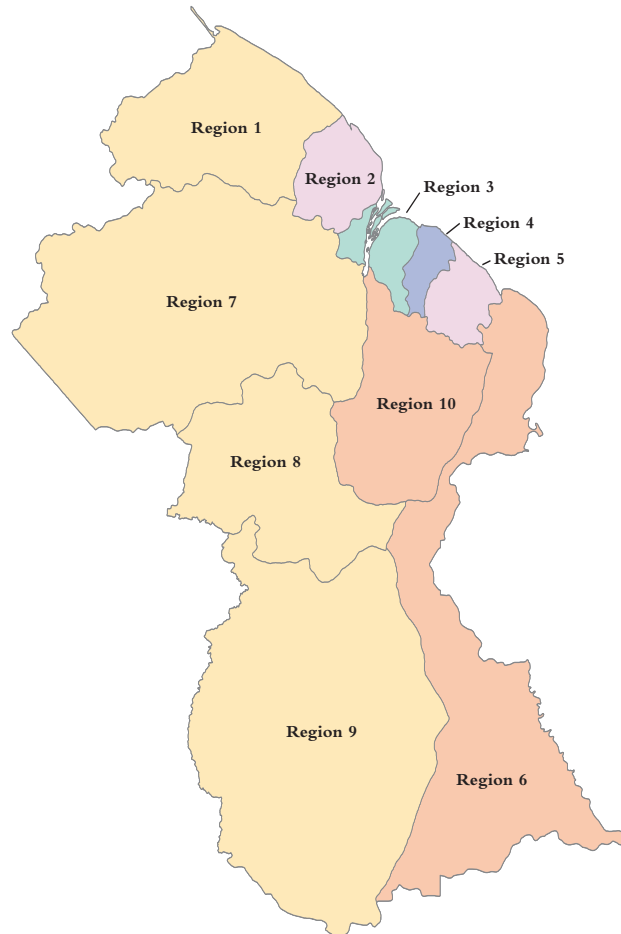


# **Rapid Situation Analysis of the Education Sector's Response to HIV & AIDS in the Context of School Health and Nutrition in Guyana**

This Rapid Assessment was developed in partnership with the  
Ministry of Education of the Cooperative Republic of Guyana.



# Rapid Situation Analysis of the Education Sector's Response to HIV & AIDS in the Context of School Health and Nutrition in Guyana



THE WORLD BANK

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## List of Abbreviations and Acronyms

|         |   |
|---------|---|
| AIDS    | Acquired Immune Deficiency Syndrome             |
| ART     | Anti-retroviral therapy                         |
| ARV     | Anti-retroviral                                 |
| BoS     | Bureau of Statistics                            |
| BMI     | Body Mass Index                                 |
| CARICOM | Caribbean Community                             |
| CFNI    | Caribbean Food and Nutrition Institute          |
| COSHOD  | Council for Human and Social Development        |
| CNHOS   | Caribbean Network of Health-Promoting Schools   |
| CPCE    | Cyril Potter College of Education               |
| CPDT    | Continuous Professional Development of Teachers |
| DFID    | Department for International Development, UK    |
| EFA     | Education for All                               |
| FRESH   | Focusing Resources on Effective School Health   |
| FTI     | Fast Track Initiative                           |
| GoG     | Government of Guyana                            |
| GSHS    | Global School Health Survey                     |
| GTU     | Guyana Teachers' Union                          |
| HFLE    | Health and Family Life Education                |
| HIV     | Human Immunodeficiency Virus                    |
| HSDU    | Health Sector Development Unit                  |
| IDPs    | International Development Partners              |
| ILO     | International Labour Organisation               |
| ISHI    | International School Health Initiative          |
| ISY     | In-school Youth                                 |
| LRCs    | Learning Resource Centres                       |
| MICS    | Multiple Indicator Cluster Survey               |
| MoE     | Ministry of Education                           |
| MoH     | Ministry of Health                              |
| MDGs    | Millennium Development Goals                    |
| NAPS    | National AIDS Programme Secretariat             |

|        |  |
|--------|--|
| NGO    | Nongovernmental Organisation                                     |
| OSY    | Out of School Youth  |
| OVC    | Orphans and Vulnerable Children                                  |
| PAHO   | Pan American Health Organization                                 |
| PCD    | Partnership for Child Development                                |
| PTAs   | Parent Teacher Associations                                      |
| SHN    | School Health and Nutrition                                      |
| STD    | Sexually Transmitted Disease                                     |
| UN     | United Nations   |
| UNAIDS | United Nations Programme on HIV & AIDS                           |
| UNDP   | United Nations Development Programme                             |
| UNESCO | United Nations Educational, Scientific and Cultural Organisation |
| UNFPA  | United Nations Population Fund                                   |
| UNGASS | United Nations General Assembly Special Session on HIV & AIDS    |
| UNICEF | United Nations Children's Fund                                   |
| USAID  | United States Agency for International Development               |
| VCT    | Voluntary Counselling and Testing                                |
| WFP    | World Food Programme   |
| WHO    | World Health Organization  |



# Executive Summary

A rapid situation analysis of the education sector's response to HIV & AIDS in Guyana was undertaken between October and November 2007. The analysis was supported by UNESCO, the World Bank, and the Partnership for Child Development (PCD) as part of ongoing efforts to support the call of the Caribbean Community (CARICOM) Ministers of Education for continuing dialogue and action towards accelerating the education sector response to HIV & AIDS in the Caribbean.

The situation analysis sought to enable the development of a comprehensive school health, nutrition, and HIV (SHN & HIV) education sector response for incorporation within the forthcoming Guyana Education Sector Strategic Plan, 2008-12. The conduct of the analysis sought to reflect the wishes of the Government of Guyana; the recommendations of previous UNESCO, World Bank, and PCD missions; and internationally agreed best practice that education sector responses to HIV should be a fundamental component of an integrated and holistic programme of school health and nutrition activities. The situation analysis also sought to contribute to a stronger presence of the education sector in the Government of Guyana's multisectoral response to HIV & AIDS, as outlined in the Guyana National HIV & AIDS Strategy 2007-11.

The priority placed on the education sector's response is based on evidence that education contributes to the knowledge and personal skills essential for the prevention of HIV, and protects individuals, families, communities, institutions, and nations from the impact of AIDS. Education helps to overcome the conditions that facilitate the spread of HIV and can create the understanding and tolerance that contribute to reduced stigma and discrimination against vulnerable and marginalised communities and people living with HIV (UNESCO 2007).

During the situation analysis, a wide range of different stakeholders (including representatives of education, health, other sectors, and civil society) were interviewed concerning SHN & HIV activities in Guyana. In addition, many different data, reports, and documents were collected and a mathematical model (Ed-SIDA) constructed in order to estimate the likely future impact of HIV & AIDS on the country's education sector.

The key findings of the situation analysis were as follows:

- At present, responsibility for coordination within the education sector of SHN & HIV activities in Guyana is dispersed. Lack of coordination is resulting in gaps in provision, duplication, and the waste of resources. There is an urgent need to improve the coordination of activities significantly in order to strengthen leadership in this area.

- The overall prevalence of HIV in Guyana is approximately 1.6 percent (Ministry of Health 2006). Recent data on HIV show that the prevalence of infection is highest in the country's coastal regions 3, 4, and 5, with the prevalence highest in region 4 at 4percent. No data are available concerning the prevalence of infection in regions 1, 8, or 9. Clear data about the prevalence of HIV in different high-risk groups are also lacking.
- A mathematical model, Ed-SIDA, used to estimate the future impact of HIV & AIDS on the education sector found that in coming years the prevalence of HIV among teachers is likely to increase from 1.5 percent to 2 percent. If untreated, this will result in a mortality rate of approximately 0.3 percent, or around 11 teachers per annum. The equivalent of five additional teachers per annum would also be needed to cover teacher absences resulting from HIV & AIDS. The model found that because of their age, the prevalence of HIV among secondary school teachers is likely to be around 1 percent higher than that among primary school teachers. Were anti-retroviral therapy (ART) to be accessed by all teachers who need it, deaths and absenteeism would be markedly reduced, causing considerable financial savings in coming years (approximately US\$113,000 per annum by 2015). Were treatment provided, the number of HIV-positive teachers would rise considerably as greater numbers of infected teachers would survive on treatment and continue teaching. Although the Ministry of Education (MoE) would not be directly responsible for the costs of treatment, it would bear some financial burdens such as those related to provision of counselling services.
- With respect to other health and nutrition conditions affecting school-age children in Guyana, data suggest that poor nutrition is most common among Amerindians, who are concentrated in regions 1, 2, 8, and 9 (these data, however, are nearly 10 years old). The interior regions of the country are also those most affected by diarrhoeal disease. Mental health and obesity concerns are concentrated in the coastal and urban centres. Alcohol consumption and substance abuse are concerns among out-of-school youth (OSY) sampled from regions 3, 4, 6, and 10 and may be a problem among OSY in other regions as well.
- MoE policy making concerning SHN & HIV has been initiated. Drafts are in place addressing (i) the teaching of health and family life education (HFLE) and (ii) workplace HIV issues (the latter based on ILO/UNESCO's "An HIV & AIDS Workplace Policy for the Education Sector in the Caribbean"). There is now a need to consolidate these efforts within an integrated education sector SHN & HIV policy. Such a policy should address areas where policy gaps remain, such as policy with respect to the education needs of orphans and vulnerable children and MoE coordination and leadership of SHN & HIV activities.
- Considerable efforts have been made to expand life skills-based health education in Guyana, particularly at the primary level with the development and implementation of the CARICOM-led HFLE curriculum. More than 2,000 teachers (almost one-quarter of the workforce) have been trained in the subject.
- Clean water and sanitation are being provided in many schools in Guyana by a number of different stakeholders, including government departments such as the Planning Unit in the MoE, development partners such as PAHO and UNICEF, and nongovernmental organizations (NGOs). The extent and technical appropriateness of interventions is uncertain.
- Delivery of school-based health and nutrition services (such as deworming, provision of vaccinations, and so forth) within schools has been largely MoH-led and poorly coordinated with The MoE. Considerable scope exists for the expansion of teacher-led delivery of interventions under the supervision of local health workers.

- Monitoring and evaluation of all activities is poor, reducing policy makers' ability to make good decisions and to allocate resources appropriately.

Upon conclusion of the situation analysis, the findings were discussed at a high-level workshop attended by the Minister of Education, the Hon. Dr. Desrey Fox, and a number of key stakeholders from education, health, other sectors, and civil society. The following recommendations were made as priorities for action and inclusion in the development of the education sector strategic plan. Most recommendations related to matters of policy.

- MoE should develop a comprehensive school health, nutrition, and HIV & AIDS policy which should be reflected in Guyana's general education policy and the country's Education Sector Strategic Plan, 2008-12. The policy should build upon existing MoE draft policies, including the education sector HIV & AIDS policy and the HFLE policy.
- The policy should make clear that the MoE should bear primary responsibility for coordination and ownership of all SHN & HIV activities in Guyana.
- The policy should use the Focusing Resources on Effective School Health (FRESH) framework as its coordinating principle in parallel with the framework for action of the UNAIDS Global Initiative on Education HIV & AIDS (EDUCAIDS), which is led by UNESCO. The policy should also reference existing frameworks such as PAHO's Health Promoting Schools and UNICEF's Child Friendly Schools. Other resources should include *A Guide to HIV and AIDS Policy Development for the Education Sector* (CARICOM-EDC-UNESCO) and *An HIV/AIDS Workplace Policy for the Education Sector in the Caribbean* (ILO-UNESCO).
- The policy should enable the coordination of different stakeholders through the creation of a SHN & HIV unit within The MoE which should be responsible for convening a coordinating body which would bring together the contributions of different stakeholders. In line with this, The MoE should lead efforts to construct a Memorandum of Understanding between The MoE and key stakeholders, especially Ministry of Health (MoH).
- The policy and strategic plan development should draw upon the data presented in this rapid analysis, but needs to be strengthened through further collection of data on different aspects of the health of Guyanese school-age children preferably disaggregated by region. These should include data on children's health, water, and sanitation in Guyanese schools and the educational needs of orphans and vulnerable children.
- The policy should strengthen future decision making through the enhancement of monitoring and evaluation of SHN & HIV activities in Guyana.
- Formation of policy and strategy should be guided by examples of international and regional best practice in this sphere, including the work of CARICOM, UNESCO, the World Bank, PAHO, UNICEF, and others.

In addition to these matters of policy, two key recommendations were made with respect to operational issues.

- Strengthening of the provision of HFLE should continue apace. Especial attention should be paid to strengthening preservice training of new teachers at the Cyril Potter College of Education (CPCE) and its centres.
- Ongoing sensitisation of Guyanese teachers should occur to educate them more about SHN & HIV issues and to encourage greater uptake of health services such as voluntary counselling and testing (VCT) and provision of ART.





# 1

## Background to the Situation Analysis

### **HIV and Education**

In recent years, the education sector has come to play an increasingly important role in preventing HIV & AIDS. Children of school age have the lowest HIV infection rates of any population sector. Even in the worst affected countries, the vast majority of schoolchildren are not infected. For these children, there is a window of hope, a chance to live a life free from AIDS, if they can acquire knowledge, skills, and values that will help to protect them as they grow up. Providing young people with the “social vaccine” of education offers them a real chance at a productive life (World Bank 2002). Young people who fail to complete a basic education are more than twice as likely to become infected with HIV, and the Global Campaign for Education (GCE) has estimated that some 7 million cases of HIV & AIDS could be avoided by the achievement of Education for All (GCE 2004).

But adolescents and young people are still not getting enough information; simply supplying facts about sex and HIV & AIDS is not enough to alter risky behavior. Information must be supplemented with training in life skills, such as critical and creative thinking, decision making, and self-awareness, and with the knowledge, attitudes, and values needed to make sound health-related decisions.

Furthermore, education will not change the course of the epidemic unless it empowers young girls and promotes positive masculinity amongst young boys. Gender disparities are a significant factor placing women at increased risk of HIV infection and causing them to bear the greater burden of the disease. The type of education and school environment matters—education can reproduce social imbalances and inequities, or it can transform societies.

At the same time, the AIDS epidemic is damaging the education systems that can provide this social vaccine by killing teachers, increasing rates of teacher absenteeism, and creating orphans and vulnerable children who are less likely to attend school and more likely to drop out. Because of the impact of the epidemic, some countries are beginning to experience a reversal of their hard-won educational gains, while others are being further set back. Affecting supply, demand, and quality of education, HIV & AIDS limits the capacity of education sectors to achieve Education for All (EFA), and of countries to achieve their targets towards the Millennium Development Goals (MDGs).

The education sector plays a central role in the multisectoral response to HIV & AIDS. The priority placed on the education sector's response is based on evidence that education contributes to the knowledge and personal skills essential for the prevention of HIV, and protects individuals, families, communities, institutions, and nations from the impact of AIDS. Education helps to overcome the conditions that facilitate the spread of HIV and can create the understanding and tolerance that contribute to reduced stigma and discrimination against vulnerable and marginalised communities and people living with HIV (UNESCO 2007).

There is a need for the sector both to utilise available resources effectively and to address HIV & AIDS within the education system systematically. This situation analysis has taken place in order to inform the production of an education sector HIV & AIDS policy in Guyana and also to inform the country's production of an education sector strategic plan for the years 2007-11. It aims to be a timely document that will enable Guyana to develop a formal strategy for an education sector response to the epidemic.

## **HIV & AIDS Prevention in the Context of School Health and Nutrition Programming**

In recent years, concern has been raised about the dominant approaches to responding to HIV & AIDS that either see the epidemic as a condition that calls for a biomedical and pharmaceutical response, or as a condition resulting from human behaviour practices and hence requiring a response that focuses on changing that behaviour (Kelly 2006). Both approaches have been critiqued for their concentration on the immediate causes and effects of HIV & AIDS and their failure to deal with the underlying and structural causes of the epidemic such as poverty, malnutrition, poor health, lack of education, gender disparities, and stigma and discrimination. A particular deficiency seen in the behaviour change approach is its unspoken assumption that different patterns of behaviour are real possibilities for an individual and its failure to address the social factors that shape behaviour. Although there is global agreement that prevention should be the mainstay of the response to the epidemic, too much of the activity currently espoused seems destined to involve a never-ending struggle with the immediate causes of the epidemic—sexual behaviour, mother-to-child transmission, blood supplies, and injecting drug use. But because initiatives do not directly or sufficiently concern themselves with the underlying issues that result in the continuance of the epidemic, their impact is liable to be highly limited.

In response to these concerns, there is increasing recognition within the education sector of the need to position HIV & AIDS prevention within the context of holistic programmes of school health and nutrition. This stems from three factors: the need to support education itself, the need to avoid “vertical” programmes, and the need to combat stigma and discrimination.

### ***Support for Education***

It is increasingly recognised that enabling children to complete a primary school education is one of the most effective ways to prevent HIV & AIDS. Children who have completed education are better placed to make the life choices and to have the life chances that can help release them from many of the complex web of factors that drive the epidemic. In terms of preventing HIV & AIDS, it is therefore essential that everything possible be done to help children stay in school. Poor health and malnutrition are important underlying factors for low school enrollment, absenteeism, poor classroom performance, and early school dropout, as

reflected in the World Declaration on Education for All. Programmes to achieve good health, hygiene, and nutrition at school age are therefore essential to the promotion of basic education for all children.

Good health and nutrition are not only essential inputs but also important outcomes of basic education of good quality. First, children must be healthy and well nourished in order to participate fully in education and gain its maximum benefits. Early childhood care programmes and primary schools which improve children's health and nutrition can enhance the learning and educational outcomes of school children. Second, education of good quality can lead to better health and nutrition outcomes for children and for following generations. In addition, a healthy, safe, and secure school environment can help protect children from health hazards, abuse, and exclusion.

Positive experiences by WHO, UNICEF, UNESCO, and the World Bank suggest that there is a core group of cost-effective activities which could form the basis for intensified and joint action to make schools healthy for children and so contribute to the development of child-friendly schools. These agencies are now developing a partnership for Focusing Resources on Effective School Health. This FRESH Start approach was launched at the World Education Forum in Senegal, April 2000, and, as will be seen, has been used to focus the structure and considerations of this situation analysis.

### ***Avoiding Vertical Programming***

In recent years there has been a move within health systems away from "vertical" programmes: activities that concentrate on addressing a single issue only. This is because most health problems do not exist within isolation, but are located within a web of other concerns and are best dealt with when all are addressed together (for example, a child infected with HIV is at increased risk of other infections and may be less likely to complete basic education). Most vertical programmes have been found to be unsustainable, readily resourced when the conditions they address are in vogue but rapidly failing when the attention of funders moves on to other issues. For these reasons, the long-term prospects for addressing issues have been found to be favoured most when they are tackled as part of a holistic package.

