FINAL REPORT

REGIONAL SITUATION ANALYSIS OF ACCELERATING THE EDUCATION SECTOR RESPONSE TO HIV AND AIDS IN THE EAC PARTNER STATES
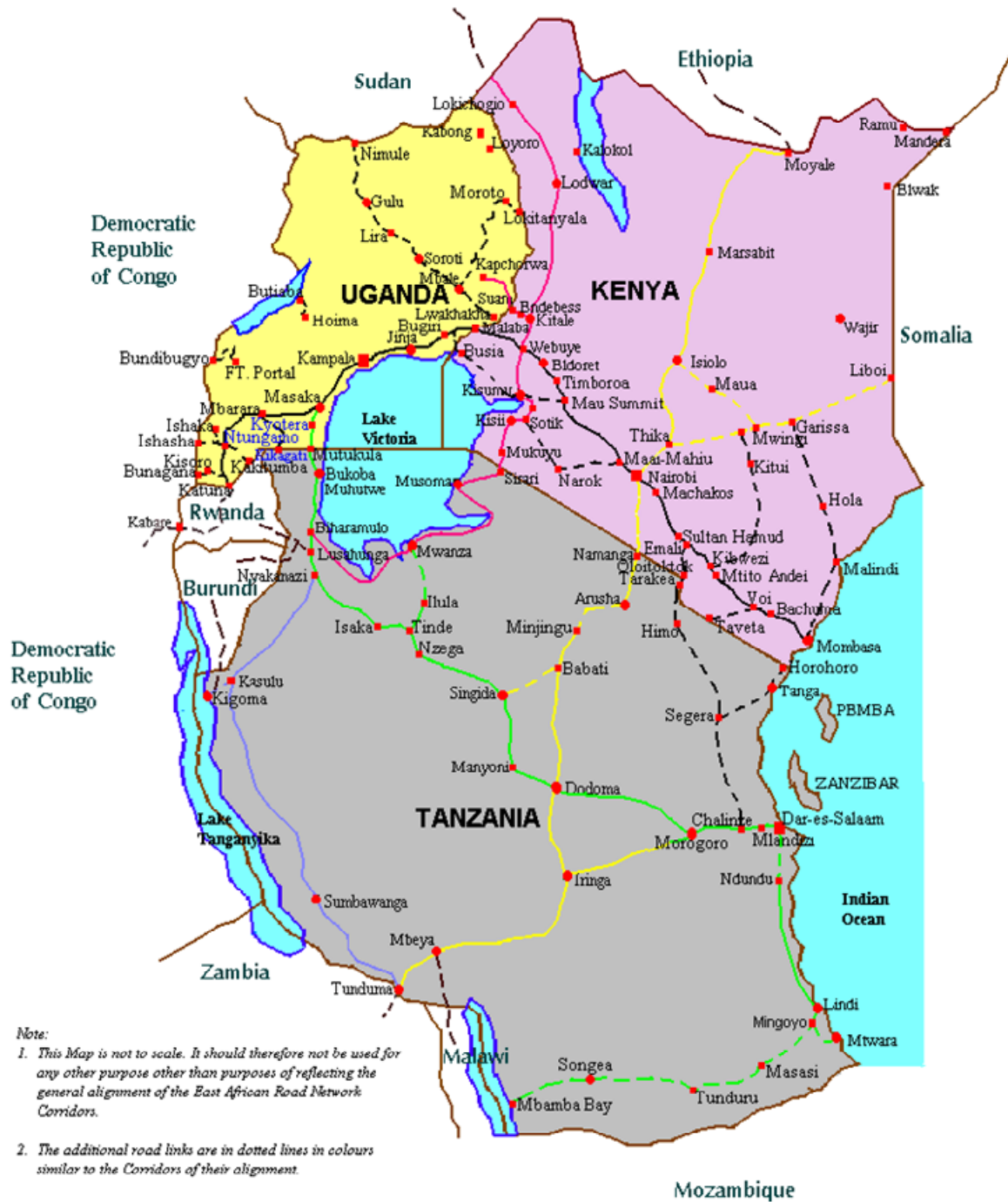

EAC Secretariat

Meeting Ready Version for Review at the EAC Technical Committee Meeting on the Education Sector Response to HIV and AIDS

October 2009

East Africa Community Partner States

Sudan

Ethiopia

Lokichogio

Kabong

Loyoro

Kalokol

Ramu

Mandera

Nimule

Moroto

Lodwar

Moyale

Democratic
Republic
of Congo

Gulu

Lira

Lokitanyala

Biwak

Soroti

Kapchorwa

Marsabit

Butiab

Mbale

KENYA

UGANDA

Suam

Bndebess

Hoima

Lwakhakha

Kitale

Wajir

Bugiri

Malaba

Somalia

Jinja

Busia

Webuye

Isiolo

Liboi

Bundibugyo

Kampala

Bidoret

Maua

FT. Portal

Kisumu

Timboroa

Masaka

Mau Summit

Garissa

Mbarara

Kisii

Mwingi

Ishaka

Kyotera

Lake
Victoria

Sotik

Mukuyu

Thika

Kitui

Ntungamo

Maai-Mahiu

Ishasha

Rikagati

Mutukula

Kisoro

Kakitumba

Bukoba

Musoma

Sirari

Narok

Nairobi

Machakos

Hola

Bunagana

Katuna

Muhutwe

Sultan Hamud

Kabare

Rwanda

Bharamulo

Namanga

Emali

Kibwezi

Malindi

Lusahunga

Mwanza

Oloitoktok

Mtito Andei

Tarakea

Nyakanazi

Burundi

Ihula

Arusha

Voi

Bachuma

Isaka

Tinde

Minjingu

Himo

Taveta

Democratic
Republic
of Congo

Nzega

Babati

Mombasa

Horohoro

Kasulu

Singida

Segera

Tanga

Kigoma

PBMBA

ZANZIBAR

Manyoni

Dodoma

Lake
Tanganyika

TANZANIA

Chalinze

Dar-es-Salaam

Morogoro

Mlandizi

Iringa

Ndundu

Indian
Ocean

Sumbawanga

Mbeya

Zambia

Tunduma

Lindi

Mingoyo

Mtwara

Note:
1. This Map is not to scale. It should therefore not be used for
any other purpose other than purposes of reflecting the
general alignment of the East African Road Network
Corridors.

Malawi

Songea

Masasi

2. The additional road links are in dotted lines in colours
similar to the Corridors of their alignment.

Mbamba Bay

Tunduru

Mozambique

Source: East Africa Community (EAC) Secretariat, (6 February 2008)

TABLE OF CONTENTS

LIST OF BOXES, FIGURES AND TABLES

Tables

ACKNOWLEDGEMENTS

ABBREVIATIONS AND ACRONYMS

ABEK   Alternative Basic Education for Karamoja
ACU   AIDS Control Unit − Kenya
ADEA   Association for the Development of Education in Africa
AECU   AIDS Education Coordination Unit
AIDS   Acquired Immune Deficiency Syndrome
AMPATH   Academic Model Providing Access to Healthcare
AMREF   African Medical and Research Foundation
ARI   Acute respiratory infection
ART   Antiretroviral therapy
ARV   Antiretroviral
CBO   Community-based and organisation
CDLS   District AIDS Control Committee
COPE   Complementary Opportunities for Primary Education
DAC   District AIDS Committee
DAT   District AIDS Task Force
DFID   Department for International Development − United Kingdom
DHS   Demographic and Health Surveys
EAC   East African Community
EANNASO   Eastern African National Networks of AIDS Service Organisations
ECD   Early Child Development
ECE   Early Childhood Education
ECOWAS   Economic Community of West African States
ECSA   East, Central and Southern African region
EFA   Education for All
EI   Education International
EMIS   Education Management Information System
ESACIPAC   Eastern and Southern Africa Centre of International Parasite Control
ESWAPI   Education Sector Workplace HIV/AIDS Policy Implementation
FBO   Faith-based organisation
FLART   First line antiretroviral therapy
FPE   Free Primary Education
FRESH   Focusing Resources on Effective School Health
FTI   Fast Track Initiative
GAMET   Global AIDS Monitoring and Evaluation Team
GER   Gross enrolment rate
GTZ   Deutsche Gesellschaft für Technische Zusammenarbeit (German Technical
            Cooperation)
HIV   Human Immunodeficiency Virus
IATT   UNAIDS Inter-Agency Task Team on Education
ICASA   International Conference on AIDS and STIs in Africa
IEC   Information, Education and Communication
ILO   International Labour Organisation
IUCEA   Inter-University Council for East Africa
KEMRI   Kenya Medical Research Institute
KENEPOTE   Kenya Network of HIV-Positive Teachers
KESSP   Kenya Education Sector Support Programme
KIE   Kenya Institute of Education
LVBC   Lake Victoria Basin Commission
M&E   Monitoring and Evaluation
MAP   Multi-Country HIV/AIDS Programme
MC   Male circumcision
MDGs   Millennium Development Goals

MEES	Moral Ethics and Environmental Studies − Zanzibar
MoE	Ministry of Education
MoES	Ministry of Education and Sports (Uganda's)
MoEVT	Ministry of Education and Vocational Training (Tanzania's)
MoH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare
MoPSE	Ministry of Primary and Secondary Education (Burundi's)
MOU	Memorandum of Understanding
NAC	National AIDS Council
NACC	National AIDS Control Council
NAP+EAR	Network for People living with HIV in Eastern African Region
NER	Net enrolment rate
NGO	Non-governmental organisation
OPEC	Organisation of the Petroleum Exporting Countries
ORACLE	Opportunities for Reducing Adolescent and Child Labour through Education
pART	Paediatric antiretroviral therapy
PCD	Partnership for Child Development
PIASCY	Presidential Initiative on AIDS Strategy for Communicating to Young People − Uganda
PLWH	People Living With HIV
PMM	Performance Measurement and Management
PMTCT	Prevention of mother-to-child transmission of HIV
PTR	Pupil-teacher ratio
RECs	Regional Economic Communities
RPM	Rational Pharmaceutical Management
SADC	Southern African Development Community
SAGA	Semi-Autonomous Government Agency − Kenya
SHN	School health and nutrition
SLART	Second line antiretroviral therapy
STDs	Sexually transmitted diseases
STF	Strong Talk Foundation
STIs	Sexually transmitted infections
TAAG	Teachers Anti-AIDS Action Group − Uganda
TACAIDS	Tanzania Commission for AIDS
TANESA	Tanzania-Netherlands Project to Support AIDS Control
TAPOTI	Tanzania Positive Teachers' Initiatives
TOR	Terms of Reference
TOT	Training of Trainers
TSC	Teachers Service Commission (Kenya)
TSFs	Regional Technical Support Facilities−UNAIDS
TTC	Teacher training college
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
UPHOLD	Uganda Programme for Human and Holistic Development
URT	United Republic of Tanzania
USAID	United States Agency for International Development
USLS	Unite Sectorielle de Lutte contre le SIDA (Burundi)
VCT	Voluntary Counselling and Testing
WASH	Water, Sanitation and Hygiene Programme
WFP	World Food Programme
WHO	World Health Organisation

EXECUTIVE SUMMARY

Overview

The adverse effects of HIV and AIDS on every aspect of life in sub-Saharan Africa continue to be felt more than a quarter of a century since the first HIV diagnosis in the region. Of the 22.5 million people living with HIV globally, more than 68% live in sub-Saharan Africa, where the pandemic has claimed the lives of at least 4 million people, slowed down economic growth and shortened life expectancy at birth by approximately 15 years (UNICEF, 2008).

The role of the education sector in the promotion of the health and nutrition of school-age children has assumed greater significance today than ever before. HIV prevention and mitigation are integral to comprehensive school health and nutrition (SHN) programmes. School-age children have the lowest HIV prevalence of any age group even in countries with high HIV prevalence. For school-age children, there is therefore a **window of hope**, a chance to live a life free from AIDS, if they can acquire knowledge, skills, and values that will help protect them as they grow up. Providing young people, especially girls, with the **social vaccine** of education offers them a real chance at a productive life and has been shown to have a dramatic impact on reducing levels of stigma and discrimination (GCE, 2004). The sector is now recognised as playing a key '*external*' role in HIV prevention and in reducing stigma, and an important '*internal*' role in providing access to care, treatment, and support for teachers and staff – a group that represents over 60% of the public sector workforce in many countries.

This regional situation analysis (SITAN) focuses on the responses to HIV of the education sector within the East African Community (EAC) region, which covers five partner states - Burundi, Rwanda, Kenya, Uganda and the United Republic of Tanzania (comprising Tanzania Mainland and Zanzibar). The partner states have established various mechanisms to mitigate the impact of HIV and AIDS. This includes adopting a multi-sectoral response in recognition of the seriousness and the multi-dimensional nature of the pandemic. In September 2006, the EAC Secretariat convened a meeting of its member states to explore ways for the EAC to coordinate strategic HIV and education activities among partner states (EAC, 2006a). By November 2006, Education Ministers of the EAC partner states fully supported planned activities to accelerate their education sector responses to HIV (EAC, 2006c). During the African Networks of Ministry of Education HIV Focal Points meeting, in November 2007, the EAC Secretariat requested that the Partnership for Child Development (PCD), in collaboration with the World Bank, conduct the situation analysis.

The purpose of the situation analysis is to inform implementation and resource (both technical and financial) mobilisation of the education sector component of the five-year EAC HIV and AIDS Strategic Plan 2008-2012, leading to the development of actionable plans at the sub-regional level for the improvement of educational outcomes of the partner states.

The objectives are to:

- Assess the impact that HIV is having on education, in terms of teacher illness and death, and orphans and vulnerable children, with associated costs both of impact and impact prevention by ART, and also assess the extent to which education responses to HIV and AIDS in the EAC sub-region have adopted the wider SHN approach for improving health and education outcomes; and
- contribute to sub-regional information as a database on the HIV and AIDS-related situation relevant to the education sector.

The aims are to:

- Facilitate sharing of innovations and best practices within and across countries;
- inform planning, for the development and implementation of actionable plans in the sub-regional level for the improvement of the educational outcomes;
- form a basis for the harmonisation of monitoring and evaluation (M&E) frameworks; implementation modalities; HIV-related education policies; institutional frameworks and common research needs; and
- give impetus to resource mobilisation to expand on the response to HIV and AIDS.

Methodology

An extensive review was undertaken of literary materials obtained online and from the EAC partner state education ministries, and from various stakeholders, such as, other government ministries and agencies, the EAC Secretariat and other EAC bodies, United Nations agencies, national and international non-governmental organisations (NGOs) and civil society organisations. Interviews were conducted with key informants from education ministries and their stakeholders. An estimation of the impact of HIV and AIDS on the education sector was made using the Ed-SIDA mathematical model. Country level data collected was verified at the national level. A regional meeting is scheduled to verify the regional report which has also been subject to peer review.

FINDINGS

Education Sector in the EAC

- As in sub-Saharan Africa, the EAC region is characterized by a relatively young population. Children under the age of 15 years, constitute between 42% and 50% of the total national population of EAC partner states, while 15 to 24 year-olds form over a fifth (20.5% – 21.5%).
- The Governments of the EAC partner states around the new Millennium (1996 in Uganda), recognized the rights to education for all children of school-age, and formulated Free Primary Education (FPE) policies and abolished tuition fees.
- Millions of children previously unable to access schooling enrolled into FPE, leading to increases in gross enrolment rates (GERs) from 63% to 103% prior to FPE and to 100% to 151% after FPE; and net enrolment rates (NERs) from 62% to 74% prior to FPE to 75% to 109% after FPE.
- According to most recent available data obtained from each EAC partner states, at least 28.2 million children are enrolled in primary school in the EAC region with an average pupil-teacher ratio of 52:1.
- Not all the EAC partner states are offering free secondary school education. The Government of Kenya introduced free primary education in 2003 and e free day secondary in January 2008. Parents whose children attend boarding secondary schools meet this cost. In Rwanda the tuition fees is free in the 3-year lower secondary schools. Not all children completing primary school education are able to continue to secondary education across the region. The transition in Kenya currently stands at 70%.
- URT - Zanzibar and Rwanda have extended free education to lower secondary schools, while Kenya is heavily subsidising tuition fees in public secondary schools nationally.

Health Conditions Affecting the Education Sector

Ensuring universal and equitable access to quality education for all children is a basic objective of any education sector. The attainment of full learning potential is directly dependent upon the children's good health and nutrition, as well as a safe environment conducive to learning. Provision and accessibility of quality education is not possible without addressing the health concerns of schoolchildren.

- *HIV infection*: Rates of HIV infection are lowest among children, and more so those in school than out. Like elsewhere in sub-Saharan Africa, in the EAC region, the risk of contracting HIV is higher among adolescents and young adults aged between the ages of 15 and 24 years than all other populations, and more serious among their female cohorts (WHO, 2008). As well as children being born with HIV and the high risk of adolescents contracting HIV, an additional serious effect of HIV on school-age children is the creation of orphans. Of the 12 million orphans who have lost at least one parent to HIV in sub-Saharan Africa (UNAIDS estimates, 2008a), 8.4 million reside in the EAC region.
- *Malaria:* A key health problem affecting school-age children in the EAC region is malaria. It is endemic in Uganda and Burundi where it is a leading cause of hospitalisation for students (Uganda School Health Policy in country report). A Ugandan study in 2005 estimated that pupils on average lose 7 days per term due to malaria (Mugume *et al.,* 2005 in Uganda situation analysis report).
- *Worm infections*: A leading cause of disease among children aged between 5 and 14 years is worm infections. It is estimated that half of all such children may be infected with intestinal helminths, the most prevalent being the hookworm. Areas surrounding Lake Victoria (in Kenya, Tanzania Mainland and Uganda) and Lake Albert (in Uganda), as well as the Central and Coastal provinces of Kenya are estimated to be prevalent of soil transmitted helminths and schistosomiasis of greater than 50% (country reports).
- **Other health problems**: Acute respiratory infections (ARIs), diarrhoeal diseases and vitamin A deficiencies (WHO, 2009) are other serious health-related problems affecting the education sector. Vitamin A deficiency is the single greatest cause of preventable childhood blindness. WHO (2009) also attributes alcohol use for 5% of all deaths of young people aged between 15 and 29 years. There are serious health risks associated with tobacco smoking which is reported to be common among school-age youth.

Estimates of HIV Impact on Education and Cost Implications

The Ed-SIDA mathematical model was used to estimate the impact of HIV on the education sector. The model estimated the current and future impacts of HIV, and estimated the care and support of teachers living with HIV on teachers, pupils and the achievement of EFA. The findings from the model generated revealed:

- The age-distribution of teachers varies between EAC partner states and is an important predictor of HIV prevalence, where teachers belong disproportionately to age groups more at risk of HIV infection. By contrast the teacher gender distribution is more representative and does not influence prevalence to the same extent.
- Teachers vary in their susceptibility to HIV compared to individuals of the same age and gender from the same country.
- Rwanda has younger teachers, who are at greater risk of HIV infection than their non-teacher peers of the same age and gender.
- The school-age population is expected to increase in the EAC.

- In 2005, there were 420,000 HIV-positive children in the EAC. The future number depends largely on states' successes in rolling out prevention of mother–to-child transmission (PMTCT) of HIV and paediatric antiretroviral therapy (pART).
- In 2005, there were estimated to be 8.4 million orphans in the EAC, and numbers are expected to remain stable into the future.
- The numbers of teachers living with HIV are expected to increase; there is a large unmet need for teacher access to antiretroviral therapy (ART) (10,000 in 2007; around 2% of all teachers).
- HIV imposes a large burden of absenteeism on education (4,200 teacher-years) in the EAC which could be considerably reduced through the provision of ART.
- Annual AIDS mortality is currently around 1% of the workforce and is set to decline significantly where access to ART is scaled-up.
- Provision of second-line therapy will become an issue of relevance to teacher management in the next 5 years, where its provision will prevent hundreds of teacher-years of absence in 2014 and a similar number of annual teacher deaths.
- Countries vary in their level of EFA achievement. Meeting EFA in the EAC region will necessitate a tripling of current teacher recruitment rates.
- Facilitating access to voluntary counselling and testing (VCT) and ART can remove the necessity to recruit 34,000 additional teachers who would be required to meet the achievements of EFA.
- The cost burden of HIV to the education sector in the EAC region currently totals US$10.7 million annually.
- Providing VCT and first line antiretroviral therapy (FLART) to teachers is cost-effective, providing a return of US$1.15 on the dollar. Given the provision of these treatments, further providing second line antiretroviral therapy (SLART) is also cost-effective, returning US$1.85 on the dollar.

Education Sector Response to HIV

The education sectors of the different countries of the EAC have undertaken a wide range of different activities towards the prevention and mitigation of HIV and AIDS:

Policies and Strategies

Various policies and strategies have been formulated at both regional and national levels providing guidance for the education sector's systematic response to HIV. Their development has taken into consideration existing international and regional guidelines such as Education for All (EFA), and the Dakar Declaration Framework for Action, among others.

- At the regional level, the policy response to HIV is multi-sectoral and there is neither a regional HIV and AIDS policy nor a strategic plan specific to the education sector presently. The following regional policies and strategic plans of relevance to the education sector have been formulated under the coordination and facilitation of the EAC Secretariat, and with the active participation of all Ministries of Education (MoEs), National AIDS Councils (NACs) and Ministries of Health (MoHs), among others:
  o An Integrated Multi-sectoral Strategic Plan for HIV and AIDS (2008-2012), (EAC, 2007, 2008a, 2008b, 2007a).
  o A Workplace Strategy that encompasses all four sectors of EAC Secretariat:
    i) Trade, planning, industry and finance;
    ii) Education and youth;
    iii) Agriculture, livestock, fisheries and natural resources; and
    iv) Infrastructure, transport, and public works (EAC, 2008d).

- A Strategic Plan on Sexual and Reproductive Health and Rights in East Africa for the period 2008-2013.
- A Gender and Community Development Framework.

- At the national level, all EAC partner states with the exception of Burundi have a national HIV and AIDS Strategy and an Education sector-specific HIV and AIDS Strategy; all the five states have Action Plans, and national Free Primary Education (FPE) policies for Education For all (EFA), as well as workplace policies (except one).
- All the states have education sector HIV policies with the exception of Burundi and URT - Zanzibar. In the latter, response to HIV by the education sector is referenced in the Education Policy (Burundi and Zanzibar situation analysis reports). All of the EAC partner states have either a School Health and Nutrition (SHN) policy or a Memorandums of Understanding (MOUs) between the key Ministries in place. Kenya's and Uganda's policies are however, currently in draft form.

Planning, Management and Mainstreaming

- In response to demand at national and regional levels for the establishment of concrete mechanisms for exchanging information and experiences among neighbouring countries facing similar operational challenges, the Accelerate Initiative facilitated the formation of Networks of HIV and AIDS Focal Points, including one for Eastern Africa entitled the *Education Sector HIV Network for Eastern Africa*. Members serve as MoE HIV and AIDS Focal Points and are appointed by MoE Ministers. As well as being members of the Education Sector HIV Network for Eastern Africa, the EAC partner states MoE HIV and AIDS Focal Points are members of a regional Technical Working Group (TWG) on the education sector response to HIV that is coordinated at the EAC Secretariat.
- At regional level, the education response to HIV is managed within the EAC Secretariat's Education Programme, which works closely with the EAC Health Programme, as well as with the MoE HIV and AIDS Focal Points and their education sector HIV and AIDS Network for Eastern Africa.
- All MoEs of the EAC partner states have HIV and AIDS Focal Points who are actively involved in the day-to-day coordination of the sector's response.
- NACs work closely with and provide technical guidance to the education sector responses both at national and regional levels.

Coordination

- The EAC Secretariat is the coordinator of the education sector's response to HIV within the East African region. It aims to provide guidance, for instance, in formulation of policy and strategy, programmatic interventions and capacity building for effective implementation. The Principal Education Officer has the coordinating responsibility, working closely with the MoE HIV Focal Points.
- A regional initiative is the planned harmonisation of the education system and training curriculum of all subjects from pre-primary to tertiary institutions. In this initiative, HIV is cross-cutting and will be integrated in, for example, life skills education training. In addition to national governments, a Regional Partnership Forum of NGOs/civil society organisations/faith-based organisations (FBOs) is also involved in this initiative, and aims to represent grassroots communities.
- The MoEs within the five EAC partner states coordinate the education sector's response to HIV.

Capacity Building and Decentralisation

- A great deal of effort has been put to build the capacity of the various players in the education sector response at both regional level and within countries.
- Lack of sufficient financial resources is a commonly cited challenge to the education sector's response. To address this, capacity building needs to be part of the national costed educational plan.
- At regional level presently, according to key informants, the EAC Secretariat does not have institutional capacity to respond effectively to HIV within the education sector, in terms of manpower.
- In all the partner states, the response by the education sector is being decentralised to enhance effectiveness and efficiency.

Monitoring and Evaluation Framework

- M&E is one of three principles in the *'three-ones principles'* framework to which all EAC partner states, like most sub-Saharan African countries, adhere to and this underscores the activity's importance in the sector's response to HIV.
- The regional EAC M&E of the response to HIV and AIDS has to-date mainly focused on the multi-sectoral response, rather than a specific education sector M&E response.
- At the national level, the partner states education sector HIV and AIDS M&E are at different stages and could be strengthened. Challenges include a lack of human capacity with sufficient skills for better coordination and management of the M&E programme.

HIV Prevention Education

- Burundi, Rwanda, Uganda and URT are integrating HIV and AIDS and life skills education into the overall curriculum. Kenya mainstreamed HIV and AIDS education in all subjects through infusion and integration and in January 2008 there was introduction of Life Skills as a standalone subject in the curriculum.
- Condom-related education is excluded from the content of HIV prevention education imparted by the Education Ministries to children in primary and secondary schools throughout EAC region.

Teacher Training

- Teachers have a critical role in widening and strengthening the sectoral response to HIV and AIDS and can significantly contribute to the reduction of new infections. Their training is an essential prerequisite in preparing and supporting them and other education personnel to address and impart education about issues relating to health, HIV and AIDS and nutrition.
- HIV and AIDS and life skills are not included in the curriculum for the professional preparation of new teachers in Burundi (HEARD/MTT, 2004 as cited in Burundi SITAN Report). To ameliorate this, in 2001, United Nations Children's Fund (UNICEF) and the MoE's Office of Rural Education introduced a six-year in-service training programme for primary schoolteachers. The training takes place during the summer holidays and addresses all subjects and topics of the primary education curriculum including HIV and AIDS (Burundi SITAN report).
- In Kenya, HIV and AIDS training and other activities for pre-service teachers are offered through teacher training colleges (TTCs). Kenya's TTC curriculum, in use since January 2009, includes all aspects relating to HIV and AIDS, including stigma, care and support.
- In both Kenya and URT - Tanzania Mainland, programmes targeting in-service training on HIV are offered to teachers from selected schools in all regions. In the latter,

special training in HIV and AIDS, sexually transmitted infections (STIs), life skills education, and counselling skills is also provided during pre-service training.

- Uganda also provides both pre-service and in-service training that includes HIV life skills education. Uganda's MoE's UNITY project has orientated teachers of students with special needs on effective utilisation of education materials targeting them.
- In Rwanda, life skills education for HIV and AIDS prevention is currently undergoing revision for all levels from primary through tertiary (Kenya, Rwanda and Uganda country reports).

Complementary Approaches

- At both regional and national levels, several complementary approaches are being employed targeting school-age children and out-of-school youth. At the regional level, these include an essay writing regional competition organised by the education programme at the EAC Secretariat.
- At the national level, approaches include peer education and the use of clubs (STOP AIDS clubs and health clubs)) in schools to impart peer education in all the EAC partner states. In Burundi, education programmes in local languages are being offered through the national radio, while in Uganda, an NGO is complementing the education sector's response to HIV by fostering safer sexual and reproductive health practices among 10 to 24 year-old adolescents and young adults, teachers, parents and the community at large through a radio programme and newspaper (http://www.comminit.com/en/node/116880).

Mitigating the Impact of HIV on Teachers Living with HIV

- Evidence from data provided by key informants indicates that the education ministries have put in effort into protecting and supporting teachers living with HIV. Their rights, as well as those of other teachers and staff, are spelt out in the workplace policies.
- In all EAC countries, counselling services are available at schools, although some teachers living with HIV have concerns about the confidentiality of services.
- There is evidence that much is being done by education ministries to counter discrimination and stigma at the workplace although reports from key informants suggest that problems continue.
- The presence and size of support networks for teachers living with HIV vary throughout the EAC partner states. Kenya has the oldest network (Kenya network of positive Teachers (KENEPOTE), while Burundi's and Rwanda's are the smallest and most recently formed networks. URT - Zanzibar is yet to initiate a network for teachers specifically, although they are free to join the membership of general networks for people living with HIV. These networks play an important role, allowing teachers to share experiences and providing psychosocial support.
- Teacher Unions and networks often work together to promote the welfare of teachers living with HIV, to lobby for treatment access, to carry out workshops and to put in place workplace policies.

Mitigating the Impact of HIV on Children Affected by AIDS

- The growing number of vulnerable children needing care and support in all EAC partner states poses significant concerns.
- The major needs of orphans and most vulnerable children, according to key national informants include support for school requirements such as fees, food and shelter, love and care, as well as psychological support.
- In Rwanda in 2005, 16,000 orphans and most vulnerable children in school were receiving support for tuition fees, materials, uniforms, and medical insurance.

- The Kenyan Government implements an OVC program which has been providing basic services and education to vulnerable out-of-school children through a Street Families Rehabilitation Trust Fund started in 2003. In order to mitigate the socio-economic impact of HIV and AIDS. In 2007, MoE introduced the Most Vulnerable Children (MVC) Support Grant in primary schools which goes towards purchase of uniforms, shoes, desks and sanitary wear for the girl child. In addition, through the conditional cash transfer orphans are targeted for assistance at the household level
- United Republic of Tanzania has formulated a national plan of action through the Department of Social Welfare to place orphans and most vulnerable children under institutional support services at village level.
- Additional to FPE, some of the EAC partner states have waived tuition fees in secondary schools. In URT - Zanzibar, for example, students enrolled in lower secondary school do not pay tuition fees and this has become the case in Rwanda since January 2009.
- In Burundi, the Ministry of Primary and Secondary Education (MoPSE) exempts double orphans from paying tuition fees in secondary schools.
- Conditional cash transfers are another form of support that can help overcome barriers to education and are being used in Kenya, Rwanda and Uganda (Focal Point Survey, 2007). These can be particularly effective when tied to school attendance.

School Health and Nutrition Programmes

School Health and Nutrition (SHN) programmes are an important component of health sector programmes and a key strategy for achieving EFA. The FRESH (Focusing Resources on Effective School Health) framework, endorsed by many different agencies and countries, highlights the following four core areas for SHN programmes:

1. Provision of health promoting policies in schools.
2. Increasing children's access to health and nutrition services.
3. Ensuring a safe and sanitary school environment.
4. Skills-based health education in schools.

SHN Policies

- Burundi's national health policy covers the period 2005 – 2015. School health is a priority of the government. In 2008, Kenya's National Comprehensive School Health Policy was signed and officially launched. . The policy integrates HIV&AIDS as well as STIs.
- Rwanda's National School Health Policy of 2002 integrates HIV and AIDS and provides guidelines on life skills based health education in the schools, SHN-related services and standards and procedures to make the school environment safe.
- In Uganda, the Ministry of Health has drafted a policy on school health that is awaiting approval and finalisation. Its specific objectives are to improve provision and utilisation of safe water, hygiene and sanitation facilities, among others. There is no information on the integration of HIV and AIDS issues in the Uganda draft.
- URT - Zanzibar does not have a SHN policy, the Ministry of Education & Vocation Training has however, entered into a MOU with the Ministry of Health and Social Welfare (MoHSW), to ensure that SHN services are provided in all schools.
- The SHN policies of Burundi, Kenya, Rwanda and Uganda all address HIV and AIDS issues.

School-Based Health Services

- All EAC partner states are providing school feeding services for school-age children although not nationally.

- Deworming services and reproductive health services are also provided for school-age children, while counselling services are provided to teachers.

Safe and Sanitary School Environment

Water supply, sanitation and hygiene are recognised as being central to ensuring the rights of children to survive grow and develop into healthy and fulfilled citizens of the world (UNICEF, 2008).

- All EAC partner states have national policies or policy regulation mechanisms to promote a safe child-friendly school environment. This includes regulations, such as, the provision of safe drinking water, hand washing facilities and gender-segregated toilets, to promote a hygienic environment in schools.

Skills-Based Health Education

- Although there are differences across the EAC partner states, all of them are providing skills-based health education. In addition to the HIV and life skills education, the partner states are providing skills-based education on topics such as malaria prevention and hygiene.

Conclusions

HIV and AIDS is a pressing issue for all the countries of the EAC and this has resulted in widespread action to combat the epidemic across the region. At the level of policy and planning, the regional response to the infection has occurred at the multi-sectoral level through the development of a strategic plan for HIV and AIDS, a workplace strategy that encompasses all sectors, a strategic plan on sexual and reproductive health and a gender and community framework. At the national level, specific education sector responses have been extensive and comprehensive with most countries developing sector-specific policies, strategies and action plans.

Considerable steps have been taken to enable the management and planning of HIV and AIDS responses. At the regional level, the EAC Secretariat coordinates the education sector's response to HIV within the East African region, providing countries with input about formulation of policy and strategy, programmatic interventions and capacity building for effective implementation. In the future, a regional initiative to harmonise the education system and training curriculum of all subjects from pre-primary to tertiary institutions will have considerable impact on HIV and AIDS, including the issues as a cross-cutting topic that will be integrated across the curriculum. At the national level, all Education Ministries have HIV and AIDS Focal Points who coordinate their activities through membership of an EAC Technical Working Group on HIV and AIDS and education. Focal Points are also members of the Network of Eastern and Southern African Focal Points of the Accelerate Initiative. In all countries, scale level implementation of activities is being enabled through decentralisation of activities. Efforts to monitor and evaluate the impact of activities are occurring across the region with differing levels of success.

A wide range of different activities is taking place across the EAC region. Students are learning about HIV and AIDS in the schools of all the EAC countries and complementary approaches to education such as peer counselling are common. All countries are seeking to mitigate the impact of the disease on teachers and children through measures such as VCT, the provision of anti-retrovirals (ARVs) and access to psychosocial counselling and material support for children affected by AIDS. Much activity is taking place within the context of wider SHN programming which seeks to address the spectrum of health and nutrition concerns that affect the education sector.

Mathematical modelling has been used in this report to underline the serious impact that HIV and AIDS is having upon the EACs education sector and in particular its efforts to achieve EFA. For example, each year HIV and AIDS imposes a large burden (4,200 teacher-years) of absenteeism on education in the EAC that cannot be afforded. In fact, investing in impact mitigation is cost-saving; increased teacher access to treatment saves money by the reduction of the impact of HIV on absenteeism and deaths. This report has found a strong willingness and desire of the EAC and its member states to address the challenges posed by HIV and AIDS. These, and the data collected during the situation analysis has led to the formation of recommendations discussed below.

Recommendations

Cross-Regional Coordination

For cross-regional coordination of HIV in the education sector within the EAC region, it is recommended that:

- The EAC Secretariat should formally be commissioned and resourced to build capacity in the education sector prevention and mitigation of HIV and AIDS across the region.
- Play a primary role in sharing information and promising practices through inter-country, inter-regional and inter-agency networking and in enabling the evolution of common policies and strategies responding to HIV and AIDS.
- Act as key driver in enabling cross-adaptation and complementarity of country responses to HIV and AIDS on education, and joint advocacy by Ministers of Education of the partner states for systematic and harmonised 'spread, depth and speed' of the implementation of the responses.
- Rather than seeking to establish the EAC Secretariat as a parallel coordinating body to the East African Network of MoE HIV Focal Points (Burundi, Ethiopia, Eritrea, Kenya, Madagascar, Malawi, Mozambique, Rwanda, Uganda, United Republic of Tanzania and Zambia), it is recommended that the EAC Secretariat offer formally to provide a sustainable 'home' where the mission and vision of the East African Network of the MoE HIV coordinators can be translated into accelerated responses to the impact of HIV and AIDS on education across the EAC region. This would enable EAC activities to occur constantly in coordination with the wider network but with the understanding that in some circumstances, particular activities might comprise EAC members only.
- If the EAC Secretariat undertakes such a coordinating role, it is recommended that commitment be made to staffing, resourcing, and training staff within the EAC Secretariat capable of undertaking such a task.

Collating and sharing good practices across the EAC region

The time is now ripe for the EAC Secretariat, in its capacity as the regional coordinating body, to bring together all the expertise and experience that has been accrued across the region in order better to assist the work of the community's different partner states. Such work can be strengthened by drawing also on lessons learned in other parts of the world such as Western and Southern Africa and the Caribbean. It is recommended that the EAC Secretariat could strengthen and encourage the harmonisation of different activities by bringing together experience and understanding in the following three areas:

1. **Policy Development:** A synthesis of good practice found in the policies of the EAC's member states would enable the production of a generic education sector HIV policy for the region. A particular concern would be to demonstrate how education HIV policies can be incorporated into SHN policies, ensuring their greater sustainability.

Production of such a synthesis would enable member states to critique and strengthen their existing policies and would also lead to an increasing harmonisation of policy approach across the region and its borders.

2. ***Strategic Planning:*** A similar synthesis of good practice in strategic planning would act to strengthen and harmonise activities in countries across the region.

3. ***Operational Guidelines:*** Data collected during the situation analysis has demonstrated the extensive experience and ingenuity existing in countries that enables implementation of activities to occur. It is recommended that the EAC Secretariat document enable countries to learn from each others' experience in the following areas:

    - Programme administrative and management issues.
    - Building and maintaining institutional skills and capacity.
    - Identification of human and financial resources.
    - Mainstreaming of HIV activities across education sectors.
    - Implementing gender and workplace policies across the education sector.
    - Care of teachers and children affected by HIV (including orphans and most vulnerable children).
    - Effective collaboration with other sectors/programmes.
    - Provision of education and services to out-of-school youth.
    - Addressing sensitive issues such as the use of condoms and male circumcision.
    - Enabling parents, communities, FBOs, NGOs and civil society to play an appropriate role in deciding, encouraging and supporting the education sector HIV activities.
    - The identification of geographical areas, communities and groups within the EAC region in priority need of education sector HIV and AIDS activities.
    - Position of the life skills subjects in the curricula.

Region-Wide Advocacy

The EAC Secretariat should play a key role in region-wide advocacy that would address some of the issues that act powerfully to inhibit the work of the education and other sectors to prevent and mitigate the impact of HIV. In particular, greater advocacy is needed to:

- Enhance the impact of activities taking place across the region to address the stigma and discrimination that continues to affect the countries of the EAC.
- Enhance the awareness of teachers and education sector staff irrespective about existing workplace policies and related issues.
- Enable children affected by HIV (including orphans and most vulnerable children) and their carers to know more about their rights and responsibilities.
- Encourage greater provision of free, accessible and confidential VCT services, and both first- and second-line ART for teachers and other education sector staff.
- Encourage many more teachers, adolescents and youth to seek HIV testing and encourage enhanced understanding of the need for confidentiality to be upheld for those that make use of testing.
- Promote the roll-out of PMTCT and pART in order to give children living with HIV the best possible outlook and to reduce the infection rates of children.
- Ecourage EAC countries to prepare for the increased challenges of a growing number of children living with HIV in schools.

1. BACKGROUND

Globally it has been estimated that 33.2 million people are currently living with HIV (UNAIDS, 2008a). The pandemic has claimed the lives of 2.1 million people and created 11.4 million AIDS orphans. Although no part of the world is immune to HIV and AIDS, sub-Saharan Africa, home to a tenth of the world population, is the epicentre of the pandemic. Over two-thirds of all people living with HIV reside in this region where 15,000 new infections occur daily, 25.5 million inhabitants are living with HIV with two-thirds (66.7%) of them from Eastern and Southern Africa (UNAIDS, 2008a). Due to the rising population growth rates and the effects of life-prolonging antiretroviral therapy (ART), the global numbers of people living with HIV have continued to increase. This is particularly so in most sub-Saharan African countries. Although the prevalence has been on a steady decline, the region still remains the worst hit.

The pandemic has affected all aspects of life in the region. According to the World Bank President, James Wolfensohn, HIV and AIDS is "a major development challenge, if not the most important challenge confronting Africa today". It has shortened life expectancy at birth by approximately 15 years and slowed down economic growth throughout the region. Indeed, because the risk of contracting HIV by women aged between 15 to 24 years is 2 to 6 times higher than that of their male cohorts, the life expectancy of females is lower than that of males in four African countries including one East African Community (EAC) partner state, Kenya (UNICEF, 2008).

Given the slow pace of access to ART, within the next 5 years every seventh child in the worst-affected sub-Saharan African countries will be an orphan largely because of AIDS. According to the World Health Organisation (WHO) jointly with the Organisation of the Petroleum Exporting Countries (OPEC) (WHO/OPEC, 2006) massive expansion of prevention, treatment and care efforts are required in order to halt the AIDS death toll from rising further. The Joint United Nations Programme on HIV/AIDS (UNAIDS) Executive Director Peter Piot emphasises the urgent need for the intensification of HIV prevention efforts if the gains of the past few years are to be sustained and universal access achieved (Bundy *et al.*, 2008).

1.1. The Education Sectors Role in School Health and Nutrition and HIV and AIDS

1.1.1. School Health and Nutrition

In recent years, the education sector in low-income countries has come to play an increasingly important role in the health and nutrition of the school-age child. This is largely supported by research over the past two decades which has shown that poor health and malnutrition are critical underlying factors for low school enrolment, absenteeism, poor classroom performance and dropout; all of which act as important constraints in countries' efforts to achieve Education for All (EFA) and their education Millennium Development Goals (MDGs).

Consequently, programmes have focused on improving health and nutrition for all children, particularly the poor and disadvantaged, in order to reap education and subsequent economic gains. Education sectors in sub-Saharan Africa adopted school health and nutrition (SHN) programmes in the 1990s when the EFA was launched and incorporated it within related programmes (Jukes *et al.*, 2008).

A major step forward in international coordination was achieved at the World Education Forum in Dakar in April 2000, where a joint partnership effort by the United Nations

Educational, Scientific and Cultural Organisation (UNESCO), WHO, the United Nations Children's Fund (UNICEF), and the World Bank led to the development of the FRESH (Focusing Resources on Effective School Health) framework. Based on good practices recognised by all partners, this framework provides international consensus for effective implementation of comprehensive SHN programmes (Jukes *et al.*, 2008). In order to provide a sound initial base for any SHN programme, the framework calls for four core components to be comprehensively implemented in all schools:

- Health-related school policies,
- safe and sanitary school environment,
- skills-based health education, and
- school-based health and nutrition services.

Furthermore, the following three supporting partnerships have come to be seen as integral to the effective implementation of SHN programmes:

- Health and education sectors (especially teachers and health workers);
- schools and communities; and
- pupils and stakeholders.

1.1.2. HIV and AIDS

In the recent past, HIV has become a priority for the education sector. School-age children have the lowest HIV prevalence of any age group. Indeed, even in the worst affected countries, the vast majority of schoolchildren are not infected. For these children, there is a **window of hope**, a chance to live a life free from AIDS, if they can acquire knowledge, skills, and values that will help protect them as they grow up. Providing young people, especially girls, with the **social vaccine** of education offers them a real chance at a productive life and has been shown to have a dramatic impact on reducing levels of stigma and discrimination. Some 7 million cases of AIDS could be avoided in a decade by the achievement of EFA (Global Campaign for Education (GCE, 2004).

