

Suggested Input to 2010 GMR from UNAIDS IATT on Education

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Introduction

Background

The UNAIDS Inter-Agency Task Team (IATT) on Education, convened by UNESCO, was established in 2002, with the aim of improving and accelerating the education response to HIV and AIDS. Its specific objectives are to promote and support good practices in the education sector related to HIV and AIDS and to encourage alignment and harmonisation within and across agencies to support global and country-level actions. The IATT membership includes UNAIDS Cosponsors, bilateral and private donors, and civil society organisations.

In May 2006, a working group of the UNAIDS Inter-Agency Task Team (IATT) on Education was formed to support the mainstreaming of HIV and AIDS in the GMR. Since the establishment of the Working Group, the IATT Secretariat, housed in UNESCO's Section for HIV and AIDS in the Division for the Coordination of UN Priorities in Education, has acted as the liaison between the IATT and the GMR.

For the 2008 and 2009 reports, the IATT has suggested figures, country and programme examples, and relevant references for different sections of the reports. The inclusion of related items in both reports demonstrates the fruit of this effort and the interest on both sides in supporting this collaboration.

Identified Areas of Input

The theme of the 2010 GMR on *Reaching and Teaching the Most Marginalized* has particular relevance for the IATT on Education as marginalization is a cause of HIV risk and vulnerability, and often a consequence of being HIV-positive.

Children affected by AIDS can face particular challenges in accessing educational opportunities, ensuring regular school attendance, and continuing their studies. Teachers are given an important responsibility in ensuring that children and young people acquire essential knowledge, skills and attitudes for HIV prevention. Moreover, in higher prevalence settings teachers are seen as pivotal in ensuring that pupils affected and infected as a result of the epidemic have access to care and support.

In a meeting with members of the GMR Team in February 2009, the following areas of input were suggested:

- Children affected and infected by HIV and AIDS as a significant group of the most marginalized (Case studies for making this case, and documentation of good practice to respond to their needs)
- Examination of the education policy, teaching and learning processes and curricula – their marginalizing and de-marginalizing impact on learners in a world with HIV and AIDS
- Estimating the teaching needs, costing the efforts to reach the most marginalized, due to HIV and AIDS
- Teachers as 'learners' i.e. how training programmes are or are not preparing teachers to teach the most marginalized (specific interest expressed by the GMR team in counseling/psychosocial aspects)
- Schools as centres for care and support for those marginalized by HIV and AIDS – service provision and referral
- Cases and information from outside East and South Africa, preferably from East and South East Asia, are also welcome as well as those from developed countries

This document responds to these suggested areas of input, and includes:

- A synthesis of related evidence and programmatic experience
- Suggested figures and tables
- Case studies from different regions and on different thematic areas
- A full reference list for further consultation

Overview of the Input

Children orphaned and made vulnerable by HIV and AIDS are extensively documented and recognized as marginalized. The majority of studies examining school attendance and progression have addressed children that are orphaned by HIV and AIDS, as compared to other children affected by AIDS (see box, right). However, the evidence on the impact of HIV-related orphanhood on rates of schooling is conflicting, with some indication that effects may be specific to context and findings subject to methodological variations.

There are very few studies addressing the educational needs of HIV-positive children, despite evidence that children with HIV can face health problems that can affect school entry and progression.

Some experts have suggested that eventual educational attainment is a more useful measure for HIV's impact on children than school attendance but there are limited studies addressing this measurement.

There is a growing call to move away from targeting children orphaned by AIDS as there is a body of literature demonstrating that doing so can spur resentment among equally poor and needy households; can intensify stigma and discrimination; and may create perverse incentives that undermine programme effectiveness. The Joint Learning Initiative on Children and HIV and AIDS suggests recommended reaching children and families affected by HIV and AIDS by using extreme poverty as the primary inclusion criterion, noting that in high-burden settings this form of targeting has been found to be AIDS-sensitive and can be even more so by connecting a poverty measure with at least one other criterion, such as the household dependency ratio or the degree to which households are labour-constrained.

A number of studies included in this analysis highlight HIV-related stigma and discrimination as a factor deterring parents' enrolment of their children in school or in removing them from their studies. Qualitative studies also highlight the inadequate support provided through teacher training programmes or other efforts to empower teachers to support HIV-positive learners and to address stigma and discrimination in the school setting.

The evidence of school-based support for vulnerable children in East and Southern Africa, including psychosocial support, links to child and welfare services, health interventions and HIV prevention efforts. Many of these interventions are relatively recent, with limited evaluations on the process and medium to long-term outcomes.

Of interventions to reach children affected by AIDS, a great amount of attention has been paid to conditional cash transfers. Along the lines highlighted above, experts have been calling for countries to adopt national social policies that are AIDS-sensitive, not AIDS-targeted. In the

Children affected by AIDS are those children under 18 with additional vulnerabilities and disadvantages due to HIV and AIDS, including:

- Having parents who are HIV infected or suffering from AIDS.
- Leading or living in child-headed households.
- Living in families that are caring for orphans or other additional family members due to AIDS.
- Living in communities severely devastated by HIV and AIDS.
- Being orphaned due to AIDS (maternal, paternal or both).
- Living with HIV since birth.
- Having been newly infected with HIV.
- Being especially vulnerable and at risk of HIV infection due to lack of economic or gendered power in the face of the epidemic.

Source: UNAIDS IATT on Education. 2008. *Toolkit for Mainstreaming HIV in the Education Sector: Guidelines for Development Cooperation Agencies*. Paris, UNESCO.

area of cash transfers, this would mean that HIV status would not be a criterion for eligibility, due to the possibility of stigmatizing recipient households.

Some efforts have been made to determine the impact of HIV on teachers and the related impact on education systems' ability to deliver EFA. Recent evidence suggests that: the impact of HIV on teachers varies significantly by gender and by school level they teach; it is dangerous to make generalizations about the teaching profession given that teachers' vulnerability to HIV infection is not well-researched and evidenced across country contexts.

While there is some documentation of workplace policy and training support for teachers infected and affected by HIV and AIDS, school-based HIV and AIDS programmes are predominantly focused on learners as opposed to teachers or other education staff. Available research suggests that, in general, teachers are not sufficiently empowered to address the HIV-related vulnerability and impact present in the school setting.

There is evidence that the expansion of antiretroviral therapy (ART) has contributed to extending and improving the quality of lives of teachers, but that coverage remains limited and scale-up is still required.

Some analyses have suggested that this intervention can help mitigate shortages in teaching personnel in resource-poor settings particularly affected by the AIDS epidemic.

Analyses of the cost of reaching children and teachers affected by HIV and AIDS are limited. Studies provided in this document address cash transfers, subsidies for school and nutrition supplements, and the anticipated impact of the AIDS epidemic on the education system overall. This is an area that requires more research.

1. Marginalization – Children affected by HIV and AIDS as a group of marginalized learners

1.1. HIV impact and scale of the problem

- In 2007, there were 2 million children under 15 years of age living with HIV – 8 times more than in 1990. 370,000 children under 15 years were newly infected with HIV in 2007, representing 17% of new infections (UNAIDS 2008). Sub-Saharan Africa remains the most affected region, with almost 90% of the world's children with HIV living in this region alone.
- Almost two-thirds of all young people (aged 15-24) with HIV live in sub-Saharan Africa. In this region, approximately 75% of new infections among young people are among young women. In southern Africa the gender disparities in HIV infection are particularly striking – in Malawi, South Africa, Swaziland and Zimbabwe; HIV prevalence in young men aged 15-24 was 2%, 4%, 4%, and 6% respectively, among young women of the same age, the prevalence was 9%, 17%, 22% and 11% (Stirling et al, 2008; see also graph from Piot, Mboup and Bekele, 2008 – slide 4). In some populations in sub-Saharan Africa, a fifth of girls under 18 years of age are infected with HIV.
- In 2007, nearly 12 million children under age 18 in sub-Saharan Africa were estimated to have lost one or both parents to HIV, representing about 37% of parental loss from all causes (UNAIDS and WHO 2008; Richter 2008). Zimbabwe reports that 24% of its children (aged 0–17) have lost one or both parents to HIV (UNAIDS 2008). If the current inadequate pace of scale-up of access to antiretroviral therapy (ART) continues, the number of children under age 18 orphaned as a result of HIV is expected to grow to more than 14 million by 2015. Achieving universal treatment access by 2010, however, would reduce the number of orphans in 2015 by more than five million (UNAIDS & WHO, 2008).
- Most children orphaned by AIDS live with their extended families, usually grandparents, and most often grandmothers. An analysis of data from Demographic and Health Surveys (DHS) in Burkina Faso, Cameroon, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Nigeria and Uganda found over 85% of orphans not living with the surviving parent were living with extended family. In addition, grandparents are more likely to be caretakers in high prevalence countries (in more than 50% of cases), whereas in low prevalence countries grandparents were identified as caretakers in 20-40% of cases (UNICEF, UNAIDS, PEPFAR, 2006; see also Monasch and Boerma, 2004). In South Africa, Ardington (2008) found that orphans are still absorbed into extended families but single orphans are increasingly less likely to live with the surviving parent and there is an increasing reliance on grandparents as caregivers. In Thailand, grandparents were found to be the main caretakers for 55% of all orphans due to AIDS and 67% of double orphans due to AIDS, although siblings, especially sisters, also become caretakers for their HIV-infected brothers and sisters, as well as for their children (Knodel and Saengthienchai, 2005). A recent study (Hosegood et al, 2007) in Malawi, South Africa and the United Republic of Tanzania found that all but a small minority of orphaned children are being integrated into kinship, community and other support networks. There was no evidence of an increase in child-headed households in these countries.
- There is evidence that fostered children may experience discrimination and abuse in non-kin households. The forms and level of discrimination and abuse vary and include sexual abuse of the orphans by stepfathers, relatives, and neighbours or reduced

educational opportunities (Borthwick, 2004; Case et al, 2004). Children in informal foster care arrangements may also face challenges in legal protection in cases where a legal guardian is not designated, thereby denying them the full legal protection of their rights (Subbarao and Coury, 2004).

- A South African study concluded that the probability of school enrollment is inversely proportional to the degree of relatedness of the child to the household head (Case et al, 2004). In Ghana and Niger, orphans living in a household headed by a non-relative were four times less likely to be enrolled in school than those living in a household headed by a relative, and orphans living with grandparents had no difference in enrollment than compared to non-orphans. In Niger, the magnitude differed but the trend was the same – the stronger the family relation, the more likelihood of being enrolled (Case et al, 2004, cited in The Quality Assurance Project/USAID Health Care Improvement Project and UNICEF, 2008).

1.2. Overlapping marginalization – links between poverty and HIV

- While poor individuals and households are not necessarily more likely to become infected with HIV (Gillespie et al, 2007; Shelton, Cassell, Adetunji, 2005; Dinkelman, Lam and Leibbrandt, 2007; Mishra et al, 2007a), the impact of HIV and AIDS is often magnified in conditions of poverty. For example, the financial burden associated with HIV for the poorest households in India represents 82% of annual income, while the comparable burden for the wealthiest families is slightly more than 20% (Asia Development Bank and UNAIDS, 2004 as cited in UNAIDS, 2008). Deepening poverty has been found to reduce children's access to food, particularly in families that have taken in orphans (Gillespie, 2008; Oleke, Blystad, Fylkesnes, Tumwine, 2007).
- HIV can impact the income composition of affected households. In South Africa, for example, a recent study found that affected households were more dependent on non-employment sources of income (consisting primarily of government grants) and a lower proportion of their income was derived from employment than non-affected households. Affected households face higher dependency ratios, are more subject to morbidity and mortality and face higher unemployment levels (Gow and Desmond, 2007).
- HIV-affected households face increased expenditures, especially for health. In Cambodia (Alkenbrack et al, 2004), health spending was a significantly higher (22%) percentage of household expenditures in 500 HIV-affected households than in the 500 unaffected households in the study (8%). Sixty-three percent of affected families said they spent less on children's needs in order to pay for health care or purchased less food to pay for health care (69%) as compared to unaffected families, 44% and 53%, respectively.
- In South Africa, where affected households are generally larger than non-affected ones, the decline in adult equivalent income is often 40-50% more than non-affected households. While there is evidence that affected families manage to reduce the income gap in the two years after the head of household's death, the impoverishment effect lasts several years (Barnett and Whiteside, 2007).
- In communities highly affected by HIV, many children live in households in which their own parents have fostered or are fostering orphans. In a study in Buganda, southern Uganda in 2000 (Monk 2000), 152 households were interviewed, containing 342 non-orphaned children and 383 orphans. In the majority of cases, households reported no distinction between levels of care given to orphans or to the guardian's own biological children. Researchers posited that all children in the household suffer the same

economic and other deprivations resulting from spreading resources more thinly as a 'coping' response to the epidemic (Barnett and Whiteside, 2007). Parikh et al (2007) also found no statistically significant differences in most education, health and labour outcomes between orphans and the non-orphans with whom they live (cohort of 197 recent orphans and 528 non-orphans aged 9-16 years) in KwaZulu Natal, South Africa.

1.3. Special needs of HIV-positive children

- Like other children with chronic diseases and disabilities, children with HIV face health problems which can affect school entry and progression. However, HIV-positive children are subject to different classes of special needs:
 - The infection can inflict neurological damage (Anand 2006; Blanchette et al, 2002; Wolters and Brouwers, 2005) leading to delays in development, loss of acquired motor, speech, adaptive and social skills and decreased interactions with the surrounding environment. There is evidence that early initiation of anti-retroviral therapy can assist in avoiding or limiting some of this damage (Coplan et al, 1998).
 - Children with symptomatic HIV disease may suffer from associated morbidities such as respiratory infections, malnutrition and diarrhoeal disease in greater frequency and severity. In Kenya, children of HIV-infected parents were likely to be underweight and wasted and less likely to receive medical care for acute respiratory infections (ARI) and diarrhoea (Mishra et al; 2007b).
 - They are often facing significant psychosocial health stresses in their environment with the likelihood of bereavement, poverty, and changes in caregivers (Cluver, Operario, Gardner, 2008; Cluver, Gardner, Operario, 2007; Cluver and Gardner 2007; Watts et al, 2008; Zhao et al, 2007; Atwine, Cantor-Graae, Bajunirwe, 2005; Ainsworth and Semali, 2000; Coombe, 2007).
 - The family stresses and pressures are complicated for the HIV-positive children by the fact that they have to cope with their own illness as well (UNESCO and ESART, forthcoming 2009.) This is particularly true for children who need to manage their medical needs, including for antiretroviral therapy (ART), and who wish to protect confidentiality about their HIV status in the school setting (Conway, 2005; Cooper, Risley, Drake, Bundy, 2007).

1.4. Educational status of children affected by AIDS

- There is conflicting evidence on the impact of HIV-related orphanhood on school attendance rates. In 56 countries where recent household survey data are available, orphans who had lost both parents were, on average, 12% less likely to attend school than non-orphans. In countries with HIV prevalence greater than 5%, orphans were only 4% less likely to be in school than non-orphans, suggesting that heavily affected countries are closing some of the educational disparities seen earlier in the epidemic (UNAIDS, 2008). A report using data collected in recent nationally representative Demographic and Health Surveys (DHS) and AIDS Indicator Surveys (AIS) in Cameroon, Côte d'Ivoire, Kenya, Lesotho, Malawi, Tanzania, Uganda, and Zimbabwe found that, in all countries, OVC were less likely to attend school than non-OVC when they reached adolescence; however they were as or more likely than non-OVC to attend school earlier on, between age 5 and 14 (see figure 3a, page 37, Mishra and Bignami-van Assche, 2008). In this analysis, OVC in countries with relatively lower levels of HIV prevalence were found to be more likely to attend school than children living with both parents who are not infected with HIV; however, in higher HIV prevalence countries, there was little or no difference in school rates between OVC

and non-OVC children. Figure 3b (page 37) in this report, however, shows that adolescent orphans and vulnerable children are considerably less likely to attend school in all countries (also found in IFPRI, 2007 for Malawi). Across the 7 countries with available data, the gap in school attendance between OVC and non-OVC aged 5-17 was greatest in Tanzania (by almost 12%) (see Table 17a, page 35). In all countries apart from Cote d'Ivoire, the proportion of children aged 5-17 attending school was lowest among orphans, followed by children in households affected by chronic illness.