### ***Combating Stigma and Discrimination***

In countries such as Guyana, where stigma and discrimination about HIV & AIDS are strong, presenting HIV & AIDS as a single issue within the education sector can evoke concern and even hostility with respect to teaching concerning the infection in the countries schools. Such action can reinforce stereotypes of HIV & AIDS as a condition quite unlike any other. Such problems can be avoided when HIV & AIDS is addressed within a holistic package of school health and nutrition teaching.

## **History of Education and HIV & AIDS in the Caribbean**

The Caribbean response to the HIV & AIDS epidemic in its first two decades was largely focused within the health sector. Much of the education sector's initial activity was concentrated on the provision of HIV & AIDS education and strengthening guidance and counselling within schools (Kelly & Bain 2004):

- The Health and Family Life Education initiative in the early 1990s was a CARICOM multi-agency activity in response not only to HIV & AIDS but more broadly to health and

social issues such as pregnancy, violence, substance abuse, and nutrition among adolescents (Kelly & Bain 2004). The programme was first introduced in secondary schools, but has now been extended to primary schools. Additionally, in 1996 education ministers requested all CARICOM states to develop national HFLE policies and prepare plans to translate that policy into action. In Guyana this led to the development of a draft policy on HFLE and the decision in general to infuse the subject in the curriculum rather than make it a specific subject in its own right.

- Because HIV & AIDS prevention was often viewed in terms of behaviour change, a number of ministries in the region placed the responsibilities of HIV & AIDS issues within the guidance and counselling units. Their accomplishments have been promotion of safe behaviour through HFLE, capacity building of teachers and guidance counsellors, awareness-raising activities, and community networks of parents, communities, and the public.
- The Caribbean Network of Health-Promoting Schools (CNHPS) was established in 1998. Issues relating to HIV & AIDS were part of this broader health initiative.
- In addition to the above, some HIV & AIDS-specific education initiatives were also implemented by countries, for example, Youth Challenge and HIV & AIDS in Guyana to increase youth's knowledge on HIV & AIDS through music, dance, and art.

In November 2002, recognising the potential of HIV & AIDS to deplete human resources in their countries, Ministers of Education in a regional meeting in Havana committed to a more comprehensive response to the epidemic. This included prevention education, care and support of educators and learners, and measures to reduce the impact of the epidemic on education.

An assessment of the education sector in the Caribbean in 2006 found that the countries of the Caribbean were at different stages in developing a comprehensive response to HIV & AIDS (Whitman and Oommen, 2006):

- In only two countries was an HIV & AIDS or school health policy in place, while other countries were in the process of drafting a policy.
- All 12 countries in the Caribbean are implementing HFLE, but they have different concerns such as teacher training and timetabling of the curriculum.
- Of the 12 countries, 8 reported having a policy for a safe and healthy school environment. However they reported that discrimination against people living with HIV & AIDS was a severe issue despite efforts to sensitise the MoE staff.
- The provision of services and care and support was limited. Most ministries did not provide any information about voluntary counselling and testing. HIV coordinators reported the need for more knowledge and skills in this area.

## **National Response to HIV & AIDS in Guyana**

The national response to HIV & AIDS in Guyana dates back to soon after the first AIDS case was reported in 1987. The response in the first decade was medically oriented, with the National Aids Programme set up in 1989 being part of the MoH. With the Guyana Poverty Reduction Strategy Plan highlighting HIV as an important area for multisectoral action in 2001, two National HIV & AIDS strategic plans, for 2002-06 and 2007-11, have taken a broader approach. The MoH has contributed to both the strategic processes (MoH 2006b). Specifically, the national response in 2007-11 has the main objectives of:

- Strengthening the national capacity to implement a multisectoral response
- Ensuring that all citizens, especially those most vulnerable, have access to information, preventive services such as counselling and testing, and live free of stigma and discrimination in order to reduce transmission of HIV
- Ensuring access to care and treatment for all persons living with HIV & AIDS
- Strengthening the surveillance system and monitoring and evaluation mechanisms to provide timely information for project management

## More Recent Specific Activities Leading up to the Situation Analysis

In 2006, a meeting of Ministers of Education of CARICOM on Education and HIV & AIDS (COHSOD, June 2006, Trinidad and Tobago) called for continuing dialogue and action on efforts at accelerating the education sector response to HIV & AIDS in the Caribbean.

Further to COHSOD, a meeting of International Development Partners (IDPs), including UNAIDS cosponsors and the World Bank, proposed that working together in a few countries could serve as a learning experience towards greater harmonization across the whole region. Initial efforts were suggested in Jamaica, St Lucia, and Guyana. The guiding principle within each country is the support of a sequential process in the education sector's HIV & AIDS response through the development of policy, strategy, and a funded work plan.

In line with this suggestion, a joint UNESCO-World Bank team visited Guyana on May 9-10, 2007, in order to undertake a fact-finding, stock-taking mission. In collaboration with relevant local partners, the mission sought to identify specific country needs in the education sector's HIV & AIDS response in the broader context of wider school health needs. During the visit, the following key priority areas were identified as needing particular attention (UNESCO World Bank, 2007):

- **Information and research:** Basic research and data collection on the impact of HIV & AIDS on the education sector at the national and regional levels (in terms of supply and demand) were identified as being limited.
- **Management and coordination:** All stakeholders recognized the need for capacity building of the MoE for HIV & AIDS planning, management, and coordination. The availability of an evidence-based policy and strategy on education and HIV & AIDS that integrated school health, workplace policy, in-service training on HIV & AIDS, production of learning materials and modules, and prevention of HIV & AIDS in teachers and support for teachers with HIV & AIDS was considered a tool of immediate value.
- **Continuous professional development of teachers:** While the MoE has been active (together with UNICEF, UNFPA, and the MoH) in training teachers on the HFLE curriculum, a gap was found to remain in the training provided for teachers on how to protect themselves.
- **Stigma, discrimination, and human rights, including attention to cultural differences:** Wide spread stigma and discrimination were found to be problems across the country. The adaptation of communication, teaching, and learning materials that take into consideration different local languages and levels of literacy was also lacking.

In response to these needs, UNESCO and the Partnership for Child Development proposed the provision of financial and technical support to the following activities:

- A rapid assessment of the current status of HIV & AIDS activities within the education sector, including impact projections based on existing data
- Expansion and consolidation of the current education sector policy to include workplace issues, stigma and discrimination, and cultural sensitivities
- Mainstreaming HIV & AIDS in the forthcoming Education Sector Strategic Plan with a view to supporting the development of the broadened HIV & AIDS policy and strategic plan.
- Continuous professional development of teachers.

This situation analysis occurred in response to the first three of these proposals and was conducted in line with the Terms of Reference contained in Appendix A. In particular, the situation analysis sought to respond to the third proposal, the mainstreaming of HIV & AIDS in the forthcoming Education Sector Strategic Plan with a view to supporting the development of a broadened HIV & AIDS policy and strategic plan. Specific proposals are included as to what the key recommendations for inclusion in the Education Sector Strategic Plan should be.

## 2 Methodology

The methodology for the situation analysis included the following:

- Literature review of the demographics, education, health (including HIV & AIDS) status, and behaviours/practises of school-age population and those within the education sector. This was done by reviewing different routine and survey information. A literature review of the response to the health and education needs was also conducted by reviewing policies, plans, and progress reports.
- Interviews with agencies that are part of the education and health sectors and that have a role to play in the education sector response to HIV & AIDS and health needs. (See Appendix B for the list of stakeholders).
- Estimation of the impact of HIV & AIDS on the education sector using the Ed-SIDA mathematical model. The model results were on the basis on HIV prevalence in the general population, education sector statistics, and assumptions of the impact of HIV on the education sector.
- All interviewed stakeholders were invited to a workshop at the end of the mission. The Minister of Education and other senior members of the MoE, development partners, and other ministry representatives attended the event. Initial findings of the situation analyses were presented, followed by group and plenary discussions on recommendations for the education sector response to HIV & AIDS. All the recommendations in the sections below are part of that participative process.





# 3

## The Education and Health Sectors in Guyana

### Demography

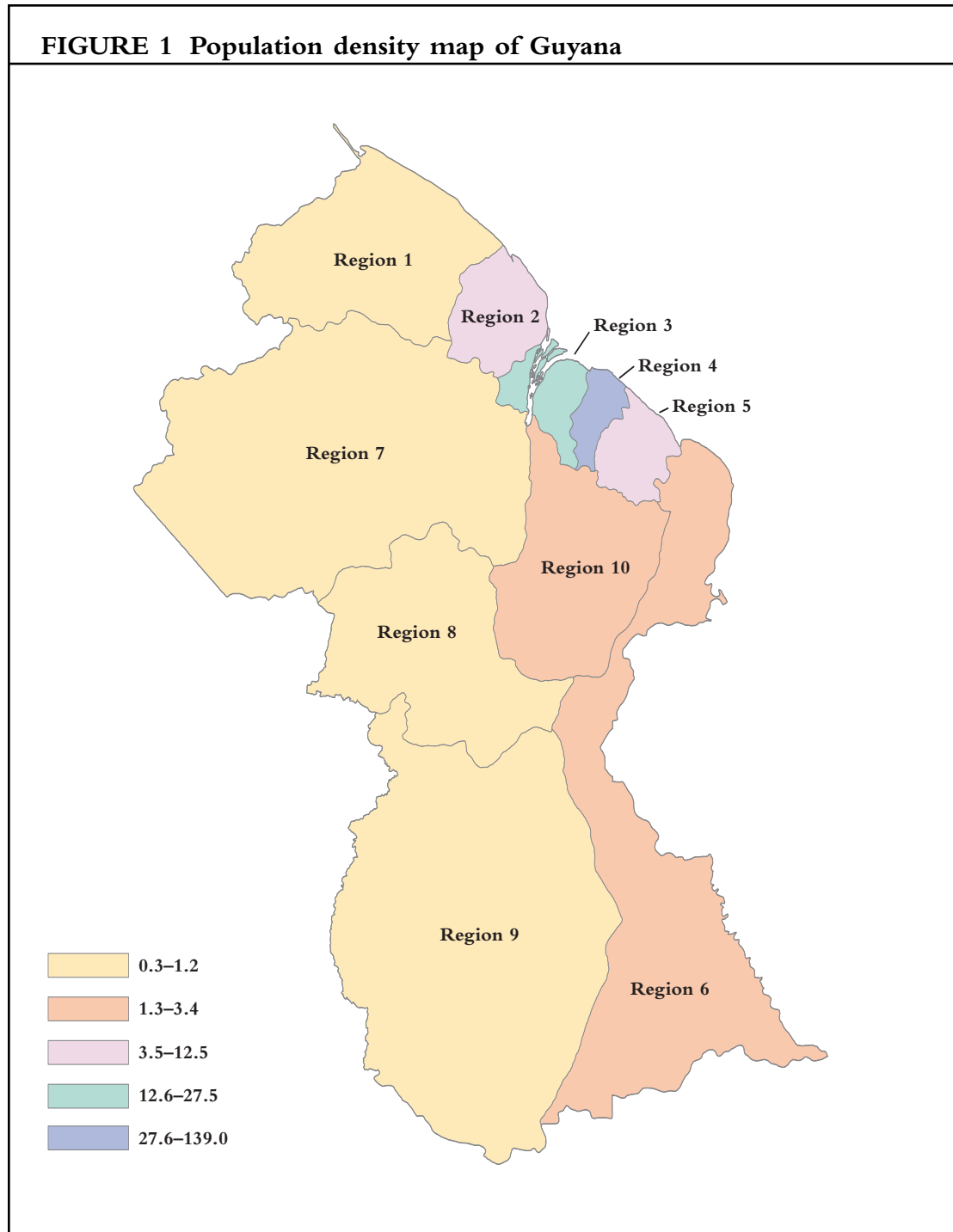
The total population in Guyana, as per the last census in 2002, was 751,223 (table 1). Most of the population (72 percent) is concentrated in the coastal regions of 4, 6, and 3 (Bureau of Statistics [BoS] 2002).

The East Indian population makes up 44 percent of the population and is concentrated evenly on the coastal regions of 4, 6, and 3, with a small percentage in regions 5, 7, and 2. The African population, which makes up 30 percent of the population, is concentrated primarily in region 4, followed by regions 6, 10, and 3. The mixed population makes up 17 percent of the population, and like the Africans, are located primarily in region 4. Amerindians, who make up 9 percent of the population, are mostly in regions 1, 2, 8, and 9.

Children in the age groups for primary and secondary schooling (5-19 years) make up a significant third of the population in Guyana. If young people eligible for tertiary education are included, then, in total, children and youth account for 41 percent of the total population.

**TABLE 1 Population distribution of Guyana by region and age group**

| Region | Total Population (%) |        | 5-9 years (%) |        | 10-14 year (%) |        | 15-19 (%) |        | 20-24 years (%) |        |
|--------|----------------------|--------|---------------|--------|----------------|--------|-----------|--------|-----------------|--------|
| 1      | 24,275               | (3.2)  | 4,150         | (4.3)  | 2,800          | (3.4)  | 1,867     | (2.8)  | 1,718           | (2.7)  |
| 2      | 49,253               | (6.6)  | 6,936         | (7.2)  | 5,965          | (7.3)  | 4,722     | (7.1)  | 3,797           | (5.9)  |
| 3      | 103,061              | (13.7) | 12,932        | (13.4) | 11,110         | (13.6) | 9,062     | (13.5) | 8,673           | (13.5) |
| 4      | 310,320              | (41.3) | 36,572        | (37.8) | 32,197         | (39.5) | 28,173    | (42.1) | 28,322          | (44.0) |
| 5      | 52,428               | (7.0)  | 7,105         | (7.3)  | 5,871          | (7.2)  | 4,502     | (6.7)  | 4,321           | (6.7)  |
| 6      | 123,695              | (16.5) | 16,442        | (17.0) | 12,959         | (15.9) | 10,576    | (15.8) | 10,211          | (15.9) |
| 7      | 17,597               | (2.3)  | 2,319         | (2.4)  | 2,056          | (2.5)  | 1,558     | (2.3)  | 1,575           | (2.4)  |
| 8      | 10,095               | (1.3)  | 1,381         | (1.4)  | 1,220          | (1.5)  | 881       | (1.3)  | 878             | (1.4)  |
| 9      | 19,387               | (2.6)  | 3,188         | (3.3)  | 2,751          | (3.4)  | 1,832     | (2.7)  | 1,290           | (2.0)  |
| 10     | 41,112               | (5.5)  | 5,635         | (5.8)  | 4,562          | (5.6)  | 3,753     | (5.6)  | 3,631           | (5.6)  |
| All    | 751,223              | (100)  | 96,671        | (100)  | 81,497         | (100)  | 66,922    | (100)  | 64,409          | (100)  |



Their distribution within the regions is also concentrated to the coastal regions of 4, 6, and 3, similar to the general population.

By 2003, there were an estimated 22,000 orphans in Guyana (newborn to 14 years), with an estimated 7,000 of them orphaned because of HIV & AIDS. The proportion of orphans who lost either of their parents to AIDS is expected to increase, and by 2009 their number will be 9,000 out of a total 23,000 estimated orphans (UNAIDS 2002).

## Schools, Students, and Teachers

This section provides initial information on the capacity of the education sector.

### *Schools*

The formal education system in Guyana includes nursery education; primary and secondary schooling; technical/vocational education; teacher training, and university (the highest level). Adult and distance and continuing education is provided by the University of Guyana. There are also special schools for those with mental and physical disabilities, and others for those with social disadvantages. The total number of schools in each region is listed in the table below. The supply of free basic education (nursery to secondary) is highest in regions with the highest school-age population, namely 4, 6, and 3 (table 2). There are one university, one teacher training college, and seven technical/vocational training colleges (MoE, 2004).

In nonformal and vocational education, the main providers are NGOs (which include faith-based organisations) and some government ministries. Some of these are listed below (UNESCO 2000). While some organisations are already involved in life skills-based health education, others have yet to do so and therein lies an opportunity for many to incorporate health and family life education in to their educational training (table 3).

### *Students*

Similar to the regional distribution of the general and school-age population, most of the enrolled students in primary and secondary schools are concentrated in the coastal regions of 4, 6, and 3 (MoE 2004).

