital herpes cause blisters, ulcers, discharges and inflammation. In all these cases, immune system cells are present in large numbers, thus providing an immediate entry point for HIV.

It is therefore 5-10 times more likely for HIV to be transmitted from one person to another, particularly when there are ulcers present. The situation is exacerbated even further because STIs in women are often asymptomatic or 'hidden'.

The presence of HIV infection in a person with an STI may result in the STI condition being more severe and treatment being less effective.

The best way of treating STIs is known as the 'syndromic approach'. It recognises that groups of STIs produce similar symptoms and that people commonly have multiple infections. The treatment therefore is given for a group of STIs, rather than trying to isolate and then treat the exact STI or STIs.

Key points

- HIV infection is the most powerful factor known to increase the risk of developing TB.
- In developing countries, anyone with TB is in a high risk group for HIV.

- The treatment of STIs has become an important strategy for containing the HIV/AIDS epidemic.

FACT SHEET: TREATMENT AND CARE

HIV/AIDS treatment and care may be defined within the following framework:

- For asymptomatic HIV-positive individuals;
- For those with early HIV disease;
- For those with late disease or AIDS; and
- For those with terminal illness.

Treatment, care and support needs are very different at different stages and are not restricted only to the infected person. The primary objectives therefore are:

▪ For the infected person	to reduce suffering and improve quality of life to provide appropriate treatment of acute intercurrent infections where available, to provide access to antiretroviral treatment
▪ For families	to render practical support to lend bereavement support

The points at which a person who is HIV infected will require treatment and care are numerous and may include:

- Treatment for STIs and TB;
- Treatment of opportunistic infections;
- Prophylaxis for opportunistic infections;
- Palliative care;
- Antiretroviral therapy.

Home-based care
Home-based care involves providing holistic care to a person with advanced HIV disease (or any other terminal condition). The aim is to reduce suffering and improve his or her quality of life. The focus of home-based care is:

- The person living with HIV/AIDS;
- The family and caregiver; and
- The children in the household.

Positive living
If you are HIV positive, this means taking control of aspects of your life such as:

- Eating a good diet whenever possible;
- Staying as active as possible;
- Getting sufficient rest and sleep;
- Reducing stress as far as possible;
- Staying occupied with meaningful activities;
- Meeting and talking to friends and family; and
- Seeking medical attention for any health problems.

Nutritional advice

Because nutritional difficulties are frequent with HIV disease – malnutrition, malabsorption and oral, oesophageal and gastrointestinal infections. For PLWHAs, good nutritional status is a critical requirement for continued health. Advice includes what foods to eat and not eat, how to

use food to boost the immune system on the one hand and to fight opportunistic infections on the other, how to prepare and store food safely, and how to maintain one's appetite.

Antiretroviral therapy

Antiretroviral drugs are used to treat HIV disease and in some instances to prevent HIV infection. There are different classes of drugs but all act to prevent replication or reduce the rate of replication of the virus and so slow the progression of the disease and prolong the survival of infected persons.

Vaccines

A vaccine is a substance that teaches the immune system to recognise and protect against a disease caused by an infectious organism or virus. Some experimental AIDS vaccines are in development, but the widespread availability of an effective vaccine is still many years away.

Key points

- It is a well-established fact that living positively can delay the onset of symptoms and extend the period of wellness in a person who is infected.

- Options such as antiretroviral therapy, which are widely used in the developed world to treat people living with HIV/AIDS, are only recently becoming available in developing countries.

FACT SHEET: UNIVERSAL PRECAUTIONS

HIV and other blood borne infections (like hepatitis B) can be transmitted in an accident or caring situation where there is contact with infected blood or other body fluids. The risk of a person becoming infected with HIV in such a situation is dependent on factors such as the extent of the contact or the sort of injury that allows the blood or body fluids to enter the person's body. The average risk of transmission is however low, approximately 0.3% following a needlestick-type injury.

There are simple guidelines to manage the risk of HIV transmission in an accident or caring situation.

- Create a safe working environment by identifying any risk situations and minimising such risks.
- Assume that everyone is HIV positive and always take precautions in an accident or caring situation.
- Ensure that personal protective first aid equipment (such as gloves) is available and that people have been trained to use the equipment.
- In the event of accidental contact with blood or body fluids, follow standard first aid procedures.
- Make sure that any contaminated materials are disposed of safely.

Key points

🗝 Prevention of exposure to blood and body fluids should always be the priority.