Integral to any comprehensive SHN programme is HIV prevention and mitigation. This understanding and key events around the millennium leading up to the 2000 Dakar World Education Forum, gave new momentum to the role of the education sector within the multi-sectoral HIV response. The sector is now recognised as playing a key 'external' role in HIV prevention and in reducing stigma, and an important 'internal' role in providing access to care, treatment, and support for teachers and staff – a group that represents over 60% of the public sector workforce in many countries.

1.1.2.1. The *'External'* Role of Education

The completion of education has been shown to decrease susceptibility to HIV as the epidemic matures (Bundy *et al.*, 2008). Young people, particularly girls, who fail to complete basic education, are more than twice as likely to contract HIV. Sixty percent of new infections in sub-Saharan Africa occur among older teens and young adults aged 15 to 24 years (UNAIDS, 2002).

There is substantial evidence that education delays sexual debut, age of marriage and first pregnancy, all of which benefit female reproductive health and mortality (Hargreaves and Boler, 2006). Studies in South Africa and Uganda show that one additional year of schooling is likely to lead to a reduction in the risk of HIV infection by at least 6.7% (Bärnighausen *et al.*, 2007; de Walque *et al.,* 2005; Hargreaves *et al.,* 2007). Girls and young women educated at higher levels are better able to negotiate safer sex and reduce HIV rates. Many women lack the power to determine who to have sex with, or when and how to have sex. The new challenge is how to empower young women to assert their sexual and reproductive

rights. Giving girls an education is widely recognised as a good way to build "girl power" (Hargreaves with Boler, 2006).

Part of the education sector's '*external*' role is also to address stigma, which remains the greatest challenge and the major barrier to accessing and providing assistance to, for example, children affected by AIDS (UNAIDS IATT, March 2008). According to UNESCO (2007), education helps to overcome the conditions that facilitate the spread of HIV and has the potential to reduce stigma and discrimination against people living with HIV by promoting understanding and tolerance. It also contributes to the knowledge and personal skills essential for the prevention of HIV and the protection of individuals, families, communities, institutions and nations from the impact of AIDS. Failure, for example, to ensure confidentiality in the school environment exacerbates the difficulties of overcoming stigma and discrimination.

1.1.2.2. The '*Internal*' Role of Education

The education sector also has an important '*interna*l' role in providing access to care, treatment and support for teachers and personnel. There are numerous ways of addressing these obstacles. For example, by fully implementing existing national and institutional policies; increasing involvement of teachers living with HIV in setting policies and giving practical advice; providing universal access to voluntary counselling and testing (VCT); care and support; addressing HIV issues during teacher training activities to reduce stigma among teachers and equipping teachers with the skills to avoid infection; and teaching young people about HIV and how to avoid infection. The education sector can also help teacher unions to support their members living with HIV and to combat stigma and discrimination, create effective national and regional support networks for teachers living with HIV, as well as increase national and institutional recognition of the social impact of HIV on teachers, in particular female teachers, living with HIV (PCD and The World Bank, 2008). The education content must be supplemented with effective training in life skills such as, critical and creative thinking, decision-making and self-awareness, as well as with the knowledge, attitudes and values that will help young people to make sound health-related decisions.

In a bid to accelerate progress towards the achievement of the universal primary education MDG goal, the EFA/Fast Track Initiative (FTI) was launched in 2002. This is a joint partnership between donors and low-income countries and is built on the following commitment by:
- Partner countries to give priority to primary education and to develop sound national education plans; and
- donors to increase support in a transparent and coordinated manner (FTI Secretariat, 2005; Fast Track Initiative: Building a Global Compact for Education).

The countries are supported by FTI donor partners to develop strategies to achieve universal completion of quality primary education. The FTI process provides the partners with a good opportunity to comprehensively review how HIV and AIDS is addressed within the country's overall education sector plan. The EAC States are all FTI countries.

1.2. The Education Sectors Response to HIV in Sub-Saharan Africa

Building on the new impetus to the education sector's role in the multi-sectoral response to HIV and AIDS, was highlighted during three key events in Africa around the new millennium: the 1999 Lusaka International Conference on AIDS and STIs in Africa (ICASA), the EFA Regional Meeting in Johannesburg and the 2000 Dakar World Education Forum (Rispel, 2006). In 2002, countries affected by HIV in sub-Saharan Africa launched the *Accelerate*

Initiative, with assistance from the UNAIDS Inter-Agency Task Team (IATT) on Education. This initiative has served as a coordinating mechanism for Ministries of Education, UNAIDS co-sponsoring agencies, bilateral donors and civil society organisations to meet their goal of accelerating the education sector response to HIV and AIDS. Its objectives are:

- promoting leadership in the education sector and creating sectoral demand for a response to HIV and AIDS;
- harmonising support among development partners so as to better assist the countries and reduce transaction costs;
- promoting coordination with national AIDS authorities and enhancing access to HIV and AIDS funds; and
- sharing information on HIV and AIDS specifically relevant to the education sector and strengthening the technical content and implementation of the education sector response.

In response to demand at national and regional levels for the establishment of concrete mechanisms for exchanging information and experiences among neighbouring countries facing similar operational challenges, the Accelerate Initiative facilitated the formation of Networks of HIV and AIDS Focal Points. The members who serve as Focal Points are officially appointed by Ministers of Education in each respective country. The networks provide a framework for consultation, sharing of experiences and expertise among actors in the field of HIV and AIDS. The following three regional networks have been formed throughout sub-Saharan Africa and function broadly within the main Regional Economic Communities (RECs) of the African Union:

- Ministry of Education Network of HIV and AIDS Focal Points for Economic Community of West African States and Mauritania[1];
- Ministry of Education Network of HIV and AIDS Focal Points Central Africa under the political umbrella of the Economic Community of Central African States[2];
- Education sector HIV and AIDS Network for Eastern Africa (operating within the sub-regional economic frameworks, such as, the EAC and the Southern African Development Community (SADC).[3]

These three regional networks have a total membership of 37 countries. The Eastern Africa Network consists of 12 countries, which includes all five partner states of the EAC.

The networks have significantly become '.... *not only conduits for sharing information, but also political structures that now determine the sub-regional sectoral agenda*' (Bundy *et al.*, 2008). They have been so successful in assuming full responsibility and ownership of the Initiative, that Accelerate activities at regional, sub-regional and national levels, now reference those initiated by the Focal Points within their Networks (Accelerate Initiative, 2008). The networks have become the drivers of regional and national level change and continue to facilitate/build dialogue between the networks and the development partners in the determination of the way forward.

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[1] Member countries: Benin, Burkina Faso, Cape Verde, Cote d'Ivoire, The Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone and Togo.
[2] Member countries: Cameroon, Central African Republic (CAR), Chad, Congo, Democratic Republic of the Congo (DRC), Equatorial Guinea and Gabon.
[3] Member countries: Burundi, Eritrea, Ethiopia, Kenya, Malawi, Mozambique, Rwanda, Uganda, United Republic of Tanzania and Zambia.

1.3. About the East African Community (EAC)

The EAC is a regional organisation of five states – Burundi, Rwanda, Kenya, Uganda and the United Republic of Tanzania – established by a Treaty ratified and signed by the latter three countries on 30th November 1999 and effected on 7th July 2000. The Republics of Burundi and Rwanda acceded to this Treaty on 18th June 2007 and became full members on 1st July 2007. The realisation of a large regional economic block has had great strategic and geo-political significance and prospects for the renewed EAC, which aims to deepen cooperation among the HIV-affected partner states in the political, economic, social and other fields for mutual benefit.

As shown in the following structure (Figure 1.1), the EAC is headed by a Summit of Heads of State. It has a legislative Assembly, a Court of Justice and a Council of Ministers.

Figure 1.1: Basic Structure of the EAC
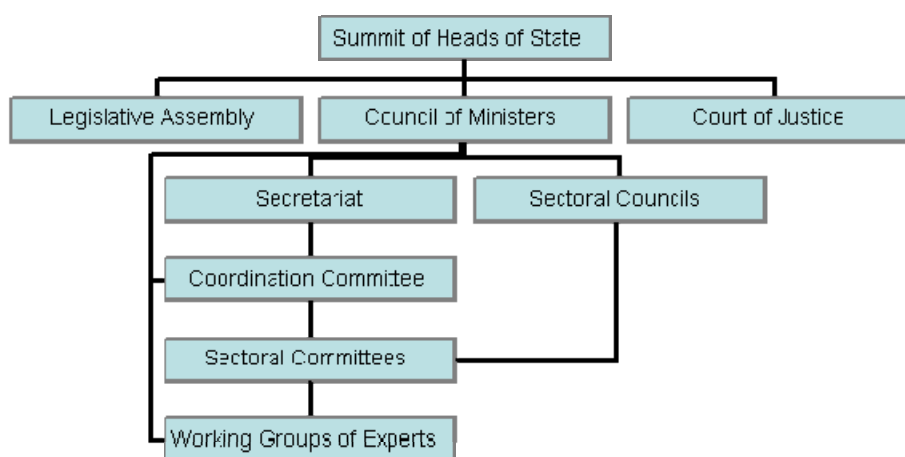
*Source:*http://www.iss.co.za/static/templates/tmpl_html.php?node_id=1410&slink_id=3036&slink_type=12&link_id=3893 Figure 1.1. provides a description of the structure from Figure 1 in Annex 5.

The Secretariat is enabled to function through the participation of a Coordination Committee, Sectoral Committees and Technical Working Groups of Experts (a detailed structure of the EAC is appended – Annex 5). The Secretariat is the coordinator of EAC's joint regional programmes, while the partner states are the implementers. In the case of the situation analysis, the Principal Education Officer (PEO) and the Health Advisor work closely with a Technical Working Group (TWG) on Accelerating the Education Sector Response to HIV &AIDS. This Group is constituted by MoE HIV focal persons from the five partner states (Source: EAC 2006c).

The EAC region covers over 1.7 million square kilometres with a combined population of approximately 127 million people and US$41 billion (2006) gross domestic product. Like elsewhere in sub-Saharan Africa, the EAC region is dominated by a relatively young population. Table 1.1 presents 2008 estimates of each state's total population and proportions of three population age groups. Children under the age of 15 years constitute the largest population in all the EAC partner states, ranging between 41.9% and 50.0%. Only a negligible proportion (<3%) of the population are at least 65 years old.

Table 1.1. 2008 Population Estimates and Land Area of EAC Partner States

	Burundi	Kenya	Rwanda	URT	Uganda	Regional total pop/land area & average % ages
Total population in 2008	8,691,005	37,953,838	9,241,661	40,213,162	31,367,972	127,467,638
Age groups (%): 0 – 14 years	46.3	42.2	41.9	43.5	50.0	44.8
Age groups (%): 15 – 24 years	20.5	20.9	21.5	21.3	20.8	21.0
Age groups (%): 15 – 64 years:	51.2	55.2	55.7	53.7	47.8	52.7
Age groups (%): >64 years:	2.5	2.5	2.4	2.8	2.2	2.5
Land Area (km^2)	25,650	569,250	24,949	886,039	199,550	1,705,438

Source: http://www.indexmundi.com/tanzania/age_structure.html;
http://www.indexmundi.com/uganda/demographics_profile.html / www.aegis.com/countries/uganda.html
http://www.indexmundi.com/kenya/demographics_profile.html http://indexmundi.com/burundi/demographics_profile.html
National Institute of Statistics of Rwanda, 2007; U.S. Census Bureau (*www.census.gov*)

1.4. The East African Community and HIV and AIDS

Some of the earliest HIV diagnoses in Africa were made in the EAC partner states between 1982 and 1984. In the 1990s, HIV and AIDS in the EAC region was characterised by rapid spread that peaked at 20% in Uganda and between 12% and 14% in the other partner states.

The HIV prevalence rates have not been uniform in any one partner state. For example, areas bordering Lake Victoria have been far more affected than elsewhere for reasons including: high mobility, gender inequality, cultural practices, prevalence of sexually transmitted infections (STIs), and poverty (AVERT, 2008; EAC, 2007 and 2008a). The area has an estimated population of 30 million people sharing common economic activities, cultures and social interactions. Generally as shown in Table I.2, there are also geographical and gender differentials throughout the region, with relatively higher rates in urban areas than in rural areas and higher rates among females than males.

The last decade has seen declines in HIV prevalence rates which are attributed to positive national responses – the most marked having been observed in Kenya and Uganda. The declines are also the result of the increased visibility of AIDS – people who have been personally affected by AIDS are more likely to change their behaviour. However, the last year has seen a small rise in the HIV prevalence rates in Kenya and Uganda most likely due to recent increases in access to HIV care and treatment services. Table 1.2 represents the national adult HIV prevalence rates of 2008 for each EAC partner state.

Table 1.2: Adult HIV Prevalence Rates by EAC Partner States

Partner States		First diagnosis of HIV (Year)	2008 HIV Prevalence Rates (%)	Males (%)	Females (%)	Urban (%)	Rural (%)
Burundi		1983	2.0 (2007)	0.4 (15-24 yr-olds) 2007	1.3 (15-24 yr olds) 2007	9.4 (2002)	2.5 (2002)
Kenya		1984	7.4	5.6	8.7	8.9 (2008)	7.0 (2008)
Rwanda (2005)		1983	3.1	3.6	2.3	7.3	2.2
United Republic of Tanzania	Tanzania Mainland	1983	5.8 (2007/08)	6.3	7.7	10.9	5.3
	Zanzibar	1986	0.6 (2004)	0.4 (2003)	1.3 (2003)	no data	no data
Uganda		1982	6.4	6.4	7.5	10.1	5.7

Sources: All situation analysis country reports; UNAIDS (2008c) (More details in **Annex 1.2**: The HIV & AIDS Situation in EAC partner states) UNAIDS/WHO 2008b); http://indexmundi.com/burundi/hiv_aids_adult_prevalence_rate.html; www.who.int/**hiv/HIV**CP_BDI.pdf; http://www.unfpa.org/hiv/docs/report-cards/rwanda_reportcard.pdf; http://www.aidskenya.org/public_site/webroot/cache/article/file/Final_KAIS_Release_Presentation.pdf(2008) http://www.who.int/entity/hiv/strategic/en/lusaka_report.doc; UNAIDS (2007); World Health Organisation (2005)

1.5. The Multi-Sectoral Response to HIV and AIDS

1.5.1. Regional Level

The EAC partner states have established various mechanisms to mitigate the impact of HIV and AIDS. These include the development and adoption of a regional multi-sectoral response in recognition of the seriousness and the multi-dimensional nature of the pandemic. The genesis of the regional multi-sectoral response at EAC level goes back to 2001 following the ratification of the EAC Treaty between Kenya, Uganda and URT and precedes the education sector's response to HIV and AIDS.

Jointly, the EAC partner states have since drawn the Regional Strategic Plan for HIV and AIDS (2008-2012), setting the vision, goal, development objective and strategic objectives, and defining strategies for their achievement, as well as determining the indicators and processes for measuring the results.

1.5.2. National Level

The national multi-sectoral response was accelerated by the declaration of HIV and AIDS as national disaster/emergency in some of the EAC states – in Kenya and Burundi (1999) and in the URT (2000). One of the major drivers of national responses was the establishment of AIDS Commissions/Councils which are the bodies charged with coordination of all national initiatives in the response to HIV and AIDS:

- Burundi's National AIDS Commission set up in 2001;
- Kenya's National AIDS Control Council and Rwanda's National AIDS Control Commission both in 2000;

- The URT has two AIDS Commissions: Tanzania Mainland's AIDS Commission was established in 2001 and Zanzibar's AIDS Commission the following year (2002).
- Uganda AIDS Commission in 1992;

With the coordination of national AIDS Councils between 2000 and 2004, all the EAC partner states developed national HIV and AIDS frameworks to guide the multi-sectoral national response:

- Kenya's National HIV and AIDS Strategic Plan 2000 – 2005;
- *URT*.: Tanzania Mainland completed its national policy on HIV and AIDS In November 2001, then formulated the first National Multi-Sectoral Strategic Framework on HIV and AIDS 2003-2007; Zanzibar's National Strategic Plan covers the period 2004/05 through to 2008/09
- Both Rwanda's national framework for the fight against HIV and AIDS and Burundi's National Strategic Plan on AIDS Control covered the period 2002-2006
- Uganda's National Strategic Framework (NSF) for HIV&AIDS 1998-2002 was formulated in 1997 (all SITAN country reports).

1.6. The Education Sectors Response to HIV and AIDS among EAC Partner States

The beginning of the East Africa's education sector's regional response to HIV can be attributed to a sub-regional workshop in Mombasa in November 2002, hosted by Kenya's Ministry of Education (MoE) and National AIDS Control Council (NACC) and the IATT Working Group to Accelerate the Education Sector Response to HIV and AIDS in Africa (Accelerate Working Group). Representatives attended the workshop from Eritrea, Ethiopia, Kenya, the URT, Uganda and Zambia drawn from the education and health sectors, National AIDS Councils (NACs), civil society and teacher unions, as well as 17 development partners. This workshop was described by the various teams as a "*watershed in their process towards developing a more effective response*" to HIV (World Bank, 2007).

A follow-up High Level Meeting on Education and HIV and AIDS in East Africa was held in Nairobi on September 29, 2003, as part of a continuing regional action by HIV and AIDS affected countries and the Accelerate Working Group. The regional effort sought to achieve EFA despite the impact of HIV and AIDS, and to strengthen the capacity of the education sector to respond effectively to related challenges. The consensus was that only through a multi-partner effort would these objectives be achieved, by promoting high level understanding and leadership, the sharing of experiences among sub-Saharan African countries, and the development of effective education sector national responses to HIV. The meeting brought together education policymakers from the six countries and facilitated the identification of future sub-regional actions and inputs to maintain the momentum of and accelerate the East African education sector response to HIV and AIDS.

In September 2006, the EAC Secretariat convened a meeting following a consultative meeting between the ministries responsible for education and development partners supporting the education sector national responses to HIV and AIDS. The purpose of the meeting was three-fold:

1. To develop a technical report on a regional strategy for supporting the education sector response to HIV and AIDS;
2. to mainstream the regional response within the calendar activities of the community; and
3. to forge and maintain partnerships for joint planning, monitoring and resource mobilisation (EAC 2006a).

The meeting was attended by delegates from the ministries of the EAC partner states responsible for education - Planning and Policy and focal persons responsible for HIV and AIDS, National AIDS Councils and non-governmental organisations (NGOs), as well as members of the UNAIDS/IATT namely the World Bank, UNICEF, UNESCO and the Partnership for Child Development (PCD).

The following vision and mission were agreed upon by this TWG to guide the activities of EAC partner states:

- *Vision:* A regional education sector responsive to HIV and AIDS and aligned towards the attainment of an AIDS free society.
- *Mission:* To accelerate the response of the education sector-wide in member countries in preventing and mitigating HIV and AIDS impacts.

The meeting identified seven areas of focus in the proposed strategic regional responses to HIV including, policy development and enhancement of infrastructure and human capacity at national and regional levels, among others. Four guiding principles for the strategic regional responses were also agreed upon during the meeting, touching on, for example, scaling up successful initiatives and ensuring gender mainstreaming in the education sector response, and being cognizant of the fact that boys are also often marginalized. The areas highlighted as well as the guiding principles are listed in Annex 3. In November 2006, Education Ministers of the EAC partner states fully supported these planned activities to accelerate their education sector responses to HIV.

Before 2002, few education systems were addressing HIV and AIDS systematically and had developed strategic plans to guide their response. The MoEs in the various EAC partner states began to teach HIV and AIDS education at varying times mostly around the new Millennium with the exception of Uganda. An HIV and AIDS curriculum was introduced in Kenyan schools in 1999 – the same year the Kenyan Government had declared HIV and AIDS as a national disaster. Rwanda's MoE was offering AIDS and life skills education by 2000 even before HIV emergency guidelines had been developed and Anti-AIDS Clubs were being formed in schools. Burundi's AIDS education in schools was being taught from 2002 and, in Uganda this was much earlier in the 1990s where both primary and secondary schools were focusing on HIV-prevention education.

1.7. The Situation Analysis

Following on from the EAC Education Ministers' recommendations to accelerate the education sector responses, the EAC Secretariat engaged with PCD and the World Bank to identify the way forward, initiating the implementation of the education sector's component of the EAC HIV and AIDS Strategic Plan 2008-2012. Data on the education sector response at the country level however, were not readily available or comparable in a form useful for regional level planning and programming in East Africa. Therefore, a situation analysis (SITAN) to collect, collate, review and analyse the education sectors response to HIV in the EAC partner states (i.e. Burundi, Kenya, Rwanda, Uganda, and the United Republic of Tanzania) was identified as the first step.

During planning discussions between the EAC Secretariat, the World Bank, the Ministry of Education HIV Focal Points and PCD at the Meeting of the African Networks of Ministry of Education HIV Focal Points, in November 2007, in Nairobi, it was agreed that a situation analysis should be conducted for the EAC.

1.7.1. Purpose and Objectives of the Situation Analysis

The purpose of the situation analysis is to inform implementation and resource (both technical and financial) mobilisation of the education sector component of the five-year EAC HIV and AIDS Strategic Plan 2008-2012, leading to the development of actionable plans at the sub-regional level for the improvement of educational outcomes of the partner states.

The objectives are to:

- assess the impact that HIV is having on education, in terms of teacher illness and death, and orphans and vulnerable children, with associated costs both of impact and impact prevention by ART, and also assess the extent to which education responses to HIV and AIDS in the EAC sub-region have adopted the wider SHN approach for improving health and education outcomes; and secondly to
- contribute to sub-regional information as a database on the HIV and AIDS-related situation relevant to the education sector.

The aims are to:

- facilitate sharing of innovations and best practices within and across countries;
- inform planning, for the development and implementation of actionable plans in the sub-regional level for the improvement of the educational outcomes;
- form a basis for the harmonisation of monitoring and evaluation (M&E) frameworks; implementation modalities; HIV-related education policies; institutional frameworks and common research needs; and
- give impetus to resource mobilisation to expand on the response to HIV and AIDS.

1.7.2. Framework of the Situation Analysis

The framework of the EAC regional situation analysis comprises of:

- An overview of the methodologies that were applied to collect, disseminate and analyse the data;
- background information on the education sector from early childhood to post-secondary learning institutions within the EAC region;
- significant health conditions identified by partner states during data collection as being relevant in affecting the education sector;
- estimations using the Ed-SIDA model on the current and future impacts of HIV to the education sector; cost implications; the care and support of teachers living with HIV, on teachers and pupils; and the achievement of EFA;
- the current education sector's response within the EAC both at regional and partner state levels;
- the existing programmes within the EAC region on school health and nutrition; and
- a summary of the outcomes drawn out from the situation analysis with the recommendations required to mobilise the education sector component of the five-year EAC HIV and AIDS strategic plan 2008-2012.

2. METHODOLOGY

This section provides an overview of the methodologies that were applied to collect and analyse the data presented in this draft regional situation analysis.

A lead consultant led the development of a situation analysis protocol and both country and regional Question Guides. The national consultants were debriefed at a workshop in Arusha, Tanzania during which the national Question Guide was further developed and adopted for use by all the consultants. It was this national Question Guide that was used to collect the information that informed the country reports referred to and appended in this draft regional situation analysis. A separate Question Guide was also used to collect regional data.

Both the country and the regional levels reviewed literature on demographics, education, HIV and AIDS and other health-related problems; relevant routine survey reports; SHN materials; policies and strategic plans; and relevant international guidelines. Such materials were collected from: the MoEs; ministries in charge of health, children, youth, gender, human rights and the East African Community; and stakeholders which included development partners, a few faith-/community-based/non-governmental organisations (FBOs/CBOs/NGOs) and civil society organisations were involved in school health-related promotion activities. These materials were reviewed in light of agreed international goals and frameworks.

Field verification and validation of the information collected for this review was achieved through interviews with representatives of local, regional (e.g. EAC Secretariat) and international agencies that were part of the education and health sectors involved in the education sector response to HIV and AIDS and health needs (see annex 1 for details of the regional key informants). The national report was validated by stakeholders, in most instances during national validation meetings.

The impact of HIV and AIDS on the education sector was estimated using the Ed-SIDA mathematical model. These projections were based on age and gender-disaggregated HIV prevalence and probably of AIDS death overtime in each state's general population, education sector statistics, and teacher relative risk data. Economic analyses were based on costs adjusted to 2009 levels and discounted into the future.

All interviewed stakeholders were invited to a workshop at the end of the situation analysis. Senior members of the MoE, development partners, and other ministry representatives from the partner states also attended the workshop.

Although the wider education sector was included as part of the situation analysis, the focus was primarily on national MoE responses to HIV, within the context of health. Therefore, a review of activities of the private sector, non-governmental organisations and faith based organisations and other agencies was not fully undertaken.

SITAN RESULTS

3. THE EDUCATION SECTOR IN THE EAC REGION

This section provides background information on the education sector in the EAC region from early childhood to post-secondary institutions of learning. The impact of HIV and AIDS on the education sector and the sectors response to HIV and AIDS are discussed later in the report. Since the analysis of tertiary education is beyond the scope of this report, it is only briefly mentioned.

3.1. Overview of the Education System

Throughout the EAC region, the government is the sole overseer of education from early childhood through post-secondary and tertiary institutions. The government is responsible for the formulation of policies related to establishment of schools and expansion of education and training opportunities: access and equity, curriculum development, national examinations and certification for teacher education. It is also the licensing authority for all private education institutions.

The curriculum used in public learning institutions at all levels except the university is developed by the MoE. Throughout the EAC region, students in the final year of primary and secondary schools, teacher training and technical colleges, sit for national examinations set and assessed by an MoE examination unit. The Government of Rwanda has recently abolished national examinations at the final year of primary school in a bid to retain many

Figure 3.1. Duration of Primary Schools in the EAC Partner States in Years
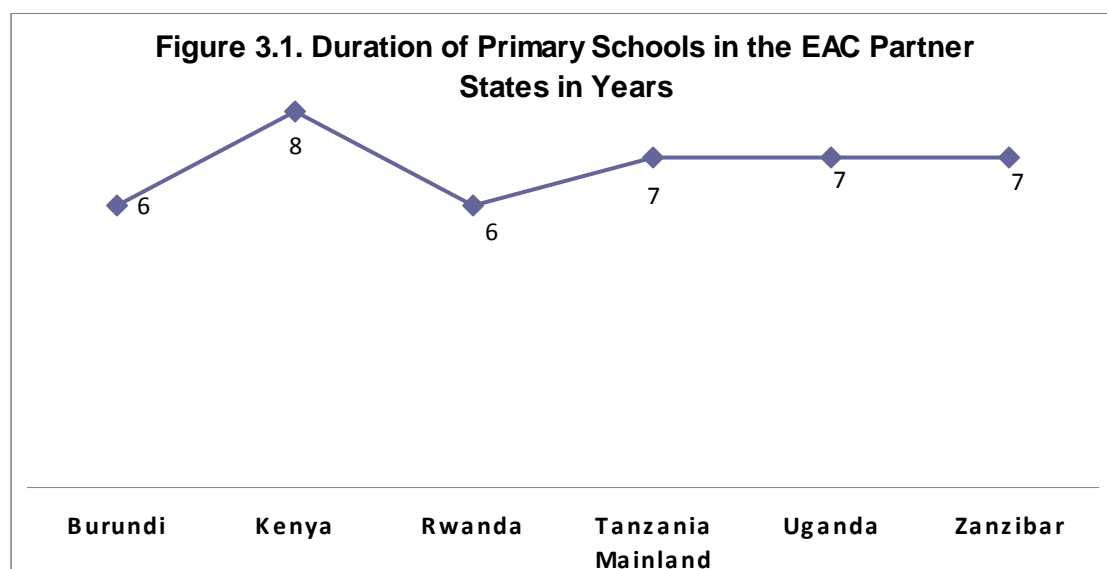
children in school longer (Rwanda SITAN report). All private education institutions that wish to be examined by this body and recognised by the government are mandated to follow the same curriculum as that of the public schools and colleges (SITAN country reports). There are minor country differences in the structure of the formal education system in the EAC partner states. For example, formal education from primary school through tertiary education generally takes 16 years in Kenya, Uganda and URT - Tanzania Mainland, and 17 years in Burundi, Rwanda and URT - Zanzibar. The duration of primary school education as outlined in Figure 3.1 is constructed from the SITAN country reports and shows the range of the duration of the of primary schools in the region (median 7.5 years).

The official age of enrolment in most countries in the EAC is between 6 and 7 years for primary education, while for secondary education it is between 13 and 14 years as shown in the following Table 3.1.

Table 3.1: Official Age at Enrolment by Education Levels

Education levels	Burundi	Kenya	Rwanda	Uganda	United Republic of Tanzania	
					Tanzania Mainland	Zanzibar
Early Childhood Education	4	4	3 - 6	4 – 5	5 - 6	4 - 6
Primary	7	6	7	6	7	
Secondary/Lower Secondary	13 – 14	14	13	13	13	14

3.2. Early Childhood Education

Throughout the EAC region, provision of Early Childhood Education (ECE) is neither universal, nor compulsory or examinable. This does not however imply that the governments of the EAC partner states do not appreciate its value. The entry age is on average between 4 and 5 years, but varies between countries as shown in Table 3.2.

Unlike in many EAC partner states, the Government of the URT is involved in the provision of ECE (pre-primary) albeit supplemented by the private sector, for example, of the 181 institutions offering ECE in Zanzibar, 24 are Government. A few ECE classes are also supported by the Government of Burundi. In all the other EAC partner states, ECE is provided by communities, and FBOs, as well as individuals and the private sector. All governments are however responsible for the development of ECE curriculum, monitoring training of teachers and inspection of teaching to ensure the quality of the education imparted.

Overall in the EAC region, the enrolment in ECE is relatively low as the available net enrolment rates (NERs) and gross enrolment rates (GERs) data in Table 3.2 show, which is not surprising since ECE, as neither universal nor compulsory. Kenya has the highest number of children (nearly 1.67 million) enrolled in ECE institutions constituting an NER of 58.8%. The high number of children enrolled in Kenya and URT's Tanzania Mainland seriously challenges the capacity of ECE providers to hire teachers and maintain small classes as indicated by the pupil-teacher ratios (PTRs) of 56 and 55 children per teacher in Kenya and Tanzania Mainland respectively.

Table 3.2: ECE Enrolment and Number of School teachers

| | Burundi | Kenya | Rwanda | United Republic of Tanzania | | Uganda |
				Tanzania Mainland	Zanzibar	
Number of Children in ECE	5,600 (2006)	1,720,245 (2008)	<10% of all 3-6 year olds	874,081 (7.5% private) (2008)	15,601 (2007)	45,762 (2007)
Gross/Net Enrolment Rates	1.8% (GER 2005)	60.2% (NER 2006) GER 2008 = 62.0%	2.5% (GER 2002)	28.7% (GER 2005)	no data	1.5% (NER 2007)
ECE Teachers	421 (2006)	78,230 (2008)	552 (2002)	16,597 (2008)	977 (2007)	2,006 (2007)
Certified/ Trained Teachers	66% (2004)	40%	N/A	8.6% (2008)	77.4% (2007)	81%
Pupil-Teacher Ratio	29: 1(2006)	22.0	35:1 (2002)	55: 1	17: 1 (2007)	23: 1

Sources: World Development Indicators Database; All SITAN country reports; www.uis.unesco.org

According to the available data on the NERs and GERs presented in Table 3.2, children of ECE age who are not enrolled are greater in number than those enrolled. This is because ECE is not compulsory in any of the EAC partner states. Kenya has the highest proportion of ECE age children (59%), in comparison to URT's 36.3% in Tanzania Mainland and 13.8% in Zanzibar, and under 10% in Rwanda. All these children miss out on the foundation given to the few who are enrolled in preparation for primary school.

3.3. Primary School Education

In the last decade, EAC partner states, like numerous sub-Saharan African countries, reintroduced Free Primary Education (FPE) Policy, in line with the EFA and MDGs international agendas. This was a continuation of efforts in the 60s and 70s of expanding universal access to primary education, and in recognition and respect of the right of every child to formal education (Oketch and Rolleston, 2007). The provision of FPE throughout the EAC region attests to the partner states' commitment to the achievement of universal accessibility of education by children of school-age. The impact of HIV on the achievement of the enrolment and PTR components of the EFA goals is discussed in section 5.4 in the Impact Analysis section. Throughout the region, the governments generally meet the cost of tuition fees, while parents provide their children with school uniforms, lunch, stationery, exercise and text books. The Government of Kenya however also provides the latter three instructional materials.

The commencement of FPE in the EAC partner states varies from one to the other, the earliest being Uganda and latest Burundi (see Figures 3.2. and 3.3.). National policies on EFA have enabled many orphans and children from poor families to access formal education. Before the primary school fee had been an obstacle in keeping many children out of school. This is clearly demonstrated by the GER and NER increases that followed the abolition of tuition fees in primary school education in all EAC partner states (Riddle, 2003). In abolition of tuition fees led to dramatic increases in enrolment in all EAC partner states as illustrated in Figures 3.2 and 3.3. Uganda, for example, abolished the fees in 1996 and by 1998 primary school enrolment had increased by 70%, while in URT, NER increased from 57% to 85% within one year (PCD and CRS, 2009 in press). Figures 3.2 and 3.3 present comparative NER and GER data across the EAC partner states before and after the introduction of FPE using the most recent available data.

Figure 3.2: GER before and after introduction of FPE
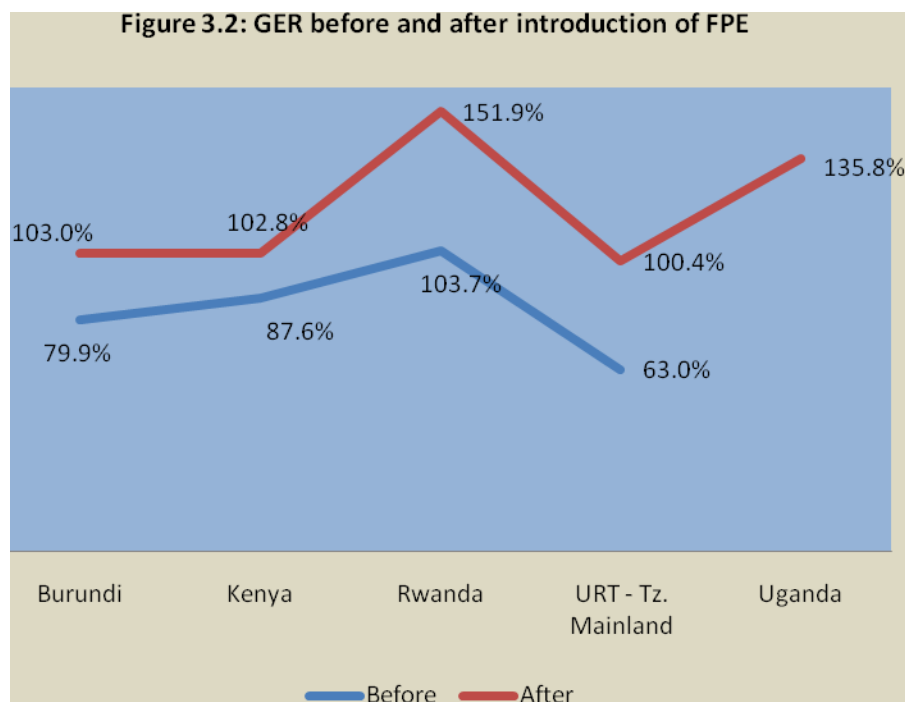
Note: There is no information on Uganda's GER before FPE (universal primary education).

Not all the children of school-age who had been out-of-school however were able to enrol, which implies that there are other obstacles to school enrolment, for example, school uniforms and books (Education International, 2007).
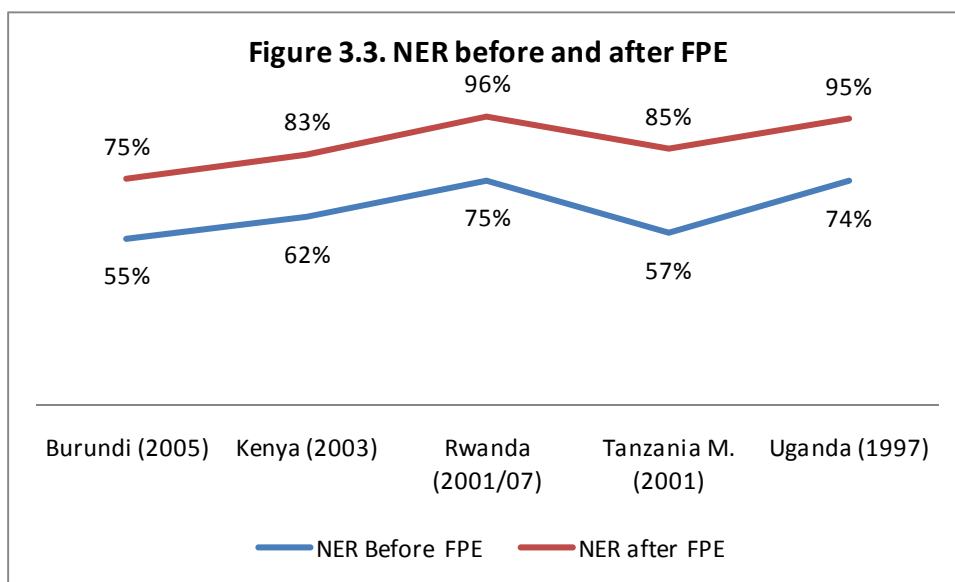
Figure 3.3. NER before and after FPE

Table 3.3 provides available data on primary school enrolment, GER and NER, in the EAC partner states, teacher data and PTRs. The data presented in Table 3.3 gives an indication

of the millions of children enrolled in primary schools in the EAC region. Despite the increases in enrolment following the removal of school fees, Burundi, Kenya and URT - Zanzibar are still experiencing shortfalls in NER. This is demonstrated in the number of children who are out of school in these countries. The data also shows the commitment of EAC partner states to bridge the gender disparities in the states. Information on gender analysis is presented in Section 3.3.1.

Table 3.3. Primary School Enrolment and Number of Schoolteachers.

| | Burundi | Kenya | Rwanda | United Republic of Tanzania | | Uganda |
				Tanzania Mainland	Zanzibar	
School-age population	1, 283, 000 (2005)	7,397,046 (2008)	1,712,432 (2008)	7,217,000 (2005)		6,309,000 (2005)
Children in Primary Schools	1,739,450 (2008)	7,632,113 (2007)	2,019,991 (2006)	8,410,094 (2008)	199,938 (2006)	7,537,971 (2007)
Female Students	49.2% (2006)	3,575,209 (2008)	51.3%	no data		50%
GER	103% (2006)	109.6% (2008)	151.9%	112.3% (2008)	100.3%	113.2 (2007)
NER	75% (2005)	92.5% (2008)	94.2% (2008)	97.2% (2008)	75.7% (2005)	94.6 (2007)
Pupil-Teacher Ratios	54:1 (2006)	45: 1 (2007)	74: 1 (2007)	54: 1 (2008)	31:1 (2005)	53:1 (2007)
No. of Primary Schoolteachers	24,452 (2006)	170,957 (2007)	31,037 (2007)	154,895 (2008)	8,790 (2005)	152,086 (2007)
Certified/Trained Teachers	88% (2005)	98.8% (2004)	91.0% (2008)	82% (2008)	no data	84.8% (2005)
Percentage of repeaters (%)	29% (2006)	6% (2005)	15%	5%		13% (2005)
Survival rate to grade 5 (%)	88% (2005)	83% (2004)	46% (2003)	87% (USI estimation)		49% (2004)
School life expectancy (ISCED) 1-6 years	7.4 (UIS estimation)	9.7 (2004)	8.5 (2005)	5.3 (1999)		10.3 (2004)
Out of school children	324,000 (2006)	644,222 (2008)	303,000 (2005)	143,000 (2006)		n/a
% of out of school children who are female	53% (2006)	48% (2006)	45% (2005)	65% (2006)		n/a

Sources: UNESCO Institute of Statistics website; country reports; EFA Global Monitoring Report 2009. http://www.ei-ie.org/barometer/en/profiles_detail.php?country=burundi;

All the EAC governments have faced challenges in their capacity to recruit more teachers in tandem with the huge increases in school enrolment, as can be seen in Table 3.3 in the PTRs in all the states with the exception of URT – Zanzibar's. Such ratios are obstacles to provision of quality education and individual attention by the teacher to the children. A teacher with 50 or more children can neither give quality attention to any child, nor attend to those with special needs. However, the primary schools are staffed by a large proportion of trained teachers. In both Kenya and Uganda, the proportions of untrained teachers are negligible – 1.2% and 2.4% respectively, compared to between 12% and 18% in the other EAC partner states. Key informants in Burundi reported a shortage of buildings, desks and textbooks.

The percentage of primary school repeaters varies between countries – 29% of children in Burundi repeat, 15% in Rwanda, 13% in Uganda, 6% in Kenya and 5% in URT indicating likely differences in education quality and efficiency. The proportion of children who enrol in

primary school but discontinue prematurely is a variable that cannot be ignored. Between 83% and 88% of children in Burundi, Kenya and the URT make it to grade 5, while only 46% to 49% of children in Rwanda and Uganda respectively survive to grade 5. Clearly, this is an area in need of significant improvement. The percentage of repeaters also varies between countries – 29% of children in Burundi repeat, 15% in Rwanda, 13% in Uganda, 6% in Kenya and 5% in the URT. Figure 3.4 presents the proportions of boys and girls who were able to complete primary school education in 2005 (2000 in Rwanda). Premature discontinuation of schooling by children of primary school age is highest in Rwanda, with an average of only 22% and 19% of boys and girls respectively completing primary education (see Figure 3.4). In Burundi, according to more recent available data, 58.5% of the children enrolled were able to complete primary school education in 2008. (Republic of Burundi, January 2009) The scenario is however different in Kenya where in 2005 over nine-tenths of both boys and girls completed primary education schooling (UNESCO Institute of Statistics, www.uis.unesco.org).

Figure 3.4. Proportions of Children Completing Primary Education in 2005 in the EAC Partner States (in 2000 for Rwanda)

Country	Males	Females
Burundi	39	30
Kenya	94	92
Rwanda	22	19
URT**	58	55
Uganda	57	51
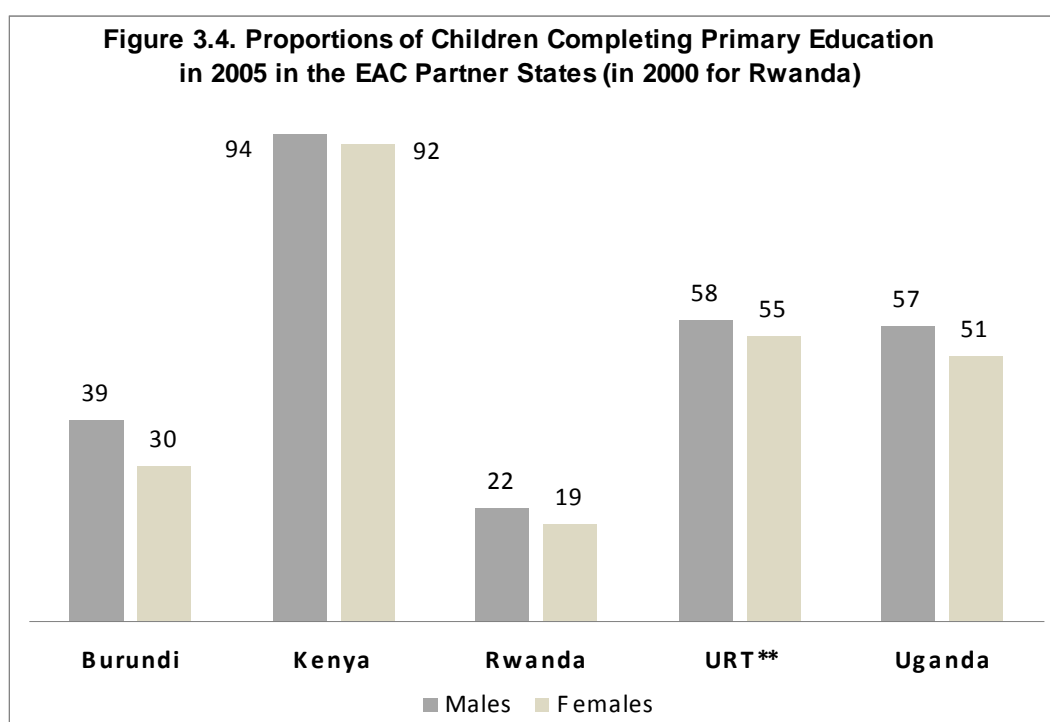
URT** United Republic of Tanzania.
Source: Constructed from UNESCO Institute of Statistics website, www.uis.unesco.org.