Within the formal education system, the net enrolment rate in primary schooling was generally greater than 90 percent in both boys and girls between 2001 and 2005 (figure 2). However in secondary schools, this rate was nearer to 72 percent. Subregional estimates were not available

The 2002 census may be more indicative of overall enrolment, in both formal and nonformal education. More than 90 percent of the child population (5-14 years) that represents

**TABLE 2 Regional distribution of types of schools**

| Region | Nursery | Primary | Secondary | Special Education | Technical/Vocation training |
|--------|---------|---------|-----------|-------------------|-----------------------------|
| 1      | 12      | 42      | 43        | 0                 | 0                           |
| 2      | 49      | 38      | 29        | 0                 | 1                           |
| 3      | 62      | 60      | 36        | 0                 | 2                           |
| 4      | 67      | 54      | 44        | 1                 | 3                           |
| 4-GT   | 37      | 32      | 32        | 3                 | 7                           |
| 5      | 36      | 32      | 26        | 0                 | 2                           |
| 6      | 68      | 55      | 30        | 1                 | 4                           |
| 7      | 27      | 29      | 18        | 0                 | 0                           |
| 8      | 15      | 21      | 21        | 0                 | 0                           |
| 9      | 30      | 46      | 42        | 0                 | 0                           |
| 10     | 25      | 31      | 28        | 1                 | 1                           |

**TABLE 3 Providers of nonformal education**

| <b>Name of NGO</b>                           | <b>Type of nonformal education</b>                              | <b>Skills-based health education</b> | <b>Other</b>                 |
|--|---|--------------------------------------|------------------------------|
| Institute of Distance & Continuing Education | Literacy, vocational training, education skills                 | Family life, community development   | Employment, parenting        |
| Adult Education Association                  | Literacy, academic, technical/ vocational training <sup>a</sup> |                                      |                              |
| Commonwealth Youth Programme                 |   |                                      | Entrepreneurial youth work   |
| Guyana Red Cross                             |   | Community health, first aid          | Parenting                    |
| Guyana Responsible Parenthood Association    |   | HIV & AIDS, sexual health            | Parenting                    |
| VARQA Foundation                             | Literacy  | Community rehabilitation/health      |                              |
| Hindu Dharmic Sabha                          | Literacy, vocational training                                   |                                      | Self-employment              |
| Central Islamic Organisation of Guyana       | Vocational training, religion                                   | Family life, health                  |                              |
| Women Affairs Bureau                         | Literacy  | Life skills                          | Entrepreneurship, leadership |
| YWCA   | Literacy  | Life skills                          |                              |
| Roadside Baptist Centre                      | Literacy, vocational training                                   |                                      |                              |
| St. Francis Xavier Group                     | Literacy  |                                      | Youth leadership             |
| Name of Government agency                    | Type of nonformal education                                     | Health education                     | Other                        |
| Guyana National Service <sup>a</sup>         | Literacy, technical & vocational training                       |                                      |                              |
| Guyana Prison Service                        | Literacy, academic, vocational training                         |                                      | Para-military                |
| Social Impact Amelioration Programme (SIMAP) | Technical, vocation training                                    |                                      | Community development skills |
| Public Service Ministry (PSM)                | Literacy  |                                      | Management Skills            |
| Ministry of Agriculture                      | Technical and vocational training                               |                                      |                              |
| Ministry of Health                           | Technical and vocational training                               |                                      |                              |
| Ministry of Foreign Affairs                  | Profession training   |                                      |                              |
| Ministry of Culture, Youth & Sport           | Vocational training   |                                      |                              |

a. The Guyana National Service was disbanded in 2002, now. It's staff and functions now absorbed within the Ministry of Culture, Youth and Sport

**TABLE 4 Regional distribution of primary and secondary enrolment and attendance**

| Region        | Primary enrollment (%) |       | Primary % average attendance | Secondary (%) |       | Sec. % average attendance |            |         |
|---------------|------------------------|-------|------------------------------|---------------|-------|---------------------------|------------|---------|
|               |                        |       |                              |               |       | Sec Dept                  | Comm. high | Gen Sec |
| 1             | 5585                   | (5)   | 66                           | 2344          | (3)   | 65                        | 57         | 73      |
| 2             | 7341                   | (7)   | 82                           | 5009          | (7)   | 61                        | 62         | 77      |
| 3             | 13874                  | (13)  | 76                           | 8068          | (12)  | 60                        | 58         | 77      |
| 4             | 20652                  | (19)  | 72                           | 8402          | (13)  | 46                        | 39         | 79      |
| 4- Georgetown | 20931                  | (19)  | 79                           | 18111         | (27)  | NA                        | 65         | 84      |
| 5             | 8170                   | (7)   | 75                           | 5053          | (8)   | 47                        | NA         | 55      |
| 6             | 18764                  | (17)  | 76                           | 10692         | (16)  | 56                        | 54         | 75      |
| 7             | 3010                   | (3)   | 80                           | 1799          | (3)   | 71                        | NA         | 74      |
| 8             | 1502                   | (1)   | 76                           | 932           | (1)   | 63                        | NA         | 86      |
| 9             | 4413                   | (4)   | 84                           | 2285          | (3)   | 75                        | NA         | 72      |
| 10            | 6586                   | (6)   | 84                           | 4446          | (7)   | 67                        | 75         | 72      |
| All           | 110828                 | (100) | 76                           | 67141         | (100) | 58                        | 57         | 77      |

primary and (partly) secondary schooling reported either part-time or full-time enrolment in school. Only 41 percent and 9 percent of 15- to 19-year-olds and 20- to 24-year-olds, respectively, were enrolled in a full-time or part-time school.

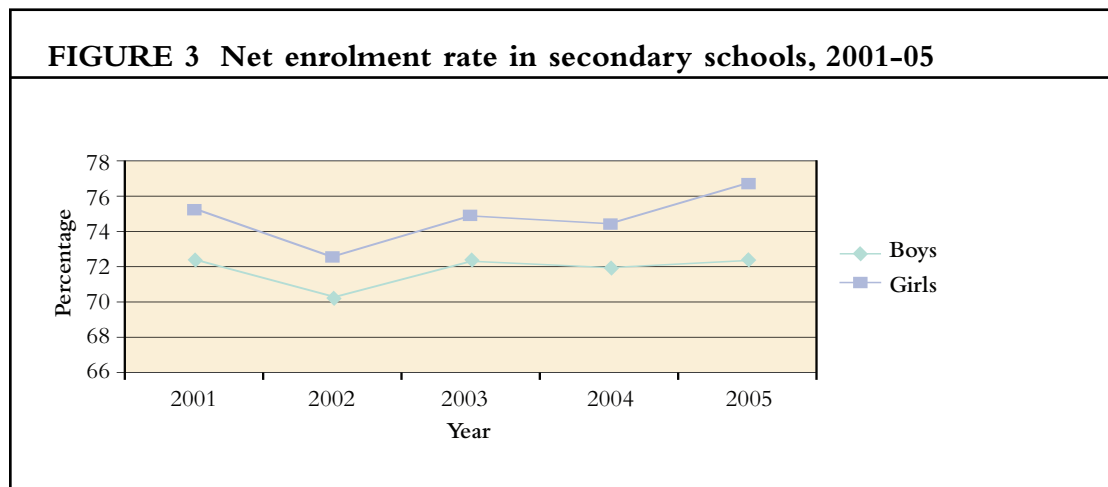
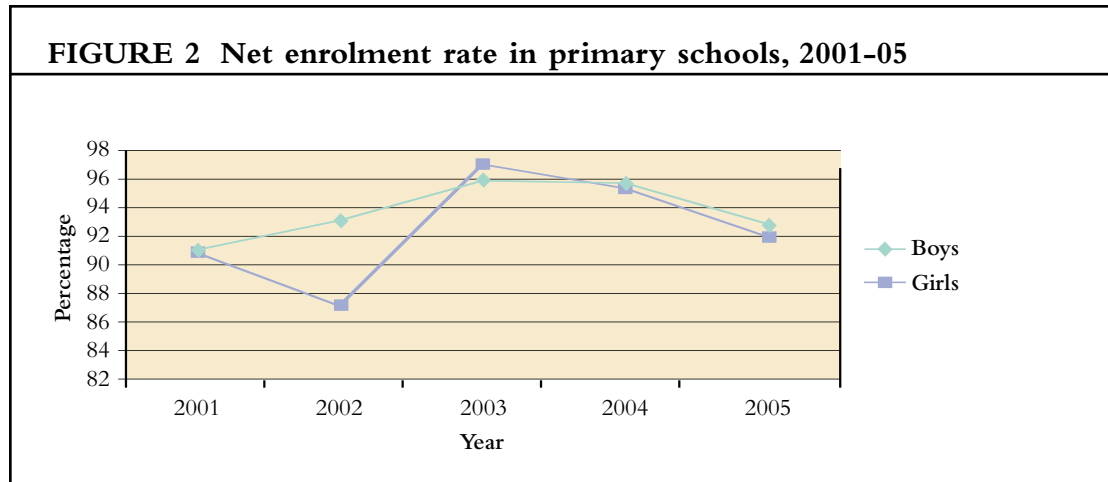
In primary schools, while enrolment was generally over 96 percent in 2004, the average attendance rate was 76 percent. Region 1 had the lowest attendance rate, at 66 percent. The repetition rate was low (1 percent) in 2004, except for regions 1 and 9, where the rate was 8 percent. The average dropout rate in the country was 4 percent in 2004, with regions 4 and 7 showing the highest rates, at 7 and 6 percent, respectively (MoE 2004).

In secondary schools the attendance rate varied by the type of school. General secondary schools had a better attendance rate (76.5 percent), with the exception in region 5 (55 percent). In secondary departments of primary and community high schools, the attendance rate was around 57 percent. The repetition rate was generally higher for boys than girls (13 percent versus 9 percent). In general secondary schools, regions 1 and 8 showed the highest repetition rate (31.5 percent and 39.5 percent, respectively). The average dropout rate was higher in secondary departments of primary and community high schools (14.5 percent) than in general secondary schools (7 percent) (MoE 2004).

### **Teachers**

The total number of primary school teachers in Guyana in 2004 was 4,013; 464 were in secondary departments of education; 2,419 were in general secondary schools; and 50 were in community high schools (MoE 2004).

In primary schools, 57 percent of teachers are trained. Region 2 has the highest percentage of trained teachers (65 percent), while in other coastal regions it varies between 55 and 63



percent. The hinterlands have fewer trained teachers, with the exception of region 7 (57 percent). Regions 8, 1, and 9 have 21, 26, and 34 percent, respectively (MoE 2004). This may suggest that regions 1, 8, and 9 need more resources for training of teachers on SHN & HIV than others.

In secondary schools, the percentage of trained teachers varies by type of school. Secondary departments of education and community high schools have 43 and 47 percent trained teachers, respectively, while general secondary schools have 56 percent trained teachers. As in primary schools, regions 8, 9, and 1 have the lowest percentage of trained teachers (25, 36, and 42 percent, respectively) as well as lowest total number of teachers (40, 102, 93) respectively (MoE 2004).

The pupil-teacher ratio in primary and secondary schools in 2004 was well within the generally accepted EFA goal of 40:1 in all regions (MoE 2004). This, however, includes both teachers who are trained and untrained and therefore does not adequately represent teaching quality.

**TABLE 5 Pupil-teacher ratio in primary and secondary schools**

| Region | Primary Schools | Secondary Schools |
|--------|-----------------|-------------------|
| 1      | 29              | 23                |
| 2      | 24              | 18                |
| 3      | 28              | 23                |
| 4      | 32              | 19                |
| GT     | 29              | 17                |
| 5      | 25              | 20                |
| 6      | 33              | 23                |
| 7      | 26              | 24                |
| 8      | 35              | 22                |
| 9      | 28              | 23                |
| 10     | 20              | 14                |

**TABLE 6 Regional distribution of government health services**

| Region | Health Posts | Health Centres | District Hospitals | Regional Hospitals | Total |
|--------|--------------|----------------|--------------------|--------------------|-------|
| 1      | 36           | 3              | 3                  | 0                  | 42    |
| 2      | 19           | 11             | 1                  | 11                 | 42    |
| 3      | 21           | 10             | 3                  | 1                  | 35    |
| 4      | 11           | 36             | 0 <sup>a</sup>     | 0                  | 47    |
| 5      | 1            | 15             | 2                  | 0                  | 18    |
| 6      | 4            | 21             | 3                  | 1                  | 29    |
| 7      | 19           | 3              | 2                  | 0                  | 24    |
| 8      | 14           | 4              | 2                  | 0                  | 20    |
| 9      | 53           | 3              | 2                  | 0                  | 58    |
| 10     | 16           | 10             | 2                  | 1                  | 29    |

a. Region 4 has 1 national hospital and 7 private hospitals.

## Health Providers in Guyana

This section provides initial information on the capacity of the health sector. The number of government health service institutes in the country, by region, is given in the table below (BoS 2006).

The overall multisectoral HIV & AIDS response (see section 1.3) is coordinated by the Presidential Commission on HIV & AIDS. The MoH units of Health Sector Development Unit (HSDU) and the National Aids Programme Secretariat (NAPS) provide management and technical support for the overall coordination (Government of Guyana [GoG] 2006). VCT and ART in Guyana are provided free of charge by some health centres and hospitals as well as by the Guyana Defence Force and NGOs. Most of the VCT and ART services in regions 1, 7, 8, and 9 are provided by mobile units. VCT sites in the different regions in

**TABLE 7 Distribution of VCT centres by region and facility**

| Region | Health Centre | Hospital | Defence Force | NGOs | Total |
|--------|---------------|----------|---------------|------|-------|
| 2      | 1             | 2        |               | 1    | 4     |
| 3      | 1             | 1        |               |      | 2     |
| 4      | 5             | 8        | 3             | 4    | 20    |
| 5      | 1             | 1        |               |      | 2     |
| 6      | 2             | 2        |               | 2    | 6     |
| 7      |               | 1        |               | 1    | 2     |
| 9      |               | 1        |               |      | 1     |
| 10     | 3             | 1        |               | 1    | 5     |
| All    | 13            | 17       | 3             | 9    | 42    |

Guyana as of 2007 number 43 (NAPS 2007).<sup>1</sup> This is an increase since 2004, when there were only 15 sites in the country.

NGOs and civil society organisations (CSOs) are also involved in a range of HIV activities, from prevention services for youth to the provision of ART. Details of their activities can be sourced from [http://www.hiv.gov.gy/partners\\_list.php](http://www.hiv.gov.gy/partners_list.php).

Other governmental organisations that are involved in the provision of HIV services are the Ministry of Agriculture; Ministry of Amerindian Affairs; Ministry of Culture, Youth and Sport; Ministry of Education; Ministry of Home Affairs; Ministry of Labour, Human Services and Social Security; Ministry of Local Government; and the NAPS within the Ministry of Health. Details of their activities can be found at [http://www.hiv.gov.gy/partners\\_list.php](http://www.hiv.gov.gy/partners_list.php).

1. Information on one of the centres is missing from the table.



# 4

## Health Conditions Affecting the Education Sector in Guyana

During the situation analysis, a range of health problems affecting school-age children were mentioned. In addition to HIV & AIDS, these included malnutrition (both undernutrition and obesity), smoking, diarrhoeal diseases, and others. In common with other Caribbean countries, Guyana is placing increasing focus on the prevention of noncommunicable diseases.

### HIV & AIDS

#### *HIV Prevalence*

The overall prevalence of HIV in Guyana is around 1.6 percent (MoH 2006). The UNAIDS estimate for 2005 was 2.5 percent. Figure 4 shows the agedistribution of HIV prevalence from the HIV Antenatal Care (ANC) Seroprevalence surveys done in 2004 (N=4,252) and 2006 (N=3,948).<sup>2</sup> Although the regions sampled in both surveys were the same, there were some differences in sampling.<sup>3</sup> When comparing results from sites common to both surveys, it was found that HIV prevalence in the 15- to 24-year age group had decreased from 2.03 percent to 1.07 percent between 2004 and 2006 (MoH 2006).

Regional HIV prevalence was not presented in the 2006 ANC survey, however, in the 2004 survey coastal regions 3, 4, and 5 had the highest prevalence. Regions 1, 8, and 9, which represent the hinterlands, were not represented in that survey.

#### *HIV-Related Knowledge, Behaviour, and Attitude*

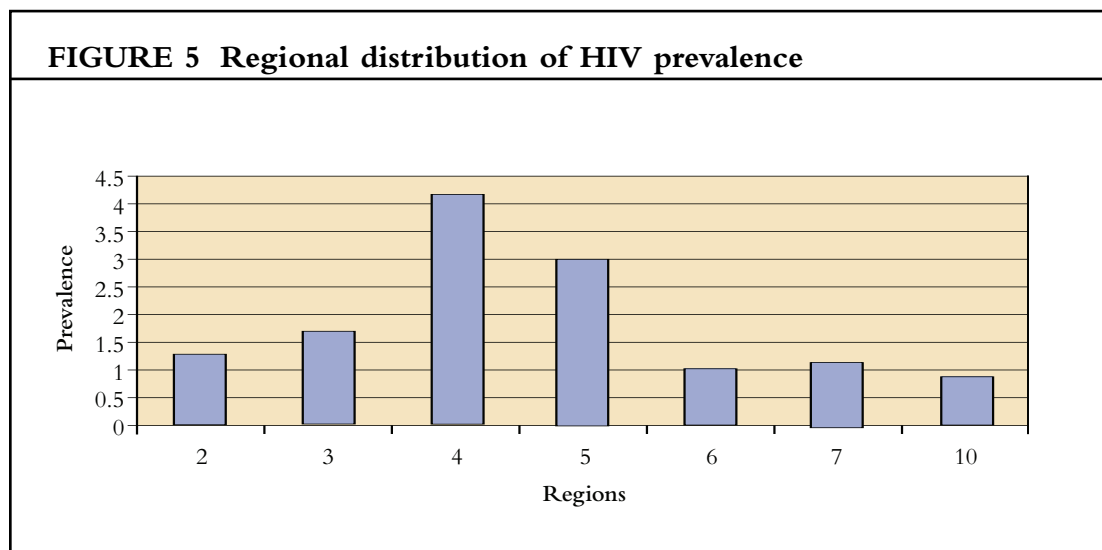
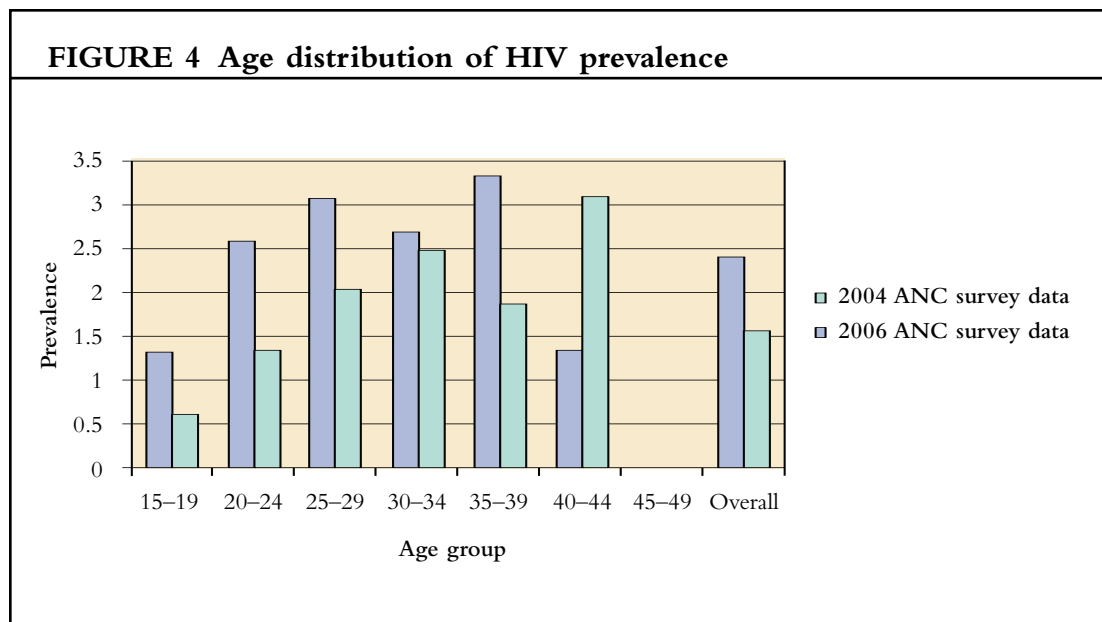
Information on HIV-related knowledge and behaviours among youth in Guyana was sourced from reports of different surveys between 2000 and 2006.<sup>4</sup> Because of differences in the definition of indicators, it was difficult to observe trends between years. Since there were many indicators, only a few that are internationally accepted (for example, UNGASS, UNAIDS) have been displayed for the most recent year (table below).