- Among countries with available data, school attendance by orphans was consistently higher in 2007 than in 2005 in high-prevalence countries, except in Cameroon and Zimbabwe (see Figure 6.3 in UNAIDS 2008 report – from UNGASS country progress reports). In a number of these countries, including Côte d'Ivoire, Gabon, the United Republic of Tanzania and Zambia, school attendance rates are higher among orphans than among non-orphans. UNICEF's Global Coordinator for HIV and AIDS noted in a recent presentation to other Cosponsor Global Coordinators and Focal Points that there are numerous pressures and incentives facing orphan caregivers to incite school attendance, which may lead to increased school attendance among this group.¹
- See Case No. 1 (Kenya) in Annex 2: In this case study, orphans are more likely to lose out on education than other children, especially female orphans.
- Some experts have suggested that eventual educational attainment is a more useful measure for HIV's impact on children than school attendance. In Uganda and Zambia, for example, while educational attainment progressively rose for five-year birth cohorts until 1977, educational levels began falling as the epidemic began reducing life expectancy (Birdsall and Hamoudi, 2004). As a result of the epidemic, children as a whole are becoming less educated in the most heavily affected countries, which may diminish national capacity in the long-run for future growth, prosperity, and development (Birdsall and Hamoudi, 2004).
- There is evidence that asset ownership, wealth status, education levels are more important in determining school attendance than orphanhood itself (Ainsworth and Filmer, 2002; Campbell et al, 2008)
- In some longitudinal studies, orphaned children in Africa have been shown to suffer setbacks in their schooling in the years after they lose their parents (Evans and Miguel, 2005; Yamano and Jayne, 2005; Case and Ardington, 2005; Evans and Miguel, 2007) and a smaller drop before the death (Evans and Miguel, 2007) likely due to pre-death morbidity, although the severity of these schooling impacts does vary substantially across low-income countries and might be dwarfed by impacts associated with household wealth (Ainsworth and Semali, 2006). Evans and Miguel (2007) also found that effects were largest among those with low baseline academic performance.
- There is some evidence that maternal orphanhood has a larger negative impact on schooling outcomes of children than paternal orphanhood (Case and Ardington, 2006; Case et al, 2004; IFPRI, 2007; Parikh et al, 2007; Nyamukapa and Gregson, 2005; Bicego, Rutstein, Johnson; 2003; Evans and Miguel 2007). However, a recent study in South Africa found no evidence that maternal orphanhood or living apart from their mother adversely affected children's schooling, cautioning against this generalisation (Timaues and Boler, 2007)
- Children with HIV may have to repeat grades due to frequent absences. In a study in Senegal, for example, many of the children with HIV were still at primary level even

¹ Note: Presentation can be requested and made available to GMR Team.

though most of them were over the age of 12 (Niang and Van Ufford, 2007; see also Ndaruhuse et al, 2008).

- In a review of the educational challenges facing children affected by HIV and AIDS in low prevalence and concentrated epidemic countries, The Quality Assurance Project, USAID Health Care Improvement Project and UNICEF (2008) noted the following:
 - **Findings with strong evidence:** In Asia, younger children living in HIV- and AIDS-affected households are not generally less likely to be enrolled in school. However, older children affected by HIV and AIDS appear less likely to be enrolled and attend school than their unaffected counterparts.
 - **Recurrent themes for which the evidence is moderate:** The role of orphanhood on enrollment is mixed and not clear cut; household structure and relationships affect the probability of orphans attending school; children and their families fear discrimination from the school administration, teachers, peers, and the community; children affected by HIV and AIDS drop out of school because of economic factors, but not necessarily because of the cost of school.
 - No strong evidence is available on impact of education interventions on OVC. Moderate evidence suggests that financial subsidies might help increase enrollment of vulnerable children in some countries.
 - Two trends from the research emerge: (1) children affected by HIV in low prevalence countries are at increased risk of not completing school to take care of a member of the affected household or to supplement the income. Increased responsibilities for the affected household seem to be a major barrier for affected children to complete their education. (2) Stigma and discrimination, real or perceived, have been reported by many studies as being a factor deterring parents to enroll their children in school.

Evidence cited on education and children affected by HIV and AIDS in low and concentrated epidemics (n=26), see full report for details of the studies

Authors	Rigor	Type (Location)
Ainsworth & Filmer 2002	Good	Controlled, cross-sectional quantitative (worldwide)
Ainsworth & Filmer 2006	Good	Controlled, cross-sectional quantitative (worldwide)
Alkenbrack et al. 2004	Good	Cross-sectional with controls (Cambodia)
Amolo et al. 2003	Fair	Descriptive qualitative (Nigeria)
Borthwick 2004	Poor	Literature review (Southeast Asia)
Case et al. 2004	Good	Controlled, cross-sectional quantitative (Africa)
Dekens & Charruau 2003	Fair	Descriptive qualitative (DR Congo)
GCE 2004	Fair	Literature review (worldwide)
GECA et al. 2005	Fair	Controlled, cross-sectional quantitative (Benin)
Gregson et al. 2001	Good	Descriptive qualitative analysis (sub-Saharan Africa)
HRW 2005	Good	Descriptive qualitative interviews (Russia)
Jianhua et al. 2006	Fair	Controlled, cross-sectional quantitative (China)
Kelly 2006	Fair	Qualitative analysis (worldwide)
Loudon et al. 2007	Good	Qualitative study (India)
New ERA Team 2006	Fair	Descriptive qualitative interviews (Nepal)
Pradhan & Sundar 2006	Good	Controlled, cross-sectional quantitative (India)
Safman 2004	Good	Descriptive qualitative (Thailand)
SCF/UK 2006d	Fair	Descriptive quantitative/qualitative (Thailand)
SCF/UK 2006 ^e	Fair	Descriptive quantitative/ qualitative (Asia)
UNICEF 2002	Good	Descriptive qualitative (Nepal)
UNICEF & SCF 2007	Good	Controlled, cross-sectional quantitative (PR Lao)
USAID-AED 2004	Fair	Literature review (Africa)
Vandemoortele & Delamonica 2000	Good	Descriptive (worldwide)

Webb 2004	Good	Qualitative study, literature review (worldwide)
WHO & UNAIDS 2000	Fair	Descriptive quantitative (worldwide)
World Bank 2002	Fair	Descriptive qualitative (worldwide)

- Beegle et al (2007) reported that orphanhood matters for health and education outcomes. In a region of northwestern Tanzania, maternal orphanhood had a permanent adverse impact of 2 cm of final height attainment and one year of educational attainment.
- Yamano (2006) examined the education attainment of former orphans, who had lost at least one parent before reaching 15, using data from a survey of 889 households in Kenya in 2004. The main findings are: Among individuals who started schooling before the Free Education Program was introduced in 1974, there is about a one year lower educational attainment among former maternal orphans compared with former non-orphans. No similar difference is found in education attainment among the younger cohorts, who started schooling after 1974. Even the Cost-Sharing Scheme introduced in 1988 did not seem to lower the educational attainment of former orphans.

2. How the learning environment/educational policies/programmes can contribute to the marginalization of children affected by AIDS

2.1. Stigma and discrimination

Stigma and discrimination, real or perceived, have been reported by many studies as being a factor deterring parents to enroll their children in school or in removing them from their studies.

- A large qualitative study in India (Loudon et al, 2007) of children affected by HIV (with an HIV-positive parent or orphaned by AIDS) reported that stigma was one of the major reasons for dropping out of school. In focus groups of 281 pre-adolescents (aged 9–12), 295 adolescents (1–17), 487 care givers, and 441 heads of households, children reported that ostracism and humiliation by their peers were their major concerns. Young children reported losing interest in their studies, becoming depressed, and dropping out of school because of taunts by peers. The adult caregivers all reported that stigma and discrimination by teachers was the major educational barrier. Some caregivers reported that children with HIV-positive parents had been refused school admission. Moreover, the study reported key informant interviews with more than 300 service providers where 43% reported being aware of the exclusion of HIV-affected children for services related to well-being, 29% were aware of exclusion related to education, and 41% were aware of exclusion within the health sector.
- In a study examining the educational needs of HIV-positive learners, every HIV-positive child interviewed in Namibia and Tanzania cited personal and continuing experience of the negative consequence of disclosure, and emphasised greater safety in silence (UNESCO and ESART, 2008). For example, a girl in Dar es Salaam said: *“At home my mother and myself have tested and been found positive. She has told me not even to tell my relatives, not even my own sister because she is afraid I will be stigmatised.”* (UNESCO and ESART, 2009c forthcoming). A nine-year old Namibia boy living with HIV said *“My friends will just laugh at me and leave me out the group if I tell that I am HIV-positive. Then who will my friends be?”* (UNESCO and ESART, 2008). Confidentiality remains a concern, as expressed by this 16-year old positive learner, *“I told my teacher I needed to go to the ARV clinic and she told the other teachers and children that I was HIV-positive.”* HIV-positive learner, 16-year-old boy (UNESCO and ESART, 2009b forthcoming).
- In Malawi, as a result of stigma and social exclusion, children were found to tend to form their own informal peer groups (IFPRI, 2007).
- In a study in Senegal, children with HIV may face problems of integration and, although no systematic discrimination was observed in schools, they were more likely to attend Koranic schools (Niang and Van Ufford, 2007)
- Anecdotal evidence from a case study in Haiti suggests that schools do not welcome children who are perceived to be HIV-positive (Loudon, 2006). The same was reported in Indonesia where a local district education officer admitted that the school’s regulation was to expel any HIV-infected child (SCF/UK, 2006a). In Thailand, a qualitative descriptive study using interactive activities (111 children) and in-depth interviews of 25 children found that those with HIV were denied admission to school. Although Thai law ensured access, educators expressed fears regarding the reactions of other (unaffected) parents to having HIV-positive students enrolled (SCF/UK, 2006b).

- A large household survey in India interviewing 6225 adults from non-HIV affected households indicated that 58% of women and 43% of men would not send their children to a school with an HIV-positive child (Loudon et al, 2007).
- Infected and affected children who are granted admission and attend school have been ridiculed or ostracized by peers according to some studies. For example, in case studies in Haiti and Brazil, infected teens reported experiencing violence and fighting amongst their peers in schools as a response to their HIV status (Abadia-Barrero and Castro, 2006; Loudon, 2006); and in western Europe, a cross-sectional study of children and adolescents living with HIV-positive parents found that HIV-positive children had significantly more reports of discrimination than HIV-negative ones (Nostlinger et al, 2006). In Benin, a cross-sectional study of orphans and vulnerable children (including those affected by HIV and AIDS) with a control group showed that orphans and vulnerable children were more likely to be rejected or isolated at school than the control children, although the percentage was not high nationally (5.3% compared to 2%), but in some regions the percentage of rejected orphans and vulnerable children rose to 15% (GECA et al, 2005).

2.2. Teachers' and other education staff's attitudes

- In a large qualitative study in India (Loudon et al, 2007; focus groups of 281 pre-adolescents (aged 9–12), 295 adolescents (1–17), 487 care givers, and 441 heads of households) of children affected by HIV (with an HIV-positive parent or orphaned by AIDS), some children reported that, in some cases, teachers actively discriminate and even mistreat affected children in the classroom by neglecting or abusing them.
- In a study examining the educational needs of HIV-positive learners, one school counsellor in a focus group in Namibia said she feels inadequate as she may not give the right help or deal with learners' issues in the right way. She felt she needed training to support learners in disclosing their status and in taking appropriate action, as well as in dealing with stigma and discrimination. She told researchers: *"I know the problem is out there, and there must be many learners who are affected by it, but I don't know where to start, or how to cope if these issues are raised, so I just avoid the topic"* (UNESCO and ESART, 2009b forthcoming).
- In a study examining the educational needs of HIV-positive learners, a key informant from the Ministry of Education in Namibia told researchers: *"The two biggest problems of dealing with HIV and its consequences in schools are the pervasive atmosphere of intolerance and emotional abuse in schools, and the lack of training for teachers in counselling... In such an environment, HIV-positive children dare not disclose their status. School principals need to be trained to create caring environments in their schools, and school counsellors need to take a more active interest in assisting vulnerable children"* (UNESCO and ESART, 2009b forthcoming).

2.3. School environment

- In Senegal, children from affected families reportedly frequently missed class due to involvement in domestic duties, obtained poor results, and faced difficulties in buying school stationery and other materials (Niang and Van Ufford, 2007). The challenges faced by affected children can contribute to a school environment characterized by distress, anxiety, confusion and lower teaching efficiency (Coombe, 2007).

- In areas with high HIV prevalence, it is important to be especially vigilant about hygiene in schools and preschools to protect children as far as possible from opportunistic infections. Clean water supplies, hygienic toilets and the hygienic preparation of school meals are always important in schools, but standards need to be particularly high in schools with HIV-positive children (UNESCO and ESART, forthcoming 2009.)
- Experience in Tanzania suggests that problematic teacher-pupil relationships create one of the most significant barriers to potential success of programmes on sex, relationships and HIV education (Plummer, et al, 2008). In a study at a teacher-training college in Zambia, inappropriate teacher-student relationships were found to be widespread, affecting the quality of learning (Ramos, 2008). Kelly (2008) has referred to this relationship as 'sexually transmitted grades', referring to the exchange of sexual favours for educational rewards such as improved marks, access to the content of examinations, or grade progression. In Ghana and Malawi, a culture of impunity was found, whereby little if any action was being taken by educational authorities in response (Leach et al, 2003). Codes of conduct are critical for child protection, with established mechanisms for dealing with problematic teacher-student relationships in place and operational.
- Data obtained from a survey in Uganda illustrate the challenges of achieving 100% coverage of a policy intervention (Kiragu et al, 2007, cited in Clarke 2009):
 - over 76% of all schools had a procedure in place for dealing with 'defilement' (sexual harassment or sex between teachers and learners);
 - 85% of all schools had a policy in place to deal with teachers who make schoolgirls pregnant;
 - 60% of all schools had a procedure in place that allows learners to anonymously submit questions or report problems;
 - 75% of all schools reported that they had a protocol in place to address the confidentiality of the guidance and counseling sessions;
 - 60% of all schools (80% of intervention schools and 33% of comparison schools) had a record-keeping system in place for counseling sessions; 67% of all schools had a referral system in place with local health facilities.
- Reliable information on violence, including gender-based violence and sexual harassment, in the school-setting is under-reported and largely unaddressed (OSISA and ActionAid, 2006). The data collected generally do not differentiate between experiences in and outside of the school setting (Lloyd, 2007).
- In many settings in sub-Saharan Africa, established teaching culture and practice are authoritarian and didactic and hardly conducive to the trusting relationship and participatory approach required for sex and HIV education programmes (Gordon, 2008)
- Cited in the Global AIDS Alliance (2007)
 - According to the 2006 UN Secretary-General's *World Report on Violence Against Children*, 6% of school girls in Ghana indicated that a teacher has made them trade sex for grades.
 - Human Rights Watch reports that, among South African rape survivors who indicated their relationship to the perpetrator, 37.7% were raped by a teacher or principal.
 - The following "promising practice" are documented:

- The USAID-supported Safe Schools Program, piloted by DevTech Systems and active in 60 communities in Ghana and Malawi, takes a holistic approach to developing violence-free schools. It provides adaptable training manuals on life skills and violence prevention, power dynamics in the classroom, and psychosocial support for survivors of violence. The programme focuses on three types of interventions: prevention programmes including “trainings for students, parents, community members and teachers aimed at reducing violence, developing response networks of volunteer community counselors for victims, and instituting reporting systems that encompass legislation strengthening at the school or community level.”
- Plan Togo’s Programme – works to: (a) develop capacity for children to participate in youth organizations and advocate for their rights, and (b) increase the capacity of caretakers (parents, teachers, community leaders) to provide a protective environment for children.