All governments have increased their budget commitment to FPE. In 1998 for example, Uganda more than doubled the education allocation from 12% in 1992 to 25% (Riddle, 2003). At the end of the final year of primary education in all the EAC partner states, the pupils sit for a national examination, and the results are used to determine which students can proceed to secondary school level. This was the situation in Rwanda, however, up until January 2009, when the Government abolished the end of primary school national examination in order to encourage the children to proceeding to the three-year lower secondary school cycle. At the same time, the Government also abolished tuition fees in the lower secondary cycle.

3.3.1. The Gender Factor in Primary School Enrolment and Completion

The importance of gender in school enrolment and teacher recruitment deserves a separate subsection. There are no gender differences in primary school enrolment in Uganda. Rwanda has more girls in primary schools (51.3%) than boys (48.7%), which is unusual

elsewhere in sub-Saharan Africa. In Burundi and Kenya, more boys than girls are enrolled in primary schools by 4 and 2 percentage points respectively. Figure 3.5 highlights the proportions of male and female students enrolled at primary and lower/upper secondary school levels in the various EAC partner states for which data are available. As can be noted from Figure 3.5., the gender differences in pupil enrolment in primary schools ranging from zero (in Uganda) to four percentage points (in Burundi) is undoubtedly insignificant. More females are enrolled in Rwanda's primary schools than males, even though the differences are negligible (2 percentage points), which is unusual and an indicator of a positive emerging trend. Uganda has as many male as females enrolled. Education International (EI) (2007) explains that, while in the lower grades girls and boys have equal access to education, at higher levels boys are favoured when educational choices have to be made. This is reflected in the differences in the proportion of girls and boy who complete primary school, with boys having higher completion rates in all countries (see Figure 3.4). The difference is greatest in Burundi, where the rate for boys in 8% higher than it is for girls. In Uganda the rate is 6% higher for boys and in Rwanda and the URT, it is 3% higher. Kenya has the smallest difference, of 2%. As detailed in Section 1.1.2, ensuring that girls are educated is a key part of the education sector response to HIV and these gender differences in completion rates need to be addressed to mitigate against HIV. Information on a safe school environment for girls is covered in Section 7.

Figure 3.5. Enrolment at Primary School Level (%)
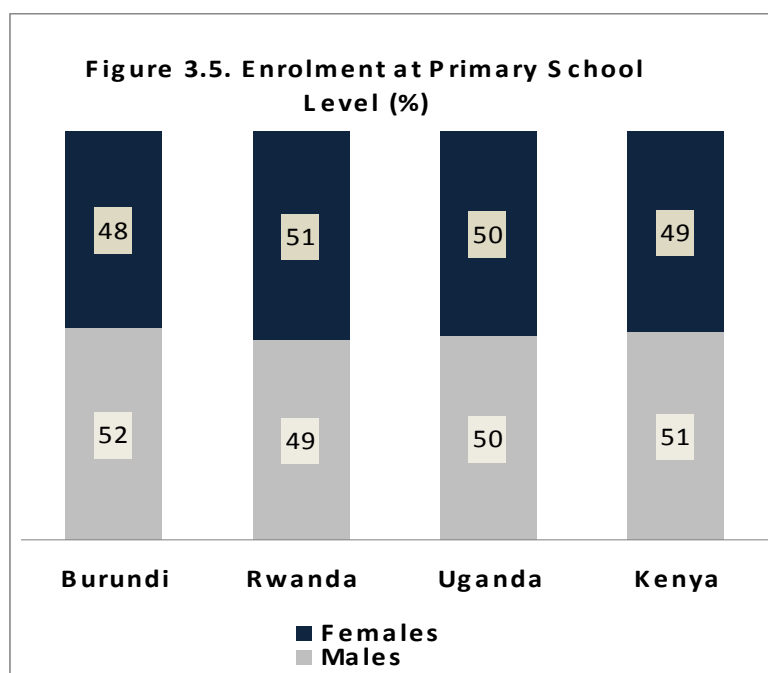
Note: Data for primary school enrolment in URT for lower secondary school enrolment are not available.

3.4. Secondary School Education

There are some differences in the structure of secondary school education between the EAC partner states. For example, Kenya's secondary school structure is the only one with a one four-year secondary level, while Burundi, Rwanda, URT - Tanzania Mainland and Uganda have two – lower and higher secondary levels (advanced level in the latter two countries). URT - Zanzibar, like Kenya's secondary school structure, differs from that of the other states, in that there are three levels as Table 3.4 illustrates. What is referred to as 'lower secondary' education has two cycles, all the states with the exception of Kenya, offer higher (A levels) secondary education, from which qualifying students may proceed to universities and other post-secondary colleges.

As mentioned earlier, at the end of the final year of secondary school education, students in all five states sit for national examinations administered by the MoE's National Examining Board. The relatively low enrolment in secondary schools compared to primary schools is a concern in the region (see Table 3.5). In order to increase access and reduce costs of secondary schooling, secondary education is subsidised to some extent in the partner states. In 2007, Uganda's Education Ministry launched the Universal Post Primary Education and Training Policy with the aim of:

- Increasing equitable access to post primary education and training;
- assuring the achievement of the gender parity MDG in education delivery by 2015;
- enhancing sustainability of the universal primary education; and
- reducing the high costs of secondary education.

Table 3.4. The Structure of Secondary and Tertiary Education in EAC Partner States

		Lower Secondary School	Higher Secondary School	Tertiary Education	Total No. of Years
Burundi		4	3	2-4	15 – 17
Kenya		4	-	4	16
Rwanda		3	3	4-5	16 – 18
URT	Tanzania Mainland	4	2	3 – 5	16
	Zanzibar	1st cycle lower secondary = 3 years 2nd cycle lower secondary = 2 years	2 (Advanced secondary)	3	17
Uganda		4	2	3	16

Source: Country situation analysis reports.

Similarly since January 2008, the Government of Kenya has heavily subsidized secondary school tuition fees in public institutions. In addition, bursaries are made available in all 210 constituencies which also assist children from poor families. The Government of Rwanda at the beginning of 2009 abolished tuition fees in the lower 3-year secondary school level. Throughout the region, parents continue to meet the expenses for school uniforms, some books, lunch and boarding facilities (if required). Lower secondary education in URT - Zanzibar, like in Rwanda, is free. In 2005, the Tanzanian Government halved secondary school fees and provided subsidies for the remaining cost balance through a special programme. Since then, an education fund has been set up to increase children's access to education. Addressing gender imbalance has also been started by the government, although parents still have to buy books and uniforms (Education International, 2007).

Enrolment in secondary schools is lower than that in primary schools, as displayed in table 3.5. While Burundi has the highest enrolment (GER 82%), it also has the highest number of grade repeaters (22%). GER is approximately 50% in Kenya and URT - Zanzibar and decreases to the low 20's in Rwanda and Uganda. In URT – Tanzania Mainland, GER is 11.7%. However, the URT and Uganda both have low numbers of pupils repeating (2%). These figures demonstrate that while increasing enrolment is important, countries need to also consider education quality issues, ensuring that children are gaining the most from their education.

Table 3.5: Secondary School Enrolment and Number of Schoolteachers
(Excludes higher secondary schools in Burundi, Rwanda, Uganda and URT)

		Burundi	Kenya	Rwanda	United Republic of Tanzania		Uganda
					Tanzania Mainland	Zanzibar	
Children in Secondary School		152,496 (2006)	1,382,211 (2008)	288 036 (2008)	1,118,476 (2008)	59,831 (2004)	914,000 (2008)
GER		Total: 82%	50.0% (2006)	22.0% (2008)	11.7% (2005)	69.0% (1st cycle): 26.2% (2nd cycle) (2005)	19:0% (2008)
NER		no data	43% (2006 estimate)	13.9 % (2008)	6.3% (2003)	14.0% (2006)	16% (2005)
% of repeaters all grades		22% (2007)	1.3%	no data	2%* (2008)	2%* (2008)	1-2% (2008)
Student:Teacher Ratio		19: 1 (2004)	28.2 : 1 (2005)	18.7:1 (govt schools) 16.7:1 (private) (2008)	41:1 (govt.) 24:1 (private) (2008)	No data	33:1 (2007)
Secondary School-teachers	Numbers	5,173* (2004)	78,096 (2005 est.)	16,105 (2008)	no data	1,695**	50,767 (2007)
	Female teachers	21% (2004)	38% (2005)	no data	no data	24.4% (2007)	24.4% (2007)
Certified/Trained Teachers		37%** (2003)	no data	5 849 (2008)	no data	no data	43,219 (2008)

* only includes teachers in public schools; ** percentage of trained teachers for lower and higher secondary schools; † estimate for lower and higher secondary schools. *Sources:* UNESCO Institute of Statistics website, http://www.uis.unesco.org/; Situation analysis country reports; United Republic of Tanzania (URT, 2004); http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/EXTAFRREGTOPEDUCATION/ ** this figure needs to be verified.

A relatively smaller proportion of students are enrolled in higher secondary schools in the region (see Table 3.6.), with fewer girls than boys attending school, especially in Burundi, Uganda and URT - Zanzibar.

Table 3.6 presents some statistics on higher or advanced secondary school education (A Levels in Uganda and URT – Tanzania Mainland). Throughout the EAC region, the number of students decreased as the education level increased.

Tuition fees charged for enrolment in upper secondary education is an obstacle to completion of schooling at this level (Education International, 2007), which has been a concern for all governments in the EAC region. The Government of Uganda, according to EI (2007) has introduced programmes to promote the education of girls.

Table 3.6: Higher Secondary School Enrolment and Number of Schoolteachers

| | Burundi | Rwanda | United Republic of Tanzania | | Uganda |
			Tanzania Mainland	Zanzibar	
No. Enrolled	39,800 (2006)	45 128 (2008)	53,423 (2007)	2,918	128,064 (2005)
Female students (%)	15,582 (39%) (2006)	45,086 (47%) (2007)	21,643 (41%) (2007)	1,295 (44%)	51,408 (40%) (2005)
GER	7% (2006)	13% (2007)	3.7% (2007)	6% (2005)	10% (2005)
NER	no data	10%* (2006)	0.9% (2007)	no data	16% (2006)

* Includes lower and higher secondary school
Kenya's education structure is different and does not A' Levels.
Sources: www.uis.unesco.org; SITAN country reports.

3.4.1. The Gender Factor in Secondary Schools

Gender disparities widen in student enrolment at lower secondary school level by between zero (in URT - Zanzibar) and 14 percentage points in Burundi favouring male students, and a similar trend continues with education levels (see Figure 3.6.) except in Rwanda where the differences between male and female student enrolments at both levels (lower/higher) of secondary schooling remain the same (6 percentage points) in favour of males (Figures 3.6 and 3.7).

Figure 3.6. Enrolment at Lower Secondary School Level (%)

Figure 3.7. Enrolment at Higher Secondary School Level (%)
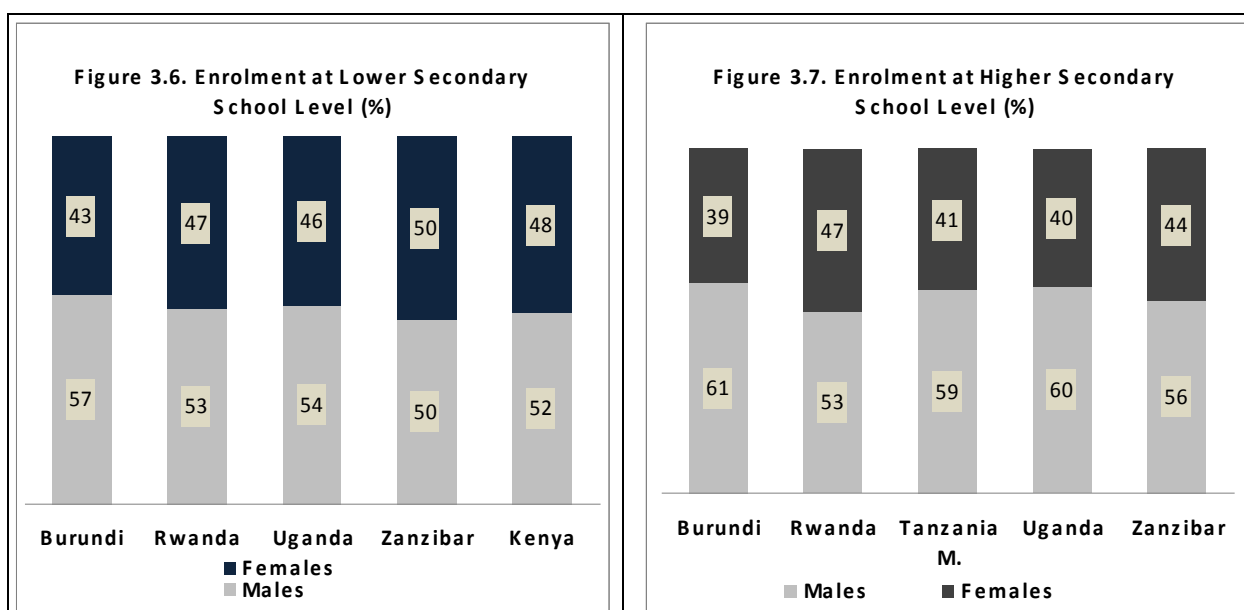
Note: Data for primary school enrolment in URT - Tanzania Mainland and Zanzibar and for lower secondary school enrolment in Tanzania Mainland are not available.

Gender differences in enrolment at primary and upper secondary widen in selected states as follows:
- Burundi from 14 (lower secondary) to 22 percentage points;
- Uganda from 8 (lower secondary) to 20 percentage points; and
- URT - Zanzibar from zero (lower secondary) to 12 percentage points.

As children progress through school, gender disparities in enrolment are increasing and are in need of urgent attention in order for girls to benefit from the 'social vaccine' that education

provides. This is especially important in light of the gender disparities that are evident in the HIV epidemic. (Information on a safe school environment for girls is covered in Section 7.)

3.5. Teachers and Teacher Training Colleges

Throughout the EAC region, teachers are trained in two types of educational institutions universities and teacher training colleges (TTCs). Universities offer degree and diploma courses for trainees who will mostly teach in secondary schools and post-secondary institutions such as technical and TTCs. Today some tertiary institutions are also training teachers for ECE. TTCs train primary schoolteachers awarding them with teaching certificates. Some TTCs offer diploma courses to trainees who later teach in secondary school. These colleges (technical and TTCs) include both public and private institutions and the trainees in both are examined by the national examining boards within each state. The MoEs oversee the training and implementation of the curriculum which they develop and also conduct in-service training programmes for selected teachers. The choice of subjects covered in the in-service programmes depends upon particular needs identified (Burundi, Rwanda, Uganda and URT SITAN reports).

The minimum requirement for admission into a TTC is 4 years of post-primary education in Kenya, Burundi, Uganda, URT - Tanzania Mainland and 6 in Rwanda and the minimum training required for primary schoolteachers is 2 years. Diploma courses take 3 years. Degree courses take a minimum of 4 years in Kenya and Rwanda, 3 years in Uganda and the URT. University education in Burundi has two cycles: 2-year and 4-year study cycles. Some courses such as Medicine and Architecture take longer to study in all EAC partner states (SITAN country reports).

Teacher attrition rates vary throughout the region. Attrition estimates were found which excluded transfers, promotions and teachers who left to pursue further training. In Kenya attrition was 2.8% between 2000-2004 (country records; primary and secondary). For Rwanda, there are several data sources reported in Kinghorn *et al.* (2003). Estimates of those teachers reported retired or deceased to the Caisse Social, result in estimates of between 0.6-2.4% between 1999 and 2002, but is likely to miss some attrition; school surveys carried out in 2000-2001 reported attrition of between 3.8-5.2%. Uganda's attrition varied between 4.3-6.9% in 1995-1998 (Hyde *et al.* 2002). URT - Zanzibar's varied between 0.5-2% between 1995 and 2005 (data provided at Ed-SIDA workshop, Morogoro, Tanzania 2007).

3.5.1. Gender Issues in Teacher Data

Analysing teacher data is challenging because of missing important data as can be seen in Table 3.7. Rwanda has more female (54.9%) primary school teachers than males, with almost an equal distribution of male (50.5%) and female (49.5%) teachers in TTCs in Kenya, and moderate gender differentials of primary schoolteachers in Kenya and Rwanda (8.4 and 9.8 percentage points, respectively).

Table 3.7: Proportions of Teachers in Primary and Secondary Schools and TTCs by Gender

	Primary Schools		Secondary Schools		TTCs	
	Males	Females	Males	Females	Males	Females
Burundi (2006)	no data	no data	79%	21% (2004)	no data	no data
Kenya (2007)	54.2%	45.8%	62.%0	38.0%	50.5%	49.5%
Rwanda (2006)	45.1%	54.9%	Lower = 76.9 Upper = 88.7	Lower = 23.1 Upper = 11.3	no data	no data
Uganda (2007)	60.7%	39.3%	75.6%	24.4%	no data	no data

* Disaggregated by gender; † estimate for lower and higher secondary schools;
Note: The teacher data available for the United Republic of Tanzania are not aggregated by gender.

Elsewhere at the various education levels for which available data are aggregated by gender, there are more male than female teachers. In all the four states (i.e. Burundi, Kenya, Rwanda and Uganda) for which data are available, however, the relatively wide gender disparities of teachers in secondary schools raises pertinent questions, such as why significantly male secondary schoolteachers are dominant. The upper secondary school in Rwanda has more male than female teachers by as many as 77 percentage points, 58 percentage points in Burundi and 24 percentage points in Kenya.

3.6. Vocational Institutions

These institutions teach vocational subjects such as secretarial, tailoring, carpentry among others. There are also specialised certificate and diploma colleges such as agriculture, hospitality, tourism, that secondary school students can enrol on for a period between 1 and 3 years.

In URT, non-formal education is provided through several programmes such as literacy and vocational training in Zanzibar. In Tanzania Mainland, its providers include the Ministries of Education and Vocational Training, Labour, Employment, Youth and Development and Health and Social Welfare, as well the Institute of Adult Education.

In Uganda, some pupils after Primary 7 do join business. Uganda's technical and vocational education training institutions provide 2 to 3-year post-primary school education programmes after which they award certificates before students join the labour market for employment. Public technical, industrial, and vocational training institutions in Kenya include national polytechnics, the Kenya Technical Teachers College, technical training institutes and the institute of technology, all of which, in 2008 had a student population of 82,500 (males 43,915, females 41,285) in 2008 and a teacher population under TSC of 3,256. Burundi's technical and vocational training institutions offer 2 to 3 year-old courses that equip students with skills in areas such as building, plumbing and carpentry. As part of in-formal education, vocational institutions in Tanzania Mainland provide adult education transferring knowledge and skills to prepare the learners for productive activities provided mainly by the Ministry of Labour; Employment; Youth and Development; and of Health and Social Welfare; and civil society Peace Corps among others. No information on institutions teaching vocational subjects was available for Rwanda.

3.7. Tertiary Level Education

The duration of tertiary education is dependent upon the course taken. Undergraduate courses leading, for example, to a Bachelor of Education, Science or Arts takes 4 years in Kenya and 3 years elsewhere. Courses in Medicine and Architecture generally take longer

throughout the region by 2 or more years than courses such as Education and Economics among others.

Each MoE has a specific unit responsible for all university matters and which also oversees the management of and regularly inspects all public and private tertiary institutions. It is the government that awards licenses and accreditation to the universities and that sets minimum qualifications for anyone wishing to enrol at these institutions of higher learning. This unit approves the curriculum developed by the public and other universities in each country. The degrees and diplomas awarded by such universities are recognised by the government. Not all degree awarding institutions are accredited by the government however. Some institutions of higher learning do not meet the standard criteria for accreditation although are still licensed to operate. The government does not recognise the degrees and certificates of these institutions.

This situation analysis has not provided details on activities of universities, in order to avoid replication of work currently being undertaken by the Inter-University Council for East Africa (IUCEA) which is currently studying the universities responses to HIV and AIDS in the region.

3.8. Out-of-School Youth and Non-Formal Education

A substantial proportion of school-age children among the rural and urban poor, are unable to access education because of socioeconomic factors (see table 3.3 for information on the number of children of primary school age who are out of school). Reaching out-of-school children and youth is a major challenge in the EAC region. All EAC states have shown concern for these populations and made attempts to provide non-formal education assistance for them.

In Burundi, non-formal education for children and adults who did not have the opportunity to attend school is mostly given by the non-governmental sector including FBOs. Courses offered include technical and vocational training in skills such as building houses, plumbing and carpentry. In 2007, Kenya's MoE supported Non-Formal Education Centres by giving capitation for training and provision of teaching and learning materials. Some of the challenges include limited MoE capacity in coordinating non-formal education, and inadequate quality control (Country reports, 2009). Non-formal education in URT - Tanzania Mainland is provided by communities and NGOs such as the Tanzania-Netherlands Project to Support AIDS Control (TANESA), African Medical and Research Foundation (AMREF) and Students Partnership Worldwide under the coordination of the Ministry of Education and Vocational Training (MoEVT). The government has drafted a specific national communications strategy, which includes specific strategies for reaching out-of-school youth. In URT - Zanzibar, on the other hand, non-formal education is provided through programmes on literacy, continuing education, vocational training and alternative education. Out-of-school youth in Uganda are being reached through non-formal education programmes and complementary approaches, the main ones being: Complementary Opportunities for Primary Education (COPE), Alternative Basic Education for Karamoja (ABEK), among others listed in the country report (see Section 6.3.4.). The current National Strategic Plan is expected to ensure that all the youth in school as well as out of school are able to access life skills education.

The establishment of Ministries for Youth in the EAC partner states attests to each government's commitment to this important population. Rwanda also has a National Council specifically for the Youth.

The percentage of female out of school children varies across the EAC partner states, as can be seen here:

%age of out of school youth who are female

- Burundi 53%
- URT 65%
- Kenya 48%
- Rwanda 45%.

3.9. Access to Education for Most Vulnerable Children

Orphans are still more likely to lose out on education than other children even with free primary education (PCD and CRS, 2009 in press). Cost of uniforms and books remains a serious obstacle to the ability of many children affected by AIDS to access formal schooling (UNICEF, World Bank *et al.* forthcoming).

There are an estimated 8.4 million orphans in the EAC partner states in 2005[4]. The number of orphans is expected to remain constant in most states but to increase in Burundi (See Figure 3.8). Orphan school attendance varied greatly between countries, in Rwanda and Burundi it was around 85% of children with both parents surviving, in Kenya and Uganda it was around 95%, and in URT – Tanzania Mainland, orphans actually attended school in greater numbers than non-orphans, with a attendance ratio of 102.[4]

Figure 3.8. Estimates of Orphans of All Causes Aged 0 to 17 Years Found in Five EAC Partner States
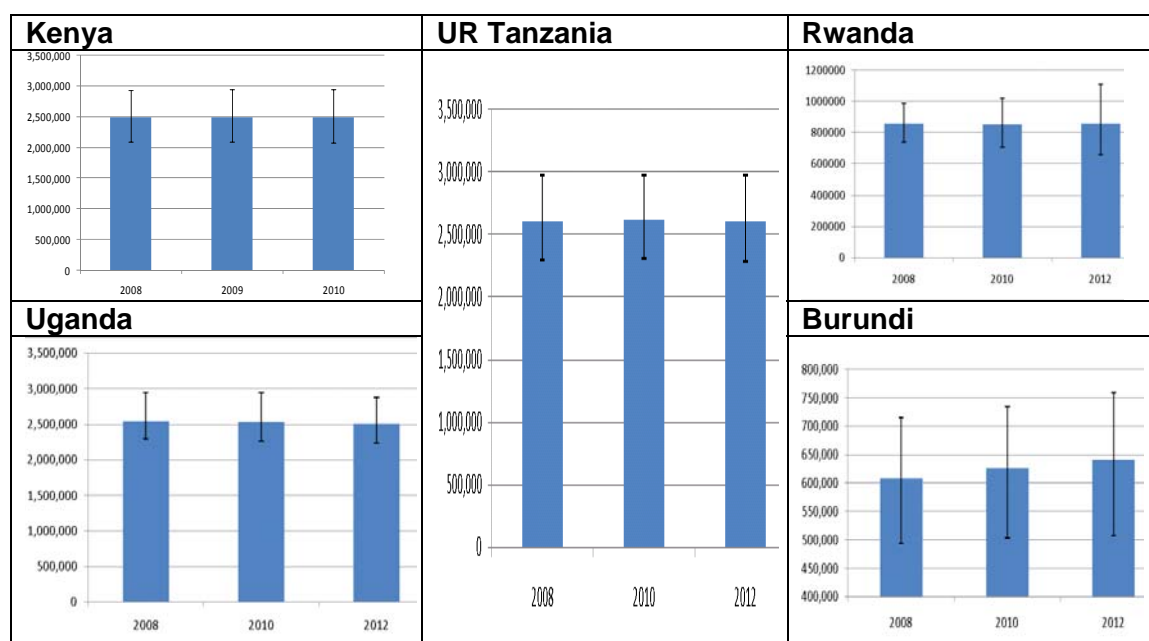
Note: Error bars represent high and low estimates. No estimate is available for Zanzibar.

Box 3.1: Partner States: Orphans and their School Attendance

The **Kenyan** orphans are less likely to be enrolled (88%) than non-orphans (92%). The proportion of full orphans aged between the ages of 10 and 14 years in school is 70% lower than that of children living with at least one parent (Government of Kenya 2004 in country report).

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[4] http://www.unicef.org/infobycountry/ Orphan data from MICS and DHS, 1997-2002.

United Republic of Tanzania: It is estimated that there are some 2.2 million children affected by AIDS in Tanzania, Mainland of which half are estimated as most vulnerable children and 48.8% of them are orphans. Of the 915,234 orphans in primary school, about 49% are female (Best, 2007, in country Report). In 2006, orphans constituted approximately 12% of the population aged 0 to 17 years. Zanzibar had an estimated 500 orphans in 2005 (Data provided at Ed-SIDA workshop, Morogoro, Tanzania 2007).

Rwanda had an estimated 185,000 orphans and most vulnerable children living with HIV in 2005 and this number is expected to grow.

Uganda in 2007 had more than 1.3 million orphans enrolled in primary schools and 231,763 orphans in secondary schools with gender differentials negligible.

Information on orphan school attendance was not available from **Burundi.**
(SITAN country reports).

The data in Table 3.8 highlight the magnitude of children from 10 African countries including all five EAC partner states, who have been orphaned by any cause including HIV-related, and the proportions of orphans who attend school. Half of the countries listed have between 2.3 million and 4.8 million orphaned children including Kenya, Uganda and the United Republic of Tanzania. The commitment of the various African governments to the attainment of EFA goals is attested by the relatively high proportions of orphans who are still able to access schooling despite their vulnerability. In Botswana, Kenya, Uganda and Zambia, more than nine-tenths of these children are indeed at school as are between 60% and 82% of the orphans in the other countries listed in Table 3.8 with the exception of South Africa where there was no data available (UNAIDS, UNICEF & WHO's estimates, 2007).

Table 3.8: Available Estimates for Orphans in Selected African Countries (2005)

	Children who have lost at least one parent due to any cause	Have lost a mother due to any cause	Have lost a father due to any cause	Have lost both parents due to any cause	Orphans attending school (1999-2005)
Botswana	150,000	110,000	100,000	56,000	99%
Burundi	600,000	310,000	400,000	110,000	70%
Ethiopia	4.8m*	2.3m	3.2m	660,000	60%
Ghana	1.0m	490,000	640,000	110,000	79%***
Kenya	2.3m	1.4m	1.3m	410,000	95%
Rwanda	820,000	490,000	620,000	290,000	82%
South Africa	2.5m	1.3m	1.6m	450,000	no data
Uganda	2.3m	1.3m	1.5m	540,000	95%
United Republic of Tanzania	2.4m	1.3m	1.5m	410,000	82%
Zambia	1.2m	860,000	800,000	420,000	92m

M* million; ** These are children who have lost both parents to AIDS, where there are no data for children in the specified country who have lost *at least one* parent to AIDS; *** Not 2005 data (year unspecified). *Source:* UNAIDS, UNICEF, WHO (2007).

Information on children living with HIV is covered in Section 4 and mitigation of the impact of HIV on children affected by AIDS is discussed in Section 6.

4.   HEALTH CONDITIONS AFFECTING THE EDUCATION SECTOR

4.1. Introduction

This section highlights those health issues identified by the partner states during the data collection as significant for the education sector.

The basic objective of any education sector is to ensure universal and equitable access to quality education for all children. However, the attainment of full learning potential is directly dependent on good health, nutrition, appropriate education and an environment conducive to learning. Provision and accessibility of quality education is not possible without addressing the health concerns of schoolchildren. Schoolchildren spend more than three-quarters of the school term within a school environment. Poor health and nutrition impacts on children's cognition and behaviour, while good nutrition and health practices at school boost school enrolment and attendance reduce drop-out rates, promote adolescent reproductive health, and help limit the spread of HIV and AIDS, consequently improving educational attainment. Moreover, there is a substantial spill-over effect on households and communities from such health practices at schools. That is, a good school health programme is likely to accelerate health for all.

The commonly referenced health problems that affect the education sector in the EAC region, particularly school-age children include: malaria, diarrhoeal diseases, and respiratory tract infections including pneumonia, measles, HIV and AIDS, skin diseases, malnutrition, mental health problems and substance abuse. Table 4.1 provides statistics for some of these key conditions in the EAC countries. Effective school health and youth programmes can help prevent or significantly reduce many of the health conditions.

Table 4.1: Statistics Relating to Some Key Health Problems in EAC Partner States

Indicator	Burundi	Kenya	Rwanda	Uganda	URT
% of <5 year-olds sleeping under a mosquito net (2003-2006)*	13	15	16	22	31
% population with adequate sanitation facilities (2004)	36	43	42	43	47
Estimated AIDS orphans (0-17 yrs), 1000s (2005)	120	1,100	210	1,000	1,100
% of <5 yr olds underweight (moderate & severe) (2000-2006)*	39	20	23	20	22

Source: www.unicef.org; DHS, and MICS, 1997-2002 in United Republic of Tanzania

4.2. HIV and AIDS

HIV & AIDS is the least cited health problem in the country reports affecting school-age children in the EAC partner states. Rates of HIV infection are lowest among children, and this more so for those children in school than out. Keeping children in school longer is likely to shield them from the risk of exposure to HIV.

4.2.1. HIV Prevalence among Youth

Like elsewhere in sub-Saharan Africa, in the EAC region, the risk of contracting HIV is higher among adolescents and young adults aged between 15 years and 24 years than all other populations, and more serious among their female cohorts (WHO, 2008). This is demonstrated by Figure 4.1 which contrasts the gender differentials in HIV prevalence in all EAC partner states. The differences are wider in some countries than others, for example, by 4.6 and 3.2 percentage points in Kenya and Uganda respectively.

Figure 4.1. HIV Prevalence (%) Among 15 to 24 Year-Old Males and Females in the EAC Partner States
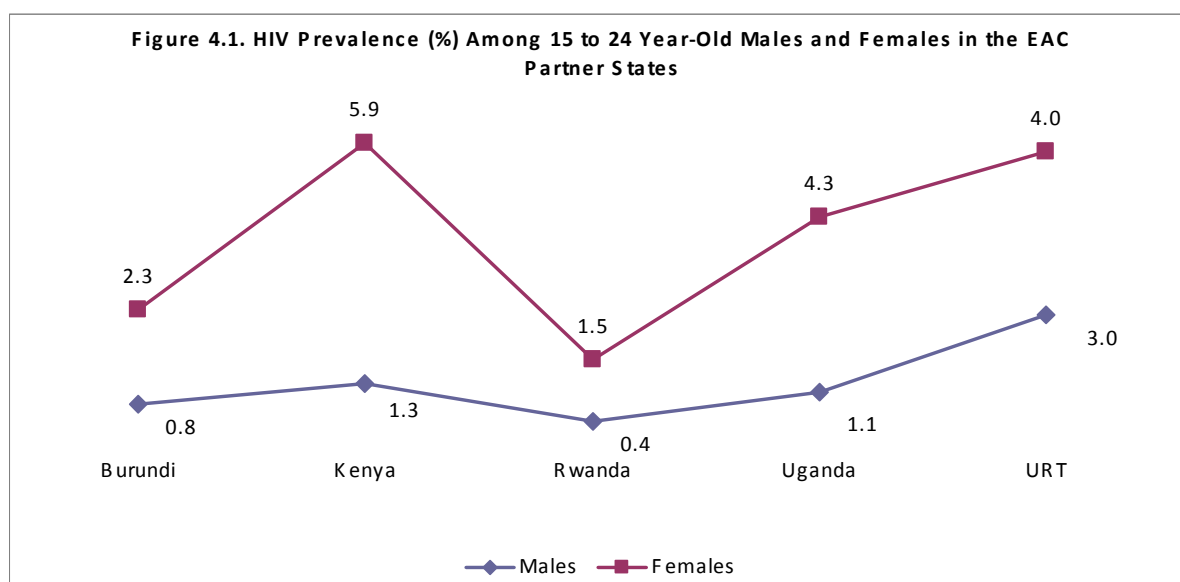
Source: www.unicef.org;

4.2.2. The Impact of HIV-Related Adult Morbidity and Mortality on Children

One of the most serious effects of HIV is the creation of orphans. UNAIDS/WHO (2008) estimates that there are about 12 million orphans under the age of 18 having lost one or both parents to HIV-related causes in sub-Saharan Africa. The EAC region, according to UNICEF estimates has 8.4 million orphans, 3.53 million of whom are orphaned by HIV and AIDS (UNICEF, www.unicef.org). Children with HIV-positive parents can be forced to assume household responsibilities beyond their years to care for their ailing parents (UNICEF, www.unicef.org).

4.2.3. HIV-Positive Children

HIV has not only created millions of orphans but also infected some of them and others. According to estimates from UNAIDS/WHO (2008), more than 2 million children are living with HIV globally and nine-tenths of them reside in sub-Saharan Africa including Eastern Africa.

It is estimated that there were 420,000 HIV-positive children (0-14) in the EAC partner states in 2005[5]. The coverage of drugs among those in need for prevention of mother to child transmission (PMTCT) and Paediatric ART (pART) varies throughout the region (See Figure 4.2.).

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[5] http://www.unicef.org/infobycountry/

Figure 4.2. PMTCT 2005, and pART Roll-Out 2006, in Five EAC Countries[6,7]

	Burundi	Kenya	Rwanda	Uganda	United Republic of Tanzania
■ PMTCT	3%	20%	36%	11%	6%
■ pART	16%	16%	35%	14%	10%
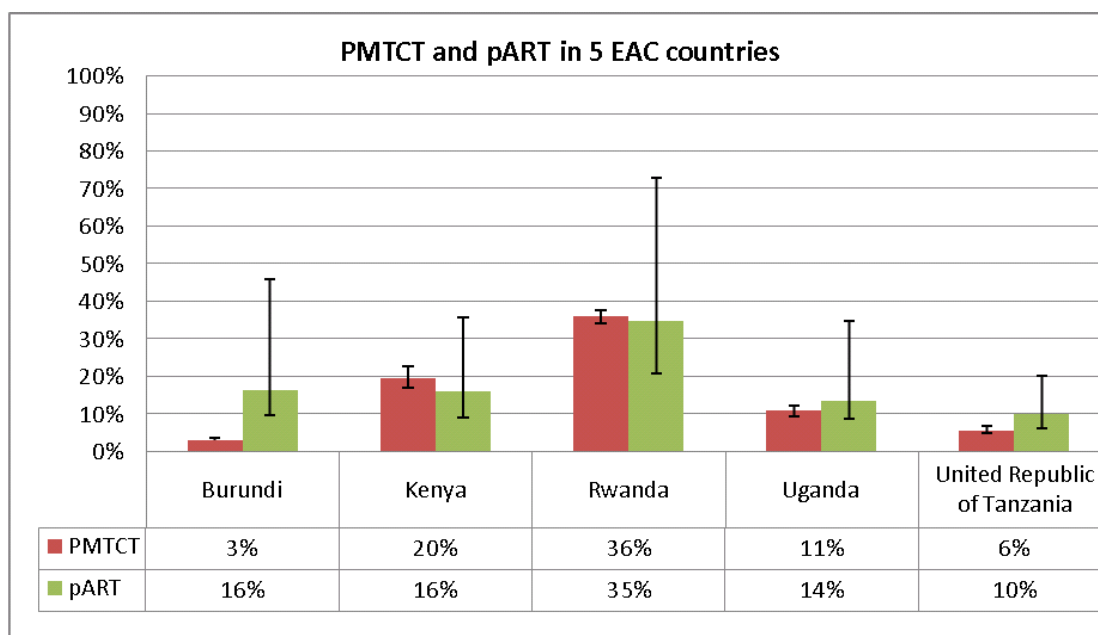
Note: Error bars represent high and low estimates.

Every country presented here needs to intensify the scale-up of PMTCT and pART. Rwanda has achieved the most, with an estimated over 30% coverage of both PMTCT and pART. The coverage of these two forms of ARV affects future numbers of children living with HIV (Cooper *et al.,* 2008). A higher rate at which infected children are protected by ARV treatment means that a significant number of children with HIV will survive to school-age, whereas a low rate of PMTCT means that children will continue to be infected around birth. Where PMTCT coverage is low and pART is high, numbers of children living with HIV are expected to increase, which is the case in Burundi, Uganda and URT. In Kenya by contrast, numbers are expected to decline, and the situation in Rwanda depends on the future provision of pART, which is more uncertain than in other countries due to lack of data.

4.2.4. Male Circumcision and HIV

Safe male circumcision has, in the last few years, attracted international attention, as an additional intervention for HIV prevention, to the extent of a WHO/UNAIDS international expert consultation, being held in March 2007 in Montreux, Switzerland to deliberate on the subject, which concluded that:

"there is unfolding evidence from randomised controlled trials, undertaken in Kenya, South Africa and Uganda, that safe male circumcision reduces the risk of heterosexual transmission of HIV infection from women to men by approximately 60%." (WHO, 2007)

The practice of male circumcision in the Eastern and Southern African regions, both of which have the highest HIV prevalence in sub-Saharan African, is not universal. WHO (2007) advises that, because male circumcision only provides partial protection against HIV, it may be considered as part of a comprehensive package of HIV prevention interventions. The following other known effective preventive interventions against sexual transmission of HIV still remain relevant: abstinence; delay of sexual relations; faithfulness; correct and

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[6] http://www.who.int/globalatlas/docs/hiv/annex3web.xls
[7] http://www.who.int/globalatlas/docs/hiv/annex2web.xls

consistent use of male or female condoms; reduction in the number of sexual partners; and effective and prompt treatment of STIs (see Annex 4).

At the EAC regional level, the potential role of male circumcision in response to HIV is considered. Indeed, the third objective of the Regional Integrated Multi-sectoral Strategic Plan (2008-2012), aims to:

- Improve the effectiveness of interventions through the harmonisation of EAC partner states' HIV and AIDS protocols, policies, plans, strategies, and legislation.

One of the strategic activities to help attain the objective is to:

- develop guidelines for making male circumcision safe and to criminalise female genital mutilation. (EAC, 2008a).

Two East African studies on male circumcision and its role have gained WHO recognition (2007). A trial in Kisumu, Kenya, of 2,784 HIV-negative men showed a 53% reduction of HIV acquisition in circumcised men relative to uncircumcised men, and a trial of 4,996 HIV-negative men in Rakai, Uganda, showed that HIV acquisition was reduced by 48% in circumcised men. (U.S. Department of Health and Human services, National Institute of Health, December 2006)

4.3. Malaria

None of the EAC partner states are free from the impact of malaria, which is a key health problem in the region and also one of the causes of infant mortality. The seriousness of malaria is evident given that, it is one of the three health problems, addressed by the Global Fund (others being HIV and AIDS and Tuberculosis). Malaria is endemic in Uganda, causing 61% of child mortalities and in Burundi where it is a leading cause of hospitalisations for students (situation analysis reports). Guerra *et al.,* (2008) report a risk to both unstable (in the provinces surrounding Lake Victoria) and stable malaria in Kenya. In Rwanda, much of the eastern and central region is also estimated to be at risk of stable malaria (Guerra *et al.,* 2008). Malaria is one of two health conditions blamed for a declining life expectancy (51%) in the United Republic of Tanzania, the other being a 6% HIV and AIDS infection rate (USAID, http://www.usaid.gov/locations/sub-saharan_africa/countries/tanzania/ index.html). According to a report by the United States Agency for International Development (USAID), URT - Zanzibar has 'essentially halted malaria transmission', while on the Mainland, malaria deaths have been reduced from 120,000 in 2005 to 60,000 in 2008, while child deaths have dropped by 24% since 2003 (USAID, http://www.usaid.gov/locations/sub-saharan_africa/countries/tanzania/index.html). The importance of malaria is one of the variables addressed by a parasitological survey in rural URT - Zanzibar targeting pre-school children and their mothers (Sousa-Figueiredo *et al.,* 2008).

A Ugandan study in 2005 estimated that pupils on average lose 7 days of schooling per term due to malaria (Mugume *et al.,* 2005 in country report). Access to medical services especially in the rural areas is a challenge and many infections are either undiagnosed or self-diagnosed. Treatment is often accessed informally resulting in a very high incidence of drug resistance, for example to Chloroquine. Malaria is preventable and one effective way of protecting people from malaria, and particularly children under the age of 5 years and pregnant mothers both of whom are at greatest risk of infection, are sleeping under treated mosquito nets. According to UNICEF (www.unicef.org), the following under five-year olds were found to be sleeping under mosquito nets between 2003 and 2006 in the five EAC partner states (see Figure 4.3.).