---

2. In 2006, although there is a high prevalence in 40–44yrs age group, the no of people tested is only 65.

3. In the 2004 survey, testing was partly anonymous and partly voluntary, while in 2006 it was anonymous. In 2006 a few additional health facilities were sampled.

4. Unicef MICS for 2000 in all 10 regions, the Behaviour Surveillance Survey 2004 in all regions except 7 and 8, the AIDS Indicator Survey 2005 in all 10 regions



In general, the percentage of youth (15-24 years) with HIV-related knowledge and practising safe sexual behaviour increases with education level. This implies that, while education improves sexual knowledge and behaviour; out-of-school youth are more vulnerable to HIV & AIDS than in-school youth. The age group of 15- to 18-year-olds is especially likely to engage in sexual activity, and of these, only one-fifth of those who had sexual intercourse in the past year got themselves tested for HIV. This is especially low as the percentage of those engaging in high-risk sex is greater than 80 percent in boys and 40 percent in girls.

Discrimination towards teachers with HIV was very high. This is a greater concern especially in urban areas and in people with a higher level of educational achievement.

**TABLE 8 HIV-related knowledge and behaviour among youth 15-24 years, 2005**

| Indicator   | Male           |      | Female |      | Total |      |
|---|----------------|------|--------|------|-------|------|
|   | N <sup>a</sup> | %    | N      | %    | N     | %    |
| <b>Knowledge about HIV prevention among young people (15-24 years)</b>  |                |      |        |      |       |      |
| % youth ages 15-24 years with comprehensive knowledge of HIV prevention   | 842            | 47.3 | 658    | 52.6 | 1500  | 50.3 |
| <b>By education level</b>   |                |      |        |      |       |      |
| Primary   | 56             | 33.4 | 74     | 26.5 | 130   | 29.5 |
| Secondary   | 532            | 45.7 | 681    | 52.7 | 1213  | 49.6 |
| More than secondary   | 69             | 70.7 | 83     | 77.0 | 152   | 74.1 |
| <b>By residence</b>   |                |      |        |      |       |      |
| Urban <sup>b</sup>  | 209            | 61.4 | 248    | 67.4 | 457   | 64.7 |
| Rural <sup>c</sup>  | 449            | 40.7 | 594    | 46.4 | 1043  | 43.9 |
| <b>First sexual experience among young people (15-24 years)</b>   |                |      |        |      |       |      |
| % of youth ages 15-24 who have had sex before the age of 15 <sup>d</sup>  | 658            | 12.9 | 842    | 8.6  | 1500  | 10.5 |
| <b>By education level</b>   |                |      |        |      |       |      |
| Primary   | 56             | 11.9 | 74     | 16.3 | 130   | 14.4 |
| Secondary   | 532            | 12.8 | 681    | 8.4  | 1213  | 10.3 |
| More than secondary   | 69             | 15.0 | 83     | 3.1  | 152   | 8.5  |
| <b>% of youth ages 18-24 who have had sex before the age of 18<sup>e</sup></b>  |                |      |        |      |       |      |
|   | 403            | 68.0 | 538    | 58.6 | 941   | 62.6 |
| <b>By education level</b>   |                |      |        |      |       |      |
| Primary   | 40             | 51.0 | 64     | 74.4 | 104   | 65.4 |
| Secondary   | 299            | 74.1 | 397    | 61.0 | 696   | 66.6 |
| More than secondary   | 64             | 49.4 | 76     | 31.5 | 140   | 39.7 |
| <b>Condom use at first sexual intercourse</b>   |                |      |        |      |       |      |
| % young men/women ages 15-24 who ever had sex and who used a condom at first sexual intercourse <sup>f</sup>                      | 381            | 54.8 | 484    | 43.2 | 865   | 48.3 |
| <b>By education level</b>   |                |      |        |      |       |      |
| Primary   | 36             | 28.5 | 63     | 32.4 | 99    | 31.0 |
| Secondary   | 294            | 56.1 | 369    | 44.2 | 663   | 49.5 |
| More than Secondary   | 51             | 66.4 | 52     | 50.8 | 103   | 58.5 |
| <b>Premarital sex</b>   |                |      |        |      |       |      |
| % never-married men/women ages 15-24 years who had sex in the last 12 months <sup>g</sup>   | 579            | 40.4 | 548    | 27.4 | 1127  | 34.1 |
| % of those who had premarital sex that used a condom in the last intercourse <sup>h</sup>   | 234            | 69.6 | 150    | 63.9 | 384   | 67.4 |
| <b>High risk sex</b>  |                |      |        |      |       |      |
| % of youth(15-24yrs) that had high-risk sex (nonmarital or cohabiting) among those who had sex in the past 12 months <sup>i</sup> | 312            | 80.5 | 436    | 40.4 | 748   | 57.1 |

(continued)

**TABLE 8 HIV-related knowledge and behaviour among youth 15-24 years, 2005 (Continued)**

| Indicator   | Male           |      | Female |      | Total |      |
|---|----------------|------|--------|------|-------|------|
|   | N <sup>a</sup> | %    | N      | %    | N     | %    |
| <b>By education level</b>   |                |      |        |      |       |      |
| Primary   | 32             | 65.5 | 60     | 19.0 | 92    | 35.2 |
| Secondary   | 236            | 79.6 | 333    | 40.2 | 569   | 56.5 |
| More than secondary   | 43             | 96.5 | 42     | 71.9 | 85    | 84.3 |
| <b>Knowledge and access to VCT</b>  |                |      |        |      |       |      |
| Among youth 15-24 years who had sexual intercourse in the past 12 months, the % that had an HIV test in the last 12 months and received results | 312            | 15.4 | 436    | 21.6 | 748   | 19.0 |

a. N in this table and in the rest of the document refers to sample size

b. This refers to urban areas in region 2,4, 6 and 10

c. This refers to rural areas in all 10 regions

d. This corresponds to UNGASS indicator 11

e. This corresponds to UNGASS indicator 11A

f. This corresponds to UNAIDS Young People's Sexual Behaviour indicator 6

g. This corresponds to UNAIDS Young People's Sexual Behaviour indicator 2

h. This corresponds to UNAIDS Young People's Sexual Behaviour indicator 3

i. This corresponds to UNGASS indicator 12

### Knowledge

In 2005, among youth (15-24 years), 53 percent of women and 47 percent of men have comprehensive knowledge about HIV & AIDS<sup>5</sup> (MoH 2006c). This knowledge is also found to increase with educational level and is higher in urban than rural youths.

### Behaviour

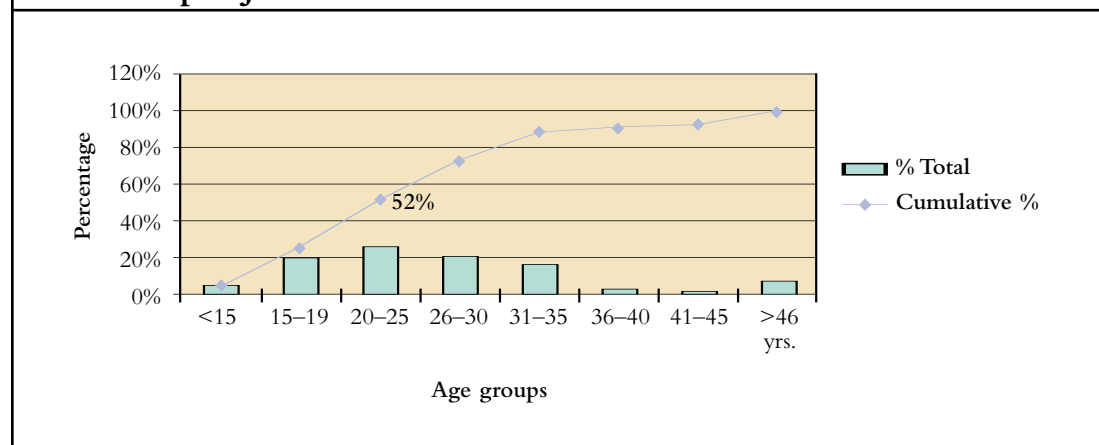
Nine percent of women and 13 percent of men among youth 15-24 years had had their first sexual experience by the age of 15. This percentage rises sharply to 59 percent in women and 68 percent percentage in men who had sex before the age of 18, among the 18- to 24-year-olds. There is a strong relation between level of education and delay in first sexual experience in women, but this was less in men (MoH 2006c).

Among never married youth, 40 percent of men and 27 percent of women reported sexual intercourse within the last 12 months. Sexual abstinence among never-married women was found to be higher in urban than rural women. Of those who had engaged in premarital sex in the past 12 months, 69.9 percent of men and 63.9 percent of women used a condom in their last intercourse. However, of those who had had sex in the previous 12 months, 81 percent of men and 40 percent of women had had high-risk sex with a nonmarital and noncohabiting partner. The percentage of those engaging in high-risk sex increased with education level, more in women than in men (MoH 2006c).

5. This UNGASS indicator is defined as percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

**TABLE 9 No. of persons tested at VCT sites between April and June 2007**

| Regions      | No. of persons |
|--------------|----------------|
| 1            | 459            |
| 2            | 535            |
| 3            | 905            |
| 4            | 16,933         |
| 5            | 235            |
| 6            | 2,170          |
| 7            | 795            |
| 9            | 407            |
| 10           | 49             |
| <b>Total</b> | <b>23,088</b>  |

**FIGURE 6 Age distribution of people calling the MoH hotline service April-June 2007**

Among youth (15-24 years) who had had sexual intercourse in the last 12 months, a slightly greater percentage of women (22 percent) than men (15 percent) had tested themselves in the last 12 months and received their results (MoH 2006c). This was consistent with the Behavioural Surveillance Survey results in out-of-school youth in 2004.

The NAPS quarterly report for the period April-June 2007 showed that 23,088 persons had been tested in their sites nationwide. Majority of those tested were from region 4.

Youth also form a large percentage of those who dial in to the MoH hotline service on HIV & AIDS and STIs (see Figure 4). A cross-section of 125 phone calls during the period April-June 2007 showed that more than 50 percent of the calls were from persons 25 years and younger (NAPS 2007).<sup>6</sup>

6. This excludes 56 people for whom age data was missing.

### Attitude

The 2000 MICS survey showed a high level of stigma and discrimination among women (15-49 years) who were asked if a HIV-positive teacher should be allowed to work (MoH 2000). This was seen to be higher in urban (50.5 percent, N= 62,616) than rural (30.2 percent, N=123,868) areas, and in those with higher-level educational achievement (none=9.3 percent, N= 2149; primary=23 percent, N=35439; secondary=40.8 percent, N= 14, 7424).

## Nutrition

Most nutritional information on school age children is available only from studies in the late 1990s and is not disaggregated by region. Obesity is indicated to be a growing problem among older children (12- to 19-year-olds) from two surveys in 1997 and 2004.

### *Anthropometric Information*

A micronutrient study by PAHO and the Caribbean Food and Nutrition Institute (CFNI) in 1997 (FAO 2003) revealed that among 5- to 9-year-olds (N=246), 8.5 percent were underweight,<sup>7</sup> 8.1 percent were stunted,<sup>8</sup> and 8.5 percent were wasted.<sup>9</sup> Girls were more stunted (12.6 percent; N=126) than boys (4.2 percent; N=119). The prevalence of overweight (wt/ht > 2SD) was higher among boys (5 percent; N=119) than girls (0.8 percent; N=127).

Similar findings of stunting (13.7 percent) and wasting (8.1 percent) were found in a 1994-95 study of primary school children ages 5-7 years (FAO 2003). A high proportion of stunting was found among Amerindian children (61.7 percent) compared to children of other ethnic groups (7.5-12.3 percent). Wasting was highest among Indo-Guyanese (14.3 percent) compared to other ethnic groups (1.5-4.3 percent). Children who were both stunted and wasted made up 1.1 percent of the total sample, with the highest prevalence among Indo-Guyanese. None of the Amerindians were both stunted and wasted.

The 1997 PAHO/CFNI study also showed that among 10- to 14-year-olds (N=196), underweight prevalence increased to 17.9 percent (BMI < 5th percentile), with more boys (23.2 percent; N=95) affected than girls (12.9 percent; N=101). Prevalence decreased among the 15- to 19-year-olds (N=210) to 11.9 percent, still with more boys (18.8 percent; N=96) underweight than girls (6.1 percent; N=114). Though it is known this was a national survey, details of the population sampled are not available.

The 1997 survey showed that overweight was a problem in older age groups as well. Among 10- to 14-year-olds, 5.1 percent were overweight, with more girls (6.9 percent; N=101) affected than boys (3.2 percent; N=95). In the 15- to 19-year-old age group, 6.7 percent were overweight, with more girls (7.9 percent; N=119) affected than boys (5.2 percent; N=96).

7. Underweight is when the weight of a child for their age is less than the cut-off (2 standard deviations) for the average population. It shows the combined effect of chronic and acute under-nutrition, and is a composite measure for growth faltering (World Bank and Oxford University Press, 2006)

8. Stunting is when the height of a child for their age is less than the cut-off (2 standard deviations) for the average population. It represents chronic under-nutrition due to inadequate nutrition over a long period of time (World Bank and Oxford University Press, 2006)

9. Wasting is when the weight of a child for their height is less than the cut-off (2 standard deviations) for the average population. It represents acute under-nutrition due to inadequate nutrition over a short period of time (World Bank and Oxford University Press, 2006)

10 This survey covered all regions excepts Regions 1,7,8 and 9.

Among children ages 12-16 years, the 2004 Global School Health Survey in Guyana (GSHS)<sup>10</sup> found that 8 percent (+/- 4 percent; N=1,199) had gone hungry mostly or always in the past month. This was not disaggregated by region. Data on height and weight of the children were available for only 180 students. Of those, 9 percent of students, both male and female, were found to be overweight.

### ***Micronutrient Deficiencies***

The 1997 study found a high iron deficiency (<12g/dl) of 56.8 percent in 5- to 14-year-old boys and girls (N=354). Iodine deficiency (urinary iodine <20Ug/L) was found in 2.5 percent of boys (N=161) and 3.9 percent of girls (N=181).

## **Diarrhoeal Diseases**

General information on water and sanitation facilities and diarrhoeal disease prevalence in the under-five age group indicates that interior rural areas have only half the access to drinking water sources and nearly double the prevalence of diarrhoea as the coastal regions.

In the 2000 MICS survey, the prevalence of diarrhoeal diseases among under-five-year-olds in the previous two weeks, as reported by mothers, was 10 percent (N=81,904). The prevalence was much higher in the interior rural areas (18 percent; N=11,026) than in the coastal urban (8 percent; N=22,384) or rural areas (10 percent; N=48,494) (BoS 2000).

While prevalence among school-age children is not known, disparities in access to improved drinking water sources were found between the interior rural areas (44 percent; N=61,562) and the coastal urban (83 percent; N=210,711) and rural areas (89 percent; N=431,635) (MICS 2000). Such disparities were not evident in use of sanitary means of excreta disposal (interior rural: 84 percent; N=61,562; coastal: 99 percent; N= 642,346). However, the 2004 Global School Health Survey (GSHS) found that among school children ages 13-15 years, 17 percents (N=1,119) had no place to wash their hands after using a toilet (WHO 2004b).

## **Mental Health**

In the urban and coastal regions of 2, 3, 4, 5, 6, and 10, mental health was a concern among secondary school youth. The 2004 GSHS found that 15.5 percent of students 12-16 years (N=1,201) had felt lonely mostly or always during the past 12 months; 12.8 percent of the students (N=1,152) said that they could not sleep because of worry most or all of the time (WHO 2004b).

## **Substance Abuse**

Information on substance abuse was sourced from reports of different surveys in 2004.<sup>11</sup> Alcohol consumption before the age of 13, well under the legal age, was found among more than half the boys and a third of the girls ages 13-16 in Guyana. Alcohol consumption was higher among out-of than in-school youth. The percentage of youth who had smoked below the legal age was also very high.

11. Global Youth Tobacco Survey 2004, Global School-based Student Health Survey 2004, Behavioural Surveillance Survey 2004.

**Table 10 Substance abuse among youth**

| Indicator  | Male           |      | Female |      | Total           |      |
|--|----------------|------|--------|------|-----------------|------|
|  | N <sup>a</sup> | %    | N      | %    | N               | %    |
| <b>Alcohol Use</b>   |                |      |        |      |                 |      |
| % ages 13–16 who had their first drink of alcohol when they were 13 yrs or younger | 491            | 52.8 | 680    | 36.2 | 1182            | 44.2 |
| <b>% of youth who ever consumed alcohol</b>  |                |      |        |      |                 |      |
| ISY (15–19 yrs)  | 474            | 70.9 | 738    | 43.0 | 1,212           | 53.9 |
| OSY (15–24 yrs)  | 708            | 75.4 | 774    | 44.4 | 1,482           | 59.2 |
| <b>Alcohol use: past 4 weeks among ISY</b>   |                |      |        |      |                 |      |
| At least once per week   | 323            | 21.7 | 311    | 9.6  | 634             | 15.7 |
| Less than once per week/ never   | 323            | 58.8 | 311    | 71.7 | 634             | 65.1 |
| Don't know   | 323            | 19.5 | 311    | 18.7 | 634             | 19.1 |
| <b>Alcohol use: past 4 weeks among OSY</b>   |                |      |        |      |                 |      |
| At least once per week   | 534            | 45.8 | 344    | 16.8 | 878             | 34.6 |
| Less than once per week/ never   | 534            | 54.1 | 344    | 83.1 | 878             | 65.5 |
| <b>Smoking</b>   |                |      |        |      |                 |      |
| % students (12–16 years) who first smoked a cigarette before the age of 10         | NA             | 30.3 | NA     | 32.1 | NA <sup>a</sup> | 31.6 |
| % students (12–16 years) who smoke 20 or more days in a month                      | NA             | 1.2  | NA     | 0.8  | NA              | 1.0  |

a. Total number of students who completed questionnaires is 1,230.

### **Drugs and Alcohol Use**

Among 13- to 16-year-olds, 53 percent of boys and 36 percent of girls said they had consumed their first alcohol before the age of 13 years (WHO 2004b). The 2004 Behavioural Surveillance Survey (BSS), in which both ISY (15–19 years) and OSY (15–24 years) were separately sampled from different regions, showed that more than 50 percent of youth had ever consumed alcohol. It was much higher in men than women (MoH 2004b). With the exception of ISY in region 9 (24 percent), this statistic varied between 42 percent and 72 percent among ISY and OSY. Among ISY in regions 1, 2, 3, 4, 5, 6, 9, and 10 who reported previous alcohol use, 16 percent had reportedly consumed alcohol at least once weekly during the previous four weeks. This was much higher among OSY in regions 3, 4, 6, and 10; 35 percent had reportedly consumed alcohol at least once weekly during the previous four weeks (MoH 2004b).