2.4. Education policy

- The Namibian Education Sector HIV and AIDS Policy emphasises that one of the duties of schools is to protect learners by not identifying their HIV status. One ironic outcome of this is that there are no special arrangements or allowances for HIV-positive learners, no indication of how many learners are positive, and as one key informant noted, “*The Ministry’s policy is to never ask about HIV status. An interesting, indirect consequence of this is that formally and officially, HIV-positive children do not exist*” (UNESCO and ESART, 2008). While infected children generally had access to treatment and other support services from NGOs, FBOs and networks of people living with HIV, their personal HIV-related needs were felt to be ignored at schools.
- A case study commissioned by UNESCO in Tanzania also found the Ministry of Education and Vocational Training conceding that “*there were no specific policies or guidelines relating to children living with HIV and AIDS*” and a pervading sense of denial at the school level (UNESCO and ESART, forthcoming 2009c).
- The first meeting of Ministers of Health and Ministers of Education to stop HIV and Sexually Transmitted Infections (STIs) in Latin America and the Caribbean led to an historic declaration pledging to provide comprehensive sex education as part of school curricula in the region. A description of the meeting and its outcomes is provided as Case No. 13 in Annex 2.
- A call to redirect prevention efforts in Asia-Pacific by the independent Commission on AIDS in Asia, and UNESCO’s response, is summarized in the Annex 2 as Case No. 14.

3. Interventions to reach children affected by AIDS

3.1. General

- The key services provided by 32 OVC programmes funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) in South Africa were found as the following:
 - Food and nutrition support - 32 (100%)
 - Psychosocial support - 27 (84%)
 - General education support - 27 (84%)
 - Child protection - 27 (84%)
 - Health – 23 (72%)
 - Economic strengthening – 23 (72%)
 - HIV prevention education – 18 (60%)
 - Shelter – 7 (22%)
 - Clinical/nutrition interventions – 6 (20%)
 - Vocational training – 6 (20%)
 - HIV treatment – 6 (20%)

Most programmes stop supporting OVC once they graduate from high school. However, Hands @ Work and Heartbeat have programmes in place to ensure that graduating OVC can either further their education at tertiary level or gain vocational skills. For example, Hands @ Work runs an educational programme which is directed at OVC who have performed well in their high school matriculation exams and require financial assistance to continue to the tertiary level. Heartbeat has a similar tertiary education fund for OVC who are high academic performers.

- In 2007, the UNICEF East & Southern Africa Regional Office (ESARO) contracted the OVC Working Group of the UK Consortium on AIDS and International Development to explore the degree to which the situation of orphans and other vulnerable children is addressed in national development instruments. The study involved desk reviews and case studies in six ESA countries. Conclusions include: (1) in all of the case study countries the integration of vulnerable children at the national policy level, particularly into the PRSPs, has made little difference in reality; (2) in contrast, integration into sectors has brought clear short-term benefits to vulnerable children; (3) off-budget resources can challenge long-term national ownership (Taylor 2008).

Table - Overview of the role of national policy instruments in bringing about short-term benefit for vulnerable children

	Kenya	Malawi	Mozambique	Tanzania	Uganda	Zambia
Relative contribution of instrument to short term benefits for orphans and vulnerable children						
PRSP/NDP	Nil	*	**	***	*	***
National AIDS Strategy	***	****	*	****	****	***
Social Protection Policy	**	**	In devpt.	In devpt.	***	

Key: The relative contribution is comparative between instruments for a country and based on a scale of one (low) to five (highest).

3.2. Education-based

- Financial subsidies might help increase enrollment of vulnerable children in high-prevalence countries: for example, programmes to subsidize school fees for children affected by HIV and AIDS (or specifically those orphaned by AIDS) have been promoted and tried in a number of high-prevalence countries. The Vulnerable Children Project implemented by the Centre for Development and Population Activities (CEDPA) in Benue State in Nigeria reported an increase in school enrollment and retention among orphans and vulnerable children once school subsidies were implemented. The Project conducted a baseline study, identified 3033 orphans (including those orphaned by AIDS but not exclusively), and found that 83% who had been reported as being enrolled in school were not attending due to expulsion for fees and other costs, although it did not include a comparison group of non-orphans. The

evaluation conducted at the end of the Project showed that 1000 orphans were enrolled in the Project, that they were attending school on a regular basis and that there were no incidents of school expulsion due to non-payment of fees (Amolo et al, 2003 reported in the Quality Assurance Project et al, 2008).

- In South Africa, the Department of Education's *HIV and AIDS Emergency Guidelines for Educators* sets out HIV facts and eight key messages about preventing HIV and related discrimination, deals with questions educators ask about sexuality education, advises on universal precautions and how to build a school culture of non-discrimination. It offers helpline numbers and channels to other support services (South Africa Department of Education 2001).

Guidelines to educators – South African Department of Education

Educators must set an example of responsible sexual behaviour. In so doing, they will protect their families, colleagues, learners and themselves.

- Because educators are well educated, they can grasp the facts about HIV and AIDS and help spread correct information about the disease and its effects.
- Almost every young person attends school, so educators have a great opportunity to discuss the disease and help the young to protect themselves from becoming infected, getting sick and dying.
- Educators are in frequent touch with parents, and can therefore spread the message about HIV and AIDS deeply into the community.
- Educators can help create an environment in the workplace where people can be open about their HIV status without fear of prejudice or discrimination.
- Educators can find creative ways to support their ill colleagues and learners, and make the school a centre of hope and care in the community.

Source: South Africa Department of Education 2001

- Children's educational programmes on radio and television (such as the Takalani Sesame Programme in South Africa), which treat HIV and AIDS as chronic conditions like any other, assist with demystifying the epidemic for the very young. This is a useful preparation for later school-based programmes on prevention of infection (UNESCO and ESART, 2009a forthcoming).
- Interventions for younger children are few and far between, partly due to the 'invisibility' of young children to planners (Fonseca, et al, 2007). At the same time, there is evidence of greater risks in early childhood (Walker et al. 2007), their long-term consequences (Grantham-McGregor et al. 2007), and the effectiveness of interventions in this age group (Engle et al. 2007). Preliminary evaluations of CARE's 5x5 Model for Early Childhood Development (ECD) in Uganda and Kenya and the establishment of "Coordinated Response Networks" (networks of service providers delivering a package of essential services through an entry point) have found that these can act as prototype wrap-around models for interventions. In the case of the 5x5 ECD model, the ECD Center serves as a practical entry point to deliver multi-sectoral interventions either directly or through referrals, for not only young children, but for their families and communities, including services relating to, but not limited to HIV and AIDS (Philbrick, 2008).
- There is considerable evidence that early HIV diagnosis can lead to greater chances of survival, fewer neurological complications, and improved health and well-being outcomes. Teachers should be aware of this and informed of referral procedures for children who appear unwell. At other levels in the ministries of education, more posts should be created for psychological services so that new programmes and curricula can be developed to meet children's needs proactively (UNESCO and ESART, 2009a forthcoming).

- HIV-infected children are more vulnerable to opportunistic infections and schools should be especially vigilant with respect to hygiene in order to protect the children's health in crowded situations (UNESCO and ESART, 2009a forthcoming).
- Case studies in Kenya, Malawi and Zimbabwe show that although schools are materially and symbolically well-positioned to be an institutional base to meet the needs of vulnerable children, they are not accountable for them and have not yet reorganized or built capacity to meet their needs. The Kenya case study highlights the importance of long-term, well-resourced partnerships among local actors (Kendall and O'Gara).
- Recommendations from a study exploring staff and student perceptions of the impact of HIV and AIDS in the Copperbelt province of Zambia (questionnaires for 72 teachers and 64 students; 6 interviews with school management teams, 6 focus groups with District Education Board Personnel, Namibia Union of Teachers staff and Copperbelt Special Education Standards Officer, focus groups with 36 students) highlighted the need for schools to be inclusive and supportive communities. For students, this would include a focus on the provision of alternative and more flexible opportunities for participation and learning; access to health and life skills education; and appropriate counseling and support. For teachers, this would include professional development opportunities to support the management of large classes and curriculum development (Robson and Sylvester, 2007).
- While many may argue that an education institution's response to HIV and AIDS should be limited to education about HIV prevention, schools and other institutions can – and do – play a significant role in supporting all the dimensions of a comprehensive response to HIV and AIDS, including prevention, treatment, care and support (UNESCO, 2008).

The Schools as Centres of Care and Support (SCCS) model was developed and tested by Media in Education Trust (MiET) Africa in 2003/4 across 3 provinces in South Africa. It was developed as an education response to the growing health and socio-economic needs of vulnerable children that were impacting negatively on their learning outcomes. The model is premised on the role of the school functioning as a hub for integrated service delivery for vulnerable children.

In 2005, MiET Africa initiated a multi-country programme, where the SCCS model was implemented by the MoEs of Swaziland and Zambia. These 2 countries, together with South Africa, implemented the programme from 2006 to 2008 with support from MiET Africa and UNICEF. In 2008, the regional SCCS initiative was officially adopted by the SADC Education Ministers as a regional programme. Now called Care and Support for Teaching and Learning, six Member States (Mozambique, Madagascar, Swaziland, South Africa, the Democratic Republic of Congo and South Africa) will participate in the first phase (2009 -2011). Partners with SADC in this initiative are MiET Africa, UNESCO and UNICEF.

Several other programmes have been implemented across the region (see boxes on next page for examples). Other case studies are available in UNESCO, 2008c [see in particular, Circles of Support (CoS) in 36 schools across Botswana, Namibia and Swaziland: School-centered care and support in KwaZulu-Natal, South Africa (MiET)].

Delivering Multiple Services through Schools: “Learning Plus”

In September 2005, 13 countries in Eastern and Southern Africa jointly committed to strengthening their national education systems using the UNICEF-sponsored “Learning Plus” approach, which harnesses schools as integrated support centres for children and families. Learning Plus uses schools to deliver child and family welfare services, such as feeding programmes; health interventions, including vaccination, micronutrient supplementation, and deworming; and HIV prevention.

In Swaziland, the Ministry of Education began bringing additional child and family services into schools in pilot areas under the “Schools as Centres of Care and Support” initiative in 2005, and initial results convinced the government to expand the programme to reach schools throughout the country. Donor agencies have complemented government action by supporting the construction of additional classrooms at many sites, expanding access to education and reducing school crowding. Communities have participated in equipping schools to fulfill their new role. Parents have organized to transport clean water to schools and provide labour to build kitchens for school feeding.

Source: UNICEF, 2008b.

HIV Alert School

The HIV Alert School model has been adopted in Ghana as a national strategy for school-based HIV prevention. The model was developed in five regions of the country, where 40 per cent of schools are certified as ‘HIV Alert’. Teachers in these schools are trained in behaviour change education for children. Parent-teacher associations and school management committees discuss HIV and AIDS as part of their regular meetings. An annual assessment and award process helps ensure that an HIV Alert School strives to maintain its status while motivating non-participating schools to seek certification. As of early December 2007, 131,572 teachers – 95 per cent of those in primary and junior secondary grades – had received training on the programme.

Source: UNICEF, 2008a.

- There is substantial evidence from principals and teachers in multiple settings that non-government agencies are providing support to schools through peer group programmes, teacher advice and counselling, and training. Such programmes are generally ad hoc, often grossly underfunded relative to the role they play (or could play) and are not generally recognized, resourced or formally contracted by the official system to undertake tasks that the system itself is apparently not capable of doing (Cornia, 2007). For example, a descriptive statistical analysis of junior secondary schools in Botswana revealed a broad range of HIV- and AIDS-related counselling services including life-skills education, care and support education and stigma reduction counselling. Teachers perceived a greater need for training in HIV and AIDS counselling skills and also in the use of information technology to support counseling (Sefhedi, 2008).
- The education system can play a role in providing psychosocial support to children affected by AIDS or by referring them to appropriate services. A recent Regional Psychosocial Support Initiative for Children affected by AIDS (REPPSI, 2007) in Eastern and Southern Africa lists five models that can be implemented in educational or other settings and provides practical guidelines for teachers in rendering social support to vulnerable children:
 1. *The Head-Heart-Social Model*, which explores how feelings and emotions alter the individual’s interactions with others. This could be applicable to teacher-learner interactions, caregiver-child interactions, or the HIV-infected child’s interactions with his or her classmates.
 2. *The Well-being Model*, which consider the well-being of the child in a holistic way with overlapping elements.

3. *The Resilience Model*, which is concerned with developing resilience for children living in difficult circumstances by building on the strengths in his or her environment.
 4. *Circles of Support Model*, which targets the gaps in support at the family, community or government service level that can be filled by support from other levels.
 5. *The Pyramid Model*, which concerns multilayered support building upwards from broadly-based community programmes, to mid-level and more focused child need programmes, and finally to specialist mental health services.
- The Life Skills Development Foundation (Chiang Mai, Thailand), with support from UNICEF, UNAIDS, Save the Children (US) and the Office of the National Primary Education Commission (ONPEC), implemented a “Child Friendly School Project for AIDS affected children” in three provinces of northern Thailand (Mae Ai-Chiang Mai Province, Sanpatong- Chiang Mai Province and Mae Chun – Chiangrai Province), 1998-2000. Evaluation of the programme found positive behavioral change in HIV affected students. Factors responsible for this improvement were the organization of “Convention on Rights of the Child” (CRC) awareness activities in schools, a) effective counseling services with constant observation of special cases, b) a thematic learning approach, c) discovering learning and e) an improved learning environment in school. Furthermore, significant improvements in regard to students’ self-esteem and depression levels were evident after a one year period of program implementation (IIEP, 2004).
 - Annex 2 summarizes 12 case studies on enabling orphans and vulnerable children to access to education.