Figure 4.3. Percentage of <5 Year-Olds Sleeping under a Mosquito Net (2003-2006)

Burundi: 13%
Kenya: 15%
Rwanda: 16%
Uganda: 22%
URT: 31%
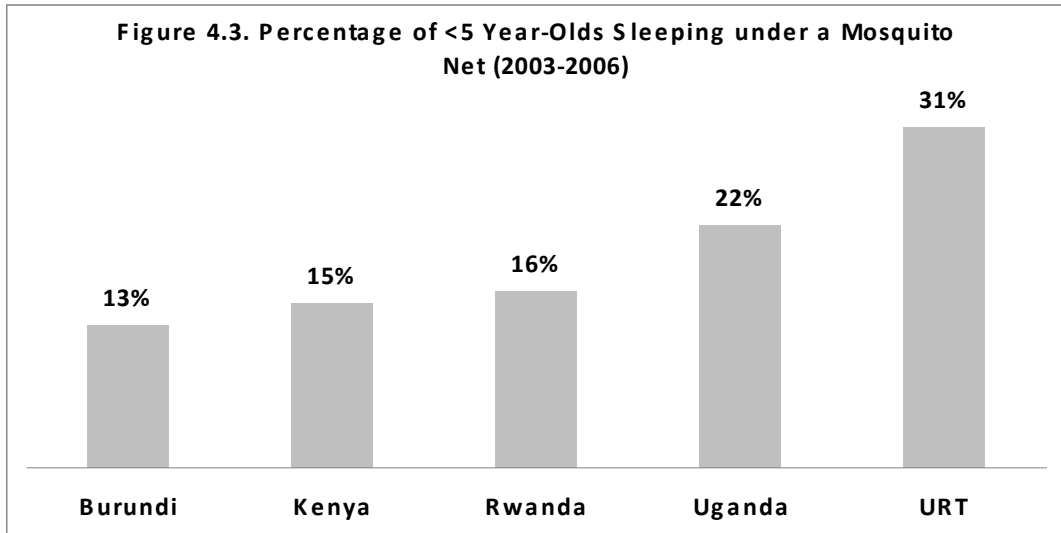
Source: UNICEF, www.unicef.org.

4.4. Worm Infections and Diarrhoeal Diseases

Worm infections are a leading cause of disease among 5 to 14 year-old children. It is estimated that half of all such children may be infected with intestinal helminths, with hookworm being the most prevalent.

The maps below (Figures 4.4. and 4.5.) provide an estimate of the prevalence of schistosomiasis and soil transmitted helminths (STHs) in the EAC. They are based on previous parasitological surveys conducted during 1980 to 2009 and represent the highest prevalence of any single species. These maps help estimate the scale of the population at risk, and can help inform the design of control approaches. See *http://www.who.int/wormcontrol/documents/en/* for details on deworming.

Figure 4.4: Maps Showing Point Prevalence Estimates of Schistosomiasis in the EAC from Parasitological Surveys
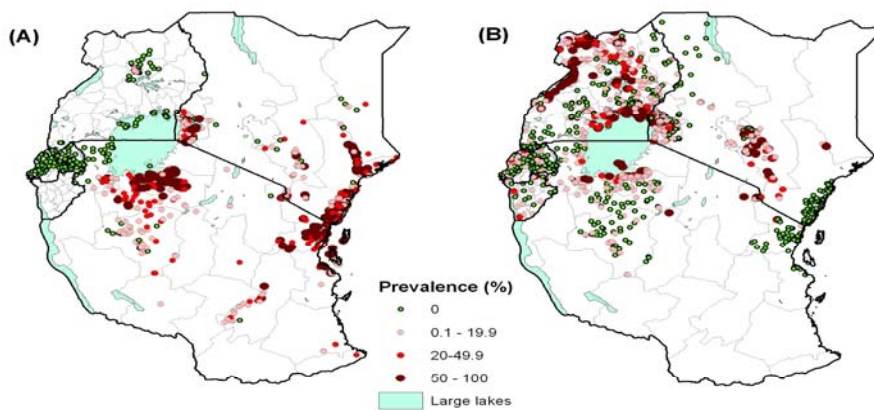
Note: (A) The geographical distribution of *schistosoma haematobium* prevalence in the EAC; and (B) The geographical distribution of *schistosoma mansoni* in the EAC.

Figure 4.5. Maps Showing Point Prevalence Estimates of STH in the EAC from Parasitological Surveys
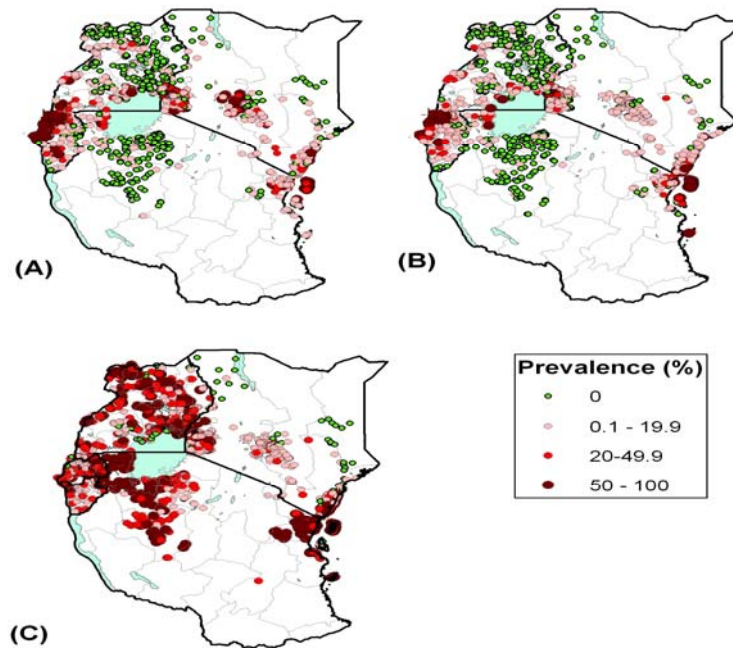
Note: (A) The geographical distribution of *Ascaris lumbricoides* prevalence in the EAC; (B) The geographical distribution of *Trichuris trichuira* prevalence in the EAC; and (C) Hookworm infection prevalence in the EAC.

It is estimated that areas surrounding Lake Victoria (in Uganda, URT - Tanzania Mainland and Kenya) and Lake Albert (in Uganda), as well as areas of the Central and Coastal provinces of Kenya have a prevalence of soil transmitted helminths and schistosomiasis of greater than 50% (country reports). A high prevalence of both species (>20%) is also found in the Zanzibar islands. Parasitological surveys conducted in Burundi show the prevalence of schistosomiasis being greater than 20% in places bordering Lake Tanganyika and Lake Cohoha.

Diarrhoeal diseases are also among key health problems affecting schoolchildren in the region. In Rwanda only 42% of the population have access to adequate sanitation. Moreover, most primary and secondary schools in Burundi do not have access to improved water sources and sanitation.

4.5. Respiratory Infections

Acute respiratory infections (ARIs) are another serious health problem affecting children in the EAC region. This is especially a concern for pre-schoolchildren. About 20% of all deaths in children under five globally are due to ARIs, 90% of which are due to pneumonia (www.who.int). Upper respiratory infections and skin infections are reported among HIV-affected schoolchildren aged between 6 and 9 years in Kenya's Suba District (Were *et al.,* 2008, in country report).

4.6. Malnutrition

Malnutrition and food insecurity are causes of concern across the EAC partner states. Burundi faces food insecurity as is the experience of approximately 28% of Rwanda's households, due to poverty, climatic irregularities and effects of civil war. Food insecurity is a major issue in many parts of Tanzania because of floods and drought among other factors. School-age children in rural areas and urban informal settlements are reported to suffer from nutritional deficiency (Republic of Kenya, 2005b in country report). The prevalence of stunting among Rwanda's children is estimated to be 45%, while that of Uganda's male and female children is 13.3% and 11.1% respectively (school health policy in country report). This is higher in rural areas. According to the 2004-2005 Tanzania's demographic health survey, 38% of children under five were chronically malnourished and have stunted growth for their age. Moreover, 30% of all regions in the country have stunted rates of more than 50% (http://www.irinnews.org/country.aspx?CountryCode=TZ&RegionCode= EAF).

WHO (2009) includes both Vitamin A and iodine deficiencies among the most common health-related problems of school-age children. Vitamin A deficiency is the single greatest cause of preventable childhood blindness while iodine deficiency is the single most common preventable cause of mental retardation and brain damage in children.

4.7. Substance Abuse in Schools

WHO (2009) attributes alcohol use for 5% of all deaths of young people between the ages of 15 and 29 years. East African laws prohibit persons under the age of 18 years to purchase or consume alcohol. A recent study in Uganda (Mukambi, 2008 in country report) reported that alcohol consumption was more likely to result in risky sexual behaviours which increased the chances of STIs and HIV. The 2006 Ugandan national sero-surveillance survey reported that 10% of youth aged 15 to 24 years (n= 7,451) had engaged in sexual intercourse when drinking alcohol. The Tanzania Global School-based Health Survey 2008 report found that 10.8% of students had drunk alcohol by their 14th birthday and that 5.4% of students had used other drugs (GSHS 2008). The Uganda report found that 12.8% of 13-15 year olds drink alcohol and 8.5 % reported ever having used drugs such as marijuana (GSHS 2003).

Also, there are serious health risks associated with tobacco where smoking is reported to be common among school-age youth. According to WHO (2009), one out of two young people who start and continue to smoke will be killed by a tobacco-related illness. The number of children reporting smoking in the past 30 days in the Tanzanian and Uganda Global School-based Health Surveys is 2.7% and 4.3% respectively.

4.8. Mental Health in Schools

While the mental health of school-age children is a concern in the region, the country reports reveal difficulties in obtaining reliable data on this issue. Mental health is cited by key informants in Rwanda as a serious concern because it affects school-age children. Rwanda, like Burundi, has been affected by protracted civil wars. In the former state, mental health is included among the topics covered by a teachers' training manual and a booklet for children both under development in Rwanda. Other health–related problems to be included are physical health, safe water, hygiene and HIV prevention (Rwanda SITAN report). Loneliness, depression and suicidal behaviour were found to be common among Ugandan and Tanzanian schoolchildren in their respective Global School-based Student health Surveys (GSHS 2003, 2008). 11 % of students in URT and 19% in Uganda had seriously considered suicide in the past year, highlighting the importance of mental health in the region.

4.9. Violence

Death and serious injuries to children resulting from violence are more likely to occur while children are in their homes or the wider community than while they are in school. However, some children are exposed to violence while in or on their way to school. Violence by education staff sometimes occurs and can include corporal punishment, psychological punishment, sexual and gender-based violence and bullying. Children can also be subjected to bullying by their peers and bullying this happens more frequently for those children from disadvantaged backgrounds. Bullying can take both verbal and physical forms. There are also reports of sexual and gender based violence in the education sector (UN, 2006). The school-age girl child is at greater risk of sexual violence and therefore of exposure to HIV and sexually transmitted diseases (STDs), unplanned pregnancy, possible harm of genital organs and psychological problems. Gender-based violence is reported to be a cause for serious concern in Burundi and is known to be a serious problem also in Kenya (situation analysis country reports).

Children with disabilities in East Africa have been found to be at greater risk of violence than non-disabled children (DCDD 2008). While there is limited data on this, the Dutch Coalition on Disability and Development estimate that 15-20% of disabled children in Kenya experience physical and sexual abuse, with mentally disabled girls the most likely to be sexually abused.

4.10. Injury

Injury is a leading cause of death and disability among school-age youth. In Uganda 15% of child mortalities are due to injuries (school health policy in the country report). According to the Global School-based Student health Survey serious injuries are high in the region, with 63% of students in Uganda and 40% of Tanzanian students reporting being seriously injured at least once during the preceding 12 months (GSHS 2003, 2008).

4.11. Disability

According to WHO, there are approximately 35 million disabled people in Africa (7% of the population) with the majority living in rural areas (WHO/AFRO 2009). These disabilities have a variety of causes, including infectious diseases, poor prenatal care, injuries, malnutrition and chronic somatic and mental conditions. Early detection and intervention can prevent an estimated 70% of childhood disabilities through vaccination and addressing malnutrition and micronutrient deficiencies (UNICEF 1999). The country reports include little information on disabilities due to difficulties in obtaining reliable data on this area.

The likelihood that some of the above health conditions affect school-age children in some of the EAC partner states even though not cited as serious problems cannot be ruled out.

5. ESTIMATES OF HIV IMPACT ON EDUCATION AND COST IMPLICATIONS

5.1. Scenarios Generated by the Ed-SIDA Model

The Ed-SIDA model was used to explore scenarios (presented below) to estimate the current and future impacts of HIV and the care and support of teachers living with HIV, on teachers, pupils and the achievement of EFA. Details of the methods are described in the 'methodology' section.

1. **VCT/ART scenarios:** Between now and 2015, VCT and ART can be provided to teachers at different levels. Here, the VCT and ART scenarios explored were (1) VCT and ART kept at current levels of provision; (2) VCT and first-line antiretroviral therapy (FLART) provided to 80% of those in need; and (3) VCT and ART provided to 80% of those in need, including both FLART and second-line antiretroviral therapy (SLART).
2. **Achievement of EFA:** Two scenarios are contrasted: that where net enrolment and teacher recruitment levels are maintained at current levels between 2008-2015, and that where they are increased to achieve 100% net enrolment and a PTR of 40.
3. **Epidemic Scenario:** The course of the epidemic in each state has uncertainty ranges generated by UNAIDS models. These have been used to generate uncertainty estimates in the teacher projections.

These above scenarios were generated and are discussed in each sub-section below.

5.2. Other Impact Assessments in the EAC Region

Goliber *et al.* (2000) made an analysis of the impact that HIV was having on education in Kenya. They gathered data on the absolute number of teacher deaths (rising to 1403 in 1999); and reported rates of AIDS mortality in the general population of 1.4%, and morbidity, 2.1%, which they assumed would apply to teachers.

Namusisi *et al.* (2008) conducted a qualitative analysis of the impact that HIV was having in Rwanda, based on answers to questionnaires on the perceived impacts.

Hyde *et al.* (2002) gathered data on teacher mortality in Uganda and made projections to 2013. The measured teacher mortality rate in 1998 was 1.11%. In order to make projections, they took the total teacher mortality, and assumed that the proportion of deaths which were due to AIDS was equal to the estimate of the rate population mortality due AIDS in 1999 in SSA made by WHO, which was 21%. They applied this rate across all years that teacher mortality data were available. To extrapolate this into the future, they applied a logistic function which forced the stabilisation of mortality. They projected that mortality rates would fall from 1999 estimated values of 0.2% to 0.1% and be maintained at this lower level.

Kinghorn *et al.* (2003) conducted a detailed analysis of the impact of HIV on education in Rwanda. Like Ed-SIDA, they used UNAIDS models to project the population prevalence by age and gender, and applied the teacher age profile. They had an excellent estimate of the teacher age profile, provided by access to the Caisse Sociale data. We use here a summary of Rwandan teacher ages from a published source. They assumed that teachers had the same susceptibility to HIV as members of the population of the same age and gender, not having any evidence to the contrary. By contrast, in this analysis, we found that teachers in Rwanda were more susceptible to HIV that the general population, and varied relative risk accordingly. Kinghorn *et al.* also treated costs in a similar way to Ed-SIDA. They assume

that the cost of absenteeism is equal to teacher's salary, and the costs of deaths, teacher training. They do not include any death benefits. Their costs of treatment included treatment of opportunistic costs, unlike Ed-SIDA; but they did not include the cost of VCT or second-line therapy. It was not necessary to be concerned with SLART when this paper was published as it was the early days of therapy. Their costs are not discounted (unlike Ed-SIDA) and were presumed to remain at constant 2002 levels. They find that, by 2009, Prevalence in teachers is expected to be 5.5%, and the mortality rate, 0.6%.

5.3. Input Data from the EAC Partner States

The analyses were carried out at the level of state, except for Kenya, where there were enough data to make projections for each Kenyan province. Table 5.1. below summarises some of the data that were input into the Ed-SIDA model.

Table 5.1. Summary of State-Specific Data Input into Ed-SIDA

		Burundi	Keny	Rwanda	URT - Tanzania	Uganda	URT-Zanzibar
Primary school-teachers	Numbers, '000s, last recorded	24	141	28	152	150	8.8
	% Female, last recorded	55%	46%	53%	48%	39%	53%
	Female average age	no data	44	33 M&F	36	30	33
	Male average age	no data	41		41	31	36
Primary School pupils	Last recorded NER	75%	75%	94%	98%	92%	77%
	Pupil-teacher ratios, last recorded	54	40	69	52	60	32
HIV	Population HIV prevalence in 2007	2%	7.8%	2.79%	6.24%	5.4%	1.70%
	% of those with HIV in need of ART in 2008	53%	22%	51%	17%	41%	12%
	% of those in need taking ART in 2008	10%	17%	58 %	6.5%	24%	50%

This modelling work explicitly examines the impact that HIV has on the achievement of EFA. To this end, the NER and PTR are examined; the further these are from their targets, the greater effort is required to recruit teachers to provide an adequate education for the growing number of children in school. Three EAC partner states (Rwanda, Uganda and URT) have over 90% of their school-age children in school, whereas the other partner states need to maintain their efforts to further their gains in increasing enrolment (see Table 5.1). Being a small and with low-density, URT – Zanzibar already has small class sizes. Kenya has an overall PTR at the target of 40, however, this average conceals considerable variation between provinces, and the other countries all have PTRs greater than the generally agreed target of 40. Therefore in the EAC region, teacher recruitment is required to meet this target. HIV will impact negatively on the states' ability to achieve these targets, and ARV up-take by teachers has the potential to mitigate these impacts. The Ed-SIDA model quantifies these impacts and estimates and projections of these are given in the results section.

Estimates are made by the model by the application of epidemiological predictions of HIV statistics for each age, gender and state to the number of teachers in the respective category. The table above therefore gives information on the likelihood of teachers to experience impacts of HIV. Figure 5.1 below gives more information on the age of all teachers by state. The age categories that teachers are most likely to belong to are also those often associated with high HIV prevalence. In addition, female teachers are younger than male teachers in three out of four states for which data on age of teachers by gender is

known (Table 5.1), which the age/gender pattern is found in the groups which suffer the highest HIV prevalence. From this demographic information alone, we expect teachers to suffer from a higher HIV prevalence than the general population does in these states. It is important to note that the age and gender of the teacher workforce varies from place to place, indicating the value of approaches such as this, where age- and gender-related susceptibility are explicitly accounted for. Teachers in Rwanda are particularly young, whereas those in Kenya are older.

Figure 5.1. Proportion of Teachers in Three Age Groups in the EAC Partner States.[8]
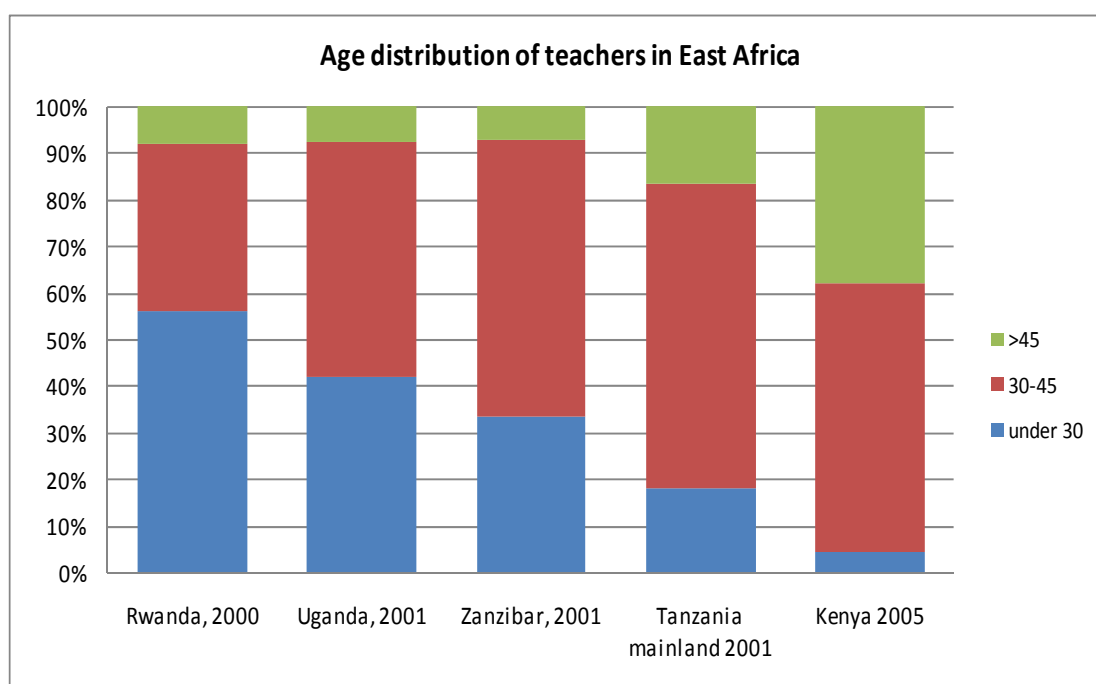
In addition to the altered risk imposed by their age and gender distribution, teachers may have different susceptibility to HIV than people from the general population of the same age and gender. An analysis of Demographic and Health Surveys (DHS) data (http://www.measuredhs.com/) determined the relative risk of teachers being infected was non-significant in Kenya and in the URT, but in Rwanda, teachers have twice the risk of the general population of being infected with HIV, which was statistically significant (see Table 5.2).

Table 5.2. Risk of Teachers Being Infected with HIV Compared to the General Population

	Kenya	Rwanda	URT
Year	**2003**	**2005**	**2004**
Prevalence in DHS sample	6.60%	3.20%	6.47%
Prevalence in teachers DHS sample	9.20%	6.40%	4.46%
P value (adjusted for age and gender)	0.135	0.048	0.586
Relative risk of teachers for infection	1.39	1.98	0.69

Note: Statistical significance was determined adjusting for the risk imposed by teachers' age and gender. *Source:* Demographic and Health Surveys (DHS).

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8 . Data from Rwanda are teachers from 12 representative primary schools from http://www.aare.edu.au/01pap/ear01163.htm. Uganda, Tanzania and Zanzibar data are random sample of grade 6 teachers from the SACMEQ study. In Kenya, data are from all teachers.

This evidence for an increased teacher risk justified running the model with an extra scenario for Rwanda; the relative risk of teachers was set at both 100% and 200% of the general population.

5.4. Impacts of HIV on Teachers, and EFA Achievement

5.4.1 Teachers living with HIV and their needs

Figure 5.3. Teachers Living with HIV by ART Need and Take-Up in the EAC Partner States, (2007-2015)
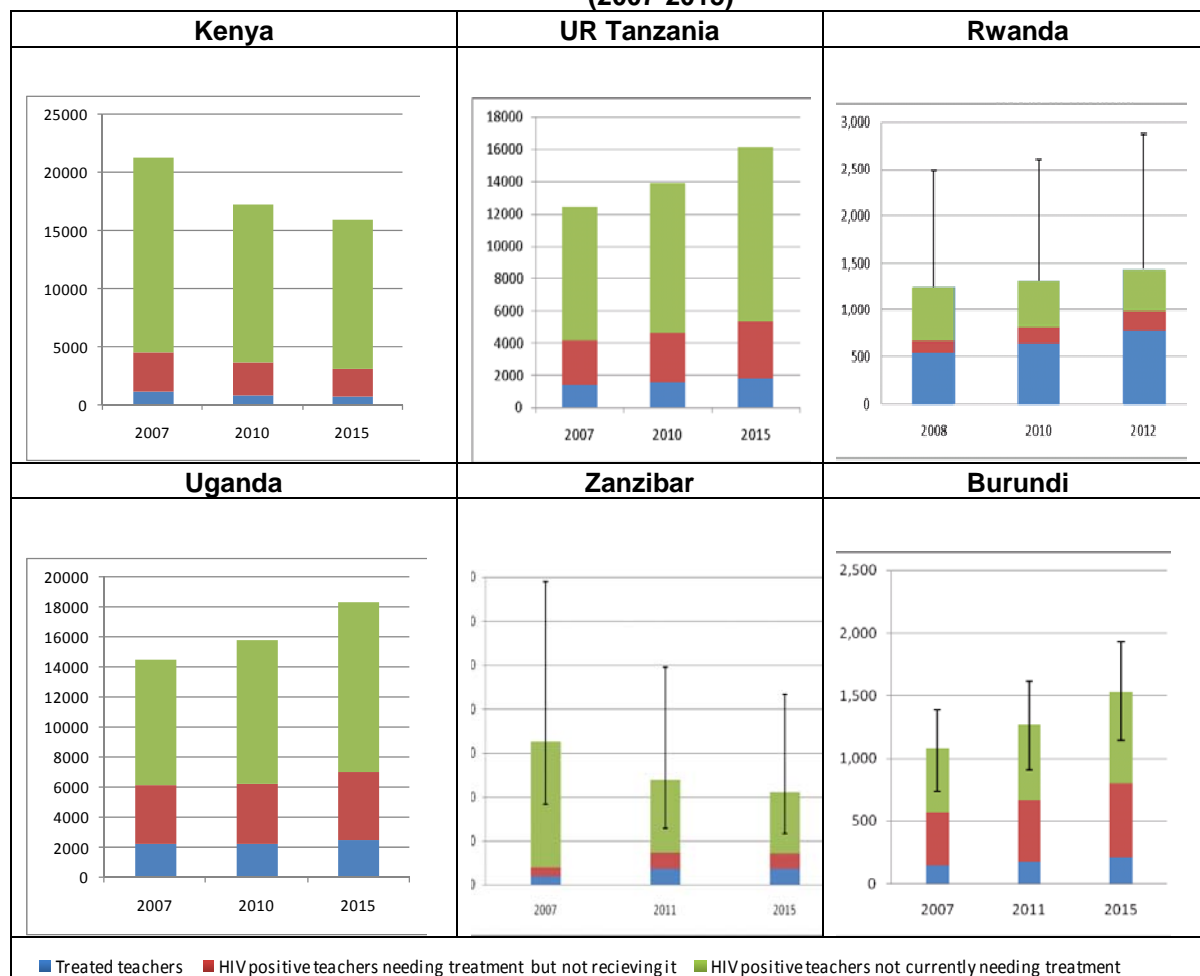
In Rwanda, error bars show the number of HIV positive teachers where the relative risk is 200% (table). In Zanzibar and Burundi, the error bars show uncertainty associated with the HIV prevalence estimates.

The number of teachers living with HIV is expected to increase in four EAC countries (see Figure 5.3.). The proportion of teachers living with HIV requiring ART varies between countries. It is highest in Burundi and Rwanda, where the latter has been very successful in facilitating access. Overall across the EAC partner states, the number of HIV-positive teachers is expected to increase, and there are estimated, in 2007, to be 10,000 teachers who require ART but are not receiving it, and are consequently in danger of dying soon. Kenya has more teachers living with HIV than any other state examined here.

5.4.2. Absenteeism Caused by HIV
Teachers living with HIV are frequently off sick, particularly so if they require ART and do not access it. Figure 5.4. displays projections of the absenteeism of teachers caused by AIDS, by ART scenario.

Figure 5.4. Teacher-Years of Absence in 2007, 2010 and 2015 by ART Scenario
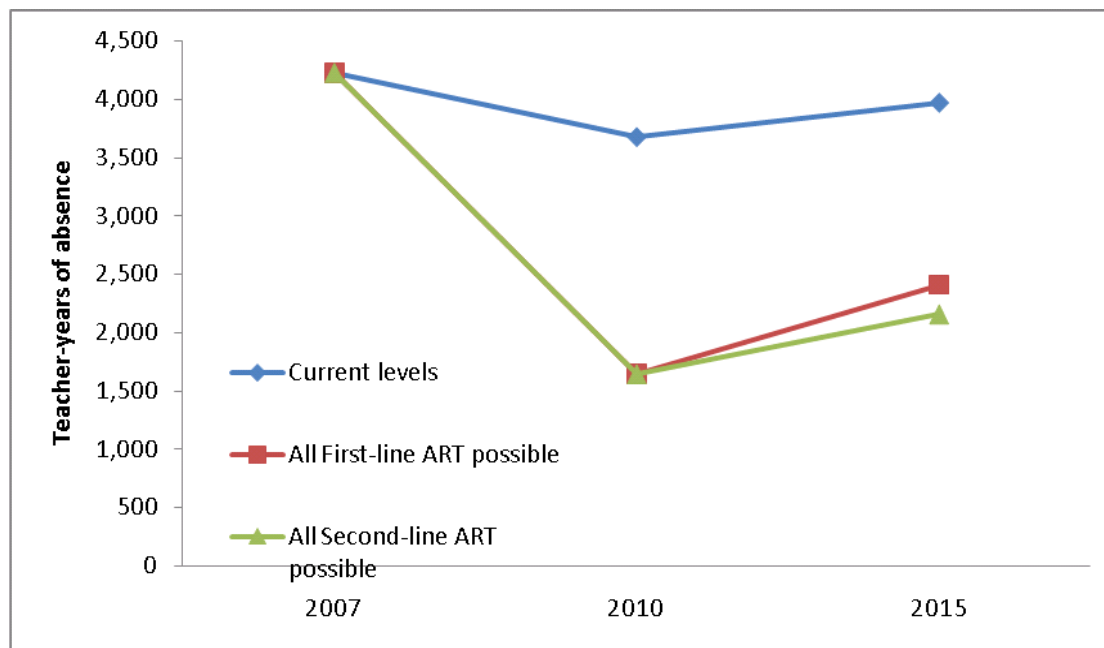
The level of "all possible FLART and SLART" is set at 80%. One teacher-year of absence is a cumulative quantity, i.e. if 12 teachers were to be absent for one month, this would equal one teacher-year of absence. In this scenario, teacher recruitment remains at current levels to 2015.

There is currently estimated to be around 4,200 teacher-years of absence annually. The number of replacement teachers that need to be employed should all AIDS absences be covered for is therefore greater than the estimated total annual absenteeism of 4,200, as if absences were distributed evenly throughout the year, at any one time, 4,200 teachers would be off sick. If ART is not provided to teachers in need beyond the proportion already treated, absenteeism is set to remain approximately stable. By contrast, absenteeism can be dramatically reduced by the facilitation of teacher access to ART.

5.4.3. Teacher AIDS Mortality by ART Scenario

Figure 5.5: Teacher AIDS Mortality in the EAC in 3 Years by ART Scenario
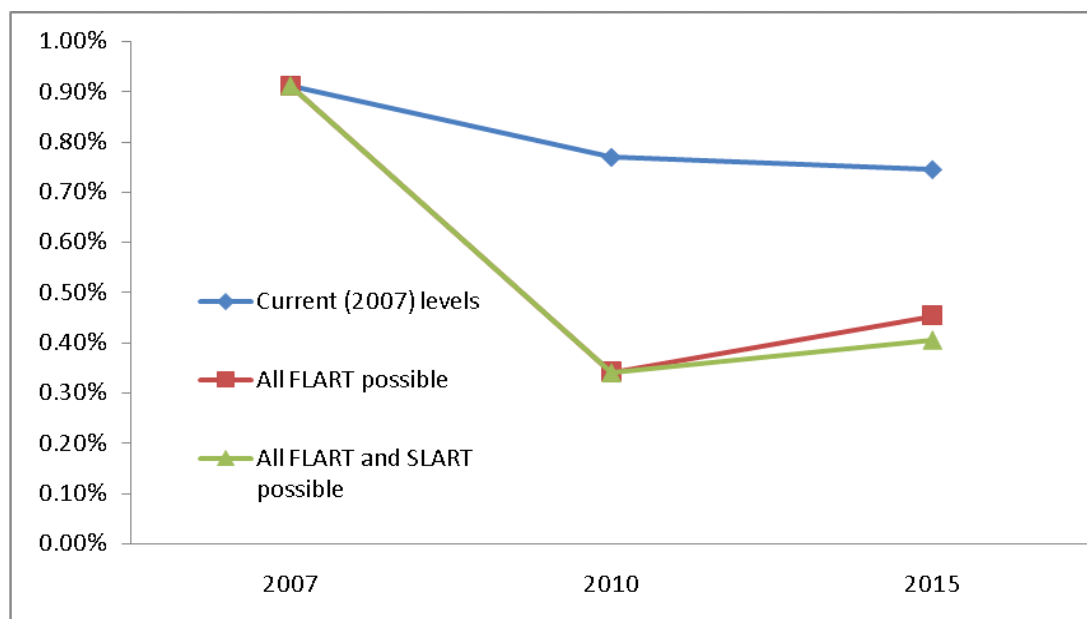
The level of "all possible FLART and SLART" is set at 80%.

If we examine the AIDS mortality of teachers in the EAC region from Figure 5.5., it can be seen that currently around 1% of the teacher workforce die each year due to AIDS. This is set to decline slightly in the years to 2015 due to the maturing epidemic. This decline can be rapidly hastened by the facilitation of teacher access to VCT and ART. Even though access to ART has only recently been increased in the EAC partner states, people who have been on first-line therapy for longest will begin to need second-line therapy before 2015. This can be seen in the above figure where the mortality rate in the scenario of first- and second- line therapy is lower than the mortality in the scenario of just first-line therapy access.

5.4.4. Enrolment

The educational planning capability of Ed-SIDA displays future school-age population, where 100% net enrolment has been achieved by 2015, and where it hasn't. This is displayed below for all the schools in the EAC region.

51

Figure 5.2: Primary Schoolchildren of Burundi, Kenya, Uganda, and the United Republic of Tanzania by Enrolment Scenario
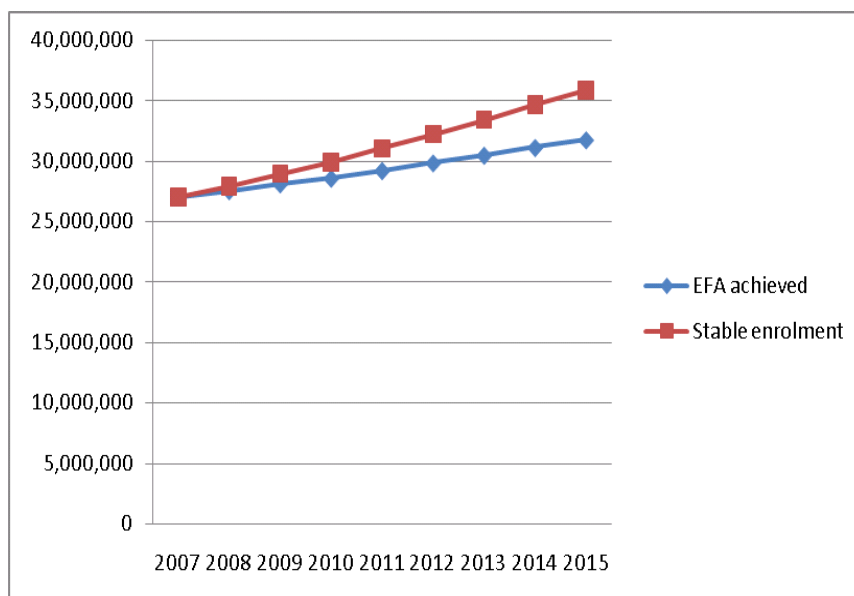
Blue diamonds = net enrolment is maintained at current levels.
Red squares = enrolment of school-age children is increased so that EFA is achieved.

The school-age population in these EAC partner states is set to increase, as can be seen where NER is stable; the population in schools still increases. Where EFA is achieved, this increase is steeper. Even to maintain current standards of education, therefore, effort is required towards expanding current education capacity in the EAC region.

5.4.4. Impact of Teacher Mortality and ART Provision on the PTR Required to Achieve EFA

5.4.4.1. Pupil-Teacher Ratios

The two components of the achievement of EFA modelled by Ed-SIDA are net enrolment ratio (which can be set to increase to 100% by 2015) and the PTR, which can be set to equal a specified low value (here, 40) by 2015. HIV affects the achievement of EFA through the mortality of teachers, which, unless compensated for by increased recruitment, increases the PTR.

Figure 5.6 shows that a low PTR consistent with EFA has not yet been achieved in the EAC region, and at current rates of teacher recruitment, the PTR is expected to increase even further from this goal. Providing ART to teachers beyond current levels can help to lower PTR (red live vs. blue line). Had the HIV epidemic not occurred (purple line), PTRs would be substantially lowered anyway.

Figure 5.6: Pupil-Teacher Ratios under Different Scenarios
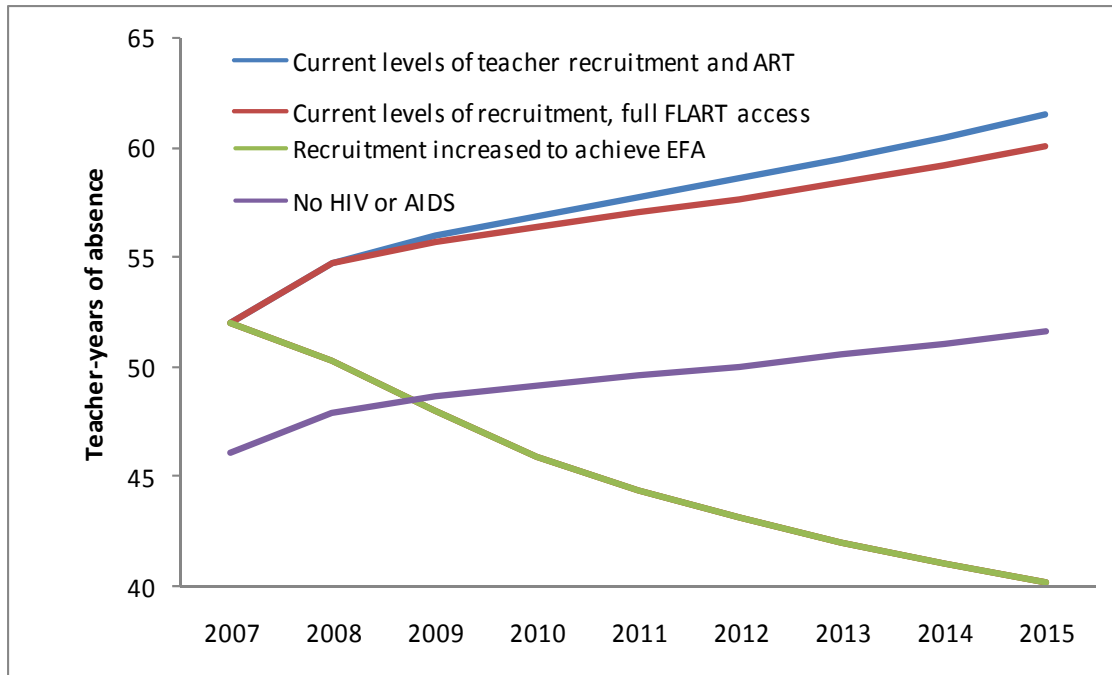
Scenarios: (1) recruitment in order to achieve EFA, (2) teacher ART access, and (3) under the counterfactual scenario where the HIV epidemic did not occur.

5.4.4.2. Quantifying Required Recruitment to Achieve the Desired PTR

Figure 5.7. Total Teacher Recruitment Required to Achieve EFA under Three Scenarios of ART Provision
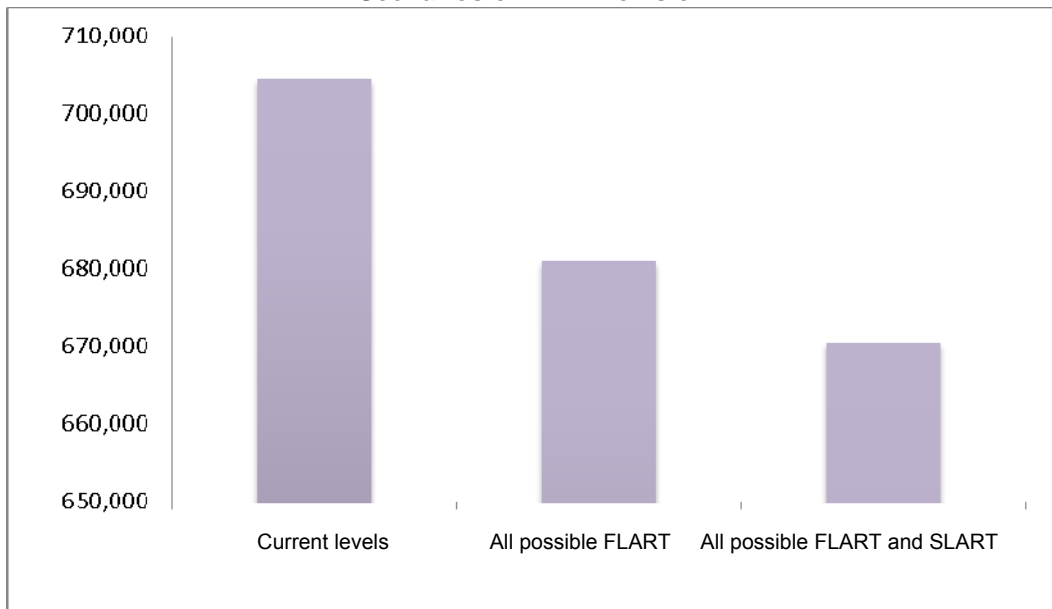
Figure 5.7 shows the total teacher recruitment required to achieve EFA and the impact that increasing ART take-up of the existing teachers has on the required recruitment, from 2007-2014 (teachers recruited in 2014 are presumed to start teaching in 2015). This figure shows that facilitating access to ART can potentially remove the neccessity to recruit as many as 34,000 teachers in these countries if EFA is to be achieved. The current levels of teacher recruitment, calculated by the model from the variations in the number of teachers and

recorded rates of attrition, are much lower than those required to achieve EFA. The total recruitment, at current levels, expected between 2007-2014 is 243,000; hence, recruitment efforts need to be approximately tripled if EFA is to be achieved.

5.5. Costs on the Impact of HIV on Education in the EAC Countries

Table 5.3. shows that, in the EAC partner states, the annual costs due to AIDS deaths will decrease slightly if ART is maintained at current levels, due to the maturing epidemic in the EAC, which means mortality among HIV-positive people is declining irrespective of the ART roll-out. (c.f. Figure 5.3. above). By contrast, the costs due to absenteeism will rise under the same scenario. This is due to (1) the negligable decline in teacher-years of absenteeism where teacher recruitment is maintained (Figure 5.2. above); and (2) the increase in the number of teachers caused by the requirement to meet EFA. Where ART is provided, annual costs of HIV to the MoEs in these countries are reduced substantially. The costs to the health sector of VCT and ART are set to rise, in part because of the continuing necessity to provide treatment to a teacher requiring it. Overtime, more teachers become elegible for treatment, while the treatment of those already treated must be maintained.

Table 5.3; Costs of HIV to Education in the EAC Partner States, in 2008 and 2015

	ART at current levels	FLART immediately increased to 80%	FLART & SLART given to as many patients needing therapy as possible
	2008	2015	2015	2015
Ministry of Education:				
Teacher training to replace AIDS deaths	$3,033,000	$2,872,000	$1,738,000	$1,565,000
Funeral costs	$13,096,000	$11,316,000	$6,731,000	$6,205,000
Covering AIDS absences	$6,446,000	$7,345,000	$4,247,000	$3,823,000
Ministry of Health:				
FLART	$396,000	$557,000	$1,165,000	$1,176,000
SLART	$0	$0	$0	$549,000
VCT	$4,656,000	$7,735,000	$17,465,000	$17,465,000

Note: Teacher recruitment was increased so that the EFA was met.

Table 5.4. details the costs and benefits of facilitating teacher access to ART and VCT. It highlights the fact that ART is life-saving, potentially averting the deaths of thousands of teachers, in addition to saving the education sector of the EAC of the order of US$100,000. The cost of facilitating teacher access to ART and VCT is less than the large saving made by reduced death and absences of teachers. The investmest of each dollar into providing VCT and FLART to the 80% of teachers taking this up as an estimated maximum proportion, returns US$1.16 due to deaths and absenteeism averted, and given this initial investment into VCT and first-line ART, the investment into second-line ART returns an even greater US$1.85 on the dollar.