Marijuana was reportedly used by 7.3 percent of ISY (15–24 years); this was higher in men (13 percent; N=474) than women (3 percent; N=738). Of those who reported marijuana use, 25 percent (16/65) reported having used it at least once per week in the previous four weeks. (MoH 2004b).

Marijuana was reportedly used by 10.1 percent of OSY (15–24 years); this was higher in men (17 percent; N=706) than women (4 percent; N=774). Of those who reported marijuana use, 70 percent (63/90) reported at least once-per-week use in the last 4 weeks.



### ***Smoking***

The Guyana Youth Tobacco survey in all regions except 1, 7, 8, and 9 showed that more than a third of the sampled students between 12 and 16 years had smoked before the age of 10. However, those who smoked frequently (20 or more days in the last month) was very low: 1 percent overall (WHO 2004).

### **Bullying and Physical Fights**

Violence among secondary school students was very high. The 2004 GSHS found that bullying was very common among boys and girls 12-16 years; 39 percent of students (N= 1,098) had been bullied at least once in the past 30 days, and 6 percent of the students reported a physical assault as a result of bully. Thirty-four percent (N=1,206) of students reported being in a physical fight in the last 12 months<sup>12</sup> (WHO 2004); this was more common for boys (46 percent; N=503) than girls (23 percent; N=690).



# 5

## Existing School Health, Nutrition, and HIV & AIDS Activities in Guyana

A strategy for the effective coordination and organisation of SHN & HIV responses used in many countries around the world is the FRESH framework. FRESH was jointly launched at the Dakar Education for All (EFA) Forum 2000 by UNESCO, UNICEF, WHO, and the World Bank. The framework, which now has more than 20 partner agencies and organisations, encompasses the fundamental principles and best practice of approaches such as the EDUCAIDS Framework of UNESCO, Child Friendly Schools of UNICEF, Health Promoting Schools of WHO, and the International School Health Initiative of the World Bank.

The framework has four pillars:

- Health-related school policies
- Life skills-based health education
- Safe and sanitary school environments
- School-based delivery of health services.

These are in turn supported by three supporting strategies:

- Effective partnerships between teachers and health workers and between the education and health sectors
- Effective community partnerships
- Pupil awareness and participation.

In this section of the document, FRESH will be used as an organising framework to enable analysis of the situation of existing school health, nutrition, and HIV & AIDS activities in Guyana. The section will begin with discussion of a cross-cutting issue that affects all aspects of the SHN & HIV response, coordination of the education sector's response to SHN & HIV.

## Coordination of the Education Sector's Response

At present, responsibility for coordination of SHN & HIV activities in Guyana is dispersed. Within the MoE, responsibility lies primarily with:

- The HIV Focal Point
- The HFLE Focal Point (a currently vacant position that is being “held” by the HIV Focal Point).

The HIV Focal Point is currently employed to work within the MoE by the Health Sector Development Unit (HSDU) of the MoH. The Focal Point operates without a department or unit in the ministry and currently receives no designated administrative support. Given the bureaucratic difficulties of mobilising funds allotted to The MoE by HSDU in particular, this lack of support can result in the Focal Point spending large amounts of time chasing administrative tasks rather than concentrating on her key work and responsibilities.

Two groups within the ministry also undertake activities that have a bearing on HIV & AIDS:

- The EFA-FTI Team, working under the supervision of the Planning Unit. As part of the “improving the learning environment” component of this activity, considerable work is taking place to improve the provision of water and sanitation in schools throughout the country. Textbooks and readers are also being provided to schools throughout the country, some of which cover HIV & AIDS topics.
- The Planning Unit brings schools and communities together to develop school improvement plans. These can cover a number of areas such as improved water and sanitation.

A wider range of other stakeholders also undertake SHN& HIV activities within the education sector:

- The MoH's Department of Adolescent Health is currently engaged in SHN & HIV activities.
- The MoH's National AIDS Programme Secretariat trains and supports a number of peer educators in secondary schools.
- The Ministry of Amerindian Affairs undertakes sensitisation of communities and training of peer educators in Guyana's hinterland areas.
- The Ministry of Labour, Human Services and Social Security provides support to orphans and vulnerable children.
- Multilateral agencies that work in schools include UNICEF (Child Friendly Schools, Magnet Schools and Escuela Nueva) and PAHO (Health Promoting Schools).
- A wide range of NGOs also undertake a number of different activities in schools including peer education and provision of teaching materials. The extent to which this occurs and the kind of services offered are largely unknown to the MoE.

At present, SHN & HIV activities with OSY are also undertaken by a number of stakeholders. These include UNFPA and the Ministry of Culture, Youth and Sport (peer education), The MoH's Adolescent Health Unit (youth-friendly health services, peer education, VCT), and many NGOs.

The MoE's SHN & HIV responses tend to be highly centralised. Regional SHN & HIV Focal Points do not exist within Guyana's 10 regions.

## Health-Related School Policy

Within the country, considerable work has already taken place with respect to the production of policy concerning SHN & HIV. Guyana already has:

- A draft education sector HIV & AIDS policy that addresses workplace issues (and is based on ILO's "An HIV/AIDS Workplace Policy for the Education Sector in the Caribbean")
- A draft HFLE policy that was developed in 1998 but that was not presented to cabinet.

In addition to these, Guyana is currently drafting a new Education Act which is likely to have some bearing on SHN & HIV issues.

A number of other policies also affect SHN & HIV in Guyana. For example, smoking has recently been banned in all primary schools. Statute also asserts that pregnant girls should be able to return to education after the birth of their baby. (although how much this happens in practice is unknown).

## Life Skills-Based Health Education

### *The Curriculum*

The primary avenue for delivery of teaching about school health, nutrition, and HIV & AIDS prevention in Guyana is the Health and Family Life Education curriculum. HFLE was developed in response to the desire of Caribbean governments to equip the region's youth to cope better with situations that arise from changing societal and family values and traditions, the perception of disintegrating community life and the development of new health problems. The initiative is a CARICOM multi-agency activity that seeks to empower young people with skills for healthy living and focuses on the development of the whole person (emotional, social, mental, physical, and spiritual). It does not specifically address school health, nutrition, and HIV & AIDS prevention but is an excellent medium through which specific materials can be addressed. For example, the Merundoi/HFLE Support Modules that emanate from the Merundoi radio serial drama programme have been distributed to schools and used as a resource for teaching about HIV & AIDS in HFLE lessons.

In Guyana, HFLE is taught in grades 1-9. In grades 1 and 2 it is given a specific time slot in the curriculum; thereafter it is "infused" in different subjects, including maths, English, and social studies. UNICEF is helping this process through production of a number of infusion guides and lesson plans for use in different subject areas. There is a HFLE curriculum for grades 7 to 10 in secondary schools, but the teaching of HFLE is not as widespread as in the primary schools, where classes are with a single teacher all day who can determine in an ordered pattern when life skills teaching should be infused. Further, teaching about the infection occurs in a number of other subjects, including science and social studies.

### ***Training***

Until recently, use of HFLE in Guyana has been slow to take off. During the last year, however, rapid progress has been made with the in-service training of around 2,000 teachers across all regions of the country. Training occurred using a training-of-trainers' model. In most places, training was of just one or two teachers per school. In Georgetown, a rather different approach was used with "whole school" training in 35 of the capital's primary schools. This latter approach was used primarily to address the widespread problem of teacher migration in Guyana. Training all teachers in a school together is likely to enhance uptake and use of the curriculum in schools. Reflecting on training, respondents indicated that this occurred best at the cluster level. Training in HFLE has currently been brought to a conclusion until an evaluation of the impact that training has had thus far has occurred. The HIV Focal Point is in negotiations with UNICEF about seeking support and funding for this activity to occur.

Training in HFLE also takes place at Guyana's Teacher Training Institute, CPCE. The college has around 2,000 students at any one time. Students at its main campus undertake three years of preservice training. HFLE is taught by a part-time lecturer as a compulsory two-credit course for all students over one semester (30 hours total). Using a participatory methodology, the course has run for the last six years (except for two years ago, when it did not run at all as there was no member of staff to teach it). HFLE is also reported to be taught in the college's learning centres around the country (six on the coast and eight in the hinterland). Students at the learning centres are working teachers who during a 3.5-year period undertake summer semesters of training alongside one day per week of training in term time (coastal centres) or two days per semester (hinterland centres). As well as HFLE, CPCE is also in discussions with the Red Cross about the possibility of offering students an elective module specifically on HIV prevention. UNESCO and the World Bank also propose to provide technical inputs in to the overall development of teacher education on HIV & AIDS (UNESCO, World Bank 2007b). The college also plans to do some work on peer education for HIV.

The total number of learners in training at CPCE is given in Table 11.

In addition to the numbers in training shown above, CPCE has an Upgrading Teachers' Programme attended by approximately 250 people. These individuals study at home and visit the centres twice per semester for tutorials. Thus, the total number of people being trained by CPCE (including Upgrading Teachers' Programme) is 2,043.

### ***Monitoring***

A specific concern for HFLE in Guyana concerns issues of monitoring and evaluation. At present there seems to be an absence of data concerning how HFLE is actually delivered in the classroom. A positive finding is that HFLE is examinable at grade 6 (common entrance). MoE staff believe that this has encouraged teachers to ensure that teaching is delivered.

### ***School Health Clubs and Peer Education Activities***

In secondary schools, life skills-based health education is delivered by the MoH's Adolescent Health Unit (established in 2005), which delivers peer education and school health clubs (in 78 schools found in all regions except region 8). The unit also runs a number of other campaigns amongst young people, including on substance abuse and road safety. Peer education is also delivered in some schools by the National AIDS Programme Secretariat and many NGOs. Clear data about the extent of delivery of activities are lacking.

**TABLE 11 CPCE Enrolment 2007-08, distribution of student teacher for certificate course by campus**

| Campus                  | Number of Students |
|-------------------------|--------------------|
| Anna Regina             | 82                 |
| Vreed-en-Hoop           | 204                |
| Georgetown (In-service) | 326                |
| New Amsterdam           | 348                |
| Rosehall                | 57                 |
| Region 1                | 47                 |
| Region 7                | 48                 |
| Region 9                | 106                |
| Turkeyen (Main Campus)  | 575                |
| <b>Total</b>            | <b>1793</b>        |

## Safe and Sanitary School Environments

### *Water and Sanitation*

PAHO's "health promoting schools" program has developed health checklists for use during the planning department's construction of school improvement plans. A rapid appraisal tool (also developed by PAHO) is being developed to help schools make good technical decisions about water and sanitation provision using the results of the checklist exercise. UNICEF's "child-friendly schools initiative" has undertaken a variety of initiatives, especially in the area of water and sanitation. As has already been mentioned, school improvement plans and the EFA-FTI (see 5.1 above) have also been used to improve schools' sanitation facilities.

### *School-Based Delivery of Health and Nutrition Services*

The MoH's Adolescent Health Unit delivers youth-friendly health services and VCT for 10- to 24-year-olds. Other departments of the MoH have previously undertaken activities in schools, including immunisations, malaria sensitisation, a national-level deworming campaign, salt iodisation, dental programmes, and others. PAHO also provides input with respect to issues such as nutrition and vision and hearing screening.





# 6

## Mitigating the Impact of HIV & AIDS on the Education Sector

### **Impact Assessment and Response Using the Ed-SIDA Model**

The estimated impact of HIV & AIDS on the education sector in Guyana was calculated using Ed-SIDA, a mathematical model that projects the impact of HIV on education, and an advocacy and planning tool. It outputs teacher impacts and cost impacts of HIV to the education sector. For details of the methods used, please see Appendix C and the Ed-SIDA manual (World Bank and Partnership for Child Development, 2006). For a summary of the data that were input into the model, please also see Appendix C. Displayed here are country-wide results for primary and secondary school education.

#### ***Treatment Scenarios***

If teachers who are HIV-positive know their status and have access to ART if they require it, the impact of HIV on education supply is greatly diminished. We display two policy scenarios, one in which VCT and ART are supplied at current estimated levels and one where ART and VCT is increased to 100 percent beginning in 2008. Current estimated levels of ART take-up is WHO's estimate of 50 percent of those who require it in the general population. The current proportion of the population undergoing annual VCT is assumed to be equal to those taking ART who require it.

The scenarios examined are therefore as follows:

- Teacher ART use remains at 2005 levels between 2006 and 2015
- All teachers undergo VCT and those found to require ART are provided with it.

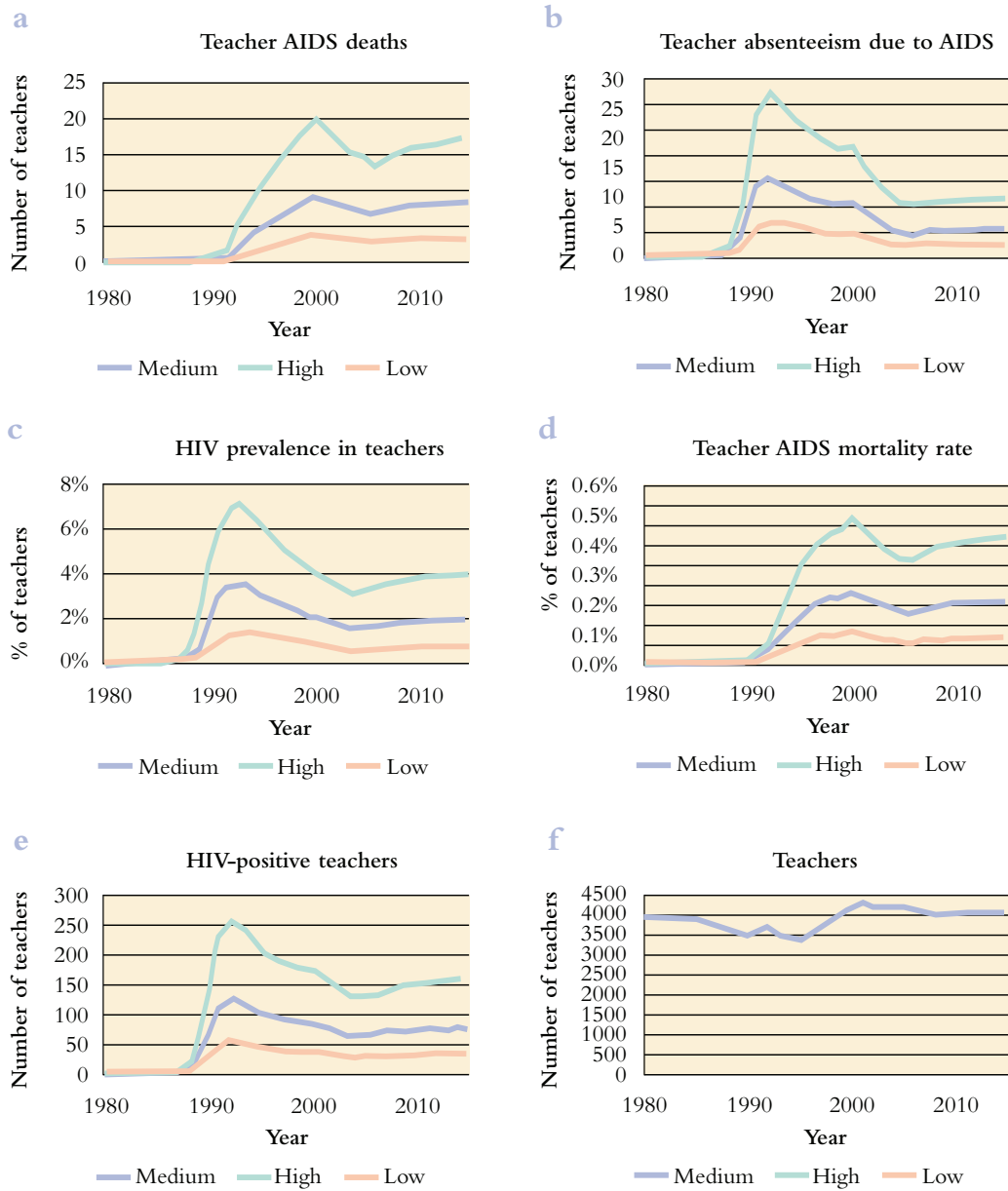
#### ***Results***

##### **Primary schools**

As teacher attrition in Guyana is high at around 8 percent, the extra attrition caused by AIDS illnesses of maximum less than 0.5 percent is significant though relatively small. Note that under this scenario, both HIV prevalence and AIDS deaths are projected to rise among teachers.