3.3. Health services

- Expanded access to antiretroviral therapy (ART) for HIV-infected adults is an imperative for the well-being of children. Longitudinal household data from Kenya indicate that children’s weekly hours of school attendance increase by over 20% within six months of initiation of antiretroviral drugs for an adult household member with boys experiencing an even larger rise of 30 percent. After nine months of treatment, the increases in school attendance were maintained with no significant drop off over the time period of the study. (Thirumurthy, Zivin and Goldstein, 2007; see also Kimou, Kouakoa, and Assi, 2008).
- In a recent study examining the education needs of HIV-positive learners in Namibia (UNESCO and ESART, 2009b forthcoming), extensive support for HIV-positive children was found to be channelled through non-governmental organizations. According to one NGO respondent: *“We do not separate HIV-positive children out of the OVC umbrella, but we can say that many of the OVCs we deal with live without parents and have to care for younger siblings. Others live with sick and dying parents, or with older relatives or foster parents who are often unable to provide care normally needed by school-going children. We assist with school fees, uniforms and food support. But there is a high dropout rate among OVCs ... they disappear usually with no follow-up by their schools. We have noticed that children who are going for ARV treatment at clinics are better monitored by health counsellors, who follow up if they miss a check-up, and they refer them for welfare assistance. Teachers do not follow up, maybe because they have large classes, but they don’t seem to care anyway.”*

3.4. Social protection

- UNICEF estimates that well-designed social cash transfer programmes could reach 80% of HIV-affected households in need of assistance in low- and middle-income countries with high HIV prevalence (UNICEF, 2007a).
- With the exception of households in which one or more members are on ART, it is not recommended that HIV status serve as an eligibility criterion for social cash transfer schemes, due to the possibility of stigmatizing recipient households (UNICEF, 2007a). Similarly, eligibility criteria targeting households that include one or more orphans, or are labour-constrained, also reach many HIV-affected households (UNICEF, 2007a).
- Among 33 countries with generalized epidemics (i.e. 1-15% of pregnant women attending antenatal clinics are HIV-positive) with data, 91% of national governments report having a specific policy or strategy to address the HIV-related needs of children orphaned or made vulnerable by HIV (UNGASS Country Progress Reports 2008). The degree to which such plans have been costed, budgeted, and implemented cannot currently be assessed, although national governments in nearly 73% of countries with generalized epidemics regarded their national efforts to address the needs of orphans and vulnerable children as above average (UNAIDS, 2008).
- 32 countries have developed or finalised national plans of action (NPAs) with benefits for orphans and vulnerable children. A recent report has noted that the process of developing these plans has generally been slow (3-7 years or more); implementation has not been taken to scale due to limited capacity of governments and other partners; and most NPAs are not fully funded (Gulaid, 2008). Engle (2008) highlights the importance of linking these plans with other government documents is essential to ensure their implementation, as in the case of Kenya and South Africa's early childhood development (ECD) policies.
- In 11 countries with HIV prevalence of 5% or greater, only 15% of households with orphans received any form of assistance in 2007. (UNAIDS, 2008)
- There is a growing call to move away from targeting children orphaned by AIDS as there is a body of literature demonstrating that doing so can spur resentment among equally poor and needy households; intensify stigma and discrimination; and create perverse incentives that undermine programme effectiveness. (Campbell 2008, Alwnick 2008; Cluver and Operario, 2008; JLICA 2008; Bachman, 2008; Richter and Rama, 2006). The Joint Learning Initiative on Children and HIV and AIDS suggests that policies, programmes and funding must be redirected to provide support for children to and through their families (JLICA; Richter 2008). JLICA recommends reaching children and families affected by HIV and AIDS by using extreme poverty as the primary inclusion criterion, noting that in high-burden settings this form of targeting has been found to be AIDS-sensitive and can be even more so by connecting a poverty measure with at least one other criterion, such as the household dependency ratio or the degree to which households are labour-constrained (Richter, 2008; JLICA 2008: p. 43). They have called on countries to adopt national social policies that are AIDS-sensitive, not AIDS-targeted.
- In eastern and southern Africa, national governments, civil society, and other stakeholders are increasingly focused on the provision of a minimum package of social protection to vulnerable children, including those affected by HIV (Webb, 2007). Such minimum packages vary considerably among countries. In Botswana, the country's Orphan Care Programme was supporting more than 53 000 children orphaned by HIV

as of December 2007, providing food baskets, psychological counselling, and educational assistance (e.g. waiver of school fees). Zimbabwe's National Orphan Care Policy takes a sectoral approach, working to strengthen community care capacity through extended families. Namibia's Ministry of Gender Equality and Child Welfare administers foster-care grants that were supporting 65 000 children in 2007, while South Africa has reached more than one million orphans and vulnerable children with support services, mostly in the form of child support grants. Among 10 countries in which 5% or more of adults are HIV-infected and where recent household surveys have been conducted, a population-adjusted average of 15% of orphans live in households receiving some form of assistance, such as medical care, school assistance, financial support, or psychosocial services. In some high-burden countries, programme utilization data suggest somewhat higher coverage than has been found in household surveys. South Africa and the United Republic of Tanzania, for example, report reaching 67% and 50%, respectively, of households that include one or more children orphaned or made vulnerable by HIV (see Table 6.1 in UNAIDS 2008).

- In South Africa, children living in households with a female pensioner receiving the Old Age Pension experienced a one-third reduction in the school non-attendance gap affecting the children of poor families (JLICA 2008 citing Adato and Bassett, 2008; Samson et al, 2004).
- An evaluation of the scale-up of the Mchinji Cash Transfer programme in Malawi found that, after one year, the percentage of children newly enrolled in school was more than twice as high in intervention households (8.3%) relative to the comparison households (3.4%). Over this period, a total of 96% of children from intervention households were enrolled in school compared to 84% of children in comparison households (JLICA 2008 citing Adato and Bassett, 2008; Miller, Tsoka and Reichert, 2008).
- An evaluation in 2007 of a conditional cash transfer programme in Paraguay (Tekoporã, "good life" in Guaraní) found school attendance rose in the various classes between 5% and 8%, which also increased the ratio of children able to advance to higher classes. The increase was particularly significant for boys between the ages of 11 and 15 (9%-15%), who normally leave school to work. This does not mean that the programme was able to significantly reduce child labour. However, the results show that Tekoporã is enabling many children – particularly from extremely poor families – to continue attending school despite their productive activities. (GTZ, 2008a). Similar results were found in a review of another conditional cash transfer programme in El Salvador: In the first 15 municipalities the number of preschool enrolments rose by 23% between the first four months of 2005 and the first four months of 2006. In grades 1-3 the number of children rose by 6%. In grade 3-6 the increase in the number of schoolchildren was 9% (GTZ, 2008b).
- Nicaragua's Red de Protección Social conditional income transfer programme contributed to increasing school attendance rates by 20 percentage points on average (17% for girls, 23% for boys) and 33 percentage points for the extremely poor. This was a combined effect of income transfers and interventions simultaneously undertaken to increase school capacity, such as employing more teachers (JLICA 2008 citing Adato and Bassett, 2008; Maluccio and Flores, 2005).
- According to UNAIDS (2008), South Africa has 1,577,200 orphans and children made vulnerable by AIDS, of which about 67% are covered by some sort of public service (notably the Child Support Grant). Support to caregivers to access grants is a growing and major role for civil society organizations: identification of those eligible, support to documentation preparation, monitoring and referral to other services (health and

education). Strengthening national policy, planning, monitoring and evaluation has been a great achievement in South Africa over the last year. Research is underway to:

- link vital-registration data with maternal orphan-hood for a national surveillance system
- Include the orphans' module in the forthcoming DHS to improve national baseline data.
- strengthen the Integrated Community Registration Outreach Programme (ICROP) operated by SASSA to increase CSG take up among 0-1 years old eligible children (Alwnick, 2008).

4. Estimating teaching needs – the impact of HIV and AIDS on teachers and how it affects education sector’s ability to meet the needs of marginalized children

To reach universal access to prevention programmes, treatment, care and support, UNAIDS has estimated that 1.5 million teachers need to be trained (UNAIDS, 2007b). The coverage of primary teachers trained (max of 1/3 in each school) and secondary teachers trained (max of 1/8 in each school) should reach 30%, 45% and 100% in low-level, concentrated and generalized/hyper-endemic areas respectively (UNAIDS, 2009).

4.1. HIV prevalence and AIDS-related morbidity and mortality among the teaching profession

- Some statistics on teacher and school heads deaths and ill-health retirements were given as below for Zimbabwe [HEAT Report (2002:65), cited in Rembe, Symphorosa (2006)]:

	1999	2000	2001
Teachers – deaths	303	57	726
Teachers – medical retirements	306	807	933
Heads – deaths	7	2	44
Heads – medical retirements	14	75	42
Teachers and heads – total deaths	310	369	770
Teachers and heads – total deaths & medical retirements	1090	882	1857
Total deaths (% of total trained teachers)	0.38	0.45	0.91
Total deaths & medical retirements (% of trained teachers)	1.29	0.98	2.05

- Early in the epidemic it was thought that teachers were at relatively high risk of HIV infection due to their high levels of social mobility (Bennel, 2002; Hargreaves, 2002). However, Clarke 2009 suggests, (1) in general the HIV vulnerability of teachers in country texts is not well researched and evidenced; (2) the impact of HIV on teachers varies significantly by gender and by school level they teach; (3) it is hazardous to make blanket generalization about the teaching profession; and (4) mortality rates for teachers are generally much lower than for the adult population as whole.
- In 2005, Bennel summarised the available information on teacher mortality in 10 high HIV prevalence countries in sub-Saharan Africa. The main conclusions of this review were as follows:
 - Teacher mortality rates (from all causes) did not exceed one percent in Southern African countries (Botswana, Lesotho, South Africa, and Swaziland) during 2003-2004, which have the highest adult HIV prevalence rates of over 20 percent. Elsewhere, mortality rates are below one percent in Tanzania and Uganda and are around two percent in Malawi and Zambia.
 - Teacher deaths account for less than 20 percent of total teacher attrition in most countries and less than 10 percent of total teacher turnover (attrition and transfers).
 - Teacher mortality rates appear to be falling or are reasonably stable in a significant number of countries. Both behaviour change and increasing access to life-prolonging anti-retroviral therapies (ART) are the principal reasons for these mortality trends.

A review in 2006 concluded that the up to date information from these five high HIV prevalence countries fully supports the key findings of the 2005 review. In particular, teacher mortality rates are declining in all these countries, which, with the possible exception of Tanzania, is due to the increasing availability of ART. It is likely therefore, that teacher mortality is also falling in other high prevalence countries, most notably Kenya, Malawi, Mozambique, Namibia, and Uganda. Teacher mortality rates have been falling in Uganda for the last five years and there was a sharp fall in teacher mortality in Malawi in 2004 (Bennell, 2006a).

- A recent study by the Partnership for Child Development and the World Bank estimated that – with current levels of coverage of ART of teachers – an additional 5.1% recruitment of teachers may be required between 2007 and 2015 to meet EFA goals (Risley et al, 2007).
- A study involving 120 schools in four districts in Kenya revealed that teachers are directly affected by HIV and AIDS, and many shoulder a heavy care and support burden - One in five teachers reported having someone in their immediate family currently infected with HIV, and a third had an immediate family member die of the disease (Kiragu et al, 2006).
- A national survey among 24,200 educating staff from 766 public schools in 9 provinces of South Africa showed that:
 - 12.7% of the sample were HIV-positive, while 30% indicated that the disease affected them in the exercising of their profession. 7% of the sample reported being affected by HIV and AIDS among their colleagues; 20% by HIV and AIDS among their learners; and 13% through ill relatives.
 - Educators who considered leaving the profession were reportedly more affected by HIV and AIDS than those educators who do not consider leaving. Significantly more potential leavers (40% [95% CI: 38.2, 41.5]) than non-potential leavers (33% [95% CI: 31.4, 34.3]) indicated being affected by HIV and AIDS among educators and learners.
 - Educators who were affected were less positive about the level of morale at their schools than those not affected by the disease.
 - Educators were emotionally affected by HIV and AIDS: 6% were depressed because of colleagues who were living with or had died from HIV; 13% were emotionally affected through HIV-positive/affected learners; and 11% reported experiencing feelings of sadness and depression because of relatives who had passed away or were living with HIV. This may impact on educator morale, which, in turn, may lead to more educators leaving their profession (Hall et al, 2005).
- HIV is but one factor that influences teacher absenteeism, and there may be considerable difficulties in obtaining robust data in this regard, given the widespread stigmatization of people living with HIV. The Global Campaign for Education (2006) has estimated that HIV and AIDS account for up to 77% of teacher absenteeism in countries with high prevalence rates. Hall et al (2005) reported longer periods of absenteeism among teachers infected and affected by HIV and AIDS. In a study which investigated teacher absences in nine schools in Kavango and Caprivi in Namibia the study results confirmed that stigma has a serious impact in some schools (Castro, Duthilleul and Caillods, 2007). HIV was never directly mentioned as a direct cause of teachers' absences; sickness was never mentioned as affecting either teachers or learners (Clarke, 2009).

- In some countries, a tenfold increase in teacher mortality and absenteeism due to HIV and AIDS is reportedly reducing both teaching time and quality. For example, a 5% increase in the teachers' absenteeism rate reduced learning by 4-8% of average gains over the year (Das et al, 2005).

4.2. Impact on the Education Sector

Although there is some debate about the extent of the impact of HIV and AIDS, there is evidence that HIV and AIDS – particularly in countries experiencing generalised or hyper-endemic epidemics are having an impact on service provision. For example, in Lesotho and Malawi, around one-third of all teacher attrition is due to terminal illness (likely HIV-related) (UNESCO, 2007). Other estimates have predicted that, in highly-affected countries, AIDS-related deaths among teachers could add four to five per cent to annual attrition rates in the sector (Grant et al, 2004). This situation is compounding challenges to hiring, retaining and training adequate numbers of teachers. It is estimated that, in order to reach EFA goals, the world will need more than 18 million new primary education teachers, compared with the 26 million available in 2004. Sub-Saharan Africa faces the greatest challenge; the teacher stock will have to increase by two-thirds, from 2.4 to 4 million, if UPE is to be reached. Allowing for attrition, which is compounded by the AIDS pandemic, sub-Saharan Africa will need 3.8 million new primary education teachers by 2015. (UNESCO, 2007)

A further major challenge in this respect is teacher deployment, since HIV-positive teachers and/or their families will wish to be posted in areas where they have close and adequate medical (and ART-providing) facilities. HIV- and AIDS-related costs are also impacting on the supply of education (UNAIDS IATT on Education, 2008).

5. Teachers as ‘learners’ i.e. how training programmes are or are not preparing teachers to teach marginalized children

5.1. HIV and AIDS-related awareness, knowledge and practice

- In a study involving 120 schools in four districts in Kenya, many teachers (62% men and 64% women) reported being “very concerned” that they could contract HIV in the school environment, yet awareness of post exposure prophylaxis (PEP) was extremely limited. Teachers (77%) reported lacking trust in school management for maintaining confidentiality and safeguarding their jobs (Kiragu et al, 2006).
- The Ghana National Association of Teachers (GNAT) and the Teachers and Educational Workers Union (TEWU) of the Ghana Trades Union Congress undertook an assessment of the awareness of HIV and AIDS in the education sector and the needs of teachers and education workers in 2007. 681 respondents (86% teachers and 14% education workers) were surveyed. The study revealed among the respondents: a high degree of awareness of HIV and AIDS (89%) and of direct benefits of HIV and AIDS education (77.6%); moderate attendance rate to HIV and AIDS education organized by Ghana Education Service (58.2%); low readiness to know their HIV status (9.4%); not very popular of condom use (15% said they used condom during casual sex); and one fifth reported abstinence completely as a way of prevention of HIV infection (Baah et al, 2007).

5.2. Preparedness, willingness and readiness to teach about HIV and AIDS

- Teachers have been cast as both heroes and villains in HIV education and related contexts, with the latter arguably attracting more publicity. While those who sexually exploit their students are clearly responsible, many teachers are not ultimately to blame for the shortcomings in service delivery. It is clear that they are not being adequately trained, resourced or supported to perform effectively in teaching about HIV and related issues. Too often, HIV education is not included in national education sector plans and policy frameworks. Some donor-driven programmes are seemingly too ambitious or poorly designed for the educational context. (Clarke, 2009)
- A study in Mozambique examined the extent to which attitude functions towards talking about condoms and sexuality impacts on teachers’ willingness to address HIV and AIDS in school and community settings in Mozambique. Data were collected through a survey among a stratified sample of 606 primary and secondary school teachers. The results of the study provide support for the fact that attitude functions selectively impact on teachers’ willingness to talk about HIV and AIDS in Mozambique and suggest that a better understanding of attitude functions may improve communication messages and be an important input into training and support of teachers. Using multinomial logistic regression the study found that teachers holding weak or moderate value expressive attitude functions were more than twice as likely to have talked about HIV and AIDS in their school and in their community in the past month and to intend to do so in the future, than those holding strong value expressive attitude functions. A similar relationship was found between strong and moderate utilitarian attitude functions and both past school and community communication behaviour as well as future intentions. A third - socio-defensive - attitude function impacted on past communication behaviour in schools and on future intentions, but not on past behaviour in communities. Possible implications for support to teachers as part of HIV and AIDS prevention and awareness are discussed (Visser, 2006).
- A survey of teachers responsible for HIV and AIDS education in public secondary schools in Cape Town, South Africa, found that had implemented HIV and AIDS

education during 2003, and female teachers were more likely to have implemented than males (74% vs. 58%). The teacher characteristics associated with implementing HIV and AIDS education included: training; self-efficacy; student focus; belief in the positive outcome of HIV education; and a sense of responsibility. School characteristics associated with teaching about HIV included: the existence of a school HIV and AIDS policy, a fair and equitable school environment and good school-community relations. The findings demonstrate the importance of effective teacher training and school policies and the value of interventions to create a supportive school environment and community support (Mathews, 2006).