Table 5.4. Total Costs and Benefits of Provision of Services to Teachers in the EAC Countries between 2008 and 2015

		FLART only	FLART + SLART
Costs	increasing ART	US$4,474,000	US$5,554,000
	increasing VCT		US$74,872,000
Benefits	rs' deaths averted	20,880	21,530
	r-years of absenteeism saved	20,770	21,530
	ving 2007-2015 to MoE of increasing ART and VCT use	US$91,801,000	US$93,803,000

Cost of FLART and VCT per teacher's death averted	US$3,800
Cost of SLART per extra teacher's death averted	US$1,660
Return on investment into FLART and VCT to education sector	US$1.16
Extra return on investment into SLART	US$1.85

These values are for the countries in the report as a whole. Costs, benefits and returns vary throughout the EAC region.

5.6. Summary of Results of Scenarios Generated to Explore the Impact of HIV on Education

The Ed-SIDA model was used to explore scenarios to estimate the current and future impacts of HIV and the care and support of teachers living with HIV, on teachers, pupils and the achievement of EFA. These scenarios were presented and discussed and overall can be summarised as:

- The age-distribution of teachers varies between EAC partner states and is an important predictor of HIV prevalence, where teachers belong disproportionately to age groups more at risk of HIV infection. By contrast, the teacher gender distribution is more representative and does not influence prevalence to the same extent.
- Teachers vary by country in their susceptibility to HIV compared to individuals of the same age and gender from the same country.
- Rwanda has younger teachers, who are at greater risk of HIV infection than their non-teacher peers of the same age and gender.
- The school-age population is expected to increase in the EAC.
- In 2005, there were 420,000 HIV-positive children in the EAC. The future number depends largely on states' successes in rolling out PMTCT and paediatric antiretroviral therapy (pART).
- In 2005, there were estimated to be 8.4 million orphans in the EAC, and numbers are expected to remain stable into the future.
- The numbers of teachers living with HIV are expected to increase; there is a large unmet need for teacher access to antiretroviral therapy (ART) (10,000 in 2007; around 2% of all teachers).
- HIV imposes a large burden of absenteeism on education (4,200 teacher-years) in the EAC which could drastically be reduced through the provision of ART.
- Annually AIDS mortality is currently around 1% of the workforce and is set to decline significantly where access to ART is scaled-up.
- Provision of second-line therapy will become an issue of relevance to teacher management in the next 5 years, where its provision will prevent hundreds of teacher-years of absence in 2014 and a comparable number of annual teacher deaths.
- Countries vary in their level of EFA achievement. Meeting EFA in the EAC region will necessitate a tripling of current teacher recruitment rates.

- Facilitating access to voluntary counselling and testing (VCT) and ART can remove the necessity to recruit 34,000 additional teachers who would be required to meet the achievements of EFA.
- The cost burden of HIV to the education sector in the EAC region currently totals US$10.7 million annually.
- Providing VCT and first line FLART to teachers is cost-effective, providing a return of US$1.15 on the dollar. Given the provision of these treatments, further providing SLART is also cost-effective, returning US$1.85 on the dollar.

6. THE CURRENT EDUCATION SECTOR RESPONSE TO HIV AND AIDS

This sub-section specifically provides information on the current education sector's response to HIV both at regional and partner state levels.

6.1. Policies and Strategies that Address HIV in the EAC Region

The development and use of policies and strategies is one of the core areas of any effective education sector response to HIV and AIDS. In general, policies and strategies demonstrate leadership commitment to key issues and provide a framework for an overall systematic and holistic response.

In all partner states multi-sectoral policies, strategies, and work-place regulations for HIV and AIDS exist, which also involve the education sector. In addition the EAC secretariat launched a regional strategic plan for HIV and AIDS in 2007, which lays out priority actions for youth and education sectors in the region. Separately, in line with their multi-sectoral frameworks, all partner states have also developed education-sector specific policies and corresponding action plans on HIV and AIDS. Priority themes covered by all partner states are HIV prevention education in schools, peer education, access to HIV information, advocacy on HIV, and development of a management capacity to response to HIV. Prevention of stigma and discrimination, and skills-based learning are important aspects to HIV prevention that need to be emphasized.

The sub-sections below provide details on the existing multi-sectoral and education sector HIV and AIDS policies and strategies at both EAC regional and partner state levels.

6.1.1. Multi-Sectoral and Education Sector Policies and Strategic Plans

6.1.1.1 Regional Level

The multi-sectoral EAC regional Strategic Plan for HIV and AIDS (2008-2012) (see Section 1.5. for details) is a key document that provides overall direction for all sector's responses to HIV in the EAC region including those of the education sector. One of four EAC programmes targeted for mainstreaming HIV and AIDS and gender by this strategic plan is that of Education and Youth. The mainstreaming of HIV and AIDS into the curriculum is a key priority referenced by this strategic plan, and the EAC education programme plans to support the development of HIV and AIDS messages in curricula across the region.

Other EAC regional policies and plans also relevant to education sector responses to HIV include:

- **HIV and AIDS workplace policy:** developed at the EAC Secretariat, with the involvement of the education sector and other sectoral areas (EAC, 2008d).
- **EAC Regional Workplace Strategy (2008):** Encompassing all sectors including education, this strategy has not yet been implemented and developed into a programme.
- **Reproductive Health Strategic Plan:** This plan works hand-in-hand with the EAC Regional Strategic Plan for HIV and AIDS (2008-2012) and addresses:
  - Adolescent and youth sexual and reproductive health, education and livelihood;
  - adolescents and youths' access to health, sexual and reproductive health information, education and services;

- gender issues and harmful traditional practices, HIV and AIDS and other STIs, and
- sexual and reproductive rights.

- ***Gender and Community Development Framework:*** This framework addresses how the education sector can help achieve the MDGs on gender equality and empowerment of women by:
  - Sensitising communities to appreciate the value of education for both boys and girls;
  - passing and enforcing by-laws to keep all school going children in school; and
  - reviewing curriculum to eliminate gender stereotyping; taking affirmative action to close the gender gap in literacy especially for children who cannot access schooling because of difficult circumstances (EAC, 2006b).

While the above plans and policies provide broad guidance on regional HIV priorities, including those relevant to the education sector, EAC Secretariat officials during the situation analysis interviews also highlighted the need for a regional education sector specific strategic plan and policy.

Although there is no specific education sector HIV policy at the regional level, there are such policies at national levels that are driving the response at that level.

6.1.1.2. National Level

It is not possible for any programme to respond to HIV and AIDS effectively without a well thought out policy and strategic plan to implement the policy. In recognition of the importance of such guidelines, most of the EAC partner states with the exception of Burundi have a national HIV and AIDS policy and strategy, as well as an education sector HIV and AIDS policy. All states' education sectors have HIV and AIDS action plan; and national policies for free primary school towards the achievement of EFA. Burundi has HIV & AIDS Guidelines which are providing the national response to HIV.

Table 6.1 highlights important health and HIV-related issues addressed by the existing MoE policies and action plans. It is important to note that boxes not highlighted do not necessarily show a failure by a specific Education Ministry to address specified issue but rather may indicate information gaps. Details on themes such as HIV prevention education (e.g. how it is taught) are under the relevant section of the report (in this case Sections 6.3.1 and 6.3.2).

Table 6.1: Issues Referenced by Various Education Ministries in the EAC Partner States

HIV and AIDS Guidelines	Burundi	Kenya	Rwanda	Uganda	United Republic of Tanzania	
					Tanzania Mainland	Zanzibar
National HIV and AIDS policy/strategy	✓	✓	✓	✓	✓	**
Education Sector Policy on HIV and AIDS	✓	✓	✓	✓	✓	✓
Education sector HIV and AIDS action plan	✓	✓	✓	✓	✓	✓
National workplace policy				✓	✓	
MoE has a workplace policy	✓	✓	✓	✓		
Themes addressed by Education Sector Policies /Action Plan on HIV and AIDS:						
a) HIV prevention						
HIV education in primary./secondary schools	✓	✓	✓	✓	✓	✓
Access to HIV information	✓	✓	✓	✓	✓	✓
Peer education	✓	✓	✓	✓	✓	✓
Behaviour change education/skills			✓		✓	
Education on sexual offences		✓				
Discrimination/stigma education		✓		✓		
VCT-related information	✓	✓	✓			
Promotes use of condoms	✓					
Increase PMTCT*	✓					
Decrease transfusion of HIV-infected blood	✓					
Ensure access of treatment				✓		
Prevention capacity building			✓	✓	✓	
Gender & human rights education						✓
Sexually transmitted diseases		✓		✓	✓	
b) Care & support						
Care and support			✓		✓	
Psycho-social support		✓				
Community mobilization		✓				
Children affected by AIDS				✓	✓	
Financial support		✓				
Cross cutting issues/impact mitigation, e.g. coordination guidelines					✓	
c) Workplace issues						
Workplace –related issues		✓	✓	✓	✓	✓
d) Management capacity & advocacy						
Development of Management capacity & advocacy on HIV	✓		✓	✓	✓	✓

	Burundi	Kenya	Rwanda	Uganda	URT	
					Tanzania Mainland	Zanzibar
Gender Policy in Education		▓				
Gender policy Principles: Gender responsiveness in policy		▓				
PLWH involved in AIDS education		▓				
National School Health Policy				(in draft)		MOU in place
Policy addresses: STDs	▓		▓		▓	
HIV and AIDS					▓	

** MoE of URT - Zanzibar does not have an education sector-specific policy for HIV, its responses to HIV initiatives are articulated in the Education Policy (RGZ, 2006 in Zanzibar situation analysis report).
Note: shaded areas indicate presence of specified guidelines.
Sources: Focal Point Survey, 2007; All situation analysis country reports.

The development of the education sector SHN and HIV and AIDS strategic plans has also taken into consideration the existing international and regions' best practices such as EFA, Dakar Declaration Framework for Action, MDGs, the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) declaration of commitment to HIV and AIDS and the United Nations Convention on the Rights of the Child. All MoE HIV and AIDS strategic policies are compliant with the *Code of Practice on HIV and AIDS* & *World of Work* developed by the International Labour Organisation (ILO). As can be seen in Table 5.1, the themes running across the various MoE HIV and AIDS strategies and action plans include prevention, care and support, impact mitigation and enabling environment.

Burundi, Rwanda, Kenya and URT - Tanzania Mainland have National SHN policies, while Uganda's policy was in draft form and awaiting finalization at the time of the conclusion of the SITAN (Focal Point Survey, 2007; Country SITAN reports).

6.1.2. Workplace Policies

There is a formidable case globally for the development and functional workplace policies addressing HIV. According to the ILO, over 20 million workers globally were living with HIV in 2001. The organisation predicted that the impact of HIV would lower the size of the labour workforce in high HIV prevalence countries to around 10% to 30% by the year 2020 than would have been the case without this HIV impact. This underscores the importance of accelerating the education sector response to HIV and AIDS in the EAC region which is one of the high HIV prevalence areas, especially as the education sector represents a considerable section (estimated >60%) of the public sector workforce in the EAC countries. All the EAC states with the exception of URT - Zanzibar and Burundi have National workplace policies (Burundi has HIV Guidelines instead, which reference pertinent work place issues.)

6.1.2.1. Regional Level

The EAC Secretariat facilitated the development of a regional HIV and AIDS *workplace policy* in 2008, the overall goal of which is "to improve access to HIV and AIDS information and services, as well as HIV and AIDS prevention, care and treatment, impact mitigation and support, and to create an enabling environment to support the above" (EAC 2008d:11). The attainment of this goal is expected to be achieved through the collective participation of all

stakeholders. Among the proposed regional activities to disseminate and implement the policy are:

- the launching of an education programme to facilitate the reduction and prevention of further spread of HIV among its employees and their families;
- ensuring prevention, care and treatment and support services for affected workers and their families;
- educating employees and their eligible dependants to ensure that those infected and affected by HIV are not stigmatised and discriminated against;
- ensuring that the EAC creates a caring and supportive environment for HIV-positive employees and their eligible dependants, including widows and orphans; and
- building the capacity of the EAC to ensure that HIV and AIDS responses are mainstreamed both internally and externally into all its organisations and institutions, directorates, projects and programmes in order to cope with the multifaceted nature of the pandemic (EAC, 2008d:11).

6.1.2.2. National Level

A large majority of EAC partner states (Kenya, Rwanda, URT - Tanzania Mainland and Uganda) have national workplace policies compliant with the laws of the land, the national HIV and AIDS policy, as well as the *ILO Code of Practice on HIV and AIDS and the world of work. As mentioned earlier, Burundi is using Guidelines which reference workplace issues. (Country Reports)* From these, various MoEs have developed their own specific policies. A priority now for all countries is the dissemination of the policy and ensuring it is enforced at all levels of the education system, including private sector providers. Box 6.1 below provides more details on the presence of work-place policies in partner states.

Box 6.1: Details on the presence of work-place policies in partner states

Burundi does not have an education sector workplace policy, but has related guidelines which reference pertinent workplace and human rights issues.

Rwanda's education sector HIV and AIDS policy addresses:
- Workplace concerns and rights for all teachers including those living with HIV, as well as other educationists.
- Many schools are located near health facilities to allow easy access to health care,
- School further from health facilities are required by the policy to have a nurse, and all students to be part of a medical insurance system.
- Tests for HIV and VCT are free
- ART services are free (Rwanda SITAN report).

Uganda and Kenya's MoEs also have workplace policies. In the former, the MoE has distributed the policy guidelines to headquarter personnel, District Education Officers, and head teachers although not all have been reached. Kenya's *Education Sector Policy on HIV and AIDS* has a section on HIV and AIDS in the workplace. The policy has been disseminated to all public secondary schools and a portion of the primary schools, but it is not sufficiently known to and understood by teachers and has not been translated into administrative practices at sub-national level (IATT, 2008).

URT: Tanzania Mainland does not have a workplace policy specific to education sector, but its Education Ministry has already set up a committee to initiate the development of one. The country has been using existing HIV guidelines developed by the Tanzania Commission for AIDS (TACAIDS) with stakeholders.

Table 6.2 highlights examples of areas addressed by MoE workplace policies in three EAC states for which information is available.

Table 6.2: Workplace and Human Rights Issues Addressed by Various Workplace Policies (and Burundi's HIV Guidelines)

Issues addressed	Burundi	Kenya	Rwanda	Uganda
Non-discrimination/stigma	▓	▓	▓	▓
Recruitment and promotion	▓	▓	▓	▓
Termination of employment	▓	▓		▓
Sick leave	▓	▓	▓	
Working hours	▓		▓	
Access to information on HIV and AIDS	▓	▓	▓	▓
Deployment and transfers	▓	▓		▓
Duties/responsibilities	▓		▓	
Access to health services/treatment		▓	▓	▓
HIV testing	▓	▓	▓	▓
Confidentiality and disclosure	▓	▓		▓
Relief services/absenteeism/ill health	▓	▓		
Training and development		▓	▓	▓
Gender responsiveness		▓	▓	▓
Occupational health and safety	▓		▓	
Retirement on medical grounds	▓	▓	▓	
Grievances and concerns (Uganda's policy adds disciplinary measures)		▓		▓
Prevention and support programmes for employees/health promotion	▓	▓	▓	▓
Condom use promotion	▓		▓	▓
Risk management		▓	▓	▓

Source: Extracted from Burundi, Kenya, Rwanda, and Uganda country SITAN reports.

As outlined in Table 6.2, existing education sector workplace policies integrate both workplace and human rights issues. In the three EAC partner states (Kenya, Uganda and Burundi) the education sector workplace policies (and Burundi's HIV Guidelines) mainly address: stigma and discrimination; access to information on HIV and AIDS; deployment and transfers; confidentiality and disclosure, as well as HIV testing. These are critical issues that deserve policy attention. In Burundi, employers are mandated to protect teachers and students infected and/or affected by HIV from discrimination and stigma and encourages them to declare their HIV status to demystify HIV and AIDS (Burundi SITAN report). With the exception of condom use promotion and risk management, the workplace policy of Kenya's Institute of Education addresses the above areas as well as psychosocial support; medical privileges, sexual harassment; abuse and exploitation; and retirement on medical grounds. While there is no workplace policy specific to the education sector currently in URT, in Tanzania Mainland, there is nevertheless, a national HIV and AIDS policy and guidelines for implementing HIV and AIDS and life skills education programmes for students, teachers and non teaching staff. There are also in Zanzibar, response initiatives articulated in the Education Policy and implemented through Moral Ethics, and Environmental Studies.

6.1.3.1. Regional Level

Since the implementation of the EAC Regional Strategic Plan for HIV and AIDS (2008−2012) commenced in July 2008 there has not been much time for the facilitation of a regional education sector response to HIV and AIDS (EAC, 2008a).
The EAC Development Strategy (2006−2010) which has informed the current EAC Regional HIV and AIDS Strategic Plan (2008−12) acknowledges the failure to adequately address the relationship between regional and existing national policies and strategies. This concern was also raised by some EAC Secretariat key informants during the SITAN (EAC, no data; EAC, 2008a).

Information collected from the EAC Secretariat interviews revealed that the personnel at the EAC Secretariat and in the region lacked sufficient capacity in HIV mainstreaming in terms of skills acquisition and sufficient manpower, both of which are necessary for effective implementation of the Regional Strategic Plan.

6.1.3.2. National Level

Lack of sufficient financial and human resources are a serious challenge in most of the states including Burundi, Uganda and the United Republic of Tanzania. In Uganda, for instance, lack of financial resources has hindered the MoE from distributing workplace policies in 48% of its sub-sectors. Lack of financial resources has also affected policy implementation in hindering or slowing down the building of personnel capacity in terms of knowledge and skills acquisition. The Ugandan MoE has not adequately sensitized its personnel, school and departmental heads about policy matters because of inadequate resources and to meet the current demand for VCT outreach services. Similar gaps in sensitisation on policy matters were found in Kenya. As mentioned earlier, the education sector HIV and AIDS policy in Kenya is not sufficiently known or understood by teachers and has not been translated into administrative practices at sub-national level. Further, there are no mechanisms in place to update the policy (IATT, 2008). Limited financial resources and personnel with adequate skills and HIV and AIDS knowledge both pose serious challenges in accelerating URT - Zanzibar's MoE related response.

Stigma and discrimination in the educational workplace is cited as a challenge and has limited uptake of available HIV and AIDS services, which raises questions concerning the extent to which workplace policies are being used in schools. Monitoring behaviour and attitude change has been difficult across the various states.

Thus, in order to ensure that policies are implemented, an analysis of barriers to their implementation and policy gaps in countries is required followed by appropriate action. The barriers/ gaps may include lack of political commitment, contested policy issues (such as condoms), absence of defined dissemination and communication arrangements, capacity issues at central and decentralised levels, absence of monitoring arrangements.

6.2. Managing and Mainstreaming the Education Sector HIV Response

The management and mainstreaming of HIV and AIDS responses into the education sector ensures HIV and AIDS is not addressed as an add-on or separate activity. Instead, it is considered an integral part of education-sector policy, strategies, curricula, actions and monitoring and evaluation efforts. Thus HIV responses are part of broader programmes that are implemented to scale and not fragmented.

The EAC Secretariat has identified primary and secondary school curricula and institutions of higher learning across all partner states as two specific areas for mainstreaming HIV and AIDS into the education sector. At regional level, the EAC Secretariat and its education and related offices are a key management structure coordinating the mainstreaming of HIV and AIDS. In addition, regional networks on HIV and AIDS such as EANNASO and the Eastern Africa Network of MoE HIV and AIDS Focal Points allow for inter-country sharing of experiences and good practices. At national level, an AIDS control unit within the MoE is the main coordinating office of national education-sector responses to HIV. Through co-ordination with other directorates and departments, the unit ensures that HIV and AIDS is mainstreamed in the core function of the Ministry. The MoE is currently implementing a Sector Wide Approach through the KESSP programme. There are 23 investment programmes and HIV and AIDS is one of them.

Efforts to decentralise HIV responses to districts and empower communities are underway in all countries. However this is met with challenges such as in capacity and resources at sub-national structures. Capacity building activities for HIV-related responses at different levels (national, districts, and schools) are reported in all countries. Moreover, the sub-regional workshops of the Accelerate Initiative and an annual short-course in SHN have served as a capacity strengthening opportunity for MoE HIV and AIDS Focal Points and other senior staff members.

Budget allocations for education sector HIV response has generally risen over the past few years, with an increase in funding availed from development partners, in addition to that provided by governments. At the regional level there have been efforts to improve the monitoring and evaluation of HIV interventions more generally and those in the education sector. For example the IUCEA is developing an integrated M&E framework for the region. In partner states, national MoEs are increasingly incorporating HIV in to their monitoring efforts given the growing emphasis on the coordination of decentralised responses. In URT – Tanzania Mainland, education sector relevant indicators is coordinated by the National AIDS committee, TACAIDS, while in Kenya, HIV specific indicators are incorporated in the national EMIS.

The sub-sections below provide details on the planning, management and mainstreaming of education sector HIV response into the EAC region including: coordination of the response, capacity building, decentralisation, budget allocation, monitoring, evaluation and research.

6.2.1. Mainstreaming of HIV and AIDS

"Mainstreaming is the articulation of the HIV and AIDS issues in national plans, allocating resources, creating an enabling environment, monitoring and evaluation, management, etc, and cascading theses to the various management levels so that they (HIV and AIDS issues) are viewed in the light of education performance indicators (access, equity, transition and quality) and link to poverty reduction/eradication outcome/impact indicators. HIV and AIDS is not an 'add on' but is infused into the systemic mandate." (World Bank Report on Think Tank, 2007:5)

The mainstreaming of HIV and AIDS into all EAC Secretariat and regional sectors is one of the *strategic interventions* proposed in the generic EAC *Development Strategy (2006-2010)* for the achievement of "*Reduced incidence of HIV and AIDS infection and its socio-economic impact in the region*" (EAC, no data:51). Education and youth is one of four EAC sectors into which EAC has taken deliberate steps to mainstream HIV and AIDS (others are trade, planning, industry and finance; agriculture, livestock, fisheries and natural resources; infrastructure, transport, and public works). The Development Strategy highlights the importance of mainstreaming HIV and AIDS within two specific areas in the education sector:

- The primary and secondary curricula throughout the EAC region (discussed in Section 6.4 below); and
- universities and other institutions of higher learning (EAC, no data).

The EAC Secretariat plans to commission a consultancy to initiate this mainstreaming of HIV and AIDS into school curricula (see Section 6.3.2 for details). Recently (June 2008) the EAC Secretariat convened a regional meeting in Entebbe, Uganda on the mainstreaming of gender and HIV/AIDS interventions into various regional development sectors and strategies plans (EAC, 2008c). This was the second workshop, an earlier one having been held in August 2007 at the Ngurdoto Mountain Lodge, Arusha, Tanzania, since which a lot has been accomplished nationally in the region (see Annex 10 for further details).

In March 2007, the World Bank conducted a Think Tank Consultative forum on behalf of the Accelerate Working Group. The forum provided the opportunity for key regional stakeholders in the Education Sector to brainstorm, identify and discuss key issues that eventually would be for the framework for HIV and AIDS mainstreaming responses by the education sector in the Eastern and Southern Africa region (World Bank Report on Think Tank, 2007). This framework however, according to a key informant, is not yet in place. One of the outcomes of the forum was a consensus and adoption of a working definition of HIV and AIDS mainstreaming.

The importance of mainstreaming was highlighted during the 3rd Annual Meeting of the African Networks of Education Sector HIV Focal Points in December 2008, with the Eastern African Network identifying the integration of HIV and SHN and the subsequent mainstreaming of both issues into the education sector plans and strategies as a priority for countries (Networks/PCD/World Bank 2009). Details of the extent various countries have mainstreamed HIV into the education-sector such as their policies, strategies, management, and curricula are given under the relevant sections of the report (Sections 6.1.1, 6.1.2, 6.2.2, 6.3.2 respectively).

6.2.2. Management and Coordination of the HIV Response

6.2.2.1. Regional Level

The regional education sector response to HIV is coordinated by the EAC Secretariat which has assigned the responsibility specifically to the Principal Education Officer (PEO) who works closely with the Health Advisor at the EAC Secretariat. The latter is the coordinator of the regional health programme under which HIV& AIDS is currently placed. The attainment of the objectives of any EAC programme is not a one-man affair but requires the joint effort of the other regional programme coordinators and the implementers at partner state level as well as stakeholders. The Structure of the EAC is headed by a Summit of Heads of State. The Secretariat is enabled to function through the participation of a Coordination Committee, Sectoral Committees and Technical Working Groups of Experts (see Annex 5 for a detailed structure).

The EAC Secretariat aims to provide guidance to partner states, for instance, in the formulation of policy and strategy, programmatic interventions and capacity building for effective implementation. Specifically the PEO has the coordinating responsibility of working closely with the MoE HIV Focal Points and their Network. In regard to regional strategies, with the active participation of all MoEs, NACs, Ministries of Health, among others, the EAC Secretariat has coordinated the development of a regional HIV Strategic Plan which to a great extent was informed by the various national plans, gender and HIV mainstreaming. Another regional initiative example is the planned harmonisation of the education system and training curriculum – all subjects from pre-primary to tertiary institutions.

Other stakeholders of the education sector response to HIV within the EAC region include development partners: these provide technical guidance and funding support, for example the World Bank and UNAIDS. The EAC like other regions has benefited from guidelines developed by UNESCO and the ILO. UNESCO set up four regional AIDS advisor posts in 2008, one of which is located in Johannesburg and serves Eastern and Southern Africa. The service assists in strategy and policy development, coordination for HIV programming, and resource mobilisation related to UNESCO's lead and main partner responsibilities under the UNAIDS Division of Labour. One of five UNAIDS Regional Technical Support Facilities (TSFs) have also been established in Eastern Africa to provide quality assured technical assistance in agreed priority areas, which include: planning, monitoring and evaluation, implementation and management, and thematic areas as identified in collaboration with countries in the region. These strengthen coordination and capacity for effective responses at the country level. The TSFs also maintain extensive databases of national and regional expertise and/or consultants who can provide a harmonised and collaborative approach to the delivery of technical assistance in support of country partner-owned and partner-led action plans *(unesdoc.unesco.org/images/ 0014/001473/ 147360E.pdf).* According to an officer working with TSF Southern Africa, so far the TSFs have not been directly involved in the education sector response to HIV. Organisations such as the Association for the Development of Education in Africa (ADEA) have provided capacity building to the region. Tanzania has indeed hosted one of its meetings.

These development partners also work with each other, with their networks of country offices, with other UNAIDS co-sponsors and with the UNAIDS IATT on Education members to expand the base of technical assistance in support of country efforts towards comprehensive education sector responses to HIV and AIDS.

The stakeholders of the EAC education sector response to HIV also include regional networks, for example the Eastern African National Networks of AIDS Service Organisations (EANNASO) and the Education Sector HIV and AIDS Network for Eastern Africa (Eastern Africa Network). The former is a regional umbrella network of HIV and AIDS service organisations covering 14 countries in Eastern Africa including all EAC partner states. EANNASO supports member networks through acting as their collective voice, articulating regional issues surrounding HIV and AIDS to the international community (http://www.eannaso.org).

The Eastern Africa Network operates within a sub-regional framework and RECs of the EAC and the SADC (see footnote on page 4 for the list of member countries under the auspices of the REC of the African Union). It provides for the inter-country sharing of information and experiences, proposition of guidelines, promotion of good practices, and advocacy for the sector-wide and broad-based commitment and support to the education response to the effects of HIV and AIDS (see www.schoolsandhealth.org/sites/eastafrica for more details). The network meets at least once a year to advocate, share information about country level responses and promising practices, and identifies together available opportunities for resources and partnership. Information on the roles and responsibilities of the Networks is included in annex 12.

As mentioned earlier (see Section 1.2), the Eastern Africa Network was formed by HIV and AIDS stakeholders from eight Ministries of Education from the Eastern and Southern African region where 17 million people are estimated to be living with HIV. It was launched in Abuja during ICASA in December 2005. The formation of the network was in recognition of the need to accelerate the education sector response to HIV and AIDS in the sub-region through stronger and better quality actions at the national level. Following decisions jointly arrived at, during a meeting in August 2006 attended by representatives from the EAC Secretariat, the network (MoE Uganda and URT - Tanzania Mainland) agreed that the EAC would provide a sustainable 'home' where the mission and vision of the Eastern Africa Network would be

translated into accelerated responses to the impact of HIV and AIDS on education. This arrangement would also give the Eastern Africa Network a more legitimate position in the sub-region; provide for a sustainable sub-regional sharing of information and promising practices through inter-country and inter-regional networking and provide the premises for evolving common policies and strategies responding to HIV and AIDS. As with other similar networks, the EAC would allow for cross-adaptation and complementarity of country responses to the impact of HIV and AIDS on education and joint advocacy by Ministers of Education of the partner states for systematic and harmonised 'spread, depth and speed' of the implementation of the responses (Concept Note on the Ministries of Education Technical Meeting Workshop to Develop A Proposal for East African Community Coordination of the Accelerated Response to the Impact of HIV/AIDS on the Education Sector in Eastern Africa).

During the African Networks of Education Sector HIV Focal Points meeting in December 2008 these discussions were built upon and one of the meeting recommendations highlighted the hosting of meetings of the Network Coordinating Committee's by RECs as a way forward. The meeting also suggested that the networks undertake formal dialogue with the RECs about the support they require, as has recently been achieved by the Economic Community of West African States (ECOWAS) Network (Networks/PCD/World Bank, 2009).

6.2.2.2. National Level

Nationally, in all the states, the MoE oversees and is the overall coordinator of education sector responses to HIV particularly in policy matters (see Box 6.2 for details of the MoE office responsible for HIV and AIDS and annex 12). The MoEs of all the EAC partner states have at least one HIV and AIDS Focal Point hired on a full time basis to manage and provide direction in HIV and AIDS activities in the education sector. In addition to facilitating HIV and AIDS –related activities, some of the Focal Points are responsible for SHN work, for instance, Burundi. Apart from Burundi and URT - Zanzibar, all the other states also have HIV and AIDS Focal Points at the sub-national level. Half of the states (i.e. Rwanda and URT) collect data at least annually on teacher attrition and absences. The importance of such data in the planning of the sector's response to HIV cannot be over emphasised. The data are useful in the determination and monitoring of the seriousness of HIV impact on teachers and schools (Focal Points Survey, 2007; all SITAN country reports).

Box 6.2: MoE Offices in Partner States Responsible for Coordinating National HIV and AIDS Responses

- *Unite Sectorielle de Lutte contre le SIDA (USLS) in* **Burundi:** This serves as an intermediary between the MoE and partners. Its education ministry is responsible for advocacy and ensures that the main stakeholders from different sectors are involved in MoE HIV and AIDS activities.
- ***URT***: *MoE Director of Finance and Planning in Zanzibar*. Also responsible for budget and fundraising, the Zanzibar AIDS Commission has identified Tanzania Social Action Fund to enhance the management of the response at community and school levels. *MoE AIDS Education* Coordination Unit *Tanzania Mainland:* The unit is positioned in the Office of Chief Education, an office with an overall influence in the education sector*.
- *KESSP* Investment in **Kenya.**
- *MoE Full time advisor on* HIV and AIDS *in* **Uganda**: Overall coordination is carried out by a MoE HIV and AIDS Committee constituted by departmental focal persons for HIV and AIDS and representatives from affiliated agencies.
- In **Rwanda** the MoE has a school health unit responsible for health and HIV and AIDS with 3 full time personnel. This unit in turn coordinates HIV and AIDS interventions of

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The education Ministries in Kenya, Uganda and the URT have Technical AIDS Committees, with members represented in all the sub-sectors in education spearheading the sector's HIV and AIDS response activities. Generally, the TAC committees generally meet on a regular basis and their function is to, across sub-sectors, identify and develop programmes to increase awareness on HIV, ensure coordination of HIV and AIDS related activities, establish systems of networking, plan and develop institutional capacity building exercises, and monitor and evaluate activities. In all states, NACs work in partnership with their MoEs, in capacity building, provision of education materials, and M&E of HIV and AIDS programmes especially data management and updates. Among MoE stakeholders in all states are various government ministries including those in charge of health, gender, youth and social services, among others (all country reports).

The MoEs in the region also works closely with stakeholders such as NGOs and FBOs, for example, the World Vision, AMREF, Plan International, Remera, among others bilateral (e.g. USAID) and development partners – the German Technical Cooperation (GTZ), the World Bank, UNAIDS, UNESCO, UNICEF all of which have regional Focal Points for HIV and education who work closely with MoEs as well as the EAC Secretariat. The development partners working with Rwanda's MoE also include the United Nations Population Fund (UNFPA). The development partners have technical advisory roles and they also fund some programmes.

6.2.2.3. Challenges in the Management and Coordination of the HIV Response

The management of the education sector response has not been without challenges. Interview reports in Uganda reveal, for example that, HIV and AIDS activities are taken as add-on activities for the various focal persons and hence not institutionalised. Consequently, the activities are usually accorded low priority. There has also not been any budgetary allocation for HIV and AIDS activities of the MoEs from the annual budgets of the Ministry of Finance, Planning and Economic Development. Consequently, HIV and AIDS activities have depended heavily on resources from projects or donors outside the MoEs budget, which makes coordination difficult.

In Kenya, the various sub-sectors under the MoE have been found to have different needs and challenges in their responses to HIV&AIDS. The ACU focal persons at ministerial level outlined various challenges including: duplication of work at national and sub-national levels which indicates a weakness in coordination of interventions especially for partners that do not pool their resources and more often than not MoE is not aware of the activities. The pace of implementation of activities is perceived to be often slow and the procurement process too long hence making it slower.

Scarcity of resources is a challenge which runs across all states. In Kenya, for example, the budget allocated only allows for selected activities, which cannot reach every district and school. The funds available do not allow for capacity building for all schools or districts. In URT - Tanzania Mainland however, although the guideline details the requirements for collaboration, some organisations and actors do not follow the requirements. In addition, most organisations use their own training manuals and materials, thus highlighting the absence of standardised curricula to ensure minimum standards. Key informants from Zanzibar reported that the collaboration and coordination of the education sector response programmes and activities among stakeholders is relatively weak.

6.2.3. Decentralisation of the EAC's Education Sector Response to HIV

The concept of decentralisation as defined by Winkler (2007) is broadly 'enabling a relatively large number of decisions to be taken lower down the organisation in particular operating units'. Power is *decentralised* to lower levels within an organisation (administrative decentralisation), for example, transferring responsibility of a certain activity from the MoE head office to the schools (cited by Global AIDS Monitoring and Evaluation Team [GAMET], 2007).

Decentralisation reduces the costs to central governments coordinating activities across large geographic areas, although it does not guarantee improved efficiency or more equitable access to care. The success of decentralisation processes is influenced by numerous conditions that include: the capacity – managerial and technical of local personnel, systems of accountability, clarity of legal frameworks that delineate the division of responsibilities, as well as sufficient funding to fulfil mandates and to meet local priorities (GAMET, 2007). The rationale behind the decentralisation of HIV responses of any country include the reasons outlined in Annex 6.

6.2.3.1. Regional Level

The implementation of the education sector response to HIV is presently managed at the EAC partner state level. Regional decentralisation is reflected by the decision making processes concerning the inception, conceptualisation, implementation and M&E of joint programmes (Wirak 2003).

6.2.3.2. National Level

Decentralisation of the MoE response to HIV requires the empowerment of schools and communities, the local infrastructure at district and other levels down to the grassroots. Strengthening of the lower levels of the education system is particularly important in the education sector response to HIV and AIDS. It makes decentralisation processes within education relevant (Wirak, 2005).

In all these states, the response, not only by the education sector, but by the various NACs and all other sectors, is decentralised to enhance effectiveness and efficiency. This is also because the serious impact of HIV is national rather than specific to urban areas where the ministry headquarters are located. The response is decentralised in order to ensure an ongoing two-way communication between the administration at national level and all institutions of learning at the various administrative geographical areas, SAGAs, DEOs, TTCs down to the most remote grassroots levels, for instance, the OVCs at school level. In Uganda, for example, the decentralised structures on the ground include:
- *District AIDS Task Force (DAT):* Provides political oversight and guidance.
- *District AIDS Committee (DAC):* Responsible for technical planning and implementation of activities.
- District focal person for HIV&AIDS who acts as a DAT/DAC secretary.

District education officers (who are the MoEs HIV Focal Points) and inspectors of schools have the oversight of MoEs' responses at sub-national level in Kenya, Uganda and URT. At each level these officers work in consultation with the area educational inspectorate and NACs area AIDS officers. Details of the extent of decentralisation in these three countries and Rwanda are given in Box 6.3. below:

Box 6.3: Extent of Decentralisation of Education Sector Responses to HIV in Partner States

- In **Kenya**, the district and other area Education Offices designate one officer as a HIV focal person. The capacity development of these individuals is a process built through HIV&AIDS prevention and related activities, seminars and Training of Trainers (TOT) workshops. Quite often transfers and retirement imply that replacements have to be carried out.
  Semi-Autonomous Government Agencies (SAGAs), TTCs and post-secondary institutions under the MoE carry out their interventions but are coordinated by the ACU.

- **Rwanda's** AIDS Commission has decentralised its programme and established District AIDS Control Committee (CDLS) offices.

- **URT:** Decentralisation in Tanzania Mainland is down to the level of lower primary schools. There are Focal Points at lower and upper primary schools and secondary schools. In each school, committees which include counselling and guidance teachers, coordinate the HIV response. For information on the decentralisation of implementation of orphans and most vulnerable children targeted interventions see Section 6.4.6 for details.

- In addition, to emphasize the seriousness of the ministerial response to HIV and to boost efficiency and effectiveness, **Uganda** has included HIV and AIDS in its performance appraisals for secondary school heads, which are also mandated to include a budget line for HIV and AIDS without which the school budget cannot be approved. Appropriate guidelines have also been made available. Secondary school committees consist of a HIV and AIDS club patron, a counselling and guidance teacher, a senior female teacher, a senior male teacher, and heads of clubs are responsible for coordinating the school's response to HIV.

6.2.3.3. Challenges in the Decentralisation of the Education Sector Response to HIV

Transfers of HIV Focal Points, whether occasional or frequent, often slow down the response process. It also has a cost effect because the capacity of replacements must be built for effectiveness and efficiency.

One of the challenges relates to the devolution of power from headquarters to the regions/provinces/districts, etc. According to key informants from Burundi, the process of decentralisation took long to be understood in the country where people were accustomed to top-down approaches. Lack of sufficient financial resources to build the capacity of teachers in some districts in adhering to the roles and responsibilities given to them has been a challenge in Uganda. Another challenge related to the resources is that MoE in Uganda has not distributed the HIV and AIDS Strategic Plan to all educational institutions. Some secondary school heads are reported to fail to adhere to the MoE approved budget for HIV and AIDS, which as a result lead to their schools failing to implement their work plans.

Another difficulty with decentralisation is that it requires the central level to move from a focus on implementation to coordination (this is especially important in the larger countries), something which units can sometimes struggle with. Capacity building at all levels to ensure that changing responsibilities are understood is required as well as functioning communication structures between the levels. Part of the regional response could facilitate the sharing of good practice in decentralisation between the partner states.

6.2.4. Capacity Building for the Education Sector Response to HIV

6.2.4.1. Regional Level

Various regional activities help to build the capacity of the education sector in the sub-region. The Accelerate Initiative (see Section 1.6.) has built capacity in the sub-region through sub-regional and national workshops, as well as harmonising support among development partners and promoting coordination with the NACs, enhancing access to HIV funds. The annual *Strengthening Contemporary School Health, Nutrition and HIV Prevention Programmes* course co-hosted by the Eastern and Southern Africa Centre of International Parasite Control (ESACIPAC) and PCD at the Kenya Medical Research Institute (KEMRI) since 2004, focuses on building the capacity of national school health, nutrition and HIV programmes. The training course is a key activity in the Eastern Africa Network's annual plan and provides an annual forum for information exchange, debate and continued learning among programme managers and implementers engaged in SHN and HIV programming (http://www.schoolsandhealth.org/Pages/News.aspx).

To-date, 90 representatives from the ministries of education, health, social welfare, development partners, and civil society from across Africa and beyond have undergone the training. The following are the numbers of representatives from the EAC partner states trained on SHN and HIV through this course:
- 2 in Burundi;
- 16 in Kenya;
- 1 in Rwanda;
- URT: 9 in Tanzania Mainland and 2 in Zanzibar.
- 3 in Uganda.

Although the numbers are not yet large enough to make a significant impact, the capacity of health, education and nutrition among others is being strengthened by the regional ESACIPAC and PCD training and field exposure (further details in Section 6). (http://www.kemri.org/esacipac.html). URT, and Kenyan SITAN reports reference this ESACIPAC and PCD training as have developed capacity. Kenya's report, for example, specifies the development of the capacity of staff from the MoE and the MoH to facilitate effective implementation of the two ministries national comprehensive SHN policy.

6.2.4.2. National Level

In the last 5 years, building of capacity has taken place at different levels and sub-sectors in the various MoEs and their affiliate units. According to interview data, the MoE for URT - Tanzania Mainland is satisfied with the existing technical capacity of four well trained full time personnel for its response to HIV at national level, but not with that at district and zonal levels. For the MoE of Tanzania, capacity has also been boosted by the training of 21 members in the Ed-SIDA model which has provided the ministry with the opportunity to enhance advocacy and planning. The Ed-SIDA model is a tool for projection of education sector HIV estimates that can be used for planning and advocacy.

Kenya's Teachers Service Commission (TSC) has provided training targeting teachers and other personnel, counsellors at the TSC, teachers in TTCs, heads of secondary schools, field staffing officers, among others. It has produced and distributed Information, Education and Communication (IEC) materials to primary and secondary schools, as well as TTCs.

The capacity of the TSC and the Kenya Network of HIV-Positive Teachers (KENEPOTE) has been strengthened by KEMRI, which offers care and support for teachers and employees by providing nutritional products at subsidised cost, and by some FBOs and the Academic

Model Providing Access to Healthcare (AMPATH) which offers comprehensive care in selected areas of the country. Plan International-Kisumu gives supplements to teachers living with HIV in and around Kisumu and supports orphans with tuition fees. The MoE and the Kenya Institute of Education (KIE) work closely in building the capacity of teachers through in-servicing teachers and personnel at the workplace. Training on planning education sector HIV responses, implementation and monitoring skills are given on the job and often through seminars. In Kenya, UNESCO contributed to the development of the education sector HIV&AIDS policy, and UNICEF in the development of the life skills curriculum. The MOE also has a pool of national TOTs that carry out trainings of HIV prevention and life skills.

Burundi's CNLS ensures that the teaching of HIV and AIDS addresses the needs of the students, teachers and MoE personnel, and serves as an intermediary between the MoE and partners. It facilitates HIV and AIDS teaching in the education sector by providing the needed material to achieve its goal. It is also the unit responsible for funds sourcing from the donors towards HIV and AIDS activities in the schools (Burundi SITAN report).

The MoE in Uganda (2007) has taken deliberate efforts to train all senior management, HIV Focal Points and NAC personnel on HIV and AIDS, policy issues and roles and responsibilities. The ministry has also built the capacity at the level of learning institutions by training over 30,638 teacher trainees, teachers in HIV competency, facilitation and TOTs. Those trained on HIV and AIDS competency were:

- 3,450> teacher trainees;
- 18,200 primary schoolteachers;
- 1,830 teachers/school heads in post primary schools;
- 151 national facilitators;
- 539 coordinating centre tutors trained as trainers (TOTs); and
- 6,468 master trainers.

Focal persons have also been trained on integrated planning on HIV and AIDS. The trained teachers today lead behaviour change communication activities. They also offer guidance and counselling to both teachers and students. Six youth resource centres in secondary school have also been established to serve as Focal Points for HIV-related IEC activities on HIV and AIDS, as points for materials distribution.