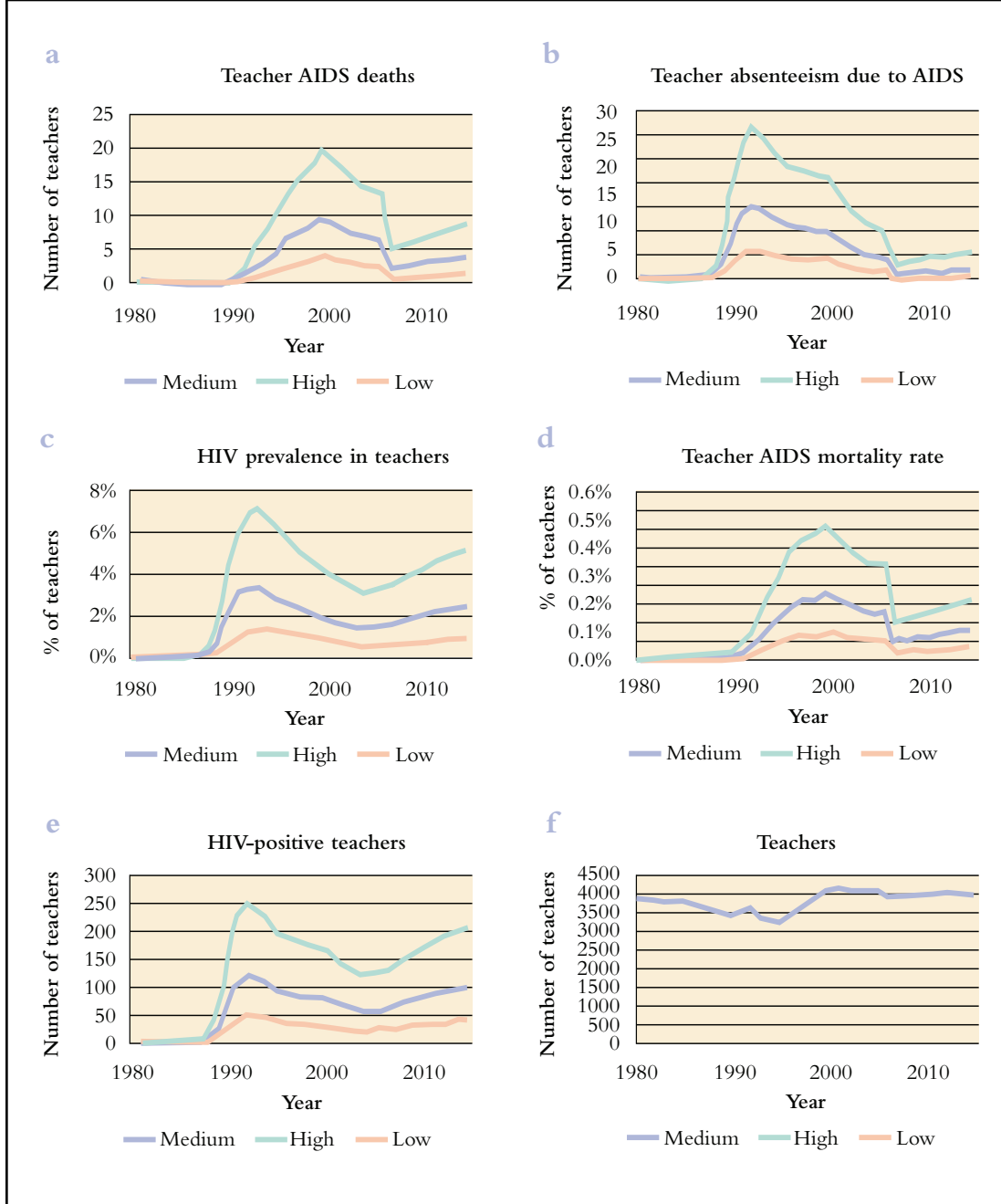
**FIGURE 7 Impact of HIV on Guyana primary teacher prevalence, absenteeism, and deaths, 2006-15, with current level of ART and VCT**

The impact of HIV on teachers in Guyana where ART and VCT are maintained at 2006 levels (here estimated to be 50 percent). Possible impacts evaluated are AIDS deaths (and percent AIDS mortality); HIV-positive teachers (and HIV prevalence); and teacher absenteeism due to AIDS, in teacher-years absent. The dark lines are the most probable course of the epidemic; the lighter grey lines represent the best-case and worst-case epidemic as projected by UNAIDS methods.

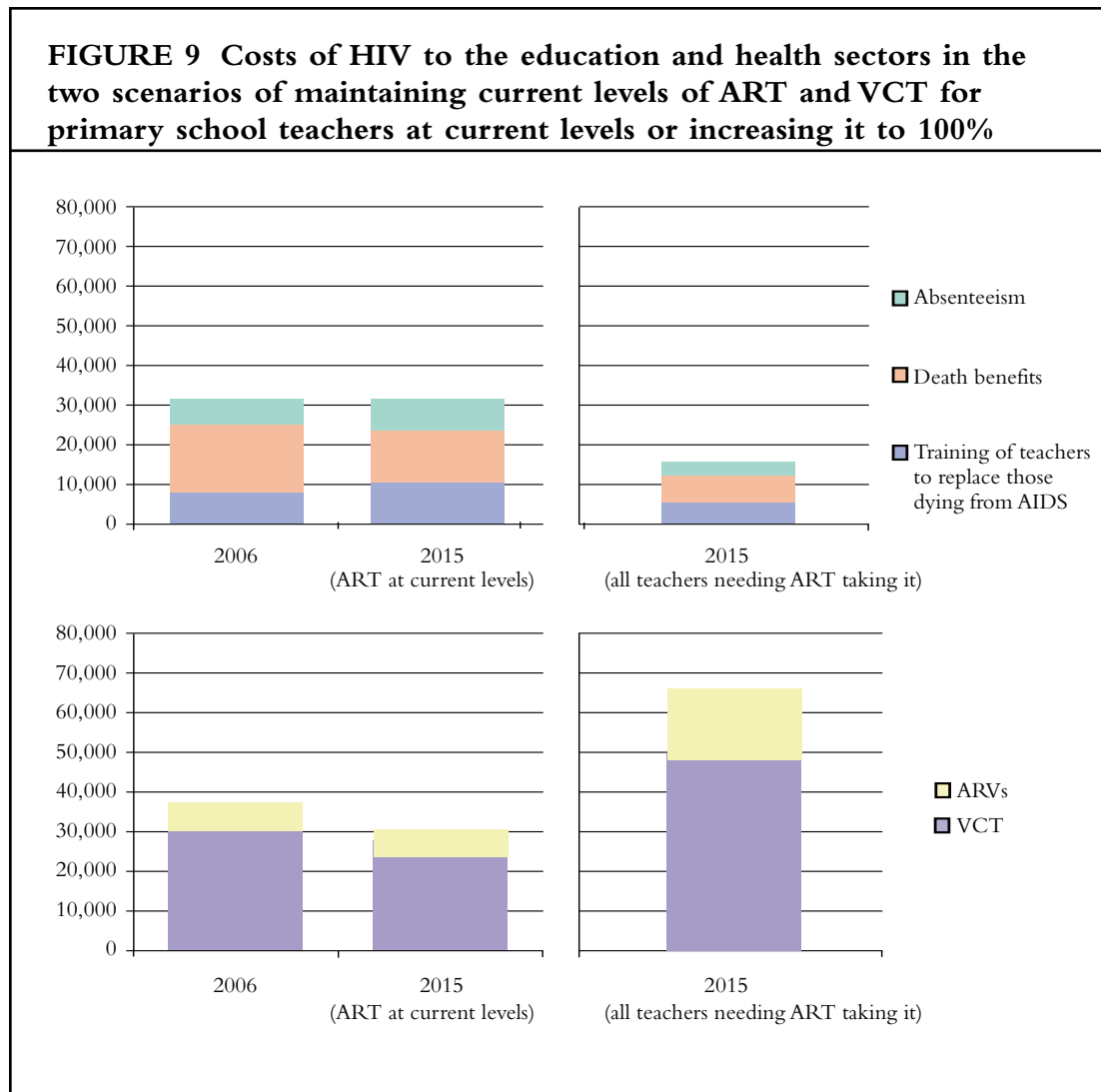


**FIGURE 8 Impact of HIV on primary teacher prevalence, absenteeism, and deaths, 2006-15, with level of ART and VCT increased to 100% from 2008**

As above, where access to ART and VCT is universal between 2007 and 2015.



It can be seen that the impact of increasing ART use is to reduce absenteeism sharply and dramatically reduce deaths of primary school teachers. Also note that HIV prevalence and HIV-positive teachers rise sharply under this scenario, as a result of the reduction in deaths among HIV-positive teachers.



Some costs of HIV to the to health and education sectors of the impact of HIV on primary education in Guyana are shown in Figure 9.

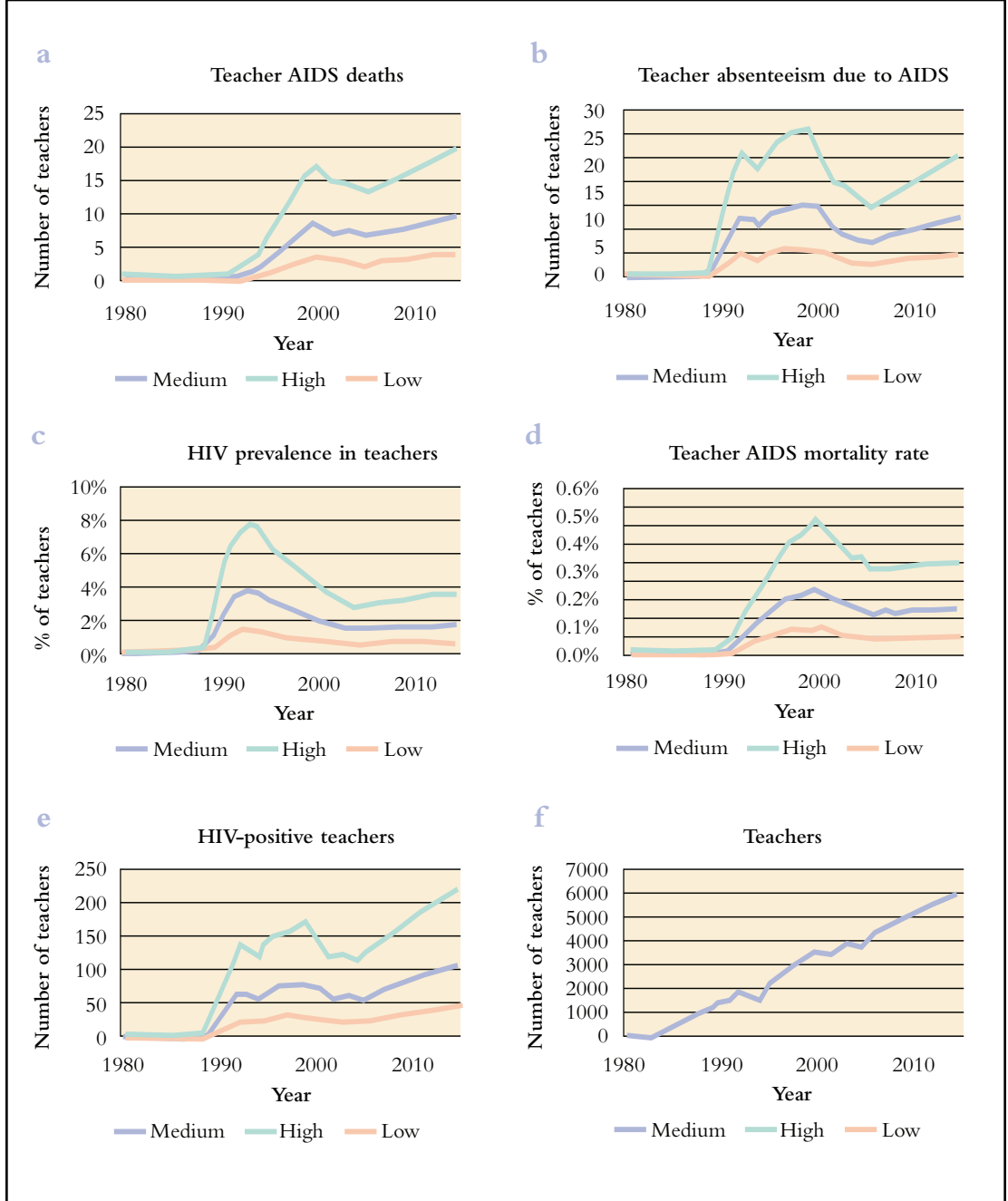
The cost of HIV to the education sector will decline slightly when current levels are maintained. This is the result of the discounting of the unit costs of ART and VCT during this time exerting a greater effect on total cost than the slight expected increase of primary school teachers now and in 2015, where impact is suppressed because of high ART uptake (50 percent). If levels are now increased to 100 percent, there will be a significant decrease in costs to the education sector. These gains to education are associated with losses to the health sector, where the cost of the extra ART and VCT required to enable universal access is greater than the gains to education.

**Secondary schools**

The maximum possible HIV prevalence is slightly higher in secondary teachers compared with primary school teachers (8 and 7 percent, respectively). This is due to differences in the age distribution of primary and secondary school teachers. Among female teachers, the modal

**FIGURE 10 Impact of HIV on Guyana secondary teacher prevalence, absenteeism, and deaths, 2006-15, with current level of ART and VCT**

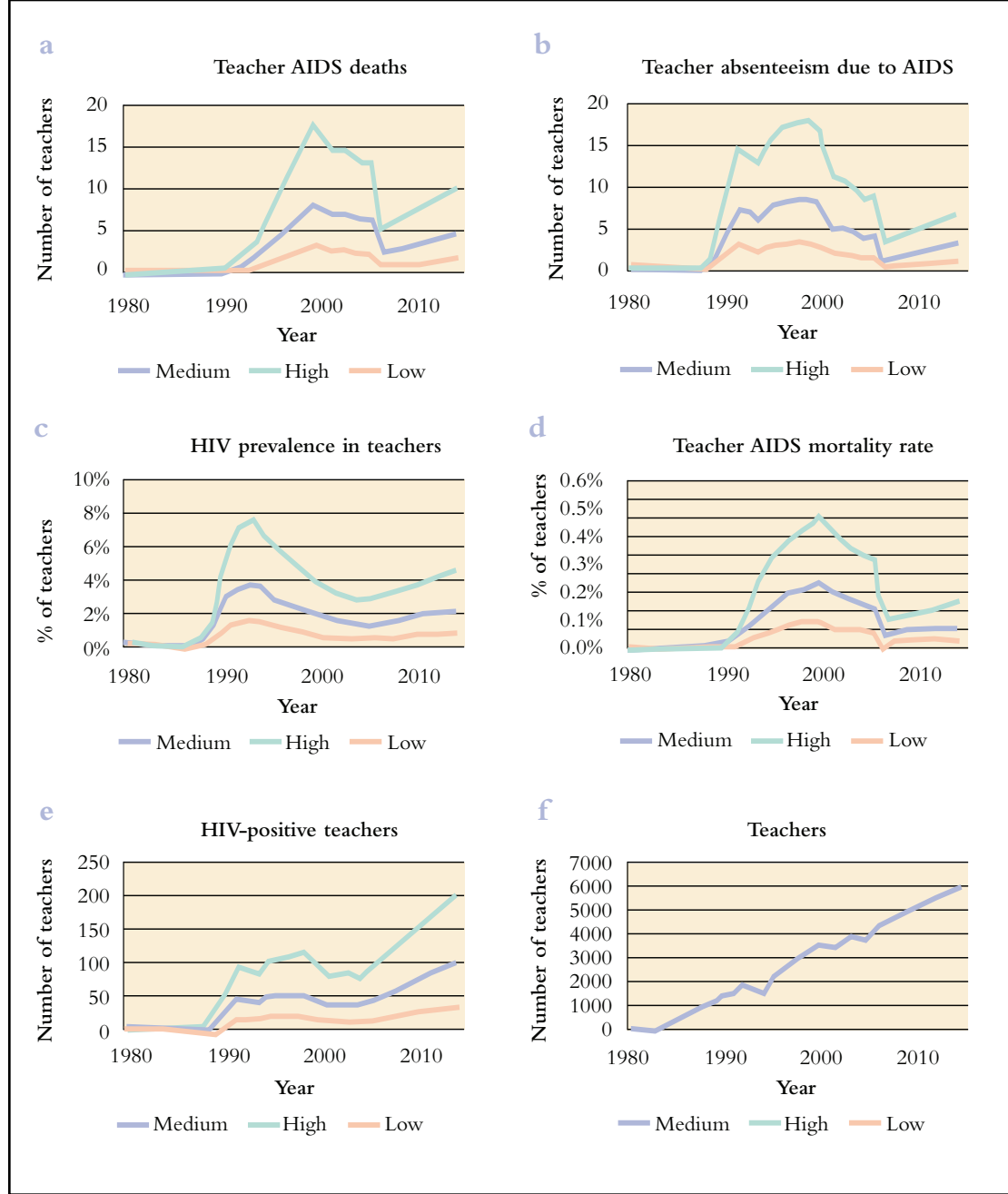
Legend as in figure 1, where teachers are here those in secondary schools, ART maintained at 50 percent beginning in 2008.



age is 20-24, whereas HIV prevalence in women in Guyana at the same time peaks in 25- to 29-year-olds. As secondary teachers have an older average age, they are slightly more at risk of being HIV-positive. In comparison with primary school teachers, the numbers of HIV-positive teachers and AIDS deaths vary more over time as the numbers of teachers vary more over

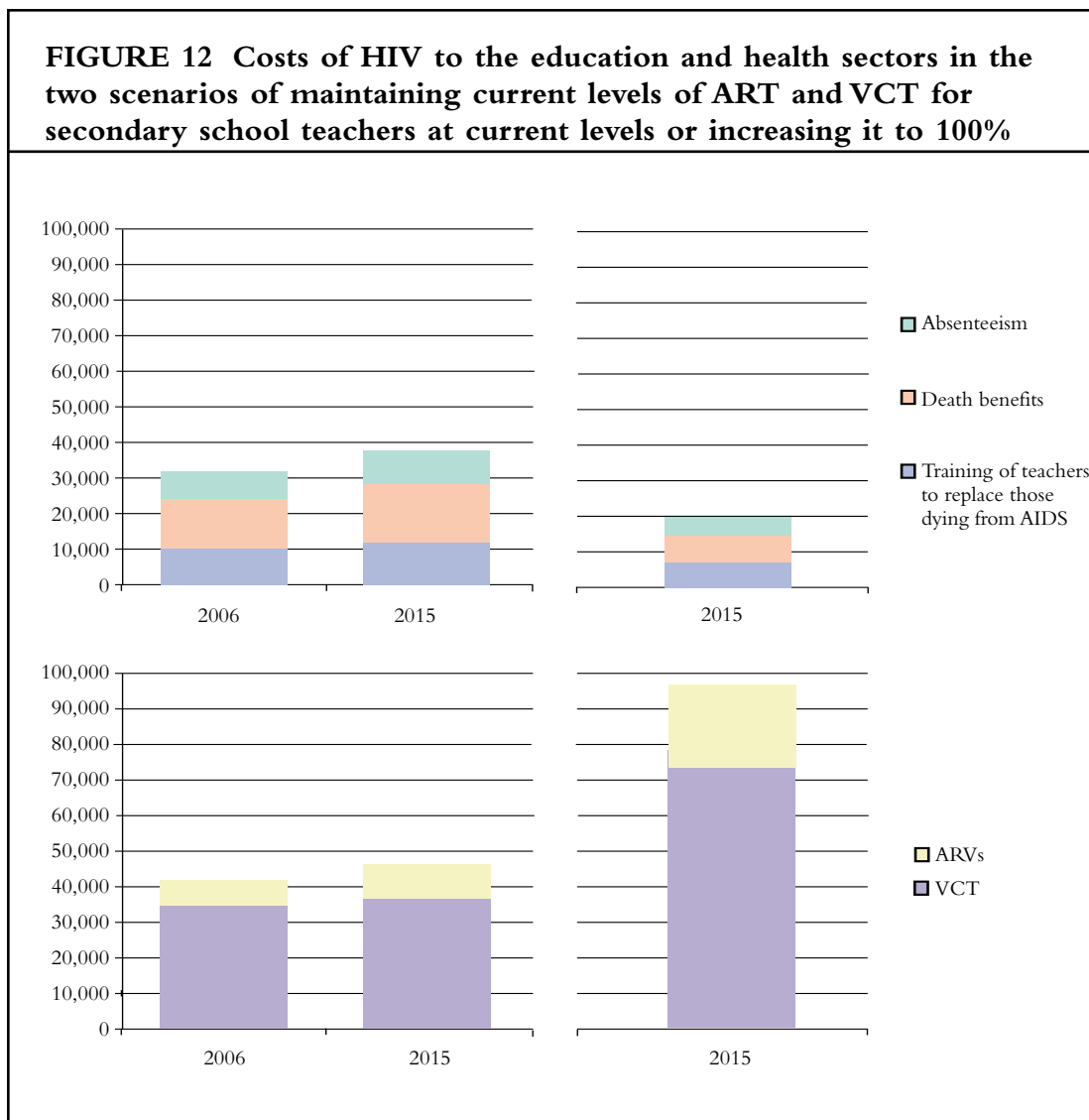
**FIGURE 11 Impact of HIV on secondary teacher prevalence, absenteeism, and deaths, 2006-15, with level of ART and VCT immediately increased to 100%**

As above, where access to ART and VCT is universal between 2007 and 2015.



time. As secondary school teachers are expected to make up an increasing proportion of total teachers, the impact of HIV on education will also need to focus on secondary teachers more in coming years.