- A study in Rwanda interviewed 728 respondents (307 men, 421 women) from 21 districts in four Provinces of Butare, Kibuye, Ruhengeri, Umutara and the city of Kigali. The target group comprised 508 primary school teachers (70% of all research participants), 16 Teacher Training Colleges teachers, 120 TTC students, 18 parents, 10 heads of primary schools and 56 primary school children. The study revealed the absence of any standardised methodologies for teaching sexuality education; hence, teachers conducted HIV and AIDS lessons in the best ways they knew how. Teachers expressed the need for an appropriate pedagogy that was participatory, included audio-visual material and other relevant teaching aids (Chege, 2002).

5.3. Access to HIV diagnosis and treatment services

- In Malawi, rapid scale up of ART has allowed 2,380 HIV-positive teachers to access life-prolonging treatment. There is evidence that this intervention can help to mitigate some of the shortages of teaching personnel in resource-poor countries affected by a generalised HIV epidemic (Makombe et al, 2007).
- In Zambia, over 12,000 teachers (of an estimated total of 60,000 teachers) have been reached with prevention messages and services from 2004-2007. Of this number, just over 5,300 have undergone voluntary counseling and testing to know their HIV status, and just over 17% of these teachers tested HIV-positive (Zambia MOE, 2007). The overall proportion of people in Zambia tested for HIV remains low (11% for males and 15% for females). Fear of the results and fear of stigma continue to be major barriers to testing. The uptake of ART has also been slow – in part because of fear of stigma – such that by the end of 2005 less than 500 Ministry of Education employees were receiving treatment. A rough estimate by the association (AATAZ) of HIV positive teachers of Zambia puts the current number of teachers that are on ART at around 2000. However, according to AATAZ, a significant number of teachers still fail to access ART on time (UNAIDS IATT on Education, 2008. For more information on Zambia's efforts to roll out ART to teachers see: G. Kombe, J. Fieno, P. Bhatt and J. Smith. 2005. Highly active anti-retroviral treatment as a bridge towards education for all in sub-Saharan Africa. Paris, UNESCO).
- A study of South African public schools revealed that 10,000 of the total 356,749 educators would be eligible for immediate antiretroviral therapy. The study results suggest that more than a fifth (22%) of the HIV-positive educator population would need antiretroviral therapy, even if health care providers use the national criteria based on WHO's conservative guidelines for the initiation of ART. Applying these findings to the total educator population of South Africa would suggest that at least 2.8% of all educators are eligible for antiretroviral therapy (12.7% HIV prevalence, 22% of HIV positives eligible for ART under national guidelines: $12.7\% \times 22\% = 2.8\%$). That means that 10 000 of the total 356 749 educators would be eligible for immediate antiretroviral therapy. Taking a CD4 cell count of ≤ 350 cells/mm³ as the level for the initiation of ART, as recommended by the guidelines of the US Department of Health and Human Services, would increase the proportion of HIV-positive educators eligible for ART to more than 23,500 (Rehle et al, 2005).

5.4. Policy and training/capacity-building support for teachers

- In Uganda, a review with local stakeholders of the policy and training support provided by the education sector identified the following gaps:
 - The implementation of policies has generally been weak because of lack of dedicated structures to do so. Many key policy documents have not been widely disseminated.
 - Stigma and discrimination remains strong for most teachers and staff remain reluctant to access VCT.
 - Infected teachers continue to face harassment from the school administration as the Education Sector Workplace Policy is not in tandem with the Public Service regulations and labour laws governing absenteeism from duty. Moreover, due to poor circulation of the policy document, not many teachers are aware of its existence, let alone its implementation.
 - There is limited psychosocial support for infected teachers and many are not quite sure of their rights. While the establishment of Teachers Against Aids Action Group (TAAG) has received recognition and acceptance by some arms of the ministry, the network lacks comprehensive support by donors as well as the ministry in decision-making, institutional strengthening, planning and sustainability.
 - Most of the HIV and AIDS Ministry of Education and Sports-based response programmes including Presidential Initiative on AIDS Strategy Communication to the Youth (PIASCY) do not target private schools. Much of the MoES policy response has tended to focus primary education with delayed scale-up to post-primary (secondary education has just started), and a major gap at university and other tertiary institutions.
 - There is a general perception from stakeholders participating in the review that the MoES' response has focused more on learners and has not moved fast enough to reach teachers. Consequently, policy interventions for teachers have been very slow with basic information/records on teachers seriously lacking at all levels of the administrative structures. Some vital information such as teachers' sickness and sick leave, mitigation of absenteeism, staff attrition and retirement is not readily available. Infected and affected teachers reportedly feel neglected and even face hostility from the administration.
- In a review of the education sector response to HIV and AIDS in Papua New Guinea, the following two achievements were identified as contributing to an effective education sector response to HIV and AIDS in the country: (1) Integration of HIV and AIDS in pre-service curricula ensuring that all teachers graduating from 2007 onwards have 36 hours of training on HIV and AIDS; (2) Integration of HIV and AIDS responsibilities into school learning improvement plans, teacher in-service plans and capacity building for communities and school boards. However, the study also identified that interventions focus more on curriculum responses for learners than support for educators, and it is

The Policy is supportive but its implementation has not been fully achieved. Translating policies into practice is a problem and many policies remain on the shelf – studying, understanding and interpretation of the policies by stakeholders is also a problem. Headteachers may need more than just getting a copy of the policy – they need sensitization and public talks. Balancing the interests of the teacher and those of the schools in terms of performance of sick teachers is a challenge. The staffing is low and yet the number of learners is increasing through UPE and USE. Headteachers are therefore in a fix especially since they cannot easily hire additional people to step in.

*(Focus group discussion with focal point persons
10 July, 2008)*

hard to determine how such capacity building efforts for teachers will pay off (Visser, 2008)

- A review in Malawi, Tanzania and Uganda found that most HIV- and AIDS-related action in the education sector has focused on learners and school curricula and that limited attention had been paid to help educators to deal with the new challenges posted by the epidemic. Moreover, even less attention had been given to protecting educators from HIV infection and to providing care, treatment and support for educators infected with or affected by HIV and AIDS. There were very few programmes addressing the needs of other education sector personnel, such as planners, managers and support staff (UNESCO IIEP, cited in UNESCO, 2008b).
- A survey conducted by Education International covering over eight countries participating in the EFAIDS Programme confirmed the fears expressed by EI and its affiliated unions: namely, that little or no time or resources are being devoted to HIV and AIDS in pre- and in-service training (EI, 2007).
- A case study on the responses of teachers' training colleges to HIV and AIDS concluded that in Zambia, teacher training colleges are being only partially responsive to the future needs of teachers and that much more support was required from the Ministry of Education and other partners (Ramos, 2008).

6. Interventions to reach teachers

- The HIV-related needs for teachers identified through a technical consultation with SADC partners organized by UNESCO in May 2007 include: (1) support to access HIV services (prevention, treatment, care and support); (2) supportive human resources policies that take account of HIV-related health needs (such as going to hospital); (3) functioning disciplinary procedures for HIV-related stigma and discrimination; and (4) psychosocial support: dealing with HIV-affected students and impact on their own lives (UNESCO, 2008d).
- Partnerships between teacher networks, unions and organizations of educators living with HIV and AIDS are playing an important role in promoting awareness, reducing vulnerability of the teaching workforce to HIV, and supporting the treatment, care and support needs of teachers affected by the epidemic. Teachers' unions are active in HIV prevention initiatives with teachers in countries such as Burundi, Mali and Sudan, organizing workshops for teachers to raise awareness of their own HIV risk. The South African Democratic Teachers' Union and the Zimbabwe Teachers Association have been active in support of the rights of HIV-positive teachers. The National Council of the Tanzania Teachers' Union, for example, allocates 1% of its membership fees to HIV and AIDS training activities (UNESCO and EI-EFAIDS, 2007). In other countries, such as Kenya, Uganda and Zambia, groups and networks of teachers living with HIV have been established to provide support for teachers by teachers. In this context, a number of countries have seen important increases in the number of teachers willing to disclose their HIV status; to lobby for their rights; and to address stigma and discrimination.
- Education International, the Education Development Center (EDC) and WHO developed in 2007 a toolkit to eliminate HIV-related discrimination within teachers' unions and provide greater support for, and involvement of, HIV-positive educators in union activities. The information and suggested actions are organised around five themes – research, policy development, advocacy, publicity campaigns and training.

The Teachers Matter Program

The Teachers Matter workplace intervention was implemented in 180 schools in four districts in Kenya. The research was based on a quasi-experimental design, and collectively the project reached over 2700 teachers. Project implementation began in 2006 and lasted about nine months (one academic year). It was a peer-led education program, guided by a 10-unit interactive manual. The intervention drew on two behavioral theories: the Theory of Gender and Power and the Transtheoretical Model. Prior to program implementation, a peer educator from each participating school was identified and received a one-week training. During the training, peer educators developed a weekly work plan, which they followed upon return to their duty stations. Peer education sessions were held weekly, and each session lasted an hour. Schools took around 36 weeks to complete the manual. Peer educators were supported by quarterly visits from the Teachers Matter study monitor, who helped with trouble-shooting and re-supply of materials. Teachers also benefited from the support of Kenya Network of Positive Teachers, a network of teachers living with HIV. Schools were provided with support materials such as tailor-made brochures and calendars, as well as other educational materials (e.g. penis model, samples of both male and female condoms, samples of ARVs, videos and posters). Because Teachers Matter was commencing activities just as the Ministry of Education was starting distribution of its Education Sector Workplace Policy on HIV and AIDS, copies of the policy were included in the project as well. Teachers Matter was implemented in partnership with the Ministry of Education and the Teacher Service Commission. It was funded by USAID and UNICEF (Kiragu, et al, School as workplace, 2008).

- Teachers with HIV should have the same employment rights as other staff. Consideration of fitness to teach should depend on an individual's physical and psychological status and HIV should be dealt with in the same way as any other chronic condition. Policies must be in place to protect HIV-positive teachers and other staff who are otherwise well from being excluded from working; refused employment or

promotion, or dismissed; or denied access to training, social security or occupational benefits (UNESCO, 2008b). Similarly, compulsory HIV testing must not be permitted and measures to protect the confidentiality of medical and treatment records should be assured.

- To support adequate human resources and capacity development in relation to HIV and AIDS and education, it is important to ensure that: structures are established and functioning (e.g. senior strategic team, ministry focal persons, operational units/teams/working groups); an enabling legal and policy framework is in place (education sector policy, workplace policy etc. with mechanism for dissemination at all levels of education system); HIV and AIDS are mainstreamed into all human resource functions (e.g. teacher workforce planning, code of conduct, support for infected and affected staff); workplace HIV and AIDS programme are developed, implemented and monitored; training and capacity-building are available related to HIV and AIDS; and partnerships and coordination are established to enhance the response (UNAIDS IATT 2008b).

TIWOLOKE: HIV and AIDS in the Education Workplace in Malawi

Malawi has a 12% HIV prevalence rate in age group 15-49 (2007 data), with major impacts on the public service, particularly the education sector. A workplace-focused behaviour change programme for primary school teachers and their partners in all 34 of Malawi's education districts implemented was initiated in 2006, with the National AIDS Commission and DfID/UK.

An intensive 2 week residential training programme based on the Stepping Stones module was adapted for Malawi to cover 35 000 teachers and 22 600 spouses.

Project outcomes:

- 7 600 teachers trained by July 2008
- Largest behaviour change programme in the public service
- Support to T'LIPO – a network of 2 500 teachers living positively with HIV and AIDS – Africa's second largest network
- Increased uptake of Voluntary Counselling and Testing (VCT) – 2500 to date
- Increased disclosure of HIV status
- Improved inter-personal relationships in families
- Increased knowledge and skills in sexual and reproductive health and rights
- New opportunities to challenge rights violations in the workplace
- New leadership opportunities for women and people living positively with HIV and AIDS in the education sector

Source: *TIWOLOKE: HIV and AIDS in the education workplace in Malawi*. ActionAid, 2008. 32 p.

7. Costing analyses – reaching children and teachers affected by HIV and AIDS

- The International Labour Organization has estimated that the cost of a social protection package for low-income countries – consisting of a small universal old-age pension, universal primary education, free primary health care and a child benefit of \$0.25 per day–ranges between 1.5% to 4.5% of gross domestic product (Pal et al, 2005), a finding supported by a similar UNICEF analysis in Mozambique (Webb, 2007).
- Based on country-defined targets for 2010, UNAIDS estimates that an investment of \$25.1 billion will be required for the global AIDS response for low- and middle-income countries in order to move toward universal access to prevention programmes, treatment, care and support. This includes \$1.7 billion in 2009 and \$2.5 billion of investments for orphans and vulnerable children. With the \$25 billion, UNAIDS estimates that: 1 million primary school teachers could be trained and 6.7 million orphans supported (UNAIDS, 2009).
- Abt Associates has suggested that if the total education workforce were provided with ART, medical costs might well exceed 0.9 per cent of the basic salary bill by 2005, and 1.8 per cent in 2010. (Abt Associates 2001).
- The 2006 Livingstone Intergovernmental Regional Conference called for costed, national social transfer plans to be integrated into national development plans within 2–3 years; and the Commission for Africa called for regular cash transfers of US\$2 billion a year rising to US\$5 or 6 billion annually by 2015. (UNAIDS Inter-Agency Task Team (IATT) on Children and HIV and AIDS, 2007).
- UNAIDS anticipates that the economic crisis will have a differential impact on countries with significant domestic spending as compared to those with significant international aid. For example, programmes with high spending on AIDS that are largely met from domestic sources (such as Botswana) will be vulnerable to their own reduced economic growth. In contrast, countries with high spending on AIDS and high dependency (such as Haiti or Mozambique) will have less scope to increase their domestic financing and will be vulnerable to reductions in international funding (UNAIDS, 2009).
- A study on the welfare and investment shock of AIDS-induced orphanhood in Africa made several estimates of the relative costs of various methods of subsidizing and caring for orphans. Deinger et al, 2001 estimated that the cost of a subsidy to provide school and nutrition supplementation (excluding administrative costs) to all vulnerable children (not just orphans) in foster families was estimated to be \$148 per child annually in Burundi and \$105 per child annually in Uganda. This was compared to Tanzania (where institutionalization of orphans cost \$649 per child annually in 1990), Eritrea (where this cost was estimated to be \$1350 in 1998), and Burundi (where it was estimated to be \$689 in 1999). A recent study postulates that these costs would be very similar in low prevalence countries (The Quality Assurance Project et al, 2008)
- Global estimates suggest that the cost of HIV to the education system could be as much as \$1 billion per year as a result of teacher deaths and absenteeism, severely hindering the ability of education systems to deliver a quality education (Buss et al, 2005).
- In Zambia, data from the Ministry of Education Planning Directorate for 2007 indicate approximately 5% (or 95.2 billion kwacha) of the 1.914 trillion kwacha overall budget

(Government, sector pool and projects) was allocated to the 'equity and gender' (also known as special issues) area of which 2.4 billion was for HIV and AIDS. Overall, therefore, 2.4% of the equity and gender budget and 0.125% the overall education budget is allocated to HIV and AIDS. Given the pressing priorities in HIV and AIDS and the enormous impact of the pandemic on the sector, this is clearly insufficient (UNAIDS IATT, 2008).

- A study by Risley and Bundy (2007) uses the Ed-SIDA model to make projections of the impact on education supply for 53 countries in three areas hardest hit by the epidemic: sub-Saharan Africa, the Caribbean and the Greater Mekong sub-region of south-east Asia. The results suggest that, in sub-Saharan Africa, the 2006 costs to education are less than half those estimated in 2002, reflecting reductions in HIV prevalence and better understanding of HIV epidemiology. Nevertheless, the impact on teacher supply is estimated to be sufficient to derail efforts to achieve EFA in sub-Saharan Africa unless teachers have universal access to treatment, care and support (Risley et al, 2007).
- See also Sperling G. 2008 for a more general discussion on financing challenges. *A Global Education Fund: Toward a True Global Compact on Universal Education*. Washington, Council on Foreign Relations/Center for Universal Education (in particular, sections on financing on pages 18-25).
- Case No. 4 in Annex 2 provides an example of financial input to reaching 7,627 students in 44 communities taking part in the "All Children Safe in School (ACSS)" programme in Swaziland, 2004.