6.2.5. Education Sector Budgetary Allocations

The EAC Secretariat has facilitated the development of an Indicative Budget totalling US$593,000 for the first year (2008-2009) of the five year strategic plan 2008-2012. In recognition of the need for an enhanced institutional (i.e. EAC Secretariat) capacity for effective implementation of regional and national responses to HIV and AIDS, the budget is intended to facilitate the attainment of the strategic plan's first objective.

The activities for capacity building include:
- The establishment and staffing of an HIV and AIDS Unit (HAU) at the EAC Secretariat and procurement of institutional support for the Unit;
- the establishment of a Steering Committee for HIV and a Technical Committee for HIV and AIDS to facilitate the implementation of the Strategic Plan; and
- the design and operationalization of a Resource Mobilisation Strategy and Financing Modality.

The Indicative Budget does not provide details regarding how the funds would be sourced (EAC, 2008).

As the EAC is currently in the early stages of planning its coordinated education sector response to HIV, it does not yet have a budget for the programme. Information on the multi-sectoral budget can be found in Annex 11.

Presenting national budget allocations and finances for education, school health, nutrition and HIV and AIDS in a logical and comprehensive sequence in the various EAC partner states appeared difficult due to two reasons as given below. Details of budget allocation for HIV in the various countries are in Annex 11:

1. There were difficulties in accessing budgetary and financial data from some partner states. For example, it was not possible to access data on Rwanda's Ministry of Education budgetary allocations.
2. Budget and expense components and their combinations differed between the states.

While there was minimal understanding on HIV funding in the education sector in Rwanda and URT - Tanzania Mainland due to lack of information, the remaining partner states had provided information on budgetary and financial allocations.

It was evident in Kenya that the MoE, in recent years, had increased its allocation and subsequently activities for HIV&AIDS due to support from development partners in addition to that already provided by the government. Between the 2007/08 and 2008/09 fiscal years, the MoE's ACU's Action Plan showed a spike in resources from US$316,203 to US$764,296 for prevention, workplace regulations, HIV response management and care and support. Of this latter figure, which consists of Government of Kenya and Development Partners' Pooled Funds, US$30,043.1 (KES 2 million) is planned for 2008-2009 M&E activities in post secondary learning institutions and in the districts, while US$123,927.8 (KES 8.25m) will be used to monitor activities funded under MVC support grants. As can be seen in Annex 11, the 2008/2009 Pooled Funds are being spent on four components – prevention, the workplace, response management and care and support of orphans and vulnerable children. A total Budget of US$292,592,870.8 (KES 19,478.2m) is allocated to Kenya's MoE School Health activities for the period (2005-2010) (Kenya report). Funds for care and support are only used on learners enrolled in primary schools but plans indicated that the same would be implemented at secondary level in the FY 2009/10.

In Uganda, development partner support dating back to 2003/04 has been in the form of specific project-based activities. For example, the United States government provided support through its projects,: Uganda Programme for Human and Holistic Development (UPHOLD); Education Sector Workplace HIV/AIDS Policy Implementation (ESWAPI) and UNITY. The main (and possibly only) priority investment project funded by the Government of Uganda under the MoE was "Strategy for HIV/AIDS and Girls Education" between 2001 and 2006. The Government of Uganda also co-funded with the World Bank the Multi-Country HIV/AIDS Programme (MAP), between the period 2001 and 2006. The education sector HIV funding has been between 2% and 8%. In addition to this, the Education Ministry has also benefited through support from other bilateral such as the Irish Government which provided US$115,594.7 (€130,000) to be used for a full time technical advisor on HIV and AIDS in the Ministry between 2002 and 2005 for (Uganda report).

In Burundi, the MoE developed a SHN budget of US$2.295 million as part of its 2005/10 strategic planning process. Priority activities include the creation of school emergency units, vaccination and school hygiene. Annex 10 provides a breakdown of the estimated budget for all school health activities for the period 2005 – 2010 (Burundi report).

URT - Tanzania Mainland's education sector spent US$34,862,656.6 on HIV and AIDS between 2003 and 2008. Annex 11 tabulates this budget by each year. The current budget for the period beginning 2008/2009 is unavailable. The budget for HIV and AIDS activities in Tanzania Mainland is allocated through the Health Ministry (Tanzania Mainland SITAN report). In Zanzibar, the MoE developed its SHN and HIV budget for the period 2007/10. As in Uganda and Kenya, it has also seen support from both within government departments as well as development partners such as the World Bank and UNICEF. In 2007 the World Bank Group granted US$42 million to Zanzibar in support of an education improvement project (World Bank, 2007). There is no information in regard to whether a proportion of the latter funds is allocated to SHN and/or HIV. UNICEF has also granted Zanzibar's Education Ministry some support but the amount was not available. US$412,976 is budgeted for the education sector's SHN and HIV and AIDS activities. Each department of the Education Ministry represented in the Technical AIDS Committee (TAC) contributes US$767 to the fund. As shown in Annex 11, impact mitigation, care, support and monitoring and evaluation activities take the largest budget vote US$206,488 followed by the vote for HIV prevention and monitoring US$102,160.9 (Zanzibar SITAN report).

6.2.6. Monitoring and Evaluation of the Education Sector Response to HIV

Monitoring and evaluation (M&E) is one of three principles in the *'three-ones principles'* framework to which all EAC states as other sub-Saharan African countries adhere to and this underscores the activity's importance in the sector's response to HIV. The Global AIDS Monitoring and Evaluation Team (GAMET) has identified 12 critical components that combine to make a national HIV M&E system that have been accepted by all development partners in defining a functional HIV M&E system. The premise is: *'if the performance objectives of all 12 components are being achieved, then the M&E system is functional'*. These and their indicators are outlined in Annex 7 (GAMET, 2006).

There is ample evidence to support three facts about the impact of HIV on the teaching fraternity (Risley and Bundy, 2007; World Bank and PCD, 2009), that:
- An estimated 122,000 teachers in sub-Saharan Africa are living with HIV;
- a vast majority of them do not know their HIV status because they have not sought testing; and
- a substantial proportion of those that do know their status, have not disclosed the information to their employers because of fear of stigma.

These facts have serious implications on the M&E of HIV and AIDS and on the planning of/and the education sector response to HIV.

6.2.6.1. Regional Level

There is evidence that a lot of effort, especially in the area of HIV, has been expended at the EAC level, although not necessarily focused on the education sector. For example, a Regional M&E Task Force for NACs is in place and EAC Secretariat's M&E Officer is a member. One of its tasks is to collect data on HIV in the region (again not specific to the education sector). There is, for example, according to a key informant at the EAC Secretariat, an M&E framework for mobile populations. Although related to the multi-sectoral response rather than the education sector, at the time of the situation analysis interviews, there were plans to recruit an M&E Officer responsible for HIV at the Lake Victoria Basin Commission (LVBC). The LVBC aims to establish a framework of harmonised policies, and protocols and vibrant networks of mobile populations for the improvement of the effectiveness of HIV and AIDS responses (EAC, 2008:14). It was also gathered from key informants that the EAC Secretariat is in the process of building a regional database on education, which is hoped to enhance regional M&E activities.

A key informant at the EAC Secretariat articulated the positive trend to build an M&E capacity within the region. The EAC has no HIV-related data specifically focused on the education sector. What is available, according to the M&E officer, is what might be pulled out of reports and is very general. The deficiency can be explained by the fact that EAC is in the planning phases of the projects.

The EAC Secretariat has been informally collaborating with EANNASO and has recently initiated the development of a Regional Planning and Monitoring and Steering Committee to oversee the M&E activities at the regional level. According to a key informant at the EAC Secretariat, the committee was proposed and names received from four of the five EAC partner states. A budget provision is available and it is likely that the activity will be carried out in the next year.

Regional achievements include harmonized HIV and AIDS indicators for prevention, standardised towards uniformity with those of the WHO. These however, are not specific to the education sector but are nevertheless applicable to it. One of the biggest regional efforts, according to a key informant at the EAC Secretariat, is the effort by the IUCEA to develop an integrated M&E framework for use in the region. The Integrated Reporting Tool has been devolved to monitor the implementation of HIV and AIDS -related activities. This tool is however not specific to the EAC Secretariat education programme. Another regional effort to monitor progress is the regional survey carried out in 34 countries in Africa by the three sub-regional networks of HIV Focal Points to monitor the progress of the education sector's response to HIV.

6.2.6.2. National Level

The Focal Point Survey (2008) reports that Rwanda, and URT do not collect information at least annually on health-related attrition and absences of teachers (Focal Point Survey, 2008). This is likely to affect these MoE's planning for teacher-targeted interventions without the actual support of accurate data. In general, the MoE in all partner states recognise M&E as an area requiring more attention and allocation of resources. While in countries like Kenya and Uganda there are plans to include HIV indicators in the District Education Management Information System, in URT, education sector relevant HIV indicators are incorporated in their respective national AIDS control agency's monitoring systems. Details of the extent of M&E of education sector HIV response programmes in partner states is provided in Box 6.4 below. Some recent relevant studies carried out in the various EAC partner states are highlighted in Annex 8.

Box 6.4: Extent of M&E of Education Sector HIV Response Programmes in Partner States

In **Kenya**, since the development of the education sector HIV and AIDS policy, the focus has been implementation through the four thematic areas. The national evaluation of the activities and intervention programmes is yet to be commissioned, but a monitoring system for teacher attrition, attendance and mortality is planned and the data generated will be maintained by the TSC. Kenya's *Education Sector Policy on* HIV and AIDS is cognizant of the need for M&E activities. The Ministry has allocated funds (i.e. USD30,043 [KSh.2 million]) for monitoring and evaluating the management of the sector's response to HIV in 40 districts, all public colleges and SAGAs (USD30,043 [Ksh 2 million]); and USD123,927.83 (KSh8.25 million) for monitoring and evaluating care and support of most vulnerable children in 1,650 most vulnerable children-supported schools. In regard to VCTs, Kenya's NAC, receives data regularly from VCT centres located in the MoE national office, on numbers counselled, tested, and so on. Kenya's Education Management Information System (EMIS) processes and sustains production of reliable and up-to-date current statistics from the sector at all times. It is being decentralised which will enable the districts to process data and relevant information before forwarding to the headquarters.   Monitoring and evaluation

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activities are carried out by a joint budget review.

The lack of an M&E system in **Burundi's** MoPSE, notwithstanding, research on HIV sero-prevalence and other related issues is ongoing and the results are constantly being incorporated into a central database. There is no evidence however that the information collected includes for example, teacher attrition and absences. This is not the only information that should be monitored regularly.

The MoE for **Rwanda** and **URT - Zanzibar** have HIV and AIDS units responsible for monitoring and evaluating HIV and AIDS interventions within the sector. In URT, TACAIDS' and ZAC's M&E Unit coordinates a routine M&E system for non-health sectors HIV and AIDS activities called Tanzania Output Monitoring System for non-medical HIV and AIDS interventions. All Regional Facilitating Agencies, district AIDS councils, ministries, departments, agencies, CBOs and NGOs are required to follow this system and to submit their reports to the AIDS Education Coordination Unit (AECU). At the district level, reports on progress towards attainment of HIV and AIDS education objectives are integrated into district comprehensive HIV and AIDS plans. The information is used to identify necessary adjustments to district programmatic interventions and is forwarded through the regional secretariat to the AECU.

The MoE's EMIS in **Uganda**, on the other hand, has developed a baseline instrument on HIV and AIDS in learning institutions to be filled by school heads. The tool captures information on: demographics and information about the schools; knowledge/prevention of HIV and AIDS programme in schools; HIV and AIDS services available in schools including VCT and those for orphans and most vulnerable children; and aspects of systems strengthening. The MoE has also provided HIV and AIDS Log Books to schools participating in Presidential Initiative on AIDS Strategy for Communicating to Young People (PIASCY) programmes for capturing data on their activities. The Centre Coordinating Tutors analyse and consolidate the data for feedback to schools and to the MoE.

6.2.6.3. Challenges Related to Monitoring and Evaluation

Lack of capacity in terms of human resources with sufficient skills, runs across a few EAC partner states (i.e. Burundi, Kenya, Rwanda and URT - Zanzibar), for better coordination and management of the M&E programme. The absence of a costed work plan on HIV and AIDS including the SHN programme at the regional, provincial, and district levels is a challenge for Zanzibar's Education Ministry. Although Uganda's AIDS Commission has designed a comprehensive M&E tool HIV and AIDS *Performance Measurement and Management (PMM) System Operational Manual'* for use nationally, it is yet to be disseminated for implementation. There are limited resources available to allow for training the users of the tool. Challenges experienced by Kenya's MoE also include the difficulties of monitoring expectations such as behaviour and attitude change.

6.3. HIV Prevention in the Education Sector

6.3.1. HIV Prevention Education

Prevention of new HIV infections is one of the core areas of the Accelerate Initiative. The education sector response to HIV includes specific HIV prevention activities aimed at different target groups; and activities aimed at mitigating the impact of HIV on orphans and most vulnerable children and teachers living with HIV. There is immense evidence from data provided by key informants that a great deal of activity is going on within schools and in the communities, as part of the education sectors' response to HIV.

HIV prevention education is being provided in every country with the aim of reducing new infections. Information gathered during the SITAN and supported by the findings of the Focal Point Survey (2008) show that HIV prevention education targets populations under the age of 15 years in and out of school, as well as young people aged 15 to 25 years. It is widely being used to supplement information imparted to adolescents and young people, in a bid to empower them to think critically and creatively, to make informed decisions and to become self-aware. Thus, HIV prevention education is provided to students in primary and secondary schools and post-secondary institutions, vocational institutions, teacher training colleges and universities, as well as out-of-school settings. The latter population attracts attention because the risk of contracting HIV is higher among them than younger and older populations, not only in the EAC region but also elsewhere in sub-Saharan Africa. HIV prevention education is also provided to teachers in training and in service as well as parents so that they may be able to protect themselves as well as impart essential life-skills. HIV and AIDS prevention interventions also take place within ministries, through advocacy activities, such as at various national and international days e.g. World Population Day/AIDS Day among others, in order to boost public awareness on HIV and AIDS issues and the need for individuals to protect themselves from HIV (country reports). A summary of the HIV prevention education in the EAC countries is provided in Box 6.5. below. Details of curricular and non-curricular modes of HIV prevention and teacher training are discussed under Sections 6.3.2 to 6.3.4. Appendix 13 contains information from EAC partner states Demographic and Health Surveys indicators relevant to HIV prevention on 15-24 year old females and males.

Box 6.5: Summary of HIV Prevention Education in EAC Countries

In **Rwanda**, HIV prevention education is taught formally to children who are at least 10 years old (in primary school grade 5). There have been calls however to extend the education to the lower classes. At the secondary school level, HIV and AIDS -related issues are included in science subjects in varying aspects. Higher education students have access to some limited counselling services.

Kenya's Institute of Education (**KIE)** has developed a life skills curriculum that has been implemented since January 2009. This was designed to take a preventive approach to HIV and AIDS education by developing and promoting psychosocial competencies to the learner. Teachers living with HIV who have disclosed their status are involved in HIV prevention education activities and also offer support and care to one another, for example in the workplace (MoE and TSC) or at fora organised by NGOs or FBOs. For example, members of KENEPOTE may occasionally be involved in public fora officially or in their individual capacity.

URT: Like in Kenya, Tanzania Mainland's Education Ministry is providing skills-based HIV and AIDS prevention education, targeting learners through classroom teaching of HIV and AIDS and life skills education, and teachers and other workers in the workplace. The MoE in Zanzibar has planned for creating awareness on HIV and AIDS through IEC materials, and to target populations (i.e. education management, ministry personnel, their partners and dependants; and stakeholders of the ministry's response to HIV and AIDS) through seminars and/or HIV and AIDS prevention outreach programmes (country reports):

Uganda's PIASCY programme has, since 2002, worked towards improving communication on HIV and AIDS, and delay of sexual activity among young people. Following the completion of a national roll-out, Uganda's Education Ministry identified 1,078 model schools for a more comprehensive implementation of PIASCY, with the view of them serving as epicentres for sharing good practices and strengthening further implementation of the PIASCY.

Since 2000, **Burundi** has been imparting HIV-related education in vernacular through Radio "*Nderagakura*" in the national language (Kirundi) hence reaching. Although the radio programmes is not transmitted country-wide, it does nevertheless reach many out-of-school youth and other populations that may not understand French with HIV prevention education. (Burundi SITAN report).

6.3.2. HIV and AIDS and Life Skills Education Curriculum

Life skills education for HIV prevention operates on the premise that young people who are its target will be able to act upon the knowledge they have acquired in different situations, thereby reducing their risk of HIV infection. It is practical and has the potential to equip the young audience with the knowledge, attitudes, and values needed to make sound health-related decisions. It is intended to be '*participatory and responsive, generating questions rather than providing clear-cut answers, and challenging young people and adults to find new ways of relating to one another.*' (Boler & Aggleton, 2004) According to a United Kingdom Working Group on Education and HIV and AIDS, life skills approaches have assumed a lot of importance in schools since it became apparent in the early 1990s, that many young people (and adults) would not change their sexual behaviour merely because they were told that they should (Save the Children and Action Aid International, 2004). Article 53 of the UNGASS declaration states:

> *"By 2005, ensure that at least 90% and by 2010 at least 95% of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection, in full partnership with young persons, parents, educators and health care providers."*

The IATT proposed that education for HIV prevention start at an early age before children and young people are exposed to risks and to be sustained as long as possible. The aim is to 'reduce individual risks, as well as reduce contextual, environmental and societal vulnerability to HIV and AIDS' (2002:14).

The SITAN found that all EAC partner states impart HIV and AIDS prevention using a curricular approach. All countries except Kenya teach HIV and AIDS education through carrier subjects (Rwanda is working towards this infusion) in formal education. Since January 2009, Kenya is using a stand-alone life skills curriculum, which is in addition to the mainstreaming of HIV and AIDS messages through infusion and integration. Moreover, all countries (no information on URT - Zanzibar) are providing HIV and AIDS education using a life-skills approach in the non-formal setting. Further, to ensure that the content of the curriculum in any state is culture-sensitive, its development is always participatory and includes stakeholders from the grassroots with the representation of FBOs. Faith institutions are also represented in the curriculum development panels, as is in the civil society, governmental organisations, and NGOs. A summary of the curricular approach to HIV prevention in partner states is provided in Box 6.6. below.

The EAC Secretariat is now facilitating the process of harmonisation of a regional curriculum for the partner states (EAC, 2007).

In March 2004, UNESCO organised an Inter-Agency Working Group on Life skills in EFA goals, with the purpose of providing a forum to the participating agencies to sharing perspectives on life skills education and contributing to coordinated efforts to support life skills education UNESCO, 2005).

Box 6.6: Summary of the Curricular Approach to HIV Prevention in EAC Partner States

The Education Sector Policy on HIV and AIDS in **Kenya** supports life skills education and

mandates instructors to offer an education aimed at developing skills and values and promoting positive behaviours that address the epidemic (country report). The curriculum has evolved from a stand-alone HIV AND AIDS curriculum in 2003, to infusion of HIV and AIDS education in other subjects, to its current stand-alone life skills curriculum. It is however important for the reader to note that the stand-alone life skills curriculum is in addition to the mainstreaming of HIV and AIDS through infusion and integration. Kenya is the only EAC partner state with a stand-alone life skills curriculum. After being pilot–tested in selected districts, the curriculum has been in use since January 2009, in primary and secondary schools, TTCs and non-formal institutions. At the time of the situation analysis interview, there were plans to develop a Teachers' Handbook and Training Manual. It is expected that teachers will employ a variety of approaches as they teach (Kenya situation analysis report). Table 6.3., summarises some of the issues addressed in the life skills curriculum for primary and secondary schools.

Table 6.3. Summary of Issues Addressed by Kenya's Life Skills Curriculum at Two Levels

Primary School Curriculum	Secondary School Curriculum
15 HIV and AIDS -related themes including topics on: • Promoting psychosocial development of learners to knowledge on HIV and AIDS prevention. • Care and support of people living with HIV. • Impact of HIV and AIDS in the society. • Addressing misconception and stigma	13 HIV and AIDS -related themes including topics on: • Life skills (e.g. responsible behaviour, time management, and communications skills). • Facts about HIV and AIDS and other STIs. • HIV prevention. • Care and support of people living with HIV

The curricular approach adopted in **Uganda** and **URT,** unlike in Kenya, is inter-disciplinary. HIV prevention education (including STIs in URT) is integrated into the core curriculum through various carrier-subjects, which include, for example in Tanzania Mainland:

- Science and Social Studies at primary school level;
- Biology and Civics at secondary school level;
- General Studies and Biology at A-Level;
- Civics at certificate TTCs; and
- General Studies at diploma TTCs.

The curriculum contains content on workplace issues that was developed by Tanzania AIDS Commission in collaboration with the Institute of Adult Education. Uganda's curriculum also addresses such critical issues as sexual and reproductive health and adolescence among others.

Burundi's MoE has received support from UNICEF to build the capacity of technical advisers in each of the 17 provinces to coordinate HIV prevention education which is taught in carrier subjects.

URT: In Zanzibar, on the other hand, HIV and AIDS and life skills education is being taught presently through Moral Ethics and Environmental Studies (MEES), which replaced Family Life Education in December 2006, following complaints from "*some parents [who] thought the subject was addressing/teaching sex*" (country report). As a result, the subject was changed in consultation with the stakeholders, to MEES in December 2006. The MEES is taught to pupils in the upper two classes of primary (Standard 6 and 7) and secondary school students (Form 1 – 4) and in teacher education. Reports from Zanzibar key informants also indicate that the integration of HIV and AIDS issues in the education curriculum has had some positive impact in responding to stigma and discrimination against

orphans and most vulnerable children and individuals living with HIV. The content of the HIV and AIDS, STD and drug abuse education is to increase knowledge, develop life skills, promote positive and responsible attitudes, assertiveness, informed decision making and provide motivational support in order to emphasise responsible sexual behaviour. The MoEVT has also recently developed a model for teaching life skills in schools, which has been commissioned to a consultant for compilation.

6.3.2.1. Challenges in HIV and AIDS and Life Skills Curriculum

The integration of HIV and AIDS education into the curriculum is a slow process and more work still needs to be done, especially at Uganda's secondary and tertiary institutions of learning (country report). The need for financial resources for developing the curriculum, pre-testing, printing and dissemination as well as monitoring is cited by key informants from Uganda. Scarcity of financial resources is also cited as a challenge in Burundi, which has hindered infusion of HIV and AIDS into the subjects being taught.

Condom education is not addressed in the curriculum in any of the EAC partner states because of cultural sensitivities. The emphasis of HIV and AIDS prevention education is on abstinence. This indicates that young people who are unable to or do not want to abstain from sexual intercourse are not being addressed by the curriculum. Another challenge is that HIV is often not taught within a wider curriculum on sex education.

Burundi key informants lament the "*weak top-down approaches and involvement of local authorities in program implementation and coordination, which delayed the decentralisation process*" (Burundi SITAN report). They also cite the lack of human resource capacity in terms of knowledge, skills and experience in imparting prevention education. In Rwanda, HIV is part of the school health programme and the MoE is currently working to include it as part of the national curriculum. Key informants in URT - Zanzibar were concerned that in spite of the increase of awareness raising campaigns, behavioural change among the target population has been slow.

6.3.3. Teacher Training

Teachers have a critical role in widening and strengthening the sectoral response to HIV and AIDS and can significantly contribute to the reduction of new infections. Their training is an essential prerequisite in preparing and supporting them and other education personnel to address and impart education about issues relating to health, HIV and AIDS and nutrition. Throughout EAC partner states, primary schoolteachers are trained in institutions that offer teaching certificates, while there are others that offer diploma certificates and universities that offer educational degree certificates in education. The latter two usually prepare teachers to teach at secondary and higher school level, including post-secondary institutions of learning, for example, vocation and TTCs. In Burundi, for instance, primary school teachers are trained in one of two special institutions, in the 'Lycées Pédagogiques' and 'Sections Normales ' and secondary school teachers at university and Teacher's School or the 'Ecole Normale Supérieure '.

In Burundi, Kenya, URT - Tanzania Mainland, and Uganda, the minimum requirement for admission into a TTC is 4 years of secondary school education. The minimum training required for teaching in primary schools is 2 years in both Burundi and Kenya.

6.3.3.1. Pre-Service Training

In Kenya, HIV and AIDS training and other activities to pre-service teachers are offered through TTCs. Kenya's TTC curriculum includes all aspects relating to HIV and AIDS, including stigma, care and support. As mentioned earlier, a stand-alone life skills curriculum is in use in TTCs since January 2009. To strengthen the training of teachers who teach HIV and AIDS, STIs and life skills education, the following topics are being taught:
- Sexual and reproductive health;
- Teaching techniques on nature, scope, transmission and prevention of HIV and AIDS and other STIs;
- Life skills education, stigma and discrimination, care and support for individuals infected and affected with HIV and AIDS and STIs (country reports).

The MoE's ACU, TSC, KIE and Kenya National Union of Teachers often plan activities related to HIV and AIDS targeting teachers.

In URT - Tanzania Mainland, special training in HIV and AIDS, STIs, life skills education and counselling skills is provided to pre-service and in-service teachers at all levels. Uganda also provides pre-service training that also includes HIV life skills education.

In 2003, there were plans by the MoE Rwanda to introduce a life-skills curriculum and the teaching of upper primary through to post-secondary education, as well as in the pre-service teacher training curriculum in 2003. This was however not carried out. Presently, life skills education for HIV and AIDS prevention, according to key informants in Rwanda, is currently undergoing revision from curriculum to modules for all levels from primary through tertiary (Kenya, Rwanda and Uganda SITAN reports). HIV and AIDS and life skills are not included in the curriculum for the professional preparation of new teachers in Burundi (HEARD/MTT, 2004 in Burundi Country Report). In URT -Zanzibar, special training in HIV and AIDS, STIs and life skills education as well as counselling skills is provided to both pre-and in-service teachers at all level, national wide. Currently, about 60% of teachers have been trained on HIV & AIDS and Life Skills education for both pre- and in service (Zanzibar SITAN report).

6.3.3.2. In-Service Training

Since 1999 and with the support of the Catholic Relief Services Burundi and the NAC, the 'Bureau National de l'Enseignement Catholique', 200 heads of Burundi schools have received training on HIV and AIDS (Burundi and Uganda SITAN the radio programmes does not extend to all parts of the country reports). About 20% of the teachers in primary schools in Burundi have not had any formal training, and the situation is worse in rural than urban areas (HDR, 2005 in Burundi SITAN report). To ameliorate this, UNICEF and the MoE's Office of Rural Education in 2001 introduced a six-year in-service training programme for primary schoolteachers. The training takes place during the summer holidays and addresses all subjects and topics of the primary education curriculum including HIV and AIDS.

A large majority of primary school teachers in Rwanda (97.4%) have received formal training, but only a relatively small proportion of them has had HIV and AIDS -related training. Indeed, a 2002 survey by the Education Ministry with UNICEF showed that:

- 80% of the teachers could correctly answer all three basic questions about HIV transmission;
- 68% knew that faithfulness to an uninfected partner reduces HIV risk; and
- 44% of the teachers reported having easy access to condoms.

These results highlighted the need for teacher education on HIV and AIDS, both so that they would possess sufficient accurate information/knowledge to protect them and to transfer the knowledge to their students. National programmes have begun raising levels of awareness and knowledge among provincial and district managers, as well as school inspectors. As early as November, 2001, HIV and AIDS training workshops were held for all provincial school inspectors and District Education Officers. In 2003, the ministry began to sensitise all primary and secondary schoolteachers on HIV and AIDS prevention and the utilisation of VCT services available at community level.

In Uganda, it is a core requirement for in-service and pre-service training of teachers to deliver age-appropriate skills-based education. The UNITY Project by the MoE of Uganda has to-date trained:

- 40 master trainers on how to integrate HIV readers into the school curriculum, into general programmes and to use them as supplementary material to reinforce PIASCY programmes.
- 9,041 teachers, coordinating centre tutors and district officials have been trained.

Through the UNITY project, the MoE has orientated teachers for students with special needs on effective utilisation of education materials that target them. This particular finding seems to confirm that there is indeed some work at TTC level that specifically targets an important population whose needs require urgent attention.

In Kenya, programmes targeting in-service teachers are offered to teachers from selected schools and geographical regions. Few if any programmes ever target all in-service teachers. The Kenya National Union of Teachers too has activities that address issues of HIV and AIDS. This arrangement seems to be similar to that of in-service teachers in the United Republic of Tanzania where, as mentioned earlier (sub-section 6.3.3.1), *special* training in HIV and AIDS, STIs and life skills education, as well as counselling skills is provided to both pre-service and in-service teachers at all levels The nutrition unit of the Ministry of Health and Social Welfare (MoHSW) in Zanzibar has been in-servicing teachers in SHN as well as giving educational talks in schools on related issues (SITAN country reports).

The capacity of teachers has been built in many of the EAC states. For example, UNESCO has boosted the capacity of teachers in 4 out of 17 provinces in Burundi, through training on how to infuse HIV education into all subjects in 2008. These teachers are called on to train others. In Rwanda since 2005, 74 teachers have received training as HIV and AIDS TOTs of other teachers. Uganda's PIASCY programmes have trained three teachers per school; and 106 District Education Officers have been trained on HIV and AIDS and life skills (country reports).

To summarise, in all the EAC partner states, teachers are trained in life skills education during both in-service and pre-service training (the latter except Rwanda). They are also taught to protect themselves and are given HIV and AIDS education (country reports, MoE HIV and AIDS Focal Point Survey, 2008).

6.3.3.3. Challenges in Teacher Training

- In Burundi, key informants decried the lack of didactic material and availability of information on specific HIV and AIDS programmes in teacher training institutions.

- A relatively large proportion of teachers (20%) have not received formal education, which is likely to be reflected in the quality of education they impact. In-service training, which is going on, addresses this challenge.
- The use of life skills approaches is relatively new in the EAC region and it will undoubtedly take time before all schools from early childhood through to post-secondary institutions have adequate capacity to deliver child-centred pedagogy for the teaching of life skills.
- In Uganda, the challenges experienced in the teaching of HIV prevention education and related activities include:
  o high attrition rate among teachers, and teacher transfers. Key informants in Uganda explained that quite often "*newly trained teachers (particularly in rural areas) do not go to the schools to which they have been posted. This makes it difficult to maintain the number and right balance of teachers that have been trained in* HIV and AIDS *in a given school".*
  o A lack of systematic approach to reach post-primary institutions including vocational and tertiary and private secondary schools;
  o A need to harmonise prevention strategies in schools including condom education to make it holistic;
  o Expansion of counselling and testing to schools, colleges and institutions of higher learning is still a problem; and
  o Key informants in Uganda articulated their concerns for students with special needs, who are estimated to be approximately 500,000 and are not being targeted for HIV prevention education.

6.3.4. Complementary Approaches

Complementary approaches to HIV prevention education supplement prevention efforts through curriculum-based teaching within formal education. Peer education is an example of a complementary approach to providing skills-based health education. It is a useful tool for imparting HIV and AIDS education and involves '*students undertaking sensitisation activities among their friends and classmates to increase knowledge on HIV and motivate them to adopt preventive behaviour'* (Focal Point Survey). The approach is not confined to school-based programmes, but has been used in a wide range of contexts with a diversity of populations, including street youth, factory workers, sex workers, drug users, prisoners, etc.) (http://www.unicef.org/lifeskills/index_12078.html). In Kenya, HIV prevention education is also being transmitted during annual drama and music national festivals.

6.3.4.1. Regional Level

The education programme of the EAC is using an innovative complementary approach to meet the development objective of a productive and creative human resource. Students from the various EAC partner states are invited to complete an essay written in either Kiswahili or English. Awards are granted at both national and regional levels.

6.3.4.2. National Level

All EAC partner states provide some form of peer education. Peer education during curricular and extra-curricular activities is used, for example, in URT - Zanzibar. Kenya's MoE not only encourages, but also facilitates peer education from primary schools through post-secondary institutions. In 2007/08, for example, the MoE's ACU held a symposium for peer counsellors and educators on HIV and AIDS at the provincial level with the aim of training 540 peer counsellors.

Use of clubs in the school is an innovating way to impart peer education. HIV and AIDS clubs are being used to impart related education informally to peers – in Burundi, Kenya,

Rwanda Uganda and URT – Zanzibar's STOP AIDS clubs. These clubs involve students themselves in conducting various extra-curricula activities which help to create their awareness, as a result, preventing them from HIV infection. Burundi's peer education is through STOP AIDS club activities in every secondary school and community outside of the schools in each commune. Anti-AIDS clubs were established in all secondary schools and higher education institutions in 1998 in Rwanda. Many however have remained inactive because of lack of resources.

The formation of health/ HIV and AIDS clubs in schools in Uganda is attributed to a 2001 directive by the MoE's permanent secretary to empower the youth with related information and knowledge and to equip them with life skills for positive change in attitude, behaviour and practices. The head teachers were also requested to support the clubs in developing plans for addressing HIV and AIDS, which would then be submitted to the local authorities for funding. With support from the Ugandan AIDS Council, the MoE has:

- Revised guidelines on club formation;
- facilitated the establishment of clubs in many government-aided secondary schools; and
- facilitated the training of club patrons in management with the aim of mainstreaming HIV and AIDS in the education sector.

Although not an initiative of the education sector, the benefits accrued by the sector's target population, from Strong Talk Foundation's (STF) radio and newspaper education material, is worth taking note of. This Ugandan NGO is complementing the education sector by fostering safer sexual and reproductive health practices among 10 to 24 year-old adolescents and young adults, teachers, parents and the community at large. *'Specifically, STF's age-appropriate, adolescent-driven newspapers are sent to schools and further distributed by CBOs, NGOs and churches; they are also inserted into the local newspaper, The New Vision'* (http://www.comminit.com/en/node/116880).

Uganda's Ministry of Education and Sports is implementing education projects targeting non-formal establishments, among the main ones being COPE, ABEK, and Child-Based Alternative Non-Formal Education.

6.3.4.3. Distribution of Condoms

There is no evidence from the information gathered in the review of both literary and online materials, and from key informants, that condom education is part of the content of the preventive education being taught within institutions of learning in the EAC partner states. In URT - Tanzania Mainland, for example, the distribution of condoms "*is nationally not allowed ..... in schools*". One of the recommendations in the Uganda's situation analysis report is for the Ministry of Education and Sports "*to review urgently its approach to prevention in the context of certain concerns in educational institutions viz condoms in schools where students are sexually active and HIV positive" (*country reports*)*.

The sensitivities and controversies that characterise sex education including condom and contraceptive-related curriculum content, goes far beyond the education sector, and communities have an important say in the matter.

6.3.4.4. Challenges in Complementary Approaches

- Lack of financial resources is a major challenge in the provision of complementary approaches by key situation analysis informants in both Burundi and Uganda.

- In all the EAC partner states, because of the mobility of out-of-school youth and the fact that they are not located in any single place in a specific geographical location, reaching out to them with education is an ongoing challenge.
- Uganda's MoE complementary education curriculum is also difficult to standardise because the target varies in age and location among other key variables.
- Peer education in most schools is mostly carried out as an extra-curricular activity hence, reaching a minority of children in any school. One common problem that characterises peer education is high turnover of the educators, and it is likely that the challenge exists although it has not been cited by key informants as a problem.

6.4. Mitigating the Impact of HIV

6.4.1. Mitigating the HIV Impact on Teachers with HIV

The education sector response to HIV includes activities aimed at mitigating the impact of HIV on teachers living with HIV. For estimates of the impact of HIV on teachers using the Ed-SIDA model and details of other impact assessments undertaken, please see Section 5.

6.4.1.1. Regional Level

Teachers living with HIV have attracted international attention because ignoring them is detrimental to the quality of the education imparted within the education sector. Initially, the involvement of HIV-positive teachers in the response to HIV mainly involved them speaking at meetings about their experiences of living with HIV as a teacher. More recently, their involvement in the regional education response has extended in line with GIPA (Greater Involvement of People Living with HIV) principle[9].

In support of HIV-positive teachers in Eastern and Southern Africa, and in commemoration of World AIDS Day (2006), a technical consultation held by EFAIDS partners (UNESCO, EI, Education Development Centre and WHO) in 2006 brought together a range of different stakeholders including HIV-positive teachers' networks, ministries of education and teacher unions from six countries in Eastern and Southern Africa – the two regions in the world which are the most highly affected by HIV and AIDS – namely Kenya, Namibia, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe. The participants reviewed actions at global, country and community levels, examined barriers and success factors to responding to the needs of HIV-positive teachers, and made recommendations on how challenges can be overcome. The consultation was framed within the goals of EFA in recognition that the EFA goals will remain unattainable if the impact of HIV and AIDS on the education sector is not adequately addressed. The key points and recommendations that emerged over the course are supported by the publication Supporting HIV-Positive Teachers in Eastern and Southern Africa: Technical Consultation Report Network (UNESCO and EI-EFAIDS, 2007. http://unesdoc.unesco.org/images/0015/001536/153603e.pdf). Teacher Unions have been building on this work, championing teachers' rights in the workplace. This includes the development of a toolkit advocating for teacher unions and Networks of Teachers living with HIV to work together (Inclusion is the answer: Unions involving and supporting educators living with HIV).

HIV-positive teachers and their networks have also been playing an increasingly important role in the African Ministry of Education HIV and AIDS Focal Point Networks, including active participation in their 2007 and 2008 annual meetings. The book *Courage and Hope: Stories from teachers living with HIV in sub-Saharan Africa* and accompanying documentary

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[9] GIPA supports the greater involvement of people living with HIV at all levels of the response.

were launched at ICASA 2008, as part of the 2008 annual network meeting. The development of the book Courage and Hope, provided teachers living with HIV, in 10 countries in sub-Saharan Africa (including the EAC countries Kenya, Rwanda, and the United Republic of Tanzania), with an opportunity to articulate their experiences and suggest effective ways of mitigating the HIV impact on them and others in similar circumstances. That only 4 teachers participated in the documentary is not an indication that others were locked out or uninvited, but rather affirms what is already stated in the documentary, that the majority of teachers living with HIV have not disclosed their HIV status to their employers among others. Participation in the documentary is in itself a disclosure of one's HIV status.

The existence of good workplace policies are however, not a guarantee that teachers living with HIV will be free of discrimination and stigma in their workplace. The policies must be implemented and efforts expended to create policy-related awareness among all teachers and education staff in the workplace. Many of the teachers in Courage and Hope were unaware of their countries HIV workplace polices and strategies, underscoring the importance of creating awareness among the policy beneficiaries (i.e. the teachers and education staff) and other populations, and to enforce the policy, which is only good if implemented. More details on the actions called for by the teachers living with HIV documented in Courage and Hope are outlined in Box 6.7. below (World Bank and PCD, 2009).

Box 6.7: Courage and Hope: Actions Called to Support HIV-Positive Teachers

- Fully implement existing national and institutional policies.
- Increase involvement of HIV-positive teachers in setting policies and giving practical advice.
- Provide universal access to VCT, care and support.
- Address HIV issues during teacher training activities to reduce stigma among teachers and to equip teachers with the skills to:
  - avoid infection; and
  - teach young people about HIV, including stigma and discrimination reduction.
- Help ensure that the roles of teacher unions are fully realized.
- Create effective national support networks for teachers living with HIV.
- Increase national and institutional recognition of the social impact of HIV on teachers, particularly female teachers, living with HIV.

Source: World Bank and PCD, 2009.

6.4.1.2. National Level

There is evidence at the national level to indicate that attention is being directed towards mitigating the impact of HIV on teachers living with and affected by HIV. Kenya, Rwanda and Uganda have undertaken assessments of the impact of HIV on the education sector and these help to guide the response (please see details in Section 5). Key mitigation interventions in EAC partner states include the development of national, sectoral and institutional workplace policies, spelling out workplace and human rights issues, countering discrimination and stigma, assuring confidentiality and providing psychosocial support and access to VCTs, and other related support.

6.4.2. Issues of Discrimination and Stigma in the Workplace

Stigma and discrimination are paramount among the obstacles in the mitigation of HIV impact on teachers living with HIV and they can inhibit and limit the uptake of available services. For example, a teacher who is living with HIV and who attended the Kenya situation analysis report validation meeting, decried the magnitude of ongoing stigma in the

workplace. She explained: "*since November 2008, some teachers have died because they would not come out in the open to seek help because of fear of stigma and discrimination.*" (Kenya country report) Addressing HIV during teacher training can help to reduce stigma and discrimination, as well as giving teachers the skills to both protect themselves from HIV-infection and to pass on HIV education messages, including those relating to stigma reduction to their students.

6.4.3. Mitigating the HIV Impact through Workplace Policies

Nationally, some MoEs in the EAC partner states, for example, Kenya and Uganda have developed workplace policies, and Burundi HIV guidelines, with the aim of institutionalising the adherence of human rights of all at the workplace, whether HIV-positive/affected or not, irrespective of one's position at the sector. The partner states without MoE workplace policies have established mechanisms to protect their teachers and other populations in the education sector who are living with/affected by HIV. For example, in Rwanda, by a government directive of 2006 the Ministry of Public Services provides support nationally for all employees living with HIV. Section 5.2 of this report provided information on existing HIV and AIDS workplace policies and in addition highlighted the human rights and workplace issues addressed by a few policies (Burundi, Kenya, Rwanda and Uganda SITAN reports). In order for these workplace policies to be effective, they need to be implemented at all levels of the Education Sector. Data was not available on the effectiveness of the policies at mitigating HIV-related impact at the school-level. More information on workplace policies is available in Section 6.1.2.

6.4.4. Voluntary Counselling Testing, Care and Support

VCT, care and support are the responsibility of the health sector. Some of the Partner State's MoEs also facilitate the provision of VCT services targeting teachers (Kenya, Rwanda, and Uganda).

Most if not all public post–secondary institutions of learning, as well as SAGAs including universities, have VCT centres where the students and staff can obtain counselling and HIV testing services. These centres are mandated to be friendly to <u>all</u> users. The services are offered at all MoE field functions, for example, music and drama festivals, during which time they are available to students, staff and the general public. There is no evidence in the country reports that counselling for and HIV testing services are available within public and private primary and secondary schools in the EAC partner states.

6.4.5. HIV-Positive Teacher Networks

The presence and size of support networks for teachers living with HIV varies throughout the partner states. KENEPOTE was one of the first such networks to be formed and is one of the largest. Teachers in other EAC partner states, including URT - Tanzania Mainland and Uganda have followed KENEPOTE's lead to create their own networks. More recently (2008) networks have been established in Rwanda and Burundi, with the support of the unions. These networks play an important role, allowing teachers to share experiences and providing psychosocial support. They also provide a voice to teachers and can play an important role, promoting GIPA within the education sector. This can include promoting access to services, participating in service delivery and becoming involved in management and policy making. The networks can also work together with the Teacher Unions to promote the welfare of teachers living with HIV, greatly increasing their ability to advocate. The toolkit 'Inclusion is the answer: Unions involving and supporting educators living with HIV' encourages Teacher Unions and Networks to work together, increasing cooperation between the two in country (EI/EDC 2007). Working with and through these networks can be

an effective way for unions to step-up their support to HIV-positive teachers. In the same way, networks that are integrated within the union structure can mobilise union members and resources for their activities. Unions involved in the EFAIDS Programme coordinate with Networks of HIV-positive teachers in the partner states to lobby for treatment access, to carry out workshops and to put in place workplace policies.

6.4.5.1. Challenges Faced by Teachers Living with HIV

Teachers living with HIV face many challenges above and beyond those of their colleagues. Stigma and discrimination remain major challenges faced by teachers living with HIV and are leading barriers to their access for testing, treatment care and support that they require. Economic hardship and varying provision of support are also challenges.