The impact of HIV on teachers in Guyana where ART and VCT are maintained at 2006 levels.



Similar trends in the benefits of ART are found among secondary teachers as primary teachers.

In secondary school teachers, as the numbers are expected to rise markedly between 2007 and 2015, this outweighs the small impact of discounted unit costs, and costs to the education sector will rise if ART and VCT are maintained at current levels. If universal access is provided, however, costs will significantly decrease. The cost to the health sector of enabling universal access is much greater than the benefits to education.

**Costs**

In the cost charts (Figures 9 and 12) and Table 12, we compare the costs of a scenario where ART and VCT are provided to all teachers requiring it to one where they are maintained at current levels. Universal access to ART and VCT saves the education sector costs as fewer teachers needed to be trained to replace those dying from AIDS, fewer death benefit are paid out to families of teachers who have died in-service, and fewer substitute teachers require

**TABLE 12 Comparison of costs of maintaining ART & VCT at current levels or increasing access to 100%**

|  | Caribbean <sup>a</sup><br>medium scenario<br>x1000 US\$ |         |                         | Guyana<br>medium scenario<br>x1000 US\$ |      |                         |
|--|---|---------|-------------------------|---|------|-------------------------|
|  | ART &<br>VCT at<br>current<br>levels                    |         | ART<br>& VCT<br>at 100% | ART &<br>VCT at<br>current<br>levels    |      | ART &<br>VCT<br>at 100% |
|  | 2006  | 2015    | 2015                    | 2006                                    | 2015 | 2015                    |
| <b>Ministry of Education:</b>  |   |         |                         |   |      |                         |
| Training new teachers to<br>replace AIDS deaths                        | \$131   | \$118   | \$30                    | \$11                                    | \$10 | \$5                     |
| Funeral costs  | \$166   | \$152   | \$42                    | \$14                                    | \$14 | \$7                     |
| Covering teachers absent<br>due to AIDS illnesses                      | \$168   | \$208   | \$74                    | £7                                      | \$7  | \$3                     |
| <b>Ministry of Health:</b>   |   |         |                         |   |      |                         |
| ART  | \$376   | \$743   | \$1,071                 | \$7                                     | \$7  | \$18                    |
| VCT  | \$1,078   | \$1,075 | \$1,608                 | \$31                                    | \$25 | \$49                    |
| <b>Total saving</b> 2007-15<br>to MoE of increasing<br>ART and VCT use | \$4,595   | \$303   |                         |   |      |                         |
| <b>Total cost</b> of increasing<br>ART between 2007 and<br>2015        | \$2,207   | \$93    |                         |   |      |                         |
| Total cost of increasing<br>VCT between 2007<br>and 2015               | \$5,559   | \$246   |                         |   |      |                         |

a. Bahamas, Barbados, Haiti, Jamaica, Trinidad Tobago, Belize, Guyana, Suriname,

training and wages to replace teachers absent because of AIDS illnesses. The costs saved by the education sector by increasing access could fund the ART of all teachers requiring it between now and 2015. Table 12 compares the Guyanan situation with the Caribbean context, where it is found that the trends are broadly similar.

The annual saving to primary education of putting all teachers on ART in 2015 is set to be US\$52,000, and in secondary school teachers, US\$61,000.

Table 13 shows that if Guyana wishes to replace those primary school teachers dying from AIDS illnesses at the current levels of ART and VCT provision, it must increase recruitment by 6.3. If ART access is increased to all who require it, however, there would be no need to increase recruitment to replace teachers dying from AIDS. AIDS illnesses require that an extra 0.3 percent of Guyana's teacher workforce are required to stand in for teacher absences caused by HIV.



**TABLE 13 Additional primary school recruitment required in Guyana and Caribbean due to HIV and AIDS**

|   | Caribbean      |            | Guyana         |            |
|---|----------------|------------|----------------|------------|
|   | ART status quo | All on ART | ART status quo | All on ART |
| Additional recruitment required in order to replace teachers dying of AIDS illnesses between 2007 and 2015 <sup>a</sup> | 1.0%           | 0.08%      | 6.3%           | 0%         |
| Substitute teachers that needed to be trained as a result of AIDS absences as a % of all teachers <sup>b</sup>          | 0.3%           | 0.3%       |                |            |

a. Denominator = total recruitment from 2007 to 2015.

b. (sum over all countries of the maximum number of substitute teachers required in any one year) (number of teachers in 2000).

### **Summary of Findings**

In summary, the findings of the model are as follows:

- In coming years, the prevalence of HIV among teachers is likely to increase from 1.5 to 2 percent, compared with current UNAIDS estimated population prevalence of 2.5 percent.
- If untreated, this will result in a mortality rate of approximately 0.3 percent, or around 11 teachers per annum.
- The equivalent of five additional teachers per annum would also be needed to cover teacher absences due to HIV & AIDS.
- ARVs are provided free of charge to all people that need them in Guyana.
- At present the take-up among teachers is estimated to be comparatively low (around 50 percent).
- Were ART to be accessed by all teachers that need it, deaths and absenteeism would be markedly reduced, saving many lives and causing considerable financial savings in coming years (approximately US\$113,000 per annum by 2015).
- Were treatment provided, the number of HIV-positive teachers would rise considerably.
- The model found that due to their age profile, the prevalence of HIV among secondary school teachers is likely to be around 1 percent higher than that among primary school teachers.
- Although The MoE would not be directly responsible for the costs of treatment, it would bear some financial burdens such as those related to provision of counselling services.

### **Workplace Issues**

Workplace issues are addressed well by the current HIV & AIDS policy draft, which is based upon the ILO policy. The extent to which activities designed to address workplace issues are taking place is uncertain. These include helping teachers protect themselves from HIV & AIDS, ensuring access of teachers to VCT, and ensuring that teachers infected with HIV & AIDS are receiving adequate care and support.

Training and sensitisation of approximately 900 teachers has been conducted by the Guyana Teachers' Union (GTU). Plans for the training of further teachers are currently being formulated and will build on the organisations' previous efforts (and with goals similar to those discussed above).

## **Orphans and Vulnerable Children**

Because the prevalence of HIV in Guyana is low, comparatively few children have thus far been orphaned as a result of HIV & AIDS. This number, however, is expected to increase. Many more children are vulnerable for reasons other than the death of a parent or parents, including infection with HIV, poverty, or family breakdown. The Ministry of Labour, Human Services and Social Security provides children with a wide range of different support activities, including food, health care, provision of school uniforms, and so forth and the MoE identifies this work as having a significant impact on Guyana's progress towards meeting its EFA goals. That said, at present, few concrete facts are known in Guyana concerning the impact that vulnerability has on education. During the analysis, concern was also expressed that children infected or affected by HIV & AIDS may be excluded from participation in the education system.

# 7

## Recommendations for the Establishment of a School Health, Nutrition and HIV & AIDS Programme in Guyana

### **Strong Leadership and Commitment to Action**

A clear desire amongst stakeholders consulted during the situation analysis (see Appendix B) was the wish to integrate sector efforts towards the control of HIV & AIDS into a more holistic package of school health and nutrition activities. Such opinion reflects the understanding of the issues evidenced by the MoE's choice of slogan for the recent (September 2007) education month in Guyana. This was "School Health, Nutrition and HIV & AIDS: Safeguarding the Future the Generation." Those interviewed considered that inclusion of HIV & AIDS in wider school health and nutrition efforts would increase the likelihood of activities' success, reduce concerns about or opposition to programming, and act to ensure the long-term sustainability of activities.

Careful thought needs to be given as to where primary responsibility for such co-ordinating efforts should lie. In the past, in many countries, responsibility for school health and nutrition activities often rested with the health sector. This was usually found to be unsatisfactory; the health sector has no control over what happens in schools and does not naturally recognise the need to ensure that activities lead to the enhancement of the education sector's goals such as improved attendance, performance, and achievement. More recently, a much more satisfactory course of action has been to place responsibility for coordination and ownership of programmes with the education sector. This ensures that activities fit well with the sector's organisation and goals and that they are sustainable in the long term. Placing primary responsibility with education does not of course negate the role that other sectors can play—their contribution is essential.

In line with these considerations it is recommended that:

- Primary responsibility for coordination of all SHN and HIV activities in Guyana should rest with the MoE.
- The education sector should be responsible for convening a coordinating body to bring together the contributions of different stakeholders
- The different components of Guyana's response should be delivered in an integrated fashion, strengthening the prospects for the achievement of long-term, sustainable solutions to the needs of the country's children.

**TABLE 14 Comparison between FRESH and UNESCO frameworks on HIV & AIDS**

| <b>FRESH Framework</b>                   | <b>UNESCO-EDC Framework</b>   |
|--|---|
| Health-related school policies           | Adoption of an overarching policy on HIV & AIDS for the thousands of learners, teachers, and staff in the education system  |
| Life skills-based health education       | Implementation of a skills-based HIV & AIDS prevention curriculum   |
| Safe and sanitary school environments    | Creation of a healthy psychosocial and physical educational environment, free from stigma, discrimination, gender inequity, sexual harassment, homophobia, and violence |
| School-based delivery of health services | Enhancement of HIV & AIDS-related treatment education, services, care, and support for learners and educators infected and affected by HIV & AIDS.                      |

- The FRESH framework should be used as the organising principle for all SHN & HIV activities in Guyana parallel with the framework for action of the UNAIDS Global Initiative on Education HIV & AIDS (EDUCAIDS), which is led by UNESCO. Activities should also occur in concert with other appropriate frameworks, including PAHO's Health Promoting Schools approach and UNICEF's Child Friendly Schools approach.

With specific reference to education sector efforts to prevent HIV & AIDS, EDUCAIDS highlights five essential components for a comprehensive education sector response to HIV & AIDS:

- **Quality education, including cross-cutting principles** that ensure that programmes are rights-based, proactive and inclusive, gender-responsive, culturally sensitive, age-specific, and scientifically accurate
- **Content, curriculum, and learning materials** that are specifically adapted and appropriate for various educational levels; are focused and tailored to various groups (for example, orphans and vulnerable children), increase prevention knowledge, attitudes, and behaviours; and focus on stigma and discrimination as well as care and support
- **Education training and support** including education of formal and nonformal teachers and provision of support groups, school and community linkages, and teaching materials
- **Policy, management, and systems**, including policy, planning, strategic partnerships and monitoring and evaluation
- **Approaches and illustrative entry points**, including school health, life skills, and peer education (UNESCO 2006).

One advantage of using the FRESH framework is that it enables ready coordination of the existing frameworks of agencies working in Guyana. For example, as the table below shows, clear correspondence exists between FRESH and the framework developed by the UNESCO and the Education Development Centre (EDC) as part of its "Advocacy and Leadership Campaign to Advance the Education Sector Response to HIV/AIDS in the Caribbean."

In line with this proposal, the remaining recommendations for the establishment of a SHN & HIV Programme in Guyana are presented under the headings of the FRESH pillars.

## SHN & HIV-Related Policy

As has been mentioned, Guyana has already developed draft policies with respect to HIV & AIDS in the education sector and HFLE. It is recommended that:

- These draft policies should now be included in a more comprehensive policy that addresses all needs for school health, nutrition, and HIV & AIDS programming in Guyana. This policy should be reflected in the country's new education act that is currently being drafted.
- The policy produced should use the FRESH framework as its guiding principle in parallel with the framework for action of EDUCAIDS, which is led by UNESCO. It should lay out clearly Guyana's policy and direction with respect to health-related policies in the country's education sector, the delivery of life skills-based health education in the country's schools, standards and procedures to make the country's schools safe and sanitary environments, and the delivery of school based health and nutrition services through the country's schools.

Particular cross-cutting issues that should also be reflected in policy development include the following:

### ***Coordination***

On meeting the many different stakeholders involved in HIV & AIDS in the education sector, both formal and nonformal (see Appendix B), it becomes immediately apparent that coordination of activities is lacking resulting in the almost certain possibility of gaps in provision, duplication, and waste of resources. There is an urgent need to improve coordination of activities significantly.

A critical issue for coordination is that, because skilled personnel migrate to other sectors, agencies, and countries, Guyana's MoE experiences a high degree of staff turnover at all levels, from the central ministry to local schools. This means that placing skills and knowledge in the hands of just one person is a very risky strategy; should that person leave his or her position (as is highly likely), there is a danger that activities will grind to a halt.

In light of the findings described above, the following recommendations are made:

- A School Health, Nutrition, & HIV & AIDS Prevention Unit should be formed in the MoE.
- The unit should coordinate all stakeholders undertaking school health, nutrition, and HIV & AIDS prevention activities in Guyana's schools. With respect to HIV & AIDS in particular, in order to strengthen a more synergistic national response, the unit should ensure the coordination of MoE responses with both NAPS (in fulfilment of the UNAIDS "Three Ones") and the HSDU.
- The unit should be staffed by the current HIV and HFLE Focal Points with appropriate administrative support.
- Careful thought is needed by the MoE concerning where the unit should be sited (within which department, for example).
- The unit should negotiate memoranda of understanding (MoU) with different stakeholders involved in school health, nutrition, and HIV & AIDS prevention. (The MoH, for example, is keen that such an MoU be produced.) It would also be helpful to develop a multi-sectoral coordinating mechanism or body for different stakeholders.

- Regional school health, nutrition, and HIV & AIDS prevention Focal Points and coordinating committees need to be identified and trained. Careful thought is needed as to who should be asked to undertake this work.

### ***Mainstreaming and Communication***

The prevention of HIV & AIDS demands the participation and commitment of all members of all sectors of society. If efforts are to be successful, responsibility cannot remain in the hands of just a few “specialised” actors; there is a need for everyone to play their part. Respondents to the situation analysis highlighted the need to mainstream issues of HIV & AIDS throughout the work of the MoE’s different departments. It was also considered essential that HIV & AIDS be kept in the constant attention of the country’s schools.

Achieving such mainstreaming poses considerable challenges for communication. Regular and clear communication will be needed if HIV & AIDS is to be kept at the forefront of the minds of schools and of members of the ministry. Further, if the MoE is to benefit from the help and expertise of the many different partners that wish to assist its efforts, there is a need to communicate clearly its activities, successes, and needs for the future.

In particular, stigma and discrimination continues to be pressing problems affecting the education sector effort to address HIV & AIDS in Guyana. Stigma acts to encourage members of the ministry to externalise HIV & AIDS issues, causing them to be regarded as “someone else’s problem.” This negatively affects the ministry’s ability to mainstream HIV issues throughout its work and to encourage staff to take appropriate and timely care of themselves (for example, through VCT).

In the light of these considerations, the following recommendations are made:

- When the education sector SHN & HIV policy and strategic plans have been developed, a process of orientation concerning these will be needed for all ministry personnel, teachers, school administrators, parents, and children.
- Each section of the ministry should then be asked to consider how the policy and strategic plan should influence their activities.
- A regular newsletter concerning school health, nutrition, and HIV & AIDS prevention should be sent to all members of the sector.
- Efforts to combat stigma and discrimination should be given particular attention.

### ***Particular Issues for Amerindian Communities***

The indigenous community of Guyana is made up of nine tribes that have varying levels of exposure to Western culture. Most people’s first language is their tribal language, with English being their second. Threats to the hinterland populations include the arrival of potentially high-risk groups such as miners and loggers. The borders of the hinterland areas with Brazil, Venezuela, and Suriname are highly porous. Many Guyanese Amerindians work in Brazil, especially in Boa Vista, a large trading port. The Ministry of Amerindian Affairs has had an HIV & AIDS programme since 2005. It has trained community facilitators of different age groups and has conducted a number of sensitisation workshops and trainings in Amerindian communities.

Particular issues for HIV & AIDS activities in hinterland areas include the following:

- Difficulties of communication given that English is not most people’s first language
- Cultural norms and practices that present challenges to the ways in which HIV & AIDS information and teaching is presented

- Issues of stigma and discrimination, especially against students and teachers who are HIV-positive.

With respect to education in the hinterland areas, school populations vary from around 40 pupils in the smallest to more than 800 in the largest. Enrolment is high, but there are problems with dropouts, repetition, and absenteeism. Only 32 percent of teachers are trained, and the MoE is currently building good standard teacher housing in hinterland areas in order to encourage recruitment. Training of new teachers takes place in hinterland centres of CPCE (see HFLE training above), and a number of teachers are now also being trained using distance education methods. Owing to the difficulty of travel in hinterland areas, the costs of education in general, and of training in particular are high. In some places, students are educated in boarding schools. The hinterland scholarship programme allows the brightest students to come to Georgetown to learn with students residing at the Amerindian Hostel. This presents both opportunities and challenges; opportunities in that students staying at the hostel return to their homes during vacations where they could be messengers of HIV education. The challenges relate to having young people living away from their homes in a culture radically different from their own.

Guyana's EFA-FTI works predominantly in regions 1, 7, 8, and 9. The programme has three major areas of activity:

- Strengthening the teaching force in hinterland areas
- Improving the learning environment of hinterland schools
- Strengthening school-community relationships

The programme's activities to strengthen the teaching force particularly lend themselves to strengthening the sector's SHN & HIV response. Through the programme, Learning Resource Centres (LRCs) are to be established in hinterland areas and these could be used for SHN & HIV teaching. The component also envisages undertaking Continuous Professional Development of Teachers (CPDT) which would offer additional opportunities for training in SHN & HIV. School feeding is currently taking place in 31 schools and is projected eventually to occur in 140.