🗝 In an accident or caring situation, 'universal precautions' implies assuming that everyone is infectious and always taking the same precautions.

FACT SHEET: WOMEN AND HIV/AIDS

Worldwide the risk of HIV infection for women is rising. Where transmission of HIV is predominantly heterosexual, women have a greater incidence of infection than men do. The reasons for this are multiple.

- The risk of becoming infected with HIV during unprotected vaginal intercourse is 2-4 times higher for women than for men. In addition, an untreated STI increases the risk of HIV transmission during unprotected sex by up to 10 times, and women with STIs are often unaware of them because the infections are 'invisible'.

- Young girls are at even greater biological risk – their physiologically immature reproductive tracts constitute ineffective barriers to HIV and other STIs. Older women also become biologically more vulnerable after menopause.

- Young girls become sexually active earlier than their male counterparts; and, at a young age, they lack the knowledge and power to control their sexual encounters, and also what happens about protection.

- The financial dependence of women on men is especially entrenched in the developing world, leaving them with little or no control over how and when they have sex. Traditionally women play the passive role in sexual encounters, which means they are unable be assertive and negotiate safer sexual practices with their partners. In Africa, simply being married is a major risk factor for women who have little control over abstinence or condom use at home or their husband's sexual activity outside.

- Condoms are incompatible with pregnancy and fertility is a powerful prerequisite to social acceptance in many societies.

- Women have less access to information and prevention measures which are available and/or distributed at work places, schools and social organisations.

- Where their lives have been disrupted by war, divorce or widowhood, or where they have lost their property because of inequitable laws and customs, women, in the absence of other viable alternatives, often turn to prostitution, with the attendant risks of infection, in order to survive.

The demands on women resulting from the epidemic are also significant.

- Women are the caregivers; of infected spouses, often whilst being infected themselves, of infected children, and of 'AIDS orphans'.
- They are also predominantly the educators and health professionals who have to spearhead and staff AIDS prevention and care programmes.
- There is a great burden on elderly women to care for and bring up grandchildren whose parents have died of AIDS.

Key points

🗝 AIDS spreads more quickly where women are economically dependent on men, are unable to read and have limited legal rights for divorce, inheritance and child custody.

FACT SHEET: CHILDREN AND HIV/AIDS

In the context of HIV/AIDS, children may be classified as infected or affected.

- Almost all HIV infections in children under 13 are the result of transmission from mother to child; during pregnancy, birth or from breastfeeding. Other modes of transmission are sexual transmission and transmission from unsafe health practices.

- The AIDS epidemic is producing large numbers of affected children and orphans and resulting in increased hardship, particularly for impoverished families. Children from households with infected family members are frequently forced to assume care and other adult responsibilities.

- Adolescents at risk of HIV infection have high levels of knowledge about HIV/AIDS, but do not perceive themselves to be at risk and do not take the need for safer sex seriously.

- Certain groups of children are particularly vulnerable:
  - Children who are sexually exploited (either commercially or at home);
  - Street children, not necessarily because of a lack of knowledge and awareness, but rather because of their low status, powerlessness and social conditions;
  - Children in detention, who are often exposed to violence, abuse and unwanted sex.

- Children from uninfected households living in affected communities are also affected, either directly, for example through day-to-day contact with their peers who have been personally affected, or indirectly by the sequelae of the epidemic such as deteriorating levels of education and health care.

The toll that the epidemic is exacting on the world's children is thus enormous and growing daily.

Affected children have multiple needs.

Physical and material needs

Food and food security

These children are vulnerable to malnutrition and under-nutrition, due both to the scarcity of food and to the weak position they occupy within guardians' homes in the household resource distribution process.

Housing, clothing and bedding

Elderly grandparents and children often cannot maintain their homes in good repair. Poverty within the extended family frequently results in repairs being neglected. Often the family's supply of bedding is reduced because the deceased parent was bedridden and incontinent before death and it is common for children to sleep on sacks on the floor. Many children have no footwear at all and own only one set of clothes.

Health care

Immunisation and simple medical care may not be reaching these children, and children under the age of five are particularly vulnerable.

Intellectual needs

Educational needs

These include books, school fees, uniforms, shoes and school trip funds. For the younger children there is also the need for after-care facilities.

Income generating skills

There is a need to provide older children with simple, marketable skills.

Psychosocial needs

Parenting

Most children have not come to terms with the reality of being orphaned and feel the loss of parental attention and of physical and social security. With the death of their parents, the normal grief process is aggravated by guilt that they were unable to save their parents, often resulting in behavioural problems.