More details on partner state activities are provided in Box 6.8.

Box 6.8: Partner State Activities to Mitigate the Impact of HIV on Teachers Living with HIV

Kenya's TSC is the employer of all teachers in public schools from primary through TTCs including vocational institutions of learning. It's ACU has a counselling unit offering VCT services at the headquarters. Teachers are free to use the services where teachers "*are informed of the services available at the national level*". In addition, at district and provincial levels there are HIV focal persons that teachers consult when in need. The TSC involves Kenya's network of HIV-positive teachers, KENEPOTE, in its capacity building programmes, in particular facilitating sessions on stigma and discrimination.

KENEPOTE has a membership of 5000 plus. KENEPOTE encourages teachers living with HIV to build and sustain psychosocial support structures wherever they are. It also encourages more teachers who are yet to declare their HIV status to do so with ease. Depending on where KENEPOTE members are located, there are organisations providing care and support to teachers who are aware of their HIV status, to seek assistance (Kenya country report, KENEPOTE Treasurer).

The MoE in **Rwanda** has conducted a VCT in 2007 in TTCs in all 30 districts of the country with support from NAC, and the World Bank MAP. About three-quarters (75.9%) of all teachers were tested for HIV. The report did not give results on HIV prevalence among the teachers tested, although it did report that the Southern Province had the highest prevalence among those tested for HIV. Following research undertaken by the Union of Education Personnel in Rwanda (SYPERWA) the Rwandese Network of teachers Infected or Affected (RRE+) was developed last year and in November 2008 had 30 members.

URT: Tanzania Mainland's national HIV treatment plan provides for free care and treatment to all individuals presenting with a HIV-related illness through the MoHSW, including teachers. According to Tanzania Mainland's HIV focal person, some teachers living with HIV are transferred to schools located near healthcare delivery facilities to enable them to seek treatment (country report). The MoE in Tanzania Mainland in 2006 has developed guidelines for counsellors in schools and teachers' colleges, trained 500 secondary schoolteachers and 32 TTC teachers in guidance and counselling. The training of primary schoolteachers has not yet taken place. Tanzania Mainland's association − Tanzania Positive Teachers' Initiatives (TAPOTI) − emphasises teachers living with HIV need to be recognised and valued for care and ART services for those in need, and the provision of medication for secondary infections associated with HIV-related disease. In Zanzibar, teachers living with HIV who require anti-retroviral therapy (ART) are provided with treatment through health care facilities like the general population according to the HIV and AIDS care and treatment guidelines of the Health Ministry. The coverage of VCT and treatment provision is national wide (country report).

In **Burundi**, all teachers and students living with HIV have the right to appropriate health care. The Government of Burundi provides medical insurance to all its employees and university students (mutuelle de la function public), which helps to meet 80% of the cost of medical care including some pharmaceutical products. The insurance covers the spouse and offspring until the age of 18 years. However, "*since the salary of teachers remains low comparative to other government employees in Burundi, the 20% medical care coverage is still unaffordable to most teachers.*" (Burundi SITAN reports).

Sometimes teachers contribute funds to financially assist others in difficulties. Burundi's MoE initiated a project to which staffs make monthly contributions to help the teacher union raise funds to pay for ART. The project has however been unsuccessful because of disagreements on amounts of contributions, which range from 0.5% to 2% of the monthly salary. With the assistance of EI and WHO–Burundi, the teachers have met and discussed the necessity for making regular contributions. There are also reports from Burundi about support for teachers living with HIV, such as transferring a *physical education* teacher unable to carry out assigned tasks to a lesser physically demanding job.

The *Association of Positive Teachers* was established in 2008 following training undertaken by the Union of Education Workers (STEB) in 9 of Burundi's provinces.

The goal of **Uganda's** Education Sector Workplace AIDS Policy Implementation Project (ESWAPI)" 2005-2008 project was to reduce the spread and mitigate the impact of HIV and AIDS among Ugandan teachers and MOES employees, by increasing adoption of behaviour change practices for the prevention of HIV transmission, increasing access to quality HIV and AIDS prevention, care and support services and empowering workplaces to implement the workplace HIV and AIDS policy. Under HIV Counselling and Testing (HCT), the project provided this service not only for enhancing HIV and AIDS prevention but also as a foundation for care, treatment, and support services; thus, it established outreaches, partnership and linkages with other service providers. Regarding palliative care, the project has been building and strengthening linkages and referrals with other HIV and AIDS service providers. The project has also been able to support the formation and strengthening of Teachers Anti AIDS Action Groups in schools (country report). Uganda's Teachers Anti-AIDS Action Group (TAAG) vision is 'to develop a self-esteemed infected teacher in a stigma- and discrimination-free environment' (EI Newsletter on EFA and HIV/AIDS Prevention in Schools, 2007).

6.4.6. Mitigating the Impact of HIV on Children Affected By AIDS

Children can be affected by HIV in a number of ways, including reduced parental care, economic hardship and increased risk of abuse and exploitation. This could be due to living in households where one or both partners is living with HIV or has died or in households that have taken in orphans and struggling under the strain. There are also those children who are living with HIV. These most vulnerable children are in need of interventions that decrease their susceptibility to HIV and support for orphans and most vulnerable children is one of nine activities proposed in the EAC Multi-Sectoral Strategic Plan for HIV and AIDS (2008-2012).

This section covers the education sector interventions that focus on providing education's 'social vaccine' to the most vulnerable children. Information on some key global initiatives protecting the rights of children is annexed (see Annex 9).

Support for children affected by AIDS in the region is one of nine activities proposed in the EAC Multi-Sectoral Strategic Plan for HIV and AIDS (2008-2012).

The magnitude of children in the EAC region who have lost one or both parents is a cause for serious concern highlighted previously in Section 3.9. There is evidence that orphans are less likely to be enrolled in school than non-orphans and this is the case, for instance, in URT - Tanzania Mainland (Mishra *et al.,* 2005, Evans and Miguel, 2007; Beegle *et al.,* 2007, all situation analysis country reports).

The effectiveness of the provision of support to orphans is however challenging throughout the EAC partner states because of their large numbers. It is important to keep in mind that the orphans given in Table 3.8 are not the only vulnerable children in any of the countries listed. There are many other reasons, for example, poverty, in addition to the loss of one or both parents that exacerbates children's vulnerability.

6.4.6.1. The Cost of Education and Cash Transfers

Poverty is often a barrier preventing children affected by AIDS from attending school and the policy of free primary schooling in the EAC partner states has partially removed this barrier. However, the hidden costs of schooling remain as do tuition fees later in the education system. In addition to FPE, some of the EAC partner states have removed tuition fees in secondary schools as detailed in Section 3.

Cash transfers (including conditional cash transfers) are another form of support that can help overcome barriers to education. They can be used to cover education costs, to compensate for the loss of income resulting from a child attending school rather than working and finally they may result in more money for food, ensuring that children are better fed impacting on their ability to concentrate during school (Adato M., Bassett L [in press]). As girls' education is more likely to be impacted negatively in poorer households, girls potentially have the most to benefit from cash transfers in terms of their education, especially when these grants are larger and/or conditional. Studies in South Africa and Zambia have shown unconditional cash transfers to increase enrolment and attendance (Case *et al.* 2005, MCDSS/GTZ 2006, Samson *et al.* 2004). However, the percentage of the money from unconditional cash transfers that is spent on education can be low and in 5 studies in East & Southern Africa varied from 3% to nearly 20% (Acacia Consultants 2007, Devereux 2002, Moller and Ferreira 2003 and MCDSS/GTZ 2006). Cash transfers that have education conditions attached to them, such as enrolment and attendance, can have more dramatic impacts on education outcomes.

Cash transfers are used in Kenya, Rwanda and Uganda (Focal Point Survey, Tomkins *et al.* 2008). A cash transfer study in Kenya found that the cash transfers decreased school absenteeism and improved academic scores among orphans over 3 years. An earlier gender difference found between girl and boy orphans was also not found following the scheme (Tomkins *et al.* 2008).

6.4.6.2. Data on Children Affected by AIDS

The Education Ministries in Burundi, Kenya, URT - Tanzania Mainland and Uganda collect data on the number of children affected by AIDS. This assists the MoE with their education planning so that they can address the needs of these vulnerable children (Country Report and Focal Point Survey). There is also some data available on children affected by AIDS in Rwanda (i.e. through school surveys).

6.4.6.3. Children Affected by AIDS as Learners

A range of psychosocial problems can impact on child attendance and concentration at school. There is also anecdotal evidence that stigma and discrimination can result in children affected by AIDS dropping out of school.. A study in Kenya found that orphans (in particular female orphans) in 10 rural districts were more likely to be absent from school than non orphans, despite the absence of fees. Orphans were also found to have lower achievement and again girls were found to be more affected (Tomkins *et al.* 2008). Uganda's 'Opportunities for Reducing Adolescent and Child Labour through Education (ORACLE)' programme trains teachers to use a variety of approaches to help young people come to terms with traumatic events (UNICEF, World Bank *et al.,* forthcoming). Information on the provision of ARVs for children, especially those at boarding school was not included in the country reports. More information on this, including the role of teachers in ensuring compliance and regular access to the drugs as well as relevant teacher training would be useful.

SHN interventions also enable access to education for orphans and most vulnerable children which increases their ability to learn when in school. These programmes are covered in depth in the following section.

Box 6.9: Some Partner State Activities to Mitigate the Impact of HIV on Children Affected by AIDS

In **Burundi**, secondary school is free for orphans who have lost both parents. School materials such as books, notebooks and pencils have been distributed to 323, 077 orphans and vulnerable children. However, national coordination and M&E remain a challenge.

URT: In Tanzania Mainland, a national plan is in place through the Department of Social Welfare with an effective data management system to identify and place children affected by AIDS under institutional support services at the village levels. The growing number of vulnerable children needing care and support is far more than the families and existing institutions can cope with. Major legislation like a review of the Child Development Policy of 1999 and the Children's Bill will provide the framework for further protection and support, but are still pending. The major needs of children affected by AIDS, according to some key national informants are: support for school requirements such as fees, food and shelter, love and care, as well as psychological support. Children living with HIV in Zanzibar are identified when they attend health care services. Within the Zanzibar AIDS Control Programme (ZACP) a programme started in 2006 supports children living with HIV until they are at least 15 years old. This support was initially provided to the HIV infected children only at the household. However, through additional support from WFP, households with children living with HIV are currently provided with food for five more persons. There is no established mechanism to date for identifying orphans and children living with HIV specific to the education sector.

The **Kenyan** Government has intervened by providing basic services and education to vulnerable out-of-school children through a Street Families Rehabilitation Trust Fund started in 2003. For the past 2 years, the Kenyan Government has been supplementing secondary tuition fees substantially and students in most day secondary schools only have indirect costs, including uniforms, school lunch, building funds and national exams (country reports).

In 2005, **Rwanda**'s NACC, the MoE and major partners developed a minimum package for children affected by AIDS at school, which resulted in 16,000 orphans and most vulnerable children receiving support for tuition fees, materials, uniforms, and medical insurance.

In **Uganda**, educational support to orphans has usually included payment of school fees and

provision of scholastic materials and uniforms for poor orphaned and other vulnerable children in primary, secondary and vocational schools. The Lots Quality Assurance Survey (Mukaire *et al.* 2004) found that school attendance of orphans in the communities that were supported by the project was 84.3% compared to 82.2% in communities where there was no project.

7. EXISTING SCHOOL HEALTH AND NUTRITION PROGRAMMES

School Health and Nutrition (SHN) programmes aim to improve the health and nutrition status of school-age children by addressing critical factors that keep children out of school and reduce their ability to learn. They are an important component of health sector programmes and a key strategy for achieving the EFA goals.

This section describes the SHN programmes existing in the EAC region. Poor health and malnutrition are important underlying factors for low school enrolment, absenteeism, poor classroom performance, and early school dropout, as reflected in the World Declaration on EFA. Programmes to achieve good health, hygiene, and nutrition at school-age are therefore essential to the promotion of basic education for all children. Bundy *et al.*, (1996:26) describe HIV prevention education as a "perfect fit" for integration into SHN programmes. A comprehensive SHN programme can also facilitate inter-sectoral participation in the promotion of children's and communities' health.

7.1. School Health Policies

School health policies are important because they demonstrate leadership commitment, and provide a framework to ensure the health and education needs of children are holistically and systematically met in all schools (Focal Point Survey, 2007). An education sector specific SHN policy is also valuable as a guide when controversial issues, such as HIV prevention education, arise and require clarification. Related health programmes ensure that schoolchildren and personnel are healthy and that the school environment too is healthy, as well as conducive for delivery of quality EFA.

As mentioned earlier (under Section 6.1.1.2. and illustrated in Table 6.1), by 2007, three countries in the region - Burundi, Rwanda and URT - Tanzania Mainland, had national policies covering SHN. Kenya and Uganda have national policies in draft form, the former awaiting approval and finalisation and the latter ready for launch (it is likely that this activity has already taken place).

Burundi, Kenya, Rwanda and Uganda's SHN policies address HIV. There are minor country differences in the integration of HIV and AIDS –related issues within SHN policies. In Burundi for instance, the SHN policy also covers HIV and both HIV and SHN within the same unit in the MoE. Rwanda's MoE has an SHN policy which is informed by the HIV/AIDS national policy. In Kenya, the SHN policy references the HIV Policy and includes HIV and AIDS and other sexually transmitted infections.

URT: although Zanzibar's education sector has no specific SHN policy, the ministries in charge of Education and Health have a memorandum of understanding on the SHN intervention structure. The former's HIV focal person is responsible for the integration of SHN and HIV & AIDS responses and plans are underway to merge SHN and HIV & AIDS responses. The health ministry's unit responsible for SHN programming does not address HIV and AIDS issues. In Tanzania Mainland, HIV and AIDS, as well as SHN, operate out of separate units.

Box 7.1: Some Partner State School Health Policies

URT: School-based health and nutrition programmes in Tanzania Mainland are incorporated into the national plan under the Education and Health Ministries and coordinated at the ministerial level. The SHN programme has the following specific objectives:

- To provide pupils with health screening services at least once a year and vaccination when required;
- to supervise environmental sanitation in schools;
- to teach heath education and promote personal hygiene in schools, and
- to train councils and regional school health coordinators.

In practice, almost all schools and teachers colleges in Tanzania are provided with healthcare services through the MoHSW health facilities.

HIV and AIDS. Although Zanzibar does not have an SHN policy, the MoEVT has entered into a Memorandum of Understanding (MOU) with the MoHSW, to ensure that SHN services are provided in all schools. The Education Ministry's Education Policy (2006) addresses these intervention programmes.

Burundi's national health policy covers the period 2005 –2015 and school health is a priority of the Government.

Kenya's National Comprehensive School Health Policy was approved in 2008 and launched. Its content is a response to two aims at achieving EFA and improved health status. The topics covered include STDs, HIV and AIDS, peer education, counselling in schools, and access to antiretrovirals (ARVs) for learners and MoE personnel, prevention, non-discrimination of the infected and affected persons. The draft policy gives directives on the delivery of SHN services, and also addresses issues of safety in the school from two perspectives: water safety, sanitation, personal hygiene, food safety, and vector and vermin control; school infrastructure and environmental safety including buildings, playgrounds, safety (e.g. fire fighting equipment) and transport safety (Kenya SITAN report).

Rwanda's National School Health Policy of 2002 integrates HIV and AIDS and provides guidelines on life skills based health education in the schools, SHN-related services and standards and procedures to make the school environment safe. Presently, development of a training manual for teachers and a booklet for schoolchildren, both including information on: mental and physical health, water safety, hygiene, as well as HIV prevention is ongoing.

Uganda's MoH has drafted a policy on school health that is awaiting approval and finalization. Its specific objectives are to: improve provision and utilisation of safe water, hygiene and sanitation facilities; integrate life skills based health education into the curricular at all levels of education; improve the provision of school-based medical care, nutrition/feeding services, access and utilisation of adolescent sexual reproductive health services; mainstream gender and disability concerns in the provision of school health services; ensure safety and protecting pupils/students from abuse and injury; strengthen and enforce the implementation of complementary health-related policies and interventions in educational institutions; strengthen the provision of effective guidance and counselling services; and initiate and/or support the existing physical education, sports and recreation activities and services in all schools. Uganda also has guidelines for improving health in educational institutions which was developed by the MoH in 2004. A tool for M&E was also developed for monitoring the health status in education institutions.

7.2. School-Based Health Services (excluding Health Education)

As mentioned in section four, there are some common health problems experienced by children of school-age in the EAC region. The school provides a conducive environment for the provision of various health-related services to many children at the same time. The coordination of health service provision is country specific and not regional. The country

reports did not include information on health services provided specifically to support children living with HIV.

According to MoE key informants, the following health services are provided in all EAC partner states
- School feeding is provided for school-age children; targeted
- deworming programmes is provided for school-age children; areas
- reproductive health services are provided for school-age children; and
- counselling services are provided for teachers.

Table 7.1. highlights other selected health services available to school-age children in the EAC partner states. A majority of the MoEs in conjunction with Health Ministries among others (all except Kenya vaccinate school-age children, while all except Uganda provide Malaria control services to school-age children).

In URT - Zanzibar, teachers living with HIV who require anti-retroviral therapy (ART) are provided with treatment through health care facilities like the general population according to the HIV and AIDS care and treatment guidelines of the Health Ministry. The coverage of VCT and treatment provision is national wide (country report)., Kenya, Rwanda and URT - Tanzania Mainland provide vitamin A capsules and iron supplements to school-age children (Focal Point Survey, 2007, SITAN country reports). Teachers in URT - Zanzibar according to key informants have been trained to provide basic medication and first aid . Only Kenya and URT - Tanzania Mainland provide medical examinations and undertake hearing and sight examinations of school-age children. All MoEs have counselling and reproductive health services for school-age children.

Table 7.1: SHN Services by the EAC Partner States

Health and Nutrition Services	Burundi	Kenya	Rwanda	URT		Uganda
				Tanzania	Zanzibar	
Education Ministry has a School Health Unit						
Vaccinations are provided for school-age children						
Vitamin A capsules are provided for school-age children						
Is an iron supplementation programmes provided for school-age children?						
Malaria control services are provided for school-age children						

Source: Data from the Ministry of Education HIV and AIDS Focal Point Survey 2008; Situation analysis country reports.

7.2.1. Deworming

Deworming programmes for schoolchildren where soil-transmitted helminths or schistosomiasis are prevalent are essential, with the frequency of intervention depending on the prevalence. As outlined above, deworming is one of the health services provided to school-age children in all EAC partner states (Focal Point Survey 2007; and country reports) as follows: in Burundi once a year, Uganda and URT - Zanzibar nationally and bi-annually, while in Rwanda the services are also national but once a year. Kenya is currently rolling out a national deworming programme through schools and deworming in URT - Tanzania is targeted to specific regions (Focal Point Survey, 2007; All SITAN country reports).

7.2.2. Presumptive Treatment of Malaria

Malaria is one of the common causes of school-age children's health problems in all EAC partner states. There is no evidence from the data available that indicates the existence of a specific national Malaria treatment programme for school-age children in any of the EAC partner states. According to the information available, in Kenya, malaria treatment was provided to school-age children under trial conditions to assess the effectiveness of presumptive treatment. The trial found that those children receiving anti-malarial treatment had reduced parasitaemia and anaemia (Clarke *et al.,* 2008). Referrals to health services are made as the need arises. In Burundi, Malaria treatment services are available albeit informally rather than through a school health programme, which often leads to relatively high incidences of resistance such as Chloroquine.

7.2.3. Nutritional Services

These take the form of micronutrient supplementations and school feeding. The integration of deworming and iron supplementation services leads to greater improvements in child health and education as iron supplementation reduces the anaemia caused by worms (Focal Point Survey, 2007). Targeted school feeding is taking place in all of the states and governments are often supported by the World Food Programme (WFP) to implement this service.

7.2.4. Screening, First Aid and Health Cards

Screening and assessment for health problems (for example, malaria and respiratory infections), first aid, and counselling services, are available in all EAC partner states, although not always nationally.

Throughout all the EAC partner states, the MoH is involved in the provision of health services to school-age children. Voluntary counselling and HIV testing services are also available, although there are no available data indicating that the services are available anywhere in primary and secondary schools in any of the states (all situation analysis country reports).

Box 7.2: Some Partner State School-Based Health Services (excluding Health Education)

In **Burundi,** screening is carried out by nurses, who visit the schools during deworming and vaccination campaigns. There is a demand for school authorities in collaboration with the MoH to set up health posts and school nurses, to take care of minor medical emergencies (i.e. wound care, fever, headache malaria and all feco-oral diseases). A school feeding programme is going on in 7 out 17 Burundi provinces (Burundi SITAN report).

URT: In Tanzania Mainland, school health services cover 17 out of 21 regions, including deworming. The MoE also has a school feeding programme supporting primary education in four drought prone and pastoralist districts. Schoolchildren also undergo health screening at the start of each year, although coverage is not yet national. First aid kits are available in most schools in Tanzania Mainland. The MoE has in collaboration with the MoH developed and distributed health progress cards to pre-primary and primary schoolchildren, although the coverage has not been national. Training has been given to school health coordinators in the regions and districts on the use and replenish of first aid kits. Teachers in Zanzibar, on the other hand, have been trained on how to provide basic medications and first aid to school pupils. School health services are carried out by the MoHSW. (Tanzania Mainland country report; Focal Point Survey, 2008)

Key informants in **Kenya** reported that most public primary and secondary boarding schools

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and TTCs have nurses employed through the MoE, who provide varied basic health services which include deworming when the need arises and hearing and sight examinations. A national deworming programme through schools is currently being rolled out. In some Kenyan regions, micronutrient supplementations are provided by interested parties not necessarily by the MoE in certain geographical locations. School feeding is provided to support socio-economically disadvantaged children in 29 districts and Nairobi slums.

Approximately 5 million **Rwandan** schoolchildren were dewormed in 2008. Hot lunches are provided to 344,741 primary schoolchildren on school days in the most food insecure areas of the country.

In **Uganda** efforts to improve the health of school-age children through dissemination of guidelines and health services, such as Tetanus immunisation in 15 districts; screening of children in a quarter of the country's districts. The finalisation and signing of the School Health Policy and MOU between the Ministries of Health and Education has been delayed and elaborated below. Uganda's children are dewormed during Child Days twice a year and the Health Ministry undertakes sensitisation in regard to iodine deficiency among young people annually.

(Focal Point Survey, 2007; SITAN country reports)

7.3. Skills-Based Health Education

The Education Ministries in the EAC partner states are providing some skills-based health education although the modality varies from state to state. In addition to the HIV and life skills education mentioned above in Section 6.3, the partner states are providing skills-based education on topics such as nutrition, malaria prevention and hygiene.

Box 7.3: Some Partner State Skills-Based Health Education Activities

In **Burundi**, the education sector is running a programme for the promotion of health education at all educational levels from primary through tertiary institutions. This includes health education to teachers for their self-protection and to enable them to protect others. The health education for teachers includes health-related topics including human reproduction, sexual violence, and communication skills. These are all part of a life skills training module that is based on the SARA Communication Initiative (Adapted Burundi version in French and Kirundi since 2003 in Burundi SITAN report). The teachers are using education materials developed by the MoH to teach elementary hygiene. The main lessons include: HIV and AIDS education and the body/food and water/environment-related hygiene.

Although **Kenya's** MoE does not currently have a standalone health education curriculum, the existing school curriculum includes topics on HIV prevention, life skills, malaria prevention and general hygiene (Appendix 2, 3 & 4 in Kenya situation analysis report). Secondary school subjects such as biology and home science include aspects of life skills, HIV prevention, malaria prevention and hygiene. Discussions are ongoing concerning how best to implement the hygiene programmes being designed, and hence promote healthy lifestyle through the school system. Health promotion and environmental education through clubs is one of the methods that could be used.

Some schools in **Rwanda** are providing life skills HIV education and the government is working with UNICEF on the integration of critical life skills into the curriculum. In areas where school feeding is taking place, students are also equipped with the relevant skills through the use of school gardens and are being trained in animal husbandry, food handling and management. An evaluation of Rwanda's School Health/HIV Prevention Project programme showed that primary schoolchildren aged between 7 to 15 years were applying

and experiencing the learning activities in the context of their life in their community. For example, getting home safely by persuading others to walk in groups, avoiding being separated from other students by older men and shopkeepers, and assessing the consequences of taking gifts from older men and boys (WHO/EI/EDC, October 2004).

URT: The nutrition unit of the Health Ministry in Zanzibar is assisting in the provision of training for in-service teachers in SHN and is also conducting educational advocacy talks in schools on issues related to SHN. Information on skills-based health education was not detailed in the Tanzania Mainland report.

Uganda's Primary Science curriculum includes components of personal hygiene for two classes (P1 and P2) and sanitation for four classes (P3 to P6). The use of posters and other media in schools is recommended as one of the approaches towards sanitation and hygiene promotion, but are not universally being used as revealed by a survey by the MoE. School heads from primary and secondary schools reported that 62% and 77% respectively did not have the posters. It is a core requirement for pre-service and in-service training of teachers to deliver age-appropriate skills-based education including hygiene management of water and sanitation. However, the MoE survey found that 64% of primary schools did not have plans for training teachers on sanitation and hygiene, while the proportion rose to 74% in secondary schools (National Curriculum Development Centre, 1999; Uganda Primary School Curriculum – Volume 1: Syllabi for Primary Schools in Uganda situation analysis report). Due to the absence of a school health policy, the provision of skills by teachers is not being taken as seriously as it should be.

7.4. Safe and Sanitary School Environment

The school environment needs to be equipped with adequate sources of drinkable water, sanitation and hygiene facilities. It is estimated that inadequate access to water and sanitation causes about 2 million child deaths a year and reduces school attendance. (World Bank Poverty Net Newsletter #117, August 2008). According to WHO, children in the age range of 5 to 14 years are particularly prone to infections of round worm and whip worm and there is evidence that this, along with guinea worm and other water-related diseases, including diarrhoea, results in significant absences from school. Schools have a gender bias where girls who are unable to access clean, safe and separate toilets and hand washing facilities, may disproportionately dropout of school at puberty, or even earlier. (http://www.who.int/water_sanitation_health/hygiene/securingsanitation1.pdf)

All EAC partner states have national policies or policy regulation mechanisms to promote a safe child-friendly school environment. This includes regulations, such as the provision of safe drinking water, hand washing facilities and gender-segregated toilets, to promote a hygienic environment in schools. Kenya, Rwanda and URT - Tanzania Mainland are the only countries known to conduct annual sanitation surveys in schools, which is important to monitor the implementation of national policies.

In addition, the providing a sanitary environment, schools also have a duty to ensure that the school is free from violence.

Box 7.4: Some Partner State Safe and Sanitary School Environment Activities

In **Burundi**, there are plans for the national school health programmes to establish psychosocial care facility in schools. The MoH has created a national service of medicine and hygiene in school in order to improve the wellbeing of the education sector. The national programmes development for a safe and sanitary school environment gives an orientation on different goals and strategies to protect the health of students and teachers

The MoE in **Kenya** identified poor primary school infrastructure as one of the barriers to improving access to primary education in Kenya because it impacts negatively on school attendance and achievement (Republic of Kenya, 2005b). Due to competing needs, the MoE acknowledges there has been a "major backlog of infrastructure provision" which was worsened by the increase in primary school enrolments in 2003. Key education reports have addressed the issue of school infrastructure and the Sessional Paper No. 5 of 2005 also highlighted the need for additional school infrastructure to support successful implementation of FPE (Republic of Kenya, 2005b In Kenya situation analysis report, 2009). The MoE is implementing the Kenya Education Sector Support Programme (KESSP) (Kenya situation analysis report, 2009) and addressing issues of safe and sanitary school environment. A draft policy is under discussion by the relevant technical committee comprising different departments in the MoE, Ministry of Public Health, Ministry of Water, Ministry of Local Government, development partners (i.e. UNICEF, the World Bank) and a number of NGOs (draft policy was not available to the consultant). Three key areas addressed by the policy are safe water provision, sanitation and hygiene.

In **Rwanda**, between 2001 and 2007 the FTI resulted in the creation of safe and adequate sanitation facilities in 50 primary schools, serving over 50,000 children (UNICEF). Currently, the United Nations body is working with the government to construct pit latrines and provide areas for hand washing in schools. Safe and sanitary school environment is integrated within the school health programmes. A circular on the environment of 1997 spells out the; availability of water, toilets, waste management and school greening requirements.

In accordance with the National Sanitation Guidelines, **Uganda's** draft school health policy provides that there should be: adequate and separate latrines for male and female pupils/students, the staff; and that there should be special latrines for people with disabilities in all educational institutions; and adequate hand washing facilities for use after toilet in all educational institutions; among others (Uganda country report).

URT: Many school children in Zanzibar come from homes which lack environmental safety and from schools without playgrounds. According to the education ministry's specifications, one pit latrine should serve at most 45 students. The ministry and UNICEF are jointly supporting schools to construct toilets national wide, while schools and surrounding communities share the responsibility for connecting them to adequate water. Previously UNICEF supplied hand-washing facilities, which are today under rehabilitation. In Tanzania Mainland, the community is expected to support the government in the provision of sanitary services in order to ensure their sustainability. Safe and sanitary school environment is integrated within the School Health Programme. In Tanzania Mainland, the community participation to support the government in the provision of sanitary services in order to ensure their sustainability is still inadequate in most parts of the country.

7.4.1. Challenges in the Provision of SHN Programmes

All EAC partner states faced some common challenges and some were specific to each in the provision of SHN programmes.

- Policy implementation can be a challenge. For example, as the Ugandan MoE's SHN draft policy has not yet been approved by the government this had affected its implementation, hence contributing to the programme being "piece meal and not holistic".
- A lack of sufficient resources (both financial and human) to allow for:
    - Comprehensive and holistic national coverage of curriculum content;

- sufficient coverage of sanitation facilities in all schools, such as supply of gender sensitive and teacher respecting toilet facilities, sanitary bins, basins and soaps in wash rooms; and
- ensuring that distant schools are reached;
- Uganda's policy governing provision of safe and sanitary school environment is yet to be launched but the process of implementation is at an advanced stage.
- In URT, community participation to support the government in the provision of sanitary services in order to ensure their sustainability is still inadequate in most parts of the country.
- Another gap identified was that, during the ongoing construction and expansion of schools, planners tend to forget the provision of safe water supply and toilet facilities.

8. CONCLUSIONS

HIV and AIDS is a pressing issue for all the countries of the EAC and this has resulted in widespread action to combat the epidemic across the region. At the level of policy and planning, the regional response to the infection has occurred at the multi-sectoral level through the development of a strategic plan for HIV and AIDS, a workplace strategy that encompasses all sectors, a strategic plan on sexual and reproductive health and a gender and community framework. At the national level, specific education sector responses have been extensive and comprehensive with most countries developing sector-specific policies, strategies and action plans.

Considerable steps have been taken to enable the management and planning of HIV and AIDS responses. At the regional level, the EAC Secretariat coordinates the education sector's response to HIV within the East African region, providing countries with input about formulation of policy and strategy, programmatic interventions and capacity building for effective implementation. In the future, a regional initiative to harmonise the education system and training curriculum of all subjects from pre-primary to tertiary institutions will have considerable impact on HIV and AIDS, including the issues as a cross-cutting topic that will be integrated across the curriculum. At the national level, all MoEs have HIV and AIDS Focal Points who coordinate their activities through membership of an EAC Technical Working Group on HIV and AIDS and education. Focal Points are also members of the Network of Eastern and Southern African Focal Points of the Accelerate Initiative. In all countries, scale level implementation of activities is being enabled through decentralisation of activities. Efforts to monitor and evaluate the impact of activities are occurring across the region with differing levels of success.

A wide range of different activities is taking place across the EAC region. Students are learning about HIV and AIDS in the schools of all the EAC countries and complementary approaches to education such as peer counselling are common. All countries are seeking to mitigate the impact of the disease on teachers and children through measures such as VCT, the provision of ARVs and access to psychosocial counselling and material support for children affected by AIDS. Much activity is taking place within the context of wider SHN programming which seeks to address the spectrum of health and nutrition concerns that affect the education sector.

Mathematic modelling data have been used in this report to underline the serious impact that HIV and AIDS is having upon the EACs education sector and in particular its efforts to achieve EFA. For example, HIV and AIDS imposes a large burden (4,200 teacher-years) of absenteeism on education in the EAC that cannot be afforded. This report has found a strong willingness and desire of the EAC and its member states to address the challenges posed by HIV and AIDS. These, and the data collected during the situation analysis has led to the formation of the following recommendations:

9. RECOMMENDATIONS

These are grouped under four core areas:
- Cross-regional coordination,
- Collating and Sharing Good Practices across the EAC Region
- Enabling Region-Wide Advocacy
- Impact/ Monitor & Evaluation, Coordination.

9.1   Cross-Regional Coordination

It is recommended that the EAC Secretariat should formally be commissioned and resourced to build capacity in the education sector prevention and mitigation of HIV and AIDS across the region. It should play a primary role in sharing information and promising practices through inter-country, inter-regional and inter-agency networking and in enabling the evolution of common policies and strategies responding to HIV and AIDS. It can be a key driver in enabling cross-adaptation and complementarity of country responses to HIV and AIDS on education, and joint advocacy by Ministers of Education of the partner states for systematic and harmonised 'spread, depth and speed' of the implementation of the responses.

The EAC contains some, but not all, the countries within the Education Sector HIV Network for Eastern Africa (which comprises Burundi, Ethiopia, Eritrea, Kenya, Madagascar, Malawi, Mozambique, Rwanda, URT, Uganda and Zambia). Rather than seeking to establish the EAC Secretariat as a parallel coordinating body to the network, it is recommended (as has elsewhere been suggested) that the EAC Secretariat offer formally to provide a sustainable 'home' where the mission and vision of the East African Network of the MoE HIV Coordinators can be translated into accelerated responses to the impact of HIV and AIDS on education across the region. This would enable EAC activities to occur constantly in coordination with the wider network but, with the understanding that in some circumstances, particular activities might comprise EAC members only.

If the EAC Secretariat is to undertake such a coordinating role, it is recommended that commitment be made to staffing, resourcing, and training staff within the Secretariat capable of undertaking such a task.

Other related recommendations include, the need for the EAC Secretariat to take stock of the strengths, weakness and critical gaps of the current education sector response in the sub-region and to share these with the partner states. The Secretariat is also called to broaden the coordination, prevention and mitigation of HIV/AIDS in schools.

9.2   Collating and Sharing Good Practices across the EAC Region

The situation analysis has demonstrated a wealth of different education sector HIV and SHN activities taking place throughout the EAC at both regional and national levels. It is recommended that the time is now ripe for the EAC Secretariat, in its capacity as the regional coordinating body, to bring together all the expertise and experience that has been accrued across the region in order better to assist the work of the community's different partner states. Such work can be strengthened by drawing also on lessons learned in other parts of the world such as Western and Southern Africa and the Caribbean. It is recommended that the Secretariat could strengthen and encourage the harmonisation of different activities by bringing together experience and understanding in the following three areas:

1. ***Policy Development:*** A synthesis of good practice found in the policies of the EAC's member states would enable the production of a generic education sector HIV policy for the region. A particular concern would be to demonstrate how education HIV policies can be incorporated into SHN policies, ensuring their greater sustainability. Production of such a synthesis would enable member states to critique and strengthen their existing policies and would also lead to an increasing harmonisation of policy approach across the region and its borders.
2. ***Strategic Planning:*** A similar synthesis of good practice in strategic planning would act to strengthen and harmonise activities in countries across the region.
3. ***Operational Guidelines:*** Data collected during the situation analysis has demonstrated the extensive experience and ingenuity existing in countries that enables implementation of activities to occur. It is recommended that the EAC Secretariat document and enable countries to learn from each others' experience in the following areas:
   - Programme administrative and management issues.
   - Building and maintaining institutional skills and capacity.
   - Identification of human and financial resources.
   - Mainstreaming of HIV activities across education sectors.
   - Implementing gender and workplace policies across the education sector.
   - Care of teachers and children affected by HIV (including orphans and most vulnerable children).
   - Effective collaboration with other sectors/programmes.
   - Provision of education and services to out-of-school youth.
   - Addressing sensitive issues such as the use of condoms and male circumcision.
   - Enabling parents, communities, FBOs, NGOs and civil society to play an appropriate role in deciding, encouraging and supporting the education sector HIV activities.
   - The identification of geographical areas, communities and groups within the EAC region in priority need of education sector HIV and AIDS activities.
   - Position of the life skills subjects in the curricula.

The Secretariat should also:
- formalize the existence of the East African Networks of Focal Points from MoEs within the EAC structures;
- formalize the relationship
- between EAC Secretariat and Teacher Unions within the framework of HIV/AIDS and Education;
- Create a website for sharing information within the sub-region;
- Organize a capacity building meeting regularly
- document and share good practices with the member states

9.3   Enabling Region-Wide Advocacy

It is recommended that the EAC Secretariat play a key role in region-wide advocacy that would address some of the issues that act powerfully to inhibit the work of the education and other sectors to prevent and mitigate the impact of HIV. In particular, greater advocacy is needed to:

- Enhance the impact of activities taking place across the region to address the stigma and discrimination that continues to affect the countries of the EAC.
- Enhance the awareness of teachers and education sector staff irrespective about existing workplace policies and related issues.

- Enable children affected by HIV (including orphans and most vulnerable children) and their carers to know more about their rights and responsibilities
- Encourage greater provision of free, accessible and confidential VCT services, and both first- and second-line ART for teachers and other education sector staff and children who require ART.
- Encourage many more teachers, adolescents and youth to seek HIV testing and encourage enhanced understanding of the need for confidentiality to be upheld for those that make use of testing. In line with this, the EAC should put in place mechanisms that encourage teachers, adolescents and youth to seek HIV testing.
- Promote the development of code of conduct for HIV testing to ensure client confidentiality is upheld.
- Promote the roll-out of PMTCT and pART in order to give children living with HIV the best possible outlook and to reduce the infection rates of children.
- Ecourage EAC countries to prepare for the increased challenges of a growing number of children living with HIV in schools.
- Advocate for formation of psycho-social support networks for the HIV infected and affected within the education sector.
- Advocate for the roll-out of PMTCT and pART in order to give children living with HIV the best possible outlook and to reduce the infection rates of children.
- Encourage EAC countries to put in place mechanisms to meet staffing needs in the face of the challenges of teacher mortality and morbidity.

9.4   Monitoring and Evaluation

- EAC Secretariat to coordinate the evaluation of the impact of activities implemented both at the national and community level.EAC Secretariat to mobilize resources to implement HIV and AIDS activities within the region.EAC Secretariat should advocate for increased HIV and AIDS resource allocation at national level to enhance sustainability.EAC Secretariat should put in place an M&E framework at regional level to respond to HIV/AIDS and Education or customize the existing frameworks.
- EAC Secretariat should encourage partner states to formulate M&E frameworks for HIV/AIDS and Education as well as in School health
- EAC Secretariat should formalize the existence of the East Africa Networks of Focal Points from Ministries of Education within the EAC structures.
- EAC Secretariat to put in place an M&E framework for the implementation modalities, of HIV related education policies, institutional frameworks, and common research needs.

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ANNEXES

ANNEX 1: REGIONAL KEY INFORMANTS, SITUATION ANALYSIS

	Name, title	Organisation	Contacts
1.	Mr. Opiyo, Project Manager, (Coordinator, EAC/AMREF Project)	AMREF	Opiyo.makoude@amref.org
2.	Lucy Ng'ang'a, Executive Director	EANNASO	eannaso@eannaso.org
3.	Joe Muriuki, Programme Coordinator	(NAP+EAR)	Nephak592003@yahoo.co.uk/napear@napafrica.co.ke
4.	Dr. S. Shongwe, Executive Director	ECSA	sshongwe@ecsa.or.tz
5.	Lilian Mwangi	ECSA	L_mwangi@ecsa.or.tz
6.	Helen Lugina	ECSA	helugina@ecsa.or.tz
7.	Peter Munene, Country Director	German Foundation for World Population	
8.	Rosalind Kirika, Senior Programme Associate	Management Sciences for Health/RPM	rkirika@msh-Kenya.org
9.	Delphine Sanglan	EI	Delphine.sanglan@ei-ie.org
10	Arno Willems	Regional AIDS Adviser for Eastern and Southern Africa	a.willems@unesco.org
1	Aster Haregot, Education Manager/UNGEI	UNICEF	aharegot@unicef.org
11	David Alnwick	UNICEF	dalnwick@unicef.org
1	Yumiko Yokozeki, Regional Chief, Basic Education & Gender Equality	UNICEF	yyokozeki@unicef.org
1	Sarah Norton-Staal, Regional Emergency Child Protection Manager	UNICEF	snortonstaal@unicef.org
1	David Delienne, Regional Adviser, Water & Environmental Sanitation	UNICEF	ddelienne@unicef.org
1	Penelope Campbell, Project Officer, Children and AIDS Section	UNICEF	pcampbell@unicef.org
1	Hind Omer, Education Officer	UNICEF	homer@unicef.org
1	Cossa Odete	WHO	cossao@zw.afro.who.int
1	Perpetue Miganda, Principal Gender & Community Development Officer	EAC	miganda@eachq.org
2	Julius Birungi, M&E Officer	EAC	birungi@eachq.org
2	Stanley Sonoiya	EAC	sonoiya@eachq.org
2	Allosius Chebet	EAC	chebet@eachq.org
2	Dr. Nyamajeje Weggoro	EAC	Weggoro@eachq.org
2	Atieno Adenyo	UNAIDS	odenyoa@unaids.org
2	Adam Lagerstedt – Senior Health Specialist	The World Bank	alagerstedt@worldbank.org
2	Stella Manda	The World Bank	smanda@worldbank.org

ANNEX 2: THE HIV AND AIDS CONDITION IN THE EAC PARTNER STATES (25 Years of AIDS Between 1981 to 2005)

In most of the countries in East Africa adult HIV prevalence is either stable or has started to decline. The latter trend is most evident in Kenya, where the HIV epidemic has been declining amid evidence of changing behaviour. Besides behavioural change, mortality of people infected with HIV several years ago has also contributed to the declines in prevalence.

Uganda was the first country in sub-Saharan Africa to register a drop in adult national HIV prevalence. The epidemic, however, remains serious with infection levels highest among women (7.5% compared to 5.0% among men) and urban residents (10% compared to 5.7% among rural residents) according to a national survey conducted in 2004–5 (Ministry of Health Uganda & ORC Macro, 2006). HIV prevalence started to decrease in Uganda in 1992, alongside evidence of substantial behaviour change that inhibited the spread of HIV (Asamoah-Odei, Garcia-Calleja & Boerma, 2004). However, that trend appears to have stabilized in the early 2000s. While the decline in HIV prevalence observed among pregnant women attending antenatal clinics in Kampala and some other urban areas appears to have persisted through 2005, other urban and most rural surveillance sites indicate an overall levelling off of prevalence during the current decade. Similarly, in a cohort study in a rural area in southern Uganda, there is evidence that HIV prevalence and incidence have levelled off since about 2000 in both men and women. It is important to note that with a population growing as rapidly as in Uganda (which has a total fertility rate of 6.7, according to the 2006 Demographic and Health Survey), a stable HIV incidence rate means that an increasing number of people acquire HIV each year. The stable HIV trends are occurring alongside an apparent recent increase in more sexual risky behaviour. In national population-based surveys conducted in 1995, 2000, 2004–5, and 2006, higher risk sex was reported by 12%, 14%, 15% and 16% of adult women respectively, and by 29%, 28%, 37% and 36% of adult men respectively. In the same surveys, condom use during sex with these partners was reported by 20%, 39%, 47% and 35% of women, respectively, and by 35%, 59%, 53% and 57% of men, respectively, indicating a lack of progress in the adoption of safer sexual behaviour in recent years. There is an urgent need to revive and adapt the kind of prevention efforts that helped bring Uganda's HIV epidemic under control in the 1990s.