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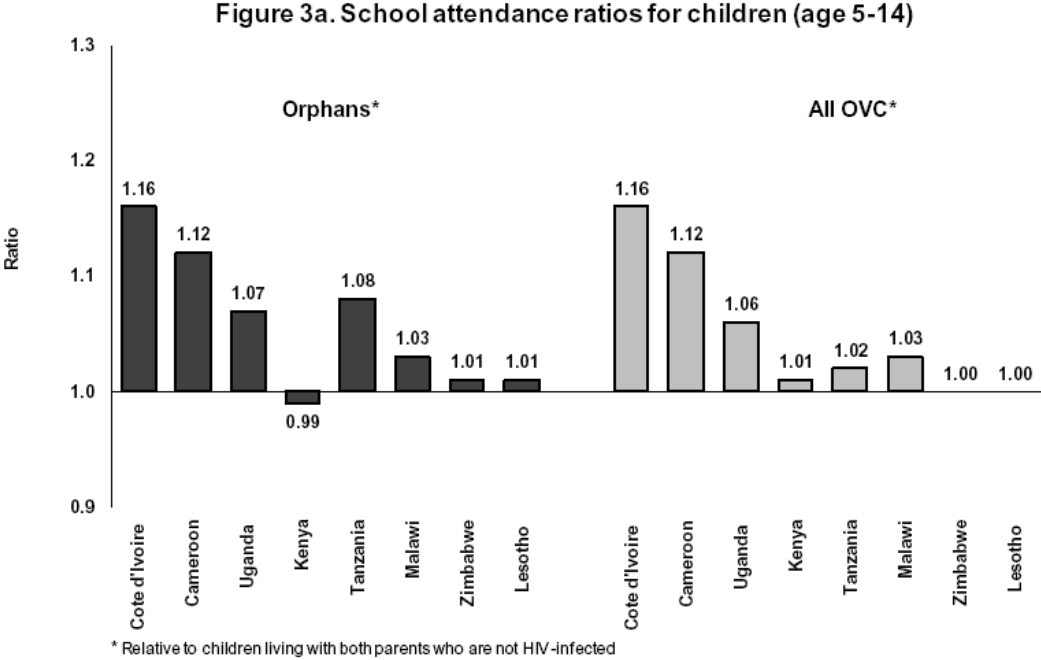
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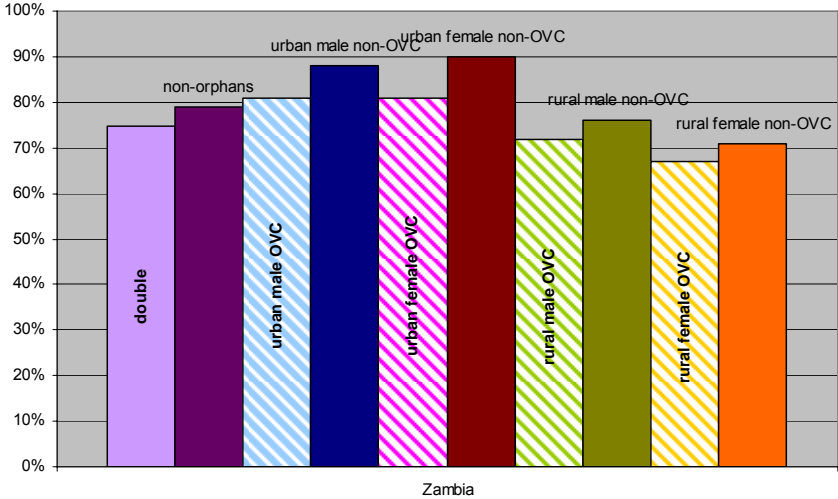
Annex 1: Suggested tables and figures for inclusion:



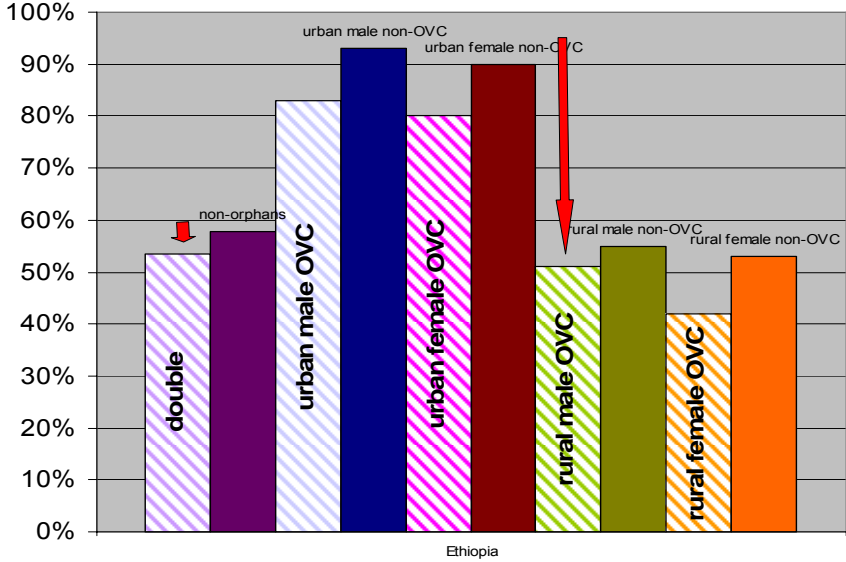
Source: Orphans and vulnerable children in high HIV-prevalence countries in Sub-Saharan Africa. DHS Analytical studies 15 Calverton : Macro International Inc., 2008. (page 37).

Below graphs from : Campbell P. (2008). No worse than their peers? Policy implications arising from a situation analysis of orphans in 11 Eastern and Southern Africa. PowerPoint presentation at the International AIDS Conference, Mexico City. <http://www.aids2008.org/Pag/ppt/MOAX0406.ppt#301>

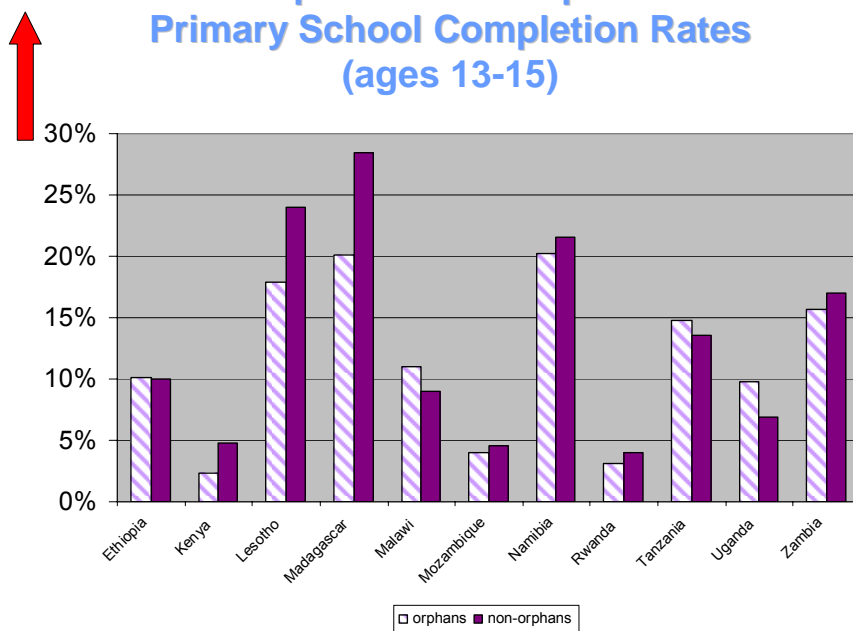
School Attendance in Zambia (ages 13-15)



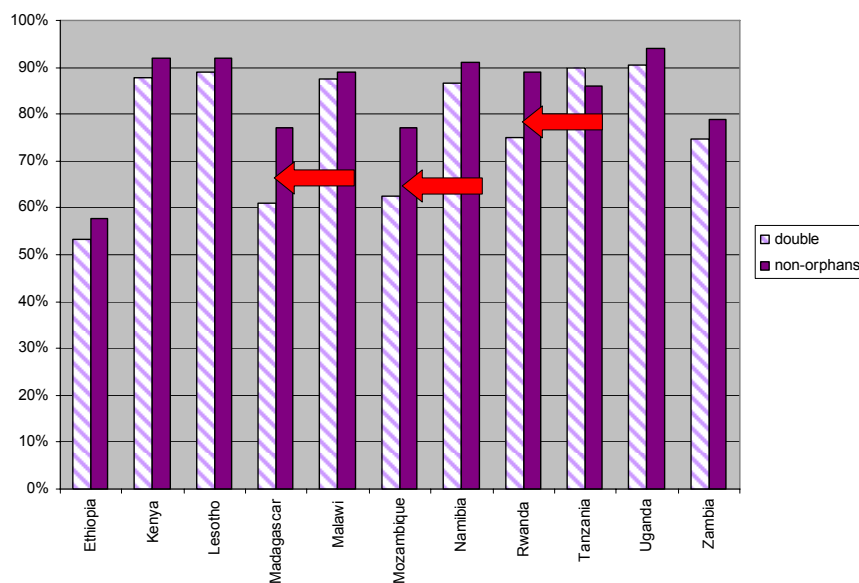
School Attendance in Ethiopia (ages 13-15)

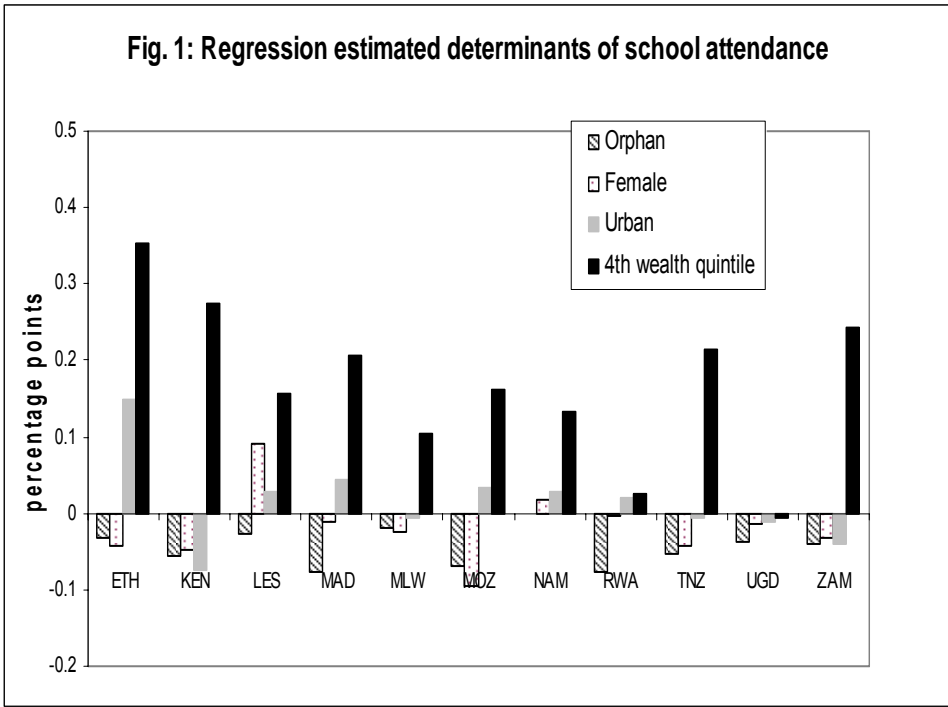


Orphan to Non-orphan Primary School Completion Rates (ages 13-15)



Double orphan/Non-orphan School attendance rates



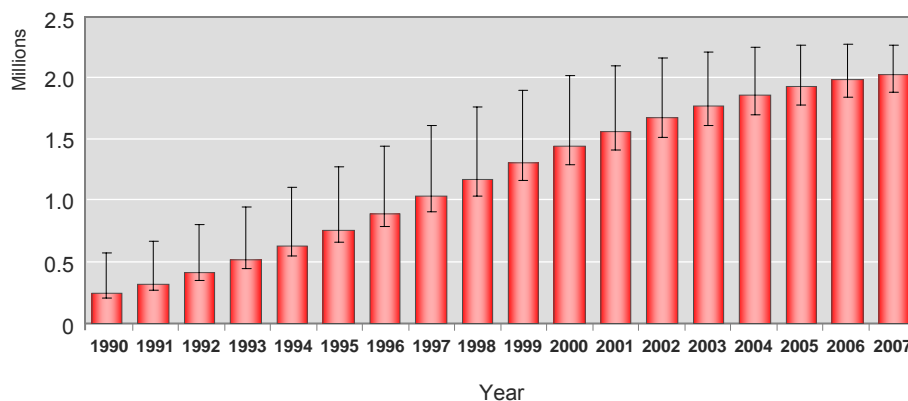


Source: Alnwick D. AIDS Affected Children: Is there an emerging consensus for programming? PowerPoint presentation at the International AIDS Conference, Mexico City. <http://www.aids2008.org/Pag/ppt/MOSAT2402.ppt>

All figures below from:
 UNAIDS (2008). 2008 Report on the Global AIDS Epidemic. Geneva: UNAIDS.
www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp



Children living with HIV globally, 1990–2007



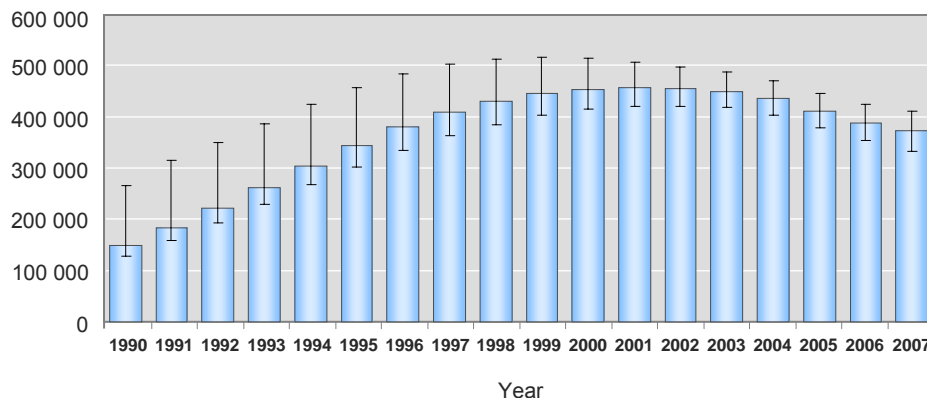
This bar indicates the range around the estimate