Because the independence of the nuclear family has been compromised, they are unable to participate effectively in the kinship network where they are perceived as a liability and many, as a result, show socialisation problems.

Child heads of households are often ill-equipped to provide proper parental guidance and discipline to their siblings, let alone the love and care which they themselves need. There is also no moral and ethical guidance for these children, where the only adult attention may be in the form of irregular and inadequate supervision.

Friends and recreation

Most children report having lost their social friends due to their rigid time budgeting which does not allow them time for play.

Non-discrimination and legal protection

Freedom from discrimination within school, foster families, orphanages etc. is another need. Where an infected parent may have been ostracised or rejected, after death the stigma may continue to cling to the orphaned children.

These children require legal protection, with respect to inheriting land and other material goods as well as protection from unscrupulous guardians, relatives and others who may abuse their rights in any number of ways. They also require a peaceful, violence and crime-free environment.

Key points

🗝 All children have physical and material needs, intellectual and educational needs and psychosocial needs. Children affected by HIV/AIDS are particularly vulnerable in all these areas, as they take on adult household, parenting and caring responsibilities. Typically these children experience a lack of supervision and care, stunting and hunger, educational failure, inadequate health care, psychological problems, disruption of normal childhood and adolescence, exploitation and discrimination.

APPENDIX TWO IMPORTANT REFERENCES

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Republic of Uganda, MoES; Education and sports sector policy and guidelines on HIV/AIDS (pre-final draft) (2004)

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UNGASS; Declaration of commitment on HIV/AIDS (2001)

APPENDIX THREE GLOSSARY OF TERMS

Affected person	A person whose life is changed in any way by HIV/AIDS due to the broader impact of this epidemic
Behaviour change	Interventions and activities to promote and sustain risk-reducing behaviour change in individuals and groups by means of tailored messages and using a variety of communication channels
Counselling[12]	A relationship between a helper and a person with a need. Counselling is designed to help a person to understand and clarify their views; and to reach self-determined goals by making choices from realistic alternatives
Discrimination	An action based on a pre-existing stigma; a display of hostile or discriminatory behaviour towards members of a group, on account of their membership of that group
Education sector	Refers to all organisations, persons, programmes, activities and role players in the field of education and training
Educator	Any person who impacts knowledge and skills within the education sector
Employee	Any person engaged in the education sector to perform a certain task for the purpose of earning a wage or salary or any other form of remuneration
Epidemic	A disease, usually infectious, that spreads quickly through a population
Gender	All attributes associated with women and men, boys and girls, which are socially and culturally ascribed and which vary from one society to another and over time
Infected person	A person who is infected with HIV, the virus that causes AIDS
Learner	A learner is a person receiving instruction and training from a learning institution or programme
Life skills	A group of psychosocial and interpersonal skills which assist a person to make informed decisions, to communicate effectively and to develop coping and self-management strategies to help them lead a healthy and productive life
Mainstreaming	Mainstreaming HIV/AIDS means a sector determining (i) how the spread of HIV is caused or contributed to by their sector; (ii) how the epidemic is likely to affect their sector's goals, objectives and programmes; and (iii) where their sector has a comparative advantage to respond - to limit the spread of HIV and to mitigate the impact of the epidemic… AND THEN TAKING ACTION!
Orphan	A child who has lost one or both parents
Peer education	Refers to activities aimed at providing factual/vital information to people of

[12] From “Guidance and counseling” reference document (no title page or date)

	a certain age, same sex, has the same interest, of the same organisation or social group, status or position on matters governing their existence
Psychosocial support	Physical, economic, moral or spiritual support provided to an individual under any form of stress
Reasonable accommodation	Any modification or adjustment to a job or to the workplace that is reasonably practicable and will enable a person living with HIV or AIDS to have access to or participate or advance in employment
Stigma	The holding of derogatory social attitudes or cognitive beliefs, a powerful and discrediting social label that radically changes the way individuals view themselves or the way they are viewed by others
Universal infection control	A simple standard of infection control practice to be used to minimise the risk of blood-borne pathogens
Voluntary counselling and testing	A confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS, including blood testing for HIV
Vulnerable child	Includes learners and children with special needs such as a physical or mental disability, as well as school age children who are out of school as a result of poverty or inability to pay school fees and learners and children infected or affected by HIV/AIDS
Workplace	Refers to occupational settings, stations and places where workers spend time in gainful employment