National HIV prevalence in **Kenya** has decreased from a high of around 14% in the mid-1990s to 5% in 2006 (Ministry of Health Kenya, 2005; National AIDS Control Council Kenya, 2007). The downward trend was especially profound in the urban sites of Busia, Meru, Nakuru and Thika, where median prevalence declined from 28% in 1999 to 9% in 2003 among 15–49-year-old women attending antenatal clinics, and from 29% in 1998 to 9% in 2002 among those aged 15–24 years.

HIV prevalence has declined also in the **United Republic of Tanzania**. The most recent information shows HIV prevalence among antenatal clinic attendees in Zanzibar ranging from 0.7% in Unguja to 1.4% in Pemba, while in mainland Tanzania it was 8.7% among women using antenatal services in 2003–2004, down from 9.6% in 2001–2002. On the mainland, a national population-based HIV survey in 2003–2004 found adult HIV prevalence of 7% in 2003–2004.

In **Burundi**, recent HIV surveillance among women attending antenatal clinics suggests that the declining trend which started in the late 1990s did not continue beyond 2005, when HIV prevalence started to increase again at most surveillance sites.

In **Rwanda**, antenatal clinic surveillance in 2005 showed that 4.1% of pregnant women were HIV positive, with the prevalence highest in Kigali (13%), but on average about 5% in other urban areas and a little over 2% in rural areas. Substantial declines in HIV prevalence were observed in Rwamagana (from 13% to 4% between 1998 and 2005) and in Gikondo in the city of Kigali (14% to 8%) (Ministère de la santé du Rwanda, 2005). The declines in HIV prevalence among pregnant women in urban areas in Rwanda were strongest in the late 1990s and infection levels appeared to have stabilized subsequently.

Source: UNAIDS & WHO (2007) <u>AIDS epidemic update,</u> Geneva, December 2007.

ANNEX 3: PROPOSED STRATEGIC REGIONAL RESPONSES AND GUIDING PRINCIPLES

Areas of focus

I.   Policy development, analysis, implementation and review
II.   Enhanced infrastructure and human capacity at national and regional level
III.   Strengthen coordination mechanism for networking and partnerships at regional, national and sub-national levels
IV.   Efficient resource mobilization, utilization and accountability within the sector-wide framework
V.   Research to inform policy development, formulation, implementation, capacity and other desirable outcomes
VI.   Review, harmonise, operationalise the monitoring and evaluation framework in education
VII.   Harmonize critical interventions (e.g. life skills curriculum, school health and nutrition and institutional framework) in the management of HIV and AIDS in education.

The Guiding Principles

I.   Add value and/or scale up successful initiatives
II. Pursue interventions that provide a comparative advantage
III. Uphold all conventions on Human rights and other HIV and AI-DS related conventions.
IV. Ensure gender mainstreaming in the context of the education sector response to HIV and AIDS.

Source: East African Community. *Meeting of the TWG on Accelerating the Education Sector response to* HIV and AIDS. K14-15 September, 2006.

ANNEX 4: A RANDOMISED CONTROLLED INTERVENTION TRIAL OF MALE CIRCUMCISION FOR REDUCTION OF HIV INFECTION RISK: THE ANRS 1265 TRIAL

A few results from the study: (http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal. pmed.0020298&ct=1)

MC (male circumcision) should be recognised as an important means to reduce the risk of males becoming infected by HIV. MC is useful and feasible even among sexually experienced men living in an area with high HIV prevalence.

Indeed, in our study the intervention delivered by local general practitioners resulted in a limited and reasonable number of adverse events and did not lead to an increase in deaths.

In addition to the protective role in men, MC will indirectly protect women and, therefore, children from HIV infection because if men are less susceptible to HIV acquisition, women will be less exposed.

Moreover, MC may also be protective against male-to-female HIV transmission, but this will require further investigation.

Women's role in promoting MC is potentially important. If women are aware of the protective effect of MC, this awareness could, in turn, have an impact on the prevalence of MC by encouraging males to become circumcised.

The protective effect of MC is high. MC provides a degree of protection against acquiring HIV infection equivalent to what a vaccine of high efficacy would have achieved.

The authors think that MC should be regarded as an important public health intervention for preventing the spread of HIV.

MC could be incorporated rapidly into the national plans of countries where most males are not circumcised and where the spread of HIV is mainly heterosexual. This is even more important at a time when no vaccine or microbicides are currently available and when delivering antiretroviral treatments under WHO guidelines will have only a small impact on the spread of HIV [27].

MC is an inexpensive means of prevention, performed only once, and men can be circumcised over a wide age range, from childhood to adulthood.

The potential impact of prevention programmes based on MC is difficult to assess at population level and requires modelling.

From the results of this study and of the meta-analysis quoted above, it can be predicted that widespread MC could lead to a strong reduction of the spread of HIV.

The availability of a simple and ancient practice with a high potential effect on the spread of HIV is remarkable and should encourage decision makers to take MC into consideration as policy.

Because most of southern and East Africa is concerned, the number of HIV infections that could be avoided by the widespread implementation of MC is high.
(Further details: http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0020298&ct=1

ANNEX 5: EAC PROFILE

The main organs of the EAC are the Summit of Heads of State and Government; the Council of Ministers; the Coordination Committee; Sectoral Committees; the East African Court of Justice, the East African Legislative Assembly; and the Secretariat.

The *Summit* consists of the Heads of State and Government of the partner states. Its function is to give general direction and impetus to the achievement of the objectives of the Community. The Summit meets at least once a year to consider the annual progress reports and such other reports submitted to it by the Council of Ministers. It may also hold extraordinary meetings as necessary.

Figure 1. Basic Structure of the EAC
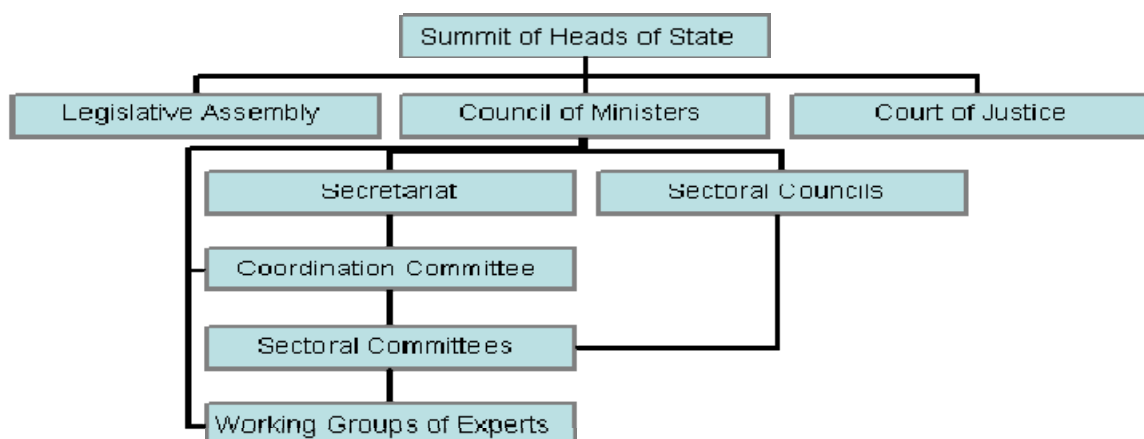
Summit meetings have been held as follows:
- 1st Summit
- 2nd Summit
- 3rd Extra-Ordinary Summit, Dar es Salaam, 30 May 2005
- Summit, Nairobi, 27-29 August 2004
- 5th Summit, Arusha, 2 March 2004
- 6th Summit, Arusha, 26 November 2004
- 7th Summit, Arusha, 5 April 2006
- 8th Summit, Arusha, 30 November 2006
- 9th Summit, Kigali, 26 June 2008

The **Council of Ministers** is the policy organ of the Community. It consists of the ministers responsible for regional cooperation of each partner state and such other ministers of the partner states as each country may determine. Among it functions, the Council promotes, monitors and keeps under constant review the implementation of the programmes of the Community and ensures the proper functioning of the regional organisation. The Council meets in regular session twice a year, one of which is held immediately preceding a meeting of the Summit, and may hold extraordinary meetings as necessary. The Council may establish Sectoral Councils to deal with such matters as arise under the Treaty, and the decisions of such councils will have the same effect as those of the Council of Ministers.

Secretariat

The Secretariat is the executive organ of the Community. It is headed by the Secretary General who is assisted by two Deputy Secretaries General and includes the offices of Counsel to the Community and other officers appointed by the Council. The core budget of the EAC's Secretariat is funded by equal contributions from the partner states. Regional Projects and Programmes are funded through the mobilisation of resources from both within and outside the region.

Autonomous Institutions of the Community are the East African Development Bank, Lake Victoria Fisheries Organisation, Inter-University Council for East Africa, East African Civil Aviation Academy and the East African School of Librarianship. The Council may also establish other institutions.

The Co-ordination Committee consists of the Permanent Secretaries responsible for regional cooperation in each partner state and other Permanent Secretaries of the countries may determine. The Committee reports to the Council of Ministers and co-ordinates the activities of the Sectoral Committees.

Sectoral Committees report to the Coordination Committee. They are established by the Council on the basis of the recommendations of the Coordination Committee that spell out their composition and functions. The Sectoral Committees prepare comprehensive implementation programmes, setting out priorities with respect to the various sectors as well as monitor their implementation.

Information on other EAC, can be found on
http://www.iss.co.za/static/templates/tmpl_html.php?node_id=1410&slink_id=3036&slink_type=12&link_id=3893
- *East African Court of Justice*
- *East African Legislative Assembly*
- *Peace and Security-Related Activities*
- *Protocol on Conflict Prevention, Management and Resolution*

http://www.issafrica.org Date: 19/04/2009

ANNEX 6: DECENTRALISATION RATIONALE

There is an increased call for decentralised HIV responses, for the following key reasons:
1. Decentralisation of the HIV response fits into **wider policy reforms** in many countries aimed at building a stronger health sector and stronger local responsiveness and accountability.
2. National HIV/AIDS responses cannot reach the necessary **scale** through centrally operated programmes. For example, centralised programmes typically do not reach enough people in rural areas.
3. A participatory approach that involves all relevant sectors (i.e. multi-sectoral approach) leads to wider **coverage and ownership of the response** - decentralization thus links with an essential process in scaling up the response to HIV/AIDS: community involvement and community empowerment.
4. Policy-makers and planners need the **input of local people** to understand the particular socio-economic conditions affecting the epidemic locally – there are enormous variations in needs and capabilities across communities, and only local stakeholders will be able to advise on programmes required.
5. **Coordination functions** must be localized in order to be effective in responding to day-to-day

needs arising from community activities.

6. Decentralization brings stakeholders together, which can improve the **flow of information** to support **informed decision making and performance evaluation.**

7. **Accountability** of service providers and contractors to local populations is easier to achieve than with distant centralized agencies.

8. Active engagement of people at the "grassroots" level is a prerequisite for wide-ranging **behavior change** – people have to trust and buy into the thinking behind the need for changing their behavior in order to change.

Source: GAMET, 2007.

ANNEX 7: THE TWELVE COMPONENTS OF AN M&E SYSTEM

Component	Central level	Decentralised government level (e.g. district council or regional council)
1. Organisational structures with M&E	Fulltime M&E unit at the NAC HIV focal persons in government ministries with M&E responsibilities Umbrella organisations have M&E officers, or HIV focal points with M&E responsibilities	Fulltime HIV M&E officers, or fulltime AIDS coordinators at decentralised government offices with HIV M&E responsibilities, or fulltime M&E officers At least one staff member responsible for HIV M&E at every HIV implementer in public sector, private sector and civil society
2. Human capacity for M&E	Capacity of all persons involved in coordinating HIV activities to be built on M&E concepts *and* system specific tasks	Build capacity of all HIV implementers, and all persons involved in coordinating HIV at decentralised level on M&E concepts *and* system specific tasks
3. M&E partnerships	National technical working group on HIV M&E	Decentralised government staff are part of national technical working group, and HIV implementers are represented on the national M&E technical working group Regional AIDS Committees work as partnership forum with general monitoring functions
4. M&E framework	National M&E framework linked to the National HIV Strategic Plan	Decentralised HIV Action Plans (which are based on the national framework) linked to guidelines for routine programme monitoring
5. Costed M&E work plan	National costed HIV M&E work plan, that includes all regional M&E work plan costs	Decentralised costed M&E work plan HIV M&E included as a separate line item in the budgets of HIV implementers
6. Advocacy, communications and culture for HIV M&E	National level advocacy and communication efforts to build M&E culture at national level. Identification of highly placed champions advocating results-based M&E	Decentralised level advocacy and communication efforts to build M&E culture at decentralised levels Identification of champions at sub-national level advocating results-based M&E
7. Routine programme monitoring	National guidelines for routine programme monitoring of HIV services – at health facilities and in the communities	Submission of routine programme monitoring data at the decentralised levels, aggregated, and submitted to the national level
8. Surveys and surveillance	National level surveys	Sample frame to be stratified by decentralised administrative units (e.g. regions, provinces), where possible and if funding allows

9. HIV Information system	National HIV information system to capture data about all 12 components of a functional HIV M&E system	Decentralised data capture system – either paper-based or electronic. Where possible, this should be integrated in the national HIV M&E system.
10. HIV learning & research	National level HIV research strategy and agenda	Inputs from decentralised levels as to specific issues to be added to the national HIV research agenda
11. Supervision & data auditing	National guidelines for supportive supervision and data auditing for 3 types of visits: National HIV M&E unit at NAC to decentralised levels, staff at decentralised levels to HIV implementers and umbrella organisations to HIV implementers	Supportive supervision and data auditing carried out by decentralised staff; reports on supportive supervision visits and data auditing visits sent to national level
12. Data use	Use of data from all levels for national policy formulation and program decision making, as well as to measure overall performance and track progress in achieving desired national goals. Creation and dissemination of national level information products, where possible data in information products should be disaggregated by decentralised administrative units	Use of local level data for program decision making at local level (with consideration of national level data and strategic information) Measure performance and track progress in achieving desired goals at sub-national level Decentralised level information products created at regional level or by national level, and decentralised workshops arranged to disseminate data

Source: M&E Assessments TWG (2007).

ANNEX 8: RECENT RESEARCH STUDIES IN THE EAC PARTNER STATES

Kenyan:
2003 Demographic and Health survey included 15-24 year olds – a target of interest to situation analysis (More details in country report Appendix 5);
2004: Survey on level of HIV/AIDS awareness among teachers by Population Council.
March 2007, TSC commissioned Institute of Policy, Analysis and Research to undertake a pilot study on the prevalence and impact of HIV and AIDS on teachers in Nairobi, Machakos and Siaya districts. Teachers' attitudes and other qualitative areas were measured. HIV testing was excluded. (TSC HIV and AIDS Magazine, 3rd ed., 2008 in country report).2002, A baseline survey on knowledge, attitudes and behaviours among the youth regarding HIV/AIDS and STIs, drugs and substance abuse by Life Skills Promoters

Rwanda: 2002: HIV and AIDS impact survey on the education sector conducted, which showed some school directors suspected some of their teachers might be living with HIV. A fifth of the directors reported that teacher absenteeism was a serious problem in their schools.

Tanzania: The Tanzania Health Indicator Study (THIS 2003-2004),

Zanzibar: A situation analysis of education sector response to HIV (2007)

ANNEX 9: GLOBAL INITIATIVES

Although not specific to the education sector, there are global initiatives that protect the rights of all

children are of relevance to situation analysis.

UNAIDS and UNICEF formulated the Framework for Protection, Care and Support of Orphans and Vulnerable Children Living in World with HIV and AIDS, which supports:
- the mobilization of community-based approaches,
- ensuring that orphans and vulnerable children have access to basic services including education, health care, and birth registration;
- ensuring the Governments protect vulnerable children by improving policies, raising awareness at all levels through advocacy and social mobilization to create a supportive environment for children and families affected by HIV and AIDS.

The *United Nations Convention on the Rights of the Child* is an international human rights treaty with a membership of 191 members (by 1999) that grants all children and young people under the age of 18 years without discrimination 40 substantial rights, among them the right to:
- Special protection measures and assistance
- Access to services such as education and health care
- Develop their personalities, abilities and talents to the fullest potential
- Grow up in an environment of happiness, love and understanding

Be informed about and participate in achieving their rights in an accessible and active manner (AIDS (UNAIDS and UNICEF, 2004, http://www.everychildmatters.gov.uk/uncrc/).

ANNEX 10: MAINSTREAMING OF GENDER AND HIV AND AIDS INTERVENTIONS

In June 2008, the EAC Secretariat convened a regional meeting on the mainstreaming of gender and HIV/AIDS interventions into various regional development sectors and strategies plans (EAC, 2008c). This was the second workshop, an earlier one having been held in August 2007 at the Ngurdoto Mountain Lodge, Arusha, Tanzania, since which a lot has been accomplished nationally in the region, including the national level activities below. **(EAC, 2008c)**

Burundi: integrating **HIV and AIDS** in the 4 main issues of the Poverty Reduction Strategy, developed Strategic National and Sectoral plans on HIV/AIDS, involved the civil society in HIV prevention and support and care interventions, provision of free medical services to HIV positive patients and developing introducing training module on HIV concept in primary schools.

Kenya: Mainstreaming HIV/ AIDS, gender, drugs and substance abuse had been included in each sector's performance contracts; Formulation of the National Policy on Gender and Development, which stressed affirmative action in all spheres of development, providing a reference point for gender mainstreaming; Introduction of heavily subsidized secondary education had enhanced the education of girls and boys and would go along way in addressing the issue of poverty; A requirement that 30% of all recruitments in the public service be women was being implemented; The establishment of the Youth Development Fund; the Government has allocated funds for '*cash transfers to orphans in homesteads in selected districts'.*

Rwanda: Gender and HIV/AIDS are cross-cutting issues in the 12 sectors addressed by the Economic Development and Poverty Reduction Strategy (2008-2012); HIV/AIDS and gender have been integrated in all sectoral log-frames; The Cabinet has approved a Gender Education Policy. A Gender Responsive Budget Initiative has been championed by the Ministry of Finance and Economic Planning. A Women's Guarantee fund in the Bank of Rwanda supported capacity building of women to enable them develop bankable projects. A five year Women Employment Strategic Plan had been developed.

United Republic of Tanzania: Both Gender and HIV were mainstreamed in Tanzania's Strategy for Growth and Reduction of Poverty. A new National Multi-Sectoral Strategic Framework 2008–2012 that integrates gender concerns was launched by the Prime Minister in February 2008 and addresses key thematic areas: prevention, care and treatment, impact mitigation, enabling environment (policies, coordination, research, resources mobilization) and monitoring and evaluation of the national response. The President's Offices Public Service and Management had developed guidelines for the public sector to address HIV/AIDS in the workplace. All Ministries, Departments and Agencies have

been directed to mainstream HIV/AIDS and gender in their budgetary processes and a specific budget code "A" is used to capture HIV/AIDS activities. In addition, regular Public Expenditure Reviews have been instituted for HIV/AIDS to track allocation and usage of resources. The Government of Zanzibar has developed a gender mainstreaming strategy and a gender action plan. The Government of Zanzibar revised the policy for protection and development of women and identified gaps are being addressed through sector strategies and policies. The Ministry of Labour, Youth, Women and Children Development coordinates gender mainstreaming in all sector strategies and policies.

Uganda: Guidelines for mainstreaming gender and HIV and AIDS into planning and budgets had been developed and were in use. HIV workplace policies were developed by different sectors and were in use. The draft mainstreaming policy was complete. Gender disaggregated data was available for four sectors.

During the workshop, some of the regional issues that emerged to scale up mainstreaming of HIV and gender into all sectors included the following regional and national needs:

The need to:
- *Involve senior personnel in gender and* HIV and AIDS *mainstreaming to ensure* effective implementation.
- *institutionalize HIV/AIDS and gender mainstreaming* through planning and budgeting
- *adopt an evidence*-based approach to HIV and AIDS and gender programming interventions
- *build the regional and national capacity in HIV and gender mainstreaming within sectors in the region and to train TOTs*
- *address the widespread misperception that gender addresses only female issues rather than those of both genders.*
- *link HIV and gender mainstreaming* in national and international goals.
- *clarify the coordinating roles of EAC, NACs and sectors in the mainstreaming of gender and* HIV and AIDS
- *develop a regional* legal framework to facilitate attention to HIV/AIDS and gender related issues
- *increase e*fforts to decentralise the mainstreaming of gender and HIV/AIDS planning and budgeting at district and lower levels.
- exchange visits between countries to enhance learning on mainstreaming gender and HIV/AIDS.
- Include M&E activities in the sectoral budgets
- Establish linkages between HIV/AIDS, gender and poverty, and HIV/AIDS and substance abuse

Source: EAC, 2008c.

ANNEX 11: BUDGETARY ALLOCATIONS FOR THE EDUCATION SECTOR'S SHN/HIV PROGRAMMES IN THE EAC PARTNER STATES

KENYA				
Kenya: MoE- AIDS Control Unit Action Plan 2008/2009 year		**Kenya's Education Ministry School Health Budget Allocation (2005-2010)**		
Components	**GOK + Devt. Partners Pooled funds in KSh.**	**Components**	**KES (in millions)**	**US$**
Prevention	(USD869,747) (KES57.9m)	School feeding	8,728.2	131,110,987
Workplace	(US$600,861) (KES40.0m	Health promotion, education and parasite prevention	249.5	3,747,873.7
Response Management	(US$952,3.66) (KES63.4m)	IEC materials, logistics and etc	41.5	623,393.8
Care and support	(US$521,998) (KES347.5m)	School health and feeding capacity building and policy development	59.0	886,270.7
Grand Total	**(US764,295.8) (KES508.8m)**	Monitoring of school health and feeding	10.400.0	156,223,994

		Total School Health	19,478.2	292,592,519

ZANZIBAR				

ZANZIBAR: Education Ministry Budget for SHN & HIV and AIDS (2007-2010) (in TZS) (Exchange Rate: US$1=TZS1,303.9 as per January 1, 2007)		**ZANZIBAR SHN & HIV and AIDS (2007-2010) (Contd.)**	
Proportion of Government total budget (2007)	19%	Remaining response activities (2009/2010)	(US$57 094.3) 74,445,300
Impact mitigation, care, support and M&E	(US$206,488) 269,239,700	Contributions of each department in MoEVT represented in the Technical AIDS Committee (TAC) (at 1 million)	(US$766.9) 1,000,000
Prevention & monitoring	(US$102,160.9) 133,207,700	World Bank Support: a) implementation of HIV and AIDS response activities	**In US$** 80,000,000
Evaluation & enabling environment (focus of 2007–2009)	(US$47,232.7) 61,586,700	b) M&E activities	5,000,000

*** excludes World Bank Support funds, and TAC contributions

UGANDA				

Resource Allocation as in National Strategic Plan 2007/8-2011/12: (Amounts in millions)

Education Sector Spending by Year (UShs millions) (2003-2007)

Components	US$)	Financial Year & %age Education	Total Education UGX	US$
Government of Uganda	299	2003/04 (2.6%)	507.45	291,973.5
PEPFAR	not determined	2004/05 (4.0%)	2,034.65	1,071,167.2
Global Fund – Round 3 Phase II	35.5	2005/06 (1.8%	1,257.64	701,455.7
Global Fund – Round 7 application	204.6	2006/07 (8.2%)	3,213.07	1,745,285
Civil Society Fund (Danida, Irish AID) (DFID – TBD)	29.0			
Partnership Fund (Danida, Irish Aid) (DFID & ACE – TBD)	7.1			
Support to Ministry of Local Government for decentralised coordination (Irish AID)	2.0			
Total	**US$1,934.7**			

TANZANIA MAINLAND		

Budgetary Allocation for the Education Sector HIV and AIDS activities, 2003-2008

Funds Received and Spent		
Financial Year	**TZS**	**US$**
2003/04	118,000,000	109,431.5
2004/05	1,750,000,000	1,535,896.1
2005/06	1,400,000,000	1,223,348.5
2006/07	1,345,000,000	1,031,520.8
2007/08	844,418,000	647,609.5
Total	**5,457,418,000**	**4,547,806.4**

Estimated Budget for All Health Activities in Burundi Schools (2005-2010) (original budget in US$)

	US$		US$
Medical visits and schedules/	150,000	Medical care of students	180,000

First medical check up			living with HIV and AIDS	
Professional orientation	100,000		Coordination of activities for health education at school	20,000
Care of the medical records	85,000		Creation of committees for school health	60,000
Medical follow-up	85,000		Surveys on knowledge and practice of school health education	60,000
Control of vaccines	300,000		School environment management: Construction of school buildings with universal norms.	30,000
Creation of emergency unites at school	500,000			
Feeding programme for nurses working at boarding schools	37,000		Hygiene promotion at school (hygiene of the body and clothes)	45,000
Medical Care and follow-up of handicapped students with chronic diseases	85,000		Recreation places management	30,000
Creation of nutrition programme for students with nutritional problems	150,000		Reinforcement of capacity to lead adequately the medical visits in schools	110,000
Maintenance of hygiene norms in schools	270,000		**Total**	**US$2,295,000**

Source: Situation analysis country reports; Oanda Currency Converter: http://www.oanda.com/converter/classic.

Local Currency/US$ Conversion Rates by Year
(http://www.oanda.com/converter/classic)

	April 2003	**April 2004**	**April 2005**	**April 2006**	**January - April 2007**	**January 2008**
Kenya						KES66.571
Uganda	UGX1,738.0	UGX1899.47;	UGX1,792.9	UGX1,841.0		
United Republic of Tanzania	TZS 1,259.5	TZS 1,139.4	TZS 1,144.4	TZS 1,259.5	TZS.1,303.9 (January 2007)	

Source: (http://www.oanda.com/converter/classic)

ANNEX 12: FOCAL POINT AND NETWORK ROLES AND RESPONSIBILITIES

Terms of Reference

A) Roles of the Focal Points

In most of the Ministries of Education in sub-Saharan Africa, there is a unit that has been created to be responsible for the education sector response to the HIV and AIDS epidemic. In some countries, it is a unit by itself while in others it is part of the school health unit or subsumed by the '*Family Life Health Education*' unit.

In the unit that is responsible for the education sector response to the HIV and AIDS epidemic, there is usually an appointed ministerial staff that is either a full or part time member of staff to coordinate work on HIV and AIDS. This person appointed by the Minister of Education is called a Focal Point person or a coordinator in some countries. Though the situation is gradually improving, the unit has in many countries been the responsibility of a single individual. In any case, the existence of a unit and a Focal Point person within a Ministry of Education is evidence that the Ministry of Education is taking responsibility for the response to the HIV and AIDS epidemic.

After 5 years of the '*Accelerate Initiative*', this is an appropriate time to review the Terms of Reference for the Focal Points. After a discussion with the four Networks of the Ministry of Education Focal Points (i.e. Eastern and Southern Network, Western and Central Africa Networks), the role of the Focal Points can be summarized as follows:

Coordination, planning and management
- Participate in the inter-ministerial HIV and AIDS Committee (taskforce) put in place within the Ministry of Education for the better coordination and implementation of HIV and AIDS activities and programs within the education sector.
- Coordinate HIV and AIDS work between the Ministry of Education, other stakeholders, Teacher Unions and the Ministry of Health by establishing channels of communication with the aim of effective collaboration.
- Work with Teacher Unions and other associations including those for Teachers Living With HIV to identify priority activities, proposals and projects for HIV prevention that can be submitted for funding by either the Ministry or by other stakeholders within the sector.
- Prepare Ministerial sector strategic and action plans with inputs from sub-national levels.
- Identify areas that need technical assistance for a successful response of the education sector to the epidemic.
- Coordinate sub-national responses to the HIV and AIDS epidemic and lead the process of developing indicators for monitoring at the schools level.
- Create/maintain strong partnerships with all stakeholders within the sector.
- Participate in the design and implementation of M&E on HIV and AIDS education activities and interventions in the education sector.
- Serve as the interface between the Ministry of Education and the National AIDS Authority as well as with the national and international stakeholders.
- Facilitate the mainstreaming of HIV and AIDS into the education sector plan and enhance mainstreaming HIV and AIDS in sub-sectors of the Ministry of Education.
- Identify strategies and actions that will enable other stakeholders to integrate HIV and AIDS concerns in their different areas of work.

Mobilizing of resources
- Advocate for funding from both national and international stakeholders.
- Mobilize resources and where possible harmonize donor funding to sector priorities.

Care and support
- Ensure care and support for educators and learners by the Ministry of Education.
- Work with Teacher Unions and other stakeholders to ensure that Voluntary Counseling and Testing (VCT) is readily available and accessible to teachers in both urban and rural areas.

Information and research
- Collect, analyze and disseminate data on HIV and AIDS activities within the education sector to stakeholders on a regular basis, such as bi-annually, quarterly or annually.
- Propose and participate in operational research on the response of the education sector to the HIV and AIDS epidemic.
- Provide information to the public on a regular basis to increase awareness of the impact of HIV and AIDS on supply, demand and quality of education and on what the education sector is doing in response to the impacts identified.
- Establish and maintain up-to-date databases on HIV and AIDS and education (e.g. organizations; inventory of experts involved in HIV and AIDS and education activities in different parts of the country; resource persons; training materials; audiovisuals; and bibliographic references).
- Advocate for the organization of a national workshop to accelerate the education sector response to the HIV and AIDS epidemic, if this has already not been done.
- Develop and share instructive materials with and about experiences of HIV-positive teachers.
- Document and disseminate good practices.

Network

- Develop work plans for the Network.
- Elaborate periodic reports of activities which should be shared with the Network on a bi-annual basis.
- Participate in the management and coordination of the Network.
- Propose and participate in operational research on the response of the education sector to the HIV and AIDS epidemic.

B) Roles of the Network

- Provide a framework through which to share information, experiences and promote good practices.
- Provide technical guidance and progress updates through Focal Points to the Ministers of Education.
- Advocate for a broad-based commitment and support to the education sector response to the HIV and AIDS epidemic at the sub-regional level.
- Provide proposition of guidelines for education sector policy, planning and management of HIV and AIDS with respect to achieving the EFA goals.
- Provide task guidelines on HIV and AIDS Focal Points and to build capacity of the HIV and AIDS Focal Points.
- Monitor the progress of the response in the countries that make up the Network.
- Strengthen communication between member countries of the Network.

ANNEX 13: DEMOGRAPHIC AND HEALTH SURVEYS HIV PREVENTION INDICATORS

EAC partner states Demographic and Health Surveys indicators relevant to HIV prevention for 15-24 year old females and males.

Indicators	Burundi (BDHS, 1987)		Rwanda (DHS, 2005)		Kenya (KDHS 2003)		Tanzania (TDHS, 2004/5)		Ugandan (UDHS, 2000/1)	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Knowledge of a formal source of condom among young people			73	37	76	53	87	77	57	57
Comprehensive knowledge about HIV & AIDS			57	54	47	34	44	47	39	47
Young people who report they could get a condom on their own			0	22	68	30				
Median age at 1st sex	-	20.8	21.3	21.6	17.5	18.1	17.5	17.4	18.3	17.3
Young people having multiple partners in last year			4	1	24	3	33	5	24	3
Young people using a condom at last higher risk sex			39	26	47	25	46	39	62	44
Condom use at first sex			12	7	14	12	20	14		

ANNEX 14: QUESTION GUIDE ANALYSIS

This tool will guide the situation analysis lead consultant in the desk review of relevant situation analysis material. The question guide will also be used to collect information from relevant personnel at EAC Secretariat, the World Bank and from Development Partners, e.g. UNICEF, UNAIDS, UNESCO, among others, that will both verify and validate the data generated from the review of literary material and fill any information arising gaps.

1.   BACKGROUND INFORMATION
      1.1   HIV and Education (No specific questions identified)
      1.2   History of HIV in the EAC region: The epidemic, multisectoral & education sector response

	Questions
1.	When did the multi-sectoral response to HIV in the E. A. region begin and how did it grow: what were its key objectives/ focus areas/ guiding policies (incl. workplace) and strategies/ multisectoral networks and coordinating bodies (if any) over the period?
2.	When did the education sector within the EA region become active in the multisectoral response and how did it grow? What were its focus areas over the period?

3. EDUCATION AND HEALTH SECTOR IN THE COUNTRY/REGION
This section provides a background of the Education Sector (at primary, secondary and tertiary level), and the Health Providers in the Country/Region

5	Are there regional data (by age and gender) for the period 2002-2007, on:
	   a. number of schools in the region,
	   b. enrolments at the various levels (e.g. early childhood development [ECD], primary and secondary schools, post secondary e.g. primary teacher colleges and non-formal education facilities),
	   c. Teachers for these institutions?
	school-age population (from ECD through to teacher training colleges)? What percentage of this is enrolled in school?

6	Who are the main stakeholders involved in SHN/ HIV and AIDS -related activities within the education sector in the region? (**Prompt**: i*nclude such networks as the regional health promoting school network coordinated by W.H.O, and the Accelerate regional network)*

4. HEALTH CONDITIONS AFFECTING THE EDUCATION SECTOR
This section provides background information on the main health conditions affecting school-age children and the education sector as a whole.

	Questions

7	What are the different types of HIV-related health conditions most common in populations of school age children in school and out in the E.A. region?
	To what extent, for example, are the following serious problems in school age children in the region:
	   a. malnutrition,
	   b. HIV and other STIs
	   c. substance abuse,
	   d. mental health problems,
	   e. water borne diseases?, and
	   f. other problems (please specify?)
	What has been the magnitude of these related health conditions since year 2002? Are there data for the period 2002 – 2007 within the education sector on these problems? (**Prompts**: Where available, *request for copies of data lists*)

5. CURRENT EDUCATION SECTOR RESPONSES TO HIV AND AIDS
This section covers issues relating to the four core areas of an effective education sector response to HIV AND AIDS (see the Checklist of Good Practice in essential reading)

5.1   Policies and Strategies that address HIV (including workplace, human rights and ethical issues)

	5.1.1 Education Sector HIV AND AIDS Strategy
7b	What regional strategies exist for the education sector response to HIV

5.1.2   Education Sector Policy for HIV and AIDS

14	What regional policies exist which incorporate HIV and to what extent do they reference the education sector and its role in the fight against HIV?
15	Has EAC Secretariat been involved in the development of the regional HIV policies, for example, in the development of education sector and national policies? **If yes,** what role has the Secretariat played and have all the states benefited from this facilitation? **If no**, what has been the obstacle that prevented the Secretariat from facilitating the development of these policies?

16	Has EAC Secretariat played any role in the:
	    a. harmonization of HIV and AIDS policies in the member states and if so what?
	    b. integration of HIV and AIDS in all policies and programmes of member states, and if so what?
	What challenges, if any, has EAC encountered in this facilitation?

17	To what extent has the EAC region harmonized HIV and AIDS policies that protect HIV-infected and affected teachers and school age children in school and out? **If yes,** are these operational in all the member states? Have there been problems in the implementation of these harmonized policies and if so what and how are the difficulties being addressed?
18	To what extent has gender been mainstreamed into EAC's HIV and AIDS policies and programmes? Has gender been integrated in the monitoring and reporting of the impact HIV and AIDS programmes and **if yes**, to what extent has this been achieved?
19	To what extent are human rights practices (especially in regard to teachers living with HIV and to orphans and vulnerable children) reflected in HIV and AIDS policies and programmes?
20	Is the EAC Secretariat's capacity strong enough to facilitate the integration of HIV and AIDS in the policies and programmes of the partner states? **If yes**, what indicates this capacity? **If no**, what has been lacking and what is needed?

22	**REGIONAL GUIDELINES**
	
	Are there regional guidelines regarding how best to:
	
	    a. Respond to HIV and AIDS under different country circumstances?
	    b. Share proven best practices in national response?

	5.1.3 Workplace HIV policy
30	Are the most vulnerable groups in the education sector in the region (e.g. **infected teachers**, and **disabled members of staff**, able to access treatment? **If yes**, how are these challenges being addressed?

31	What can be done by EAC Secretariat and regionally to ease accessibility of treatment by:
	    a. teachers and,
	    b. personnel in the education sector with disabilities?

32	What **lessons learned** observed in the development and implementation of workplace policies and strategies at:
	    a. EAC Secretariat,
	    b. Member countries' education sector, and
	    c. Regional levels?.

32	What **best practices** have been observed in the development and implementation of workplace policies and strategies at:
	    a. EAC Secretariat,
	    b. Regional levels?

| 32b | Within the EAC region, to what extent have teachers who are infected/affected by HIV been consulted in the development of any policies relating to them? **If yes**, to what extent is this routine?   Is there any evidenced that this is being done? **If no**, is there anything that can be done to facilitate the consultations and if so what? |

5.2 Planning and Management

	5.2.1 Management Structures
33	To what extent has the EAC HIV and AIDS Multi-sectoral task force been established and is it functional? Have the relevant sectors and segments of the regional economies been mobilized to respond to the challenges of HIV and AIDS? (Prompts: ask for specific details) How has the education sector specifically been mobilized? **Govt. Ministries** – Health, Education, Social Services, Gender & Youth;Planning, National AIDS Council & Consortium, & documentation

	5.2.2 Coordination
34	Have the mechanisms for coordinating EAC partners in the area of HIV and AIDS been developed? What is the mechanism for education responses? **If yes**, how strong are these mechanisms? (Prompts: e.g. what is the evidence of this strength?)**If no**, are there plans to develop these mechanisms in the near future? What efforts have been put in place to ensure supremacy of national responses and to avoid duplicity of related interventions?How is the sharing of HIV and AIDS research and information coordinated?
34b	Has EAC Secretariat designed dialogue mechanisms for these partnerships? **If yes**, how effective the mechanisms been so far?**If no**, what has hindered their involvement?
34c	To what extent is there cooperation and collaboration in the region between strategic stakeholders, e.g. Ministries of Education and Health and other relevant ministries, National AIDS Councils and Committees?
	5.2.3 Capacity and resources
35	What role/s has EAC played in building the capacity of member countries' policy makers and senior officials in mainstreaming HIV and AIDS specifically in the education sector?
36	Have the following been trained in mainstreaming processes and procedures? key EAC Secretariat staff a. personnel in the education section? What percentages of these personnel have received the training? Are there plans to train other staff members?
37	What efforts are in place to harness regional and externalHuman resources? Financial resources for an effective response to HIV & AIDS? To what extent is the education sector included in this response?
38	Have the short term technical assistance /technical staff been hired to support institutional (EAC Secretariat) capacity building? **If not**, are there plans to hire these people?
38b	Does EAC Secretariat have any long term financing capacity for the implementation of EAC HIV/AIDS Strategic Plan? Are there resources allocated to the Education sector EAC HIV strategic plan? **If yes**, what are they?**If yes**, how sustainable are these resources?
	5.2.4 Decentralization
38c	To what extent have HIV-related activities in the education sector been decentralised within the region?
39	What is the coverage of HIV Focal Points at regional level?What are the budgets, funds received, and expenditure (by funding source) for the period 2002-2007 for the education sector response within the region's sub-sectors? What responses through education are recommended? Have any guidelines been developed for the mainstreaming of HIV and AIDS in all EAC sectors and institutions? **If yes:**Are there such guidelines for the education sector?Have related work plans been drawn?

40	Which of the following have been harmonized: Legislation on sexual and gender based violence, early marriage, age of sexual consent and deliberate infections? Workplace policies for the various sectors in EAC? Training guidelines for HIV & AIDS related service provision?. Are there regional guidelines on universal access to:
	  i) prevention,
	  ii) treatment,
	  iii) care and support targeting children and youth?

5.3 Prevention

Skills-Based Health Education (incl. curriculum coverage of HIV prevention & teacher training)

	Questions
48	At what education levels (e.g. ECD through to vocational and non-formal institutions) is life skills-based HIV education provided? To what extent are there significant differences in the way this is done (e.g. peer education, class-room education, other) in EAC member states?**If yes**, what are these differences? Implementation Nothing at regional
	5.3.1 Curriculum
49	Do the member states have skills based health education curriculum for children in school and for non formal establishments? **If yes**, to what extent have EAC member states worked together in the development of this curriculum and was EAC also involved?
51	What main HIV and other health issues are incorporated in the curriculum for the various education levels (ECD trough to teacher training colleges) in the EAC region? To what extent is the HIV and AIDS curriculum grade/age specific, culturally sensitive? Does it address gender issues and the needs of orphans and vulnerable children? Are there country differences in the following; Participatory development of the curriculum development (involving stakeholders e.g. parents and students);School levels covered by the teaching of HIV and AIDS -related curriculum content; How comprehensively is HIV curriculum integrated within a holistic package of health and nutrition in education sector in the region? Is what has been/is being done adequate or is there need for improvement? What else needs to be done at regional and country levels/ To what extent does this curriculum deal with ways of controlling stigma against orphans and vulnerable children and persons living with and/or affected by HIV?
	5.3.2 Teacher training
52	What measures have been taken within the region and at country levels to strengthen the pre-service/in-service training of teachers (e.g. in training, materials, and messages) to help teachers protect themselves against HIV? Does pre- & in-service curriculum for teachers, in the various member states, address how stigma against HIV-infected and affected persons should be countered at all levels of the education sector? Is what has been done adequate or is there need for improvement and if so what?
	5.3.3 Complementary approaches

	Does the education sector contribute to the following complementary approaches to life-skills education:
	  a. Peer education
	  b. Community IEC
	  c. NGO, FBO and CBO prevention and mitigation programmes
	  d. Assistance to MoH in the promotion of youth-friendly clinics for VCT, the treatment of STIs and condom distribution

5.4 Children affected by AIDS and Teachers infected/affected by HIV

	Questions

	a. What interventions are in place in the regional education sector for:
	  i) Orphans and other most vulnerable children in school and out of school;
	  ii) Teachers infected and/or affected by HIV?
	
	 How are these populations protected against stigma?

	b. What specific benefits have the orphans and vulnerable children accrued from these interventions? (Please provide details) c. Are these interventions sensitive to gender issues (e.g. the needs of the needs of the girl- or boy-child) and **if yes** how? d. To what extent do orphans and vulnerable children who are not in school benefit from these interventions? d. **If not at all**, do the interventions target them (out-of-school HIV infected/affected orphans and vulnerable children) and if yes, how are these children reached? If not, what are the difficulties in targeting these children? What can be done to provide these out of school with the required assistance? What lessons have been learned and best practices observed from the above interventions?
	Are there any interventions in place that are targeting specifically: a. Teachers infected and affected by HIV?b. Orphans infected and affected by HIV?c. Youth who are out of schools? To what extent are gender issues integrated in these interventions? What exactly are these interventions (e.g. HIV-related education, provision of ARVs, time off during illness, among others)? What specific benefits are accrued by the teachers and orphans and vulnerable children from these interventions? (Please provide details) Are there teachers living with HIV who are not beneficiaries of the interventions and if so why? Are there challenges in the implementation of these interventions and if so what? What should be done to improve these interventions?

	Are teachers living with HIV actively involved in the response within the education sector in the EAC region at the various levels –
	   a. School level
	   b. Sub-national and national, as well as
	   c. Regional levels?
	If yes, how are they actively involved (e.g., education, life skills education and counseling, others) and in which members states is this being done?