Figure 2.5

2008 Report on the global AIDS epidemic



New HIV infections among children, 1990–2007

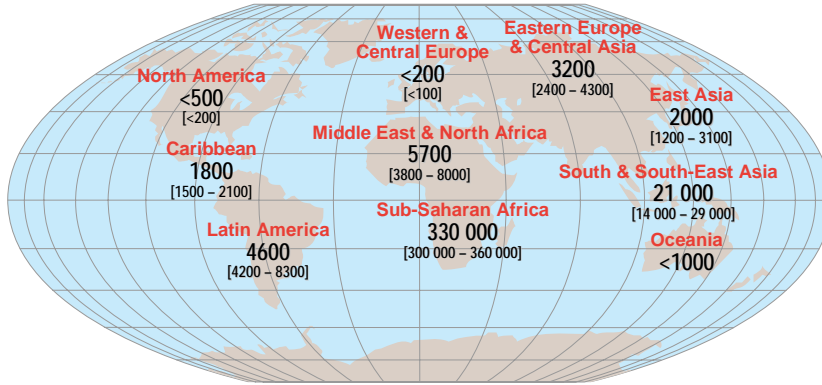


This bar indicates the range around the estimate

Figure 2.6

2008 Report on the global AIDS epidemic

Estimated number of children (<15 years) newly infected with HIV, 2007

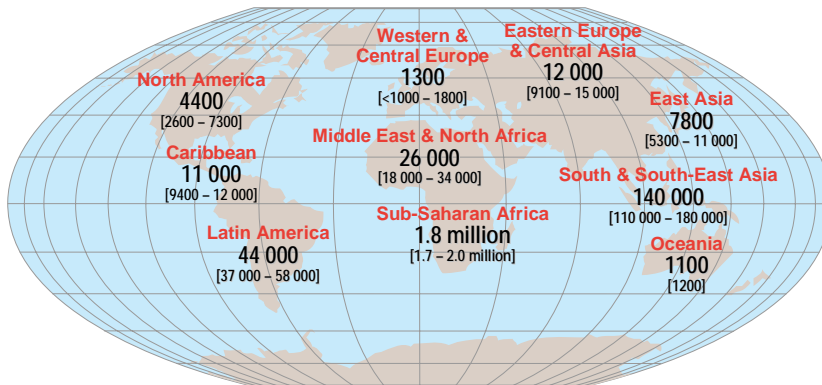


Total: 370 000 (330 000 – 410 000)

July 2008 e

8

Children (<15 years) estimated to be living with HIV, 2007



Total: 2.0 million (1.9 – 2.3 million)

July 2008 e

7

Percentage of orphans and vulnerable children aged under 18 living in households that have received a basic support package

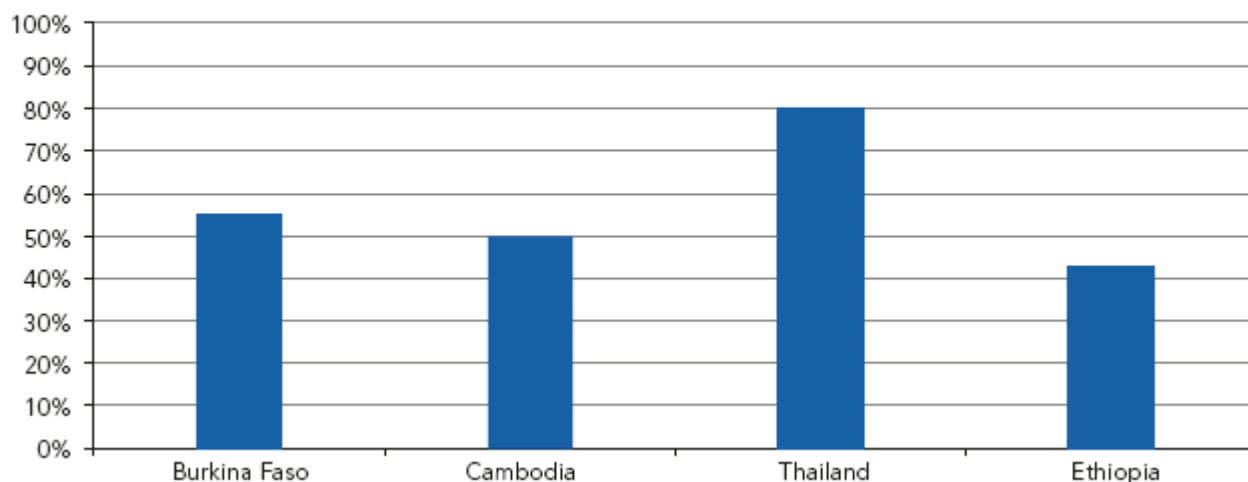


Figure 2, page 6: Example of 2010 targets to reach universal access to HIV prevention programmes, treatment, care and support.

UNAIDS. (2009). What countries need: Investments needed for 2010 targets. Geneva, UNAIDS. http://data.unaids.org/pub/Report/2009/20090210_investments_needed_2010_en.pdf

Provision of social support in the SADC region			
	Y	P	N
Counselling for learners: Can pupils and students who are affected by AIDS find help from their teachers? Or from someone else?	0	2	11
Counselling for educators: Are teachers affected by AIDS, and those who are dealing with the trauma of children affected by AIDS, getting help to cope?	0	1	12
Social support: Are children affected and infected by the pandemic receiving counselling and care? Is there a culture of care in schools and institutions?	1	1	11
Orphan needs: Is planning under way to understand and respond to the special needs of increasing numbers of orphaned and other vulnerable children?	1	5	7
Y Yes, action is being taken P Some action is planned N No action is being taken			
Source: Southern African Development Community, Human Resources Development, Second Coordinating Unit. 2001. <i>Report on Country Preparedness in Dealing with HIV and AIDS in the Education and Training Sector among SADC Member States</i> . SADC HRD SCU, Mbabane. In: Coombe C. 2007. <i>Mitigating the Impact of HIV and AIDS on Education Supply, Demand and Quality</i> . In Cornia, Giovanni Andrea (ed.). <i>AIDS, public policy and child well-being</i> . 2d edition. Florence: UNICEF-Innocenti Research Centre. http://www.unicef-irc.org/cgi-bin/unicef/Lunga.sql?ProductID=476 [Table 2, page 258.]			

Annex 2: Case Studies

Case Studies 1-12 on Enabling OVC to Access Education²

Case 1 - KENYA: Primary School Fee Abolition

The Kenya Government launched Primary School Fee Abolition in January 2003. Almost overnight, school enrolment in Kenya leapt from 5.9 million to 7.2 million.

Without extensive planning or preparation, this initiative constituted a 'positive emergency': an immediate financial vacuum as schools' income from fees was abruptly cut off; unprepared schools that led to subsequent dropouts with OVC more likely to lose out on education.

Even with FPE, orphans continue more likely to lose out on education than other children. In Kenya, the ratio of female orphans to female non-orphans attending school is 0.9, while the ratio of male orphans to male non-orphans is 0.93. The chances that both male and female orphans will attend school are significantly lower than their non-orphaned counterparts. The percentage of double orphans aged 10-14 attending school is 70% lower than that of children living with at least one parent (93%)³.

Main strategies to respond to the challenges:

1. Increase the education supply by increasing the quality and capacity of existing schools. In addition to soliciting donor support and improving schools' financial accountability to address the financial vacuum, new pedagogical methods were introduced to schools to alleviate the extreme situation of over-sized classes - On introducing Free Primary Education (FPE), class sizes in many schools rose as high as 150 children per teacher.
2. Reach OVC through enhanced non-formal education with civil society partners. Two types of non formal education are categorized in the Kenya Education Sector Support Programme (KESSP) - Non Formal Schools (NFS) which offer the formal school curriculum and Non Formal Education Centres (NFECs) which offer flexible learning schedules and diverse curricula. Increased support to such schools brought in an estimated additional 300,000 children.

The support given to non-formal education has included the following:

- Registration of non formal schools with the MoEST (previously non formal schools tended to be registered with the Ministry of Social Welfare)
- The development of an NFE database which has been collected, collated and analyzed by MOE from six urban municipalities and seven ASAL districts. This database has been crucial in the identification of NFS in urban slums enabling them to receive FPE grants
- Improved training of non-formal school teachers
- Improved supervision of the work of non-formal schools
- By December, 2005, provision of the same capitation fee to non formal schools per student as to formal schools led to 166 non formal schools receiving support totalling Ksh.42 million.
- A curriculum from non formal schools was developed by the Kenya Institute of Education and approved for national use by the minister for education early in 2007
- The development and review of draft NFE policy guidelines

The primary motivation of this measure was to improve the poor enrolment rate in Kenya, (which had decreased from 107 to 92 over the previous two decades). There is no disaggregated programme monitoring data on OVC. Nevertheless, almost universal anecdotal evidence suggested it to be one of the initiatives that offer a response to the needs

² Case No. 1-12 are extracted from the OVC Sourcebook (forthcoming 2009, World Bank, UNICEF and PCD – full version provided to the GMR Team), and Case No. 13-14 prepared by the UNESCO ED/UNP/HIV (2009).

³ The Government of Kenya. Office of the Vice-President and Ministry of Home Affairs. Report on the rapid Assessment, Analysis and Action Planning Process (RAAAP) for Orphans and Other Children Made Vulnerable by HIV/AIDS in Kenya. July, 2004.

of orphans and vulnerable children at a scale consistent with magnitude of their needs. In Kenya, the 2008 UNAIDS Kenya country progress report stated that there are 2,430,000 orphans (1,149,000 from AIDS)⁴. Kenya's 2003 Demographic and Health Survey (DHS) reported that 10.9% of 0-14 year olds were orphans⁵.

Case 2 - RWANDA: Community Child Mentoring Programme (CCMP)

The country has experienced large increases in the number of orphans and child-headed households due to the 1994 genocide and the AIDS epidemic. The 2008 UNAIDS Rwanda country progress report estimates that 1,350,820 children are orphaned or vulnerable⁶. The current UNICEF Rwanda country page states that the number of orphans is 820,000⁷, or around 16 per cent of all children. UNAIDS reported that the number of orphans due to AIDS is 220,000⁸. There are an estimated 42,000 child-headed households in the country, caring for around 101,000 children⁹.

The CCMP in Rwanda was launched in 2003 by the Bamporeze Association, a Rwandan NGO, as a way to assist children living in child-headed households. The primary goal is to support children and young people 20 and under in child-headed houses with mentors who can guide, advise and advocate, with the hope that this will have a positive influence on the capacity of the children in these households to attend and stay in school.

CCMP helps local communities provide children living in child-headed households with the practical and psychosocial support needed to enable both their integration within the life of the community and their access to education, healthcare, shelter, legal support, land ownership rights and other benefits.

While there has been little monitoring and no evaluation done of the 'Child Mentoring Programme' in 2007, the programme was active in five districts and benefited 11,123 children.

One of the main challenges regards the sustainability – as CCMP primarily encourages the very poor to help the nearly destitute.

Case 3 - RWANDA: Community Harnessed Initiatives for Children's Learning and Development (CHILD) Programme

The CHILD Programme, begun with seed money from CARE USA in 2003 and now run by CARE International in Rwanda, offers a tailored training package to older young people (12-25 years old) who have dropped out of formal schooling or who have never gone to school. Its combination of literacy training, vocational training and business skills development enables those without access to formal education to make the longer-term investment in their human capacity that is required if they are to escape from poverty.

⁴ http://data.unaids.org/pub/Report/2008/kenya_2008_country_progress_report_en.pdf

⁵ <http://www.measuredhs.com/pubs/pdf/FR151/12Chapter12.pdf>

⁶ http://data.unaids.org/pub/Report/2008/rwanda_2008_country_progress_report_en.pdf, pg 16

⁷ http://www.unicef.org/infobycountry/rwanda_statistics.html

⁸ http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp, pg 218;

⁹ http://www.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_RW.pdf, pg 7

⁹ http://www.unicef.org/infobycountry/23867_20292.html

The CHILD programme entails community establishment of low-cost, non-formal education centres; teaching in literacy and numeracy; training in vocational skills and simple business development techniques; and the provision of toolkits that enable programme graduates to establish income-generating activities.

Since its inception, the programme has benefited around 6,000 children.

Case 4 - SWAZILAND: All Children Safe in School (ACSS)

One in four adults in Swaziland is infected with HIV,¹⁰ and annual AIDS-related deaths are estimated at 10,000 out of a population of just over one million.¹¹ In 2007 it was estimated that there were 108,000 orphans and vulnerable children in Swaziland and it is estimated that by 2010 the number will increase to 113,000¹². A 2002 survey of 49 communities in Swaziland identified over 10,000 children living in child-headed households and found that most of these children were out of school.¹³ Overall, AIDS-related deaths, along with poverty, drought, food insecurity and malnutrition, are leading to rapid increases in the number of children who can be classified as vulnerable.

ACSS, an initiative introduced in Swaziland in January 2003 and which ran until 2005, used grants to schools, meals for schoolchildren, farming opportunities and improvements in water and sanitation (in select schools) to increase access of orphans and vulnerable children to quality education, and to mitigate the impact of poverty and AIDS on children attending school.

The programme began in 40 communities in Lubombo and Shiselweni, two of Swaziland's four regions. The initiative was later extended to 44 communities, and in 2005, the school meals component expanded from 80 to 95 schools. Orphans and vulnerable children ages 6–18 in Lubombo and Shiselweni were the focus of the programme, because these two regions were the worst hit by drought and poverty, with studies showing that, despite relatively low school fees, drop-out rates among all children were increasing in these regions.¹⁴

The local communities were a secondary focus of the programme in order to ensure that they were made aware of the needs of orphans and vulnerable children, and were contributing towards meeting these needs.

ACSS' success prompted the Government of Swaziland and its development partners to increase allocations for mitigating the impact of AIDS in schools. In 2004, after the Ministry of Education announced the provision of school grants to support all orphans and vulnerable children, total enrolment at primary schools increased by nearly 10,000 students - a 4.5 per cent increase in the gross primary school enrolment ratio.¹⁵

Running until 2005, the experiences and impact of the programme were subsequently used to guide the development of a number of different policies and programmatic responses to

¹⁰ http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf UNAIDS, 2007 AIDS Epidemic Update, p. 16.

¹¹ UNAIDS, 2008 Report on the global AIDS epidemic, p. 217, accessed at http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp

¹² UNAIDS, Swaziland Country Report, January 2008, p. 46-47, accessed at http://data.unaids.org/pub/Report/2008/swaziland_2008_country_progress_report_en.pdf

¹³ United Nations Convention on the Rights of the Child, Initial report of Swaziland, 2006, p. 3, accessed at [http://www.unhcr.ch/tbs/doc.nsf/0/1cf3b67f72c7bf7ec12572020051cb71/\\$FILE/G0644326.pdf](http://www.unhcr.ch/tbs/doc.nsf/0/1cf3b67f72c7bf7ec12572020051cb71/$FILE/G0644326.pdf)

¹⁴ [Source to be identified]

¹⁵ The World Bank (2006) Swaziland: Achieving Basic Education for All - Challenges and Policy Directions. The World Bank. Washington D.C. p 18. Accessed at http://www-wds.worldbank.org/servlet/WDSContentServer/IW3P/IB/2006/07/18/000112742_20060718100511/Rendered/PDF/361450v20S_Z.pdf

the needs of orphans and vulnerable children, most particularly the Second National Multisectoral HIV & AIDS Strategic Plan 2008, the National Plan of Action for orphans and vulnerable children (2006-2010), the National Multisectoral HIV & AIDS Policy (2006), the European Union Education Sector Programme (2006-) and MiET's 'Schools as Centres of Care and Support' Programme (2006-). The Government of Swaziland subsequently increased its commitment of resources for orphans and vulnerable children from E16 million (\$2.4 million) in 2004, to E47 million (\$7.09 million) in 2005 and 2006, and to E66 million (\$9.9 million) in 2007. In addition to the allocation of E47 million in 2005 and 2006, the Ministry of Education also introduced free stationery for all students in grades 1 to 4, expanded to cover all primary grades in 2007.

In 2004, financial inputs to 7,627 students in 44 communities taking part in the programme were as follows:

Community EFA Grant	\$354,069.98	(\$46 per student)
Agriculture inputs	\$41,000	(\$5 per student)
Water and Sanitation expenditure:		
Toilet construction (327 units) in 20 schools	\$182,855	
Water supply-hand pumps + one motorized pump	\$37,500	
Storage tanks (4) and gutters	\$833	
Water tankers	\$107,000	(\$14 per student)

Costs for WFP support for school feeding are not given.

Case 5 - SWAZILAND: Neighbourhood Care Points (NCP)

The NCP programme, initiated in 2003 as a way to enable local communities to care for orphans and vulnerable children and help these children realize their human rights to education and health, was also designed to address the psychosocial consequences of the AIDS epidemic by helping children deal with the trauma and loss of losing their parents to the disease.

The NCP programme uses community mobilization and the establishment of care centers, training of caregivers, provision of education activities to young children, daily hot meals, and offers of psychosocial support to help orphans and vulnerable children realize their rights to food, education, health and shelter.

By 2007 there were 625 neighbourhood care points spread throughout the four regions of Swaziland receiving some material support from UNICEF. In the UNICEF-supported centres, a total of about 5,000 caregivers, including young people, old women, and men cater to the needs of over 34,000 children. These figures exclude the many other neighbourhood care points which have not received any external support and whose day-to-day operation is sustained solely by the communities themselves.

Pre-school age orphans and vulnerable children and out-of-school children aged 4-12 are the primary focus of the programme. Older children also benefit, because they can leave younger siblings in a safe place and go back to school. The programme also benefits community caregivers.

The NCP programme is associated with minor increases in the percentage of orphans and vulnerable children who eat well and who attend school in communities served by the programme. A mid-term review of the programme in 2004 stated that "NCPs were recognized as a powerful strategy that addresses multiple issues simultaneously: they address cross-cutting issues such as hunger and poverty, HIV and AIDS, child protection

and health”.¹⁶ However, an assessment in 2006 identified challenges related to stigma associated with targeted support, cost-effectiveness and sustainability.

The government subsequently increased the budget of the Ministry of Education to take care of out-of-school children. In addition, neighbourhood care points were adopted by the government as a crucial strategy in the National Plan of Action for orphans and vulnerable children (2006–2010).

Case 6 - TANZANIA: Complementary Basic Education in Tanzania (COBET)

Initiated in 1997 in response to the country’s poor primary school enrolment rates, COBET supports the formal primary education system by providing quality basic education and life and survival skills to children – particularly girls – who are missing out on formal schooling.

The implementation involved mapping and identification of COBET learners, development of skills-based child-friendly curricula, establishment of COBET learning centres, delivery of curricula through two types of facilitators (teachers newly graduated from teacher training colleges, and paraprofessionals, community members who have as a minimum qualification a secondary school education or who are retired teachers). Training and awareness raising activities were also carried out to gain community support.

At the end of the three-year pilot phase, monitoring data showed that COBET had taught 1,530 learners in 50 learning centres in 5 districts. Of these, 449 children (173 girls and 276 boys) were orphans and 146 (78 girls and 68 boys) were children in abject poverty.

What’s more, data from the programme’s pilot phase show that learners who studied in COBET centres for three years achieved results similar to those who studied for seven years in the formal primary school system. This enabled many COBET graduates to enter secondary education.

The success in its three-year pilot phase prompted the government to expand it nationwide. At the same time, certain aspects of the programme’s pilot phase, such as its high per-pupil cost, the concern that it created a parallel structure and the sometimes mixed perceptions of its success, raise the question of whether COBET has the potential to be scaled up from a resource-hungry pilot project to a sustainable national programme of quality.

Case 7 - TANZANIA: Most Vulnerable Child (MVC) Programme

Begun in 2000, the MVC Programme focuses on community identification of the most vulnerable children and on mobilising resources at the local level to support these children. The programme also works to strengthen each community’s capacity to care for the neediest children and to foster children’s participation in the programme.

National criteria drawn from the ‘National Strategy for Community-based Care and Support of the Most Vulnerable Children’ covering areas of education, health and livelihood were used, and village ‘most vulnerable child’ committees were set up, to identify the most vulnerable children.

¹⁶ UNICEF (2004) The Government of Swaziland and UNICEF Cooperation 2001-2005: Mid-term Review, 2004. Kingdom of Swaziland.

Since its inception, the 'Most Vulnerable Child' programme has expanded from 6 to 67 districts, though without full coverage in some, and by 2007 there were approximately 11,000 villages participating, over 390,000 children in Tanzania had been identified by the programme as 'most vulnerable' with around 100,000 of them receiving support.¹⁷

Challenges remain, which include community ownership and participation as the programme rely on UNICEF financial support, and the 'most vulnerable child' committee as parallel to the existing village governance structure.

Case 8 - UGANDA: KICWA Reception Centre

Established in 1998 by the Kitgum Concerned Women's Association (popularly known as KICWA) as a reception centre in Kitgum to help meet the needs of traumatized war victims, particularly children and young people who had escaped after being abducted by rebel forces. More than 4,000 children have benefited from KICWA's services since the centre opened.

Case 9 - UGANDA: Opportunities for Reducing Adolescent and Child Labour through Education (ORACLE)

The ORACLE Programme was established in 2003 as a way to raise awareness of the worst forms of child labour – and to address this problem by improving access to quality education for children and adolescents either engaged in hazardous child labour or at risk of becoming engaged in conflict. Funded through 2007, it later became 'Livelihoods, Education and Protection to end Child Labor' (LEAP), a programme which seeks to build on Oracle's success. Key components of the programme include: Identification and assessment of children in need of assistance; providing assistance including medical treatment, primary school support, formal and non-formal education sponsorship, business skills training, start-up costs for income-generating, counselling and use of traditional/cleansing ceremonies.

Case 10 - ZAMBIA: Better Education and Life Opportunities through Networking and Organizational Growth (BELONG)

The BELONG programme, run by Project Concern International with support from the United States Agency for International Development / U.S. President's Emergency Plan for AIDS Relief and the World Food Programme, has three significant components:

1. Delivery of food commodities to schools and vulnerable households. In return for receiving food, parents and caregivers are encouraged to send children to school and make regular attendance possible. Children are also given encouragement to attend.
2. HIV and AIDS awareness. This includes distributing information, education and communication materials; using Theatre for Development (using performing arts to disseminate information), and the development and implementation of an HIV and AIDS curriculum component for street children.
3. Implementation of the WORTH economic empowerment model in collaboration with Pact Zambia. WORTH provides enrolled female caregivers of orphans and vulnerable children with literacy training, micro-credit groups and assistance with the development of small enterprises to improve household financial security. In 2007,

¹⁷ UNICEF Tanzania Annual Report 2007, p. 24.

WORTH had 218 women's groups in Zambia's Chongwe and Kafue districts, with a total of over 5,300 women caring for nearly 8,000 children

The Programme focuses on children who attend Zambia's community schools as well as those in the residential centres providing services to former street children. These facilities have a high proportion of children from poor families or from households that have been affected by AIDS. The original aim of the programme was to help lessen the impact of a 2002 food crisis on people affected by HIV and AIDS, particularly those caring for orphans and vulnerable children. With the expansion of the programme, its aim is to improve the lives and prospects of orphans and vulnerable children through the provision of a widened range of services. Supporting children's education continues to be critical to the programme's work.

The BELONG programme now provides school feeding and other supportive services to 70,000 orphans and vulnerable children attending mostly urban community schools every day; additionally, 7,800 child- and female-headed households also receive a monthly take-home ration.

Case 11 - ZAMBIA: 'Learning at Taonga Market' Interactive Radio Instruction Programme

The Interactive Radio Instruction programme in Zambia, launched in 2000, is to provide education to orphans and vulnerable children who do not otherwise have access to formal schooling. The programme, also called 'Learning at Taonga Market', is heard in approximately 900 centres throughout the country and in 2005 reached around 60,000

Main features of the IRI programme include:

Production of high-quality radio broadcasts and printed materials -

Over 1,000 Interactive Radio Instruction programmes for grades 1 to 6, with programmes for grade 7 currently under development. HIV and AIDS-related health issues, as well as instruction on personal hygiene and attitudes towards the sick, have also been included in IRI programming, complementing the Ministry of Health's School Health Project.

Establishment of IRI centres - By 2005 there were 893 IRI centres now established in all nine provinces of Zambia, reaching 56,233 learners. Many kinds of settings function as IRI centres: churches, homes, community halls, even such outdoor locations as under trees. The participation of girls and boys is fairly balanced.

Community support - Interested communities are first identified by program staff in association with MoE. Communities are then responsible for choosing a mentor to lead lessons, identifying a venue to establish as the IRI centre for the lessons, managing the centre, and providing a radio.

Training of mentors - Volunteers receive three days of formal training from the Ministry of Education, necessary because the IRI broadcasts contain a high level of pedagogical instruction regarding classroom management.

Case 12 - ZAMBIA: Zambia Open Community Schools (ZOCS)

ZOCS was established in 1992 but became fully operational in 1995 after being registered as a community school programme. ZOCS currently provides technical support to 53 schools

(17 ZOCS schools and 36 affiliated schools), ensuring the primary education of 11,500 students taught by 250 volunteer teachers.

The programme's main target groups are out-of-school children (especially girls and orphans), pregnant girls, and HIV-positive learners. Initially, the programme was geared towards children ages 9–16. More recently the programme has recognised the needs of younger children and now benefits children aged 6–18. The programme also reaches out to guardians and caregivers, in particular grandparents and others caring for orphans and vulnerable children.

ZOCS builds its work on twine pillars:

1. Enhanced educational opportunities for children – ZOCS currently provides technical, pre- and in-service teacher training and learning materials support to 53 community schools educating about 11,500 students, while working to increase number of classes in existing ZOCS community schools and to replicate successful ZOCS interventions to other districts.
2. Increased community capacity to provide such opportunities - ZOCS encourages local communities to take responsibility for and control of community schools; empowers local communities to plan, implement and monitor their activities and account for resources; seeks to recognise, develop and utilise local skills, and provides administrative and material support to local communities.

ZOCS is seen as a trailblazer in efforts in Zambia that saw numerous other organizations open community schools throughout the country, enabling many thousands of children left out of formal schooling to access education. More than 3,200 community schools – comprising about one-third of all primary schools in Zambia – have been founded by non-governmental organizations, community-based organizations, faith-based organizations and ad hoc local committees. The ZOCS programme provides a model of education for the neediest children and communities that could be replicated and sustained throughout Africa.

Case 13 - 1st Meeting of Ministers of Health and Education to Stop HIV and STIs in Latin America and the Caribbean

The first meeting of Ministers of Education and Health from Latin America and the Caribbean took place in Mexico City on 1 August 2008 to identify strategies for strengthening HIV prevention for young people. The meeting was initiated by the Government of Mexico (Ministries of Health, Education and Foreign Affairs) in partnership with the National Institute of Public Health (INSP), Mexico, and with technical and financial support from UNAIDS including: UNESCO, UNFPA, UNICEF and the UNAIDS Secretariat.

A diagnostic (situation assessment) was undertaken prior to the meeting to identify how sex education has been addressed in the 34 countries in the region. The final results were presented at a technical meeting prior to the Ministers' meeting and noted, among others, that:

- While sex education and HIV prevention education activities were usually delivered by the Ministry of Education (MoE), the content was often developed by the Ministry of Health (MoH).
- Related legislation was in place in some countries, but others had limited or no legislation.
- Comprehensive sexuality education is usually a cross-cutting subject. In a few countries, it is an extracurricular subject; in almost none is it optional.

- At primary level, the teacher is usually the main person responsible for delivering content while at the secondary level, the majority of relevant topics are covered apart from discrimination and stigma related to sexual orientation.
- Only three countries reported distribution of and/or access to condoms for youth at high school level; in one of the three, it is not official and in another one, it is only in certain provinces.
- There are improving efforts to integrate children and adolescents living with HIV (or otherwise affected by the virus).
- More work on evaluation is required.

This Summit led to the signature of an historic Declaration pledging to provide comprehensive sex education as part of school curricula in the region. In the Declaration, the Ministers aim to reach the following targets:

- By 2015, reduce by 75% the number of MoE schools that do not provide comprehensive sex education
- By 2015, reduce by 50% the number of adolescents and young people who are not covered by health services that appropriately attend to their sexual and reproductive health needs

In order to do so, the following actions were agreed upon:

- Evaluate existing programmes during 2009 and 2010
- Update content and didactic methods of curricula – in partnership with MoHs – before the end of 2010
- Incorporate new comprehensive sexuality education curricula in teacher training activities by 2015
- Undertake an impact evaluation of at least five strategies for comprehensive sexuality education, sexual health promotion or HIV/STI prevention among adolescents and young people by 2015
- Ensure an appropriate legal framework for comprehensive sexuality education programmes
- Ensure mechanisms for reporting discrimination in governmental education and health services
- Strengthen cooperation between the two ministries (joint mechanisms for planning, implementation, M&E)
- Include these issues in upcoming regional and international summits

The Regional Directors Group (including PAHO, UNAIDS, UNDP, UNESCO, UNFPA, UNICEF and WFP) has established a joint workplan which is providing:

- Logistical, technical and financial support to the functioning of the Intersectoral Working Group, its secretariat (Mexico) three sub-regional groups (Caribbean, Central America/Mexico and South America) and focal points at national level
- Logistical, technical and financial support to coordination, communication, and regional, sub-regional and national level activities
- Resource mobilization in short and medium-term perspectives
- Support for coordination with other partners

Case 14 - Redirecting Prevention Efforts in Asia-Pacific

The independent Commission on AIDS in Asia was established in June 2006, tasked with studying the realities and impact of AIDS in Asia and recommending strategies for a stronger response to HIV and AIDS. The Commission's work was financially supported by the UNAIDS Secretariat, UNICEF, UNDP and the Asia Development Bank.

The Asia Commission Report, published in 2008 and launched at the UNAIDS Programme Coordinating Board meeting in Thailand (April 2008), found that:

- While there is considerable variation in the shape and severity of AIDS epidemics across the region, all of them are driven by three key behaviours that are responsible for at least 75% of all HIV infections in the region, namely: unprotected sex in the context of sex work; unsafe injecting drug use; and unprotected sex between men with multiple partners.
- HIV epidemics in Asia are highly unlikely to sustain themselves in the 'general population' independently of commercial sex, drug injecting and sex between men.
- A mixture of a lack of knowledge, moral judgments and fear causes HIV-related stigma and discrimination, which undermine Asia's responses to the epidemic and prevent people from accessing and using a range of services that they need to protect or sustain their current health – including VCT, ART and the diagnosis and treatment of STIs.
- The coverage of interventions focusing on the three behaviours highlighted above is far too low to contain the epidemic, let alone turn it around.
- Too many resources for prevention are allocated to people at little or no risk of HIV infection. For example, adolescents who engage in one or more of the three risk behaviors mentioned above cause up to 95% of all HIV infections in their age group, but they receive less than 10% of UNAIDS Unified Budget and Workplan (UBW) resources.
- Coordination, collaboration and leadership are lagging behind, with some notable exceptions. In particular, attempts to involve non-health sectors – especially education and social welfare – have generally been unsuccessful.
- Interventions should be targeted towards reducing HIV transmission in settings where most infections occur: i.e., via unsafe injecting drug use, unsafe sex in the context of sex work and unprotected male-to-male sex.

UNESCO is the only UNAIDS Cosponsor to provide a written response to the Asia Commission Report.¹⁸ This discussion paper considers how education systems should react to the call to refocus prevention on adolescents most at risk for HIV, recommending three distinct (and complementary) strategies:

1. Address the behaviours that cause 95% of all HIV infections among young people (injecting drug use, male-to-male sex and sex work) as part of the core curriculum in order to increase the epidemiological and public health impact of these programmes.
2. Reduce stigma and discrimination of people who engage in these risk behaviours (as well as people living with HIV) by promoting an inclusive school environment, and enhancing the ability of young people who engage in these behaviours to negotiate safer behaviours and access to services.
3. Where, for political, religious or other reasons, discussion of these behaviours in the school setting is deemed inappropriate or otherwise currently not possible, schools should design and implement extracurricular responses for adolescents who engage in risk behaviours, or seek linkages to adolescent-friendly services outside of schools.

The discussion paper calls for strong collaboration and coordination among UNESCO, UNDP, WHO, UNICEF, UNFPA, and UNODC to strengthen a common approach towards meeting the needs of young people who are most at risk of HIV, and to strengthen school-based approaches for reducing stigma and discrimination of people who engage in risk behaviours.

¹⁸ UNESCO Response to the Asia Commission Report, http://www.unescobkk.org/fileadmin/user_upload/hiv_aids/Documents/Inhouse_docs/Discussion_paper_IV/UNESCO_response.pdf