In the light of these considerations, the following recommendations are made:

- In hinterland areas, production of communication materials concerning school health, nutrition, and HIV & AIDS should be produced through a participatory, community-led process rather than through a top-down process determined in Georgetown.
- The inclusion of school health, nutrition, and HIV & AIDS prevention components in the EFA-FTI should be agreed on and strengthened.

### ***Community Education and Involvement***

A concern raised by respondents to the situation analysis was the need to ensure that messages about SHN & HIV received at schools are also received and backed up by members of the community. In particular, the need to ensure the full participation of members of PTAs in training and the dissemination of messages was highlighted. The MoE's magnet schools have had some good experience with outreach to parents. Within this work, gender issues were highly apparent; while the program had good success in reaching mothers, outreach to fathers was much more difficult. Respondents to the situation analysis asserted that consultation with

the country's faith-based organisations is essential to successful implementation of HIV & AIDS activities in the sector. Concern was also raised about the inclusion of children's voices in the design of materials and activities and in the future direction of HIV & AIDS activities.

In the light of these considerations, the following recommendations are made:

- Parents, children, members of faith-based communities, and other community stakeholders should be involved in the construction of teaching materials and other health messages.
- School improvement plans (which always require the input of teachers, parents, children, and community members) should be required to include components relating to school health, nutrition, and HIV & AIDS prevention.
- When teachers are trained in HFLE (see below), school health, nutrition, or HIV & AIDS activities, PTA representatives should be trained alongside them.

### ***Monitoring and Evaluation***

Monitoring and evaluation of all activities in school health, nutrition, and HIV & AIDS prevention was found to be relatively weak. Monitoring of processes is generally stronger than monitoring of outcomes.

In the light of these considerations, the following recommendations are made:

- Clear participatory systems for monitoring and evaluation of activities need to be developed for all areas of school health, nutrition, and HIV & AIDS.
- Clear responsibility for monitoring needs to be determined and assigned to relevant departments.
- Monitoring and evaluation systems need to be costed.

## **Life Skills-Based Health Education**

As was described in section 6.3, HFLE is the backbone of Guyana's efforts in life skills-based health education. Much excellent work has already been done. The challenge now is to consolidate and extend the gains that have already been made. In the light of that understanding, the following recommendations are made:

- The evaluation of the impact of previous HFLE training should occur as soon as possible.
- Preservice teacher training in HFLE at CPCE and its centres should be strengthened and resourced. In particular, there is a need to understand better how training in HFLE is occurring at centres around the country.
- In-service training should resume as quickly as possible. The institute in charge of in-service teacher training is The National Centre for Education Resources and Development (NCERD).
- Infusion guides concerning school health and nutrition issues (for example, for hygiene and sanitation) should be developed for use in HFLE in addition to the existing guides used for HIV & AIDS teaching.
- Monitoring of HFLE teaching needs to be strengthened; templates for including a column concerning infusion of life skills in different subjects have been developed and should be used.



- More information is needed about the delivery of life skills-based health education to students in secondary and tertiary education. While the response at the primary level has been strong, the response at these levels appears to have been much more haphazard.
- Particular attention should be given to the provision of life skills-based health education to Amerindian Students staying for their education in the Amerindian Hostel in Georgetown. This would have a number of benefits: (i) It would act in support of students' welfare and studies; (ii) it would provide an easy means of working on the development of health messages suitable for use amongst Amerindian communities; and (iii) given that most students return home during vacations, training could also enable the formation of a cadre of informal peer educators in hinterland areas.

## **Safe and Sanitary School Environments**

### ***Water and Sanitation***

As has been described, considerable activity is taking place to improve water and sanitation in Guyana's schools through the work of a number of programmes. As for other aspects of the SHN & HIV response, issues of coordination and monitoring are weak. There is also concern that provision of effective technical guidance may be lacking. The following recommendations are made:

- Improved coordination is needed amongst the different providers of water and sanitation in schools.
- Improved monitoring is needed of schools' equipment and services
- With respect to providing schools with improved technical assistance: PAHO's rapid assessment tool has the potential to fill this need.

### ***Care of Orphans and Vulnerable Children***

While an extensive package of interventions for orphans and vulnerable children is reported by the Ministry of Labour and Human Services, the MoE does not of itself run any particular services for OVCs. The impact of orphaning and vulnerability on education in the country is unclear. It is recommended that:

- More data are needed concerning the impact of vulnerability on children's education.
- The provisions of the draft HIV & AIDS policy concerning the participation in education of children infected with or affected by HIV & AIDS should be implemented in full.

## **School-Based Delivery of Health and Nutrition Services**

Few data concerning the health of school-age children in Guyana are available, and even fewer disaggregated by region. Until recently, most delivery of health and nutrition services in schools has been led by The MoH. Little consideration has been given to the possibility of using the model employed in many other countries whereby teachers are enabled to deliver simple health services under the supervision of local health workers. For example, in many countries, deworming tablets are now commonly delivered by teachers). The potential for use of such a model requires further investigation. It is therefore recommended that:

- More information be gathered concerning the more general health and nutrition needs of Guyana's school children. A situation analysis concerning these should occur.
- The potential for teacher based delivery of school health and nutrition services should be explored.

## **Workplace Issues**

Guyana is in the fortunate position of being able to provide free medication to all people requiring ARVs. The use of the Ed-SIDA model has demonstrated that many teachers' lives and considerable financial resources could be saved if more teachers were encouraged to take up the services that are freely made available to them. In order for this to happen, stigma and discrimination need to be eliminated and teachers enabled to make greater use of services. It is therefore recommended that:

- The existing draft policy concerning workplace issues should be implemented in full.
- The activities of the GTU should be strengthened and, if possible, harmonised with the ongoing training efforts of the MoE.
- A focus of training should be to encourage greater use of VCT by teachers.
- In remote areas, the MoE may need to consider facilitating teachers' visits to VCT centres.

# 8

## Conclusion and Summary of Activities to Be Included in Education Sector Strategic Plan

The situation analysis demonstrates that considerable activity is already taking place within the education sector with respect to SHN & HIV. Activity is often diffuse and delivered in an uncoordinated fashion by a large number of stakeholders. Potential exists for the education sector response to be considerably enhanced, principally through improved coordination of stakeholders and through inclusion of HIV & AIDS in wider SHN interventions. Such actions would enable simple steps to be taken to enhance and synergise the different activities of the country's existing response.

At the conclusion of the situation analysis, findings were discussed at a high-level workshop attended by the Minister of Education, the Hon. Dr. Desrey Fox, and a number of key stakeholders from education, health, other sectors, and civil society. The following recommendations were made by those that attended as priorities for action and inclusion in the development of the Education Sector Strategic Plan. Most recommendations related to matters of policy:

- The MoE should develop a comprehensive school health, nutrition, and HIV & AIDS policy which should be reflected in Guyana's general education policy and the country's Education Sector Strategic Plan, 2008-12. The policy should build upon existing MoE draft policies, including the education sector HIV & AIDS policy and the HFLE policy.
- The policy should make clear that the MoE should bear primary responsibility for coordination and ownership of all SHN & HIV activities in Guyana.
- The policy should use the FRESH framework as its coordinating principle in parallel with the framework for action of EDUCAIDS, which is led by UNESCO. It should also reference existing frameworks such as PAHO's Health Promoting Schools and UNICEF's Child Friendly Schools. Other resources should include *A Guide to HIV and AIDS Policy Development for the Education Sector* (CARICOM-EDC-UNESCO) and *An HIV/AIDS Workplace Policy for the Education Sector in the Caribbean* (ILO-UNESCO).
- The policy should enable the coordination of different stakeholders through the creation of an SHN & HIV unit within the MoE that should be responsible for convening a coordinating body that would bring together the contributions of different stakeholders. In line with this, the MoE should lead efforts to construct a Memorandum of Understanding between the MoE and key stakeholders, especially the MoH.

- The policy and strategic plan development should draw upon the data presented in this rapid analysis. It also needs to be strengthened through further collection of data concerning different aspects of the health of Guyanese school-age children, preferably disaggregated by region. Such data should include children's health, water, and sanitation in Guyanese schools and the educational needs of orphans and vulnerable children.
- The policy should strengthen future decision making through the enhancement of monitoring and evaluation of SHN & HIV activities in Guyana.
- Formation of policy and strategy should be guided by examples of international and regional best practice in this sphere, including the work of CARICOM, UNESCO, the World Bank, PAHO, UNICEF, and others.

In addition to these matters of policy, two key recommendations were made with respect to operational issues.

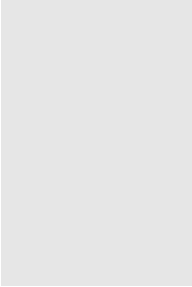
- Strengthening of the provision of HFLE should continue apace. Especial attention should be paid to strengthening preservice training of new teachers at CPCE and its centres.
- Ongoing sensitisation of Guyanese teachers should occur to educate them more about SHN & HIV issues and also to encourage greater uptake of health services such as VCT and provision of ARV.



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# APPENDIX A

## Terms of Reference of the Consultancy

Ministry of Education, Guyana

### **TERMS OF REFERENCE**

#### **Consultant: Local Situation Analysis Consultant: Education and HIV & AIDS**

##### *Broader Consultancy Objectives*

The Ministry of Education, Guyana, with support from the UNESCO Kingston Cluster Office for the Caribbean (UNESCO) and the Partnership for Child Development (PCD), Imperial College, has engaged the services of international consultants to conduct a rapid situation analysis of Guyana's education sector response to HIV & AIDS, including an impact assessment of HIV & AIDS on the sector so as to provide a baseline to inform its accelerated response in HIV & AIDS prevention education. Activities will be undertaken between the period September to October 2007.

The broader consultancy has the following objectives:

- To assess the effectiveness of Guyana's current and planned response to HIV & AIDS in the education sector, highlighting strengths and critical gaps through: (i) considering the response of all the education sub-sectors, (ii) concentrating on responses in priority areas, (iii) examining whether responses are appropriate to the situation, (iv) identifying gaps in the response and considering why they exist, and (v) analyzing why some initiatives are working well and why others may be failing;
- To enhance the education sector's capacity to effectively implement an appropriate response to the HIV & AIDS epidemic by providing evidence-based guidance to education sector policy makers and those responsible for its implementation;
- To work with a mathematical modeler (based at PCD) to develop (including the collection of appropriate data) and interpret impact projections of HIV & AIDS on the education sector with recommendations to mitigate against these;
- To consider how data collection and M & E systems (including broader school health and nutrition issues [SHN]) can be further strengthened to finesse the development of impact projections of HIV & AIDS on the education sector:

- To integrate priorities for a comprehensive HIV & AIDS education sector response, as identified by the sector's key stakeholders;
- To consider how these priorities are linked to existing SHN initiatives and how these linkages might be expanded and strengthened;
- To develop a series of recommendations for the integration of the existing education sector Workplace Policy into a comprehensive education sector HIV & AIDS policy;
- To contribute to a stronger presence of the education sector in the Government of Guyana's multi-sectoral response to HIV & AIDS by informing the design and implementation of a comprehensive, scaled-up education programme on HIV and AIDS, as outlined in the Guyana National HIV & AIDS Strategy 2007-2011;
- To contribute to the UNESCO-led, UNAIDS Global Initiative on Education, HIV & AIDS aimed at preventing the spread of HIV through education, and to protect the core functions of the education system from the worst effects of the epidemic.

There is a recognized need to contract the services of a **Local Situation Analysis Consultant: Education and HIV & AIDS** to form a critical part of the project team to work with the Ministry of Education (MoE) and the international consultants to achieve these objectives.

#### ***Local Situation Analysis Consultant: Education and HIV & AIDS***

The appointment of the **Local Situation Analysis Consultant** has the following specific objectives:

- Support the team from the Ministry of Education and the international consultants to achieve the objectives of the consultancy ;
- Contribute to the drafting of a report that evaluates the effectiveness of Guyana's current response and its plans for the immediate future, highlighting strengths and critical gaps, and outline parameters of a policy development and strategic planning exercise for the sector, citing best practices from countries with similar experiences. The report should also include the projections developed of the impact of HIV & AIDS on the education sector including current and potential implications for Guyana.

#### ***Characteristics of the Consultancy***

##### **Type of consultancy**

Individual—short term.

##### **Duration**

15 September to 31 October, 2007

##### **Place of work**

The consultant will be required to work in Guyana and to be based in Georgetown, and will be working closely with the Ministry of Education, Guyana and the international consultants

##### **Qualifications**

Degree in Education, Social Sciences, Development Studies, Public Health, Health Economics, or an equivalent qualification.



## Experience required

- At least five years experience in education sector policy development, planning and management.
- At least three years experience in working on the implications of the HIV & AIDS epidemic on the education sector in seriously affected countries/regions, and on the design of measures to strengthen the role and capacity of the education and youth sectors in prevention, management and mitigation
- Demonstrated teamwork capabilities
- Strong research skills
- Prior work experience in the Caribbean is essential. Prior experience in socio-economic or other impact assessments or evaluation exercises especially HIV & AIDS related, would be an added advantage, but is not essential.
- Fluency in English is required, as are good communication skills and a level of competence allowing self-sufficiency in basic IT packages, particularly MS Word and MS Excel.

## *Scope of Work*

The Local Situation Analysis Consultant will be expected to undertake the following activities in support of the lead consultants:

- Support the review of documentation prior to the lead consultants' arrival, contributing to the development of the lead consultants' inception paper, including preliminary analysis indicating gaps and areas to be further examined in country. The review of relevant background information on Guyana's Education Sector HIV & AIDS Response, should include UNESCO/ PCD/World Bank-commissioned and other national and international assessments;
- Assist the lead consultants, in collaboration the Government of Guyana and its current partners in the response of education – including partners in other sectors, UNAIDS cosponsors, the CARICOM Secretariat, Teachers Training Institutions and NGOs, in the development of a strategy based on information gathered in 4.1 above to identify what further information might be needed to obtain a complete picture of the current situation;
- Assist with the preparations for consultative interviews and meetings in the period leading up to the lead consultants' field visit and engage broad stakeholder input in the situational analysis;
- Brief the lead consultants on preparatory work on their arrival in Guyana for the field visit;
- Support logistical arrangements to the lead consultants during their field visits (confirming meetings and locations, contacting informants, etc. as required);
- Accompany the lead consultants to selected interviews and meetings and co-facilitating on same;
- Conduct interviews with stakeholders independently as required, and preparing interview notes;
- Assist the lead consultants in the preparation of a report that evaluates the effectiveness of Guyana's current response and its plans for the immediate future, highlighting strengths and critical gaps, and outline parameters of a policy development and strategic planning exercise for the sector, citing best practices from countries with similar experiences. The report should also include the projections developed of the impact of HIV & AIDS on the education sector (including current and potential implications for Guyana);

- Assist the lead consultants in drafting a series of recommendations for development of the education sector-specific, comprehensive HIV & AIDS Policy based on the updated situation analysis;
- Assist in the planning and facilitation of a technical meeting with education sector stakeholders to discuss and finalise the recommendations of the report;
- Provide support for any follow up or complimentary work to assist with the finalization of the draft report on the situation analysis;
- Provide general liaison services between the Ministry of Education, and the international consultants, particularly for the periods when the international consultants will not be in Guyana but working from home base.

### ***Deliverables***

The local consultant shall, in consultation with the MoE, Ministry of Health/National AIDS Programme Secretariat and the lead consultants:

- Collate and forward documentation, including comments on same, for literature review and preparation of inception paper by lead consultants by **September 26, 2007**.
- Draft, based on gaps identified in the lead consultants' inception paper in 5.1 above, a list of key informants to be interviewed and stakeholders to participate in technical meetings during the lead consultants' country visit by **October 1, 2007**.
- Prepare and confirm schedule of consultations with key stakeholders in Guyana during the lead consultants' field visit by **October 6, 2007**.
- Prepare a report of interviews and other activities undertaken during the lead consultants' field visit by **October 25, 2007**.
- Present report, revised to incorporate feedback on initial draft, including policy recommendations to MoE senior management and development partners by **October 31, 2007**.

### ***Supervision and Coordination***

The expert will be supervised by the appropriate senior officer within the Ministry of Education and will work in close collaboration with the Coordinator for HIV & AIDS Education, and in particular, the International Situation Analysis Consultants, in the execution of the assigned tasks.

## **TERMS OF REFERENCE UNESCO-PCD Consultancy to conduct a rapid situation analysis of the education sector's response to HIV & AIDS: Guyana**

### ***Background***

As outlined in UNESCO's global strategy for responding to HIV & AIDS (2007), one key objective of the organization is to enhance the capacity of Member States to implement comprehensive and scaled-up responses to HIV & AIDS, particularly in the education sector, that are informed by available evidence, based on widespread consultation with key stakeholders, undertaken through strategic alliances and partnerships at all levels and evaluated for impact.

UNESCO's contribution to the global response to HIV & AIDS is manifest in its leading the UNAIDS Global Initiative on Education and HIV & AIDS (EDUCAIDS) which acknowledges the importance of comprehensive education sector engagement as part of the national response to HIV & AIDS.

Since 2002 the UNESCO Kingston Cluster Office for the Caribbean has given the highest priority, primarily through its education programme for the Caribbean, to building the capacity of the education sector of the region to respond effectively to the AIDS epidemic. Moreover, UNESCO, alongside other partners in the Caribbean, has continuously advocated at the regional and national level for a strengthened and accelerated education sector response to HIV & AIDS, culminating in 2006 at CARICOM's special meeting of the Council on Human and Social Development (COHSOD) on education and HIV & AIDS in Trinidad & Tobago and the resultant "Declaration of Port-of-Spain" which signifies the commitment of Ministers of Education to provide strong leadership in this important area.

As a follow-up to this critically successful meeting was the emerging consensus among regional development partners to continue dialogue and action on efforts at improved inter-agency coordination in accelerating the education sector response to HIV & AIDS in the Caribbean.

At a post-COHSOD meeting of International Development Partners (IDPs) including UNAIDS cosponsors and the World Bank, discussions on how to intensify joint efforts produced an agreement that working together in a few countries would serve as a learning experience towards initiating the same type of harmonization, as appropriate, at a regional scale. The guiding principle within each country would be to support a sequential process in the education sector's HIV & AIDS response through the development of policy, strategy and funded work plan.

In May 2007, the UNESCO Kingston Cluster Office for the Caribbean, the World Bank and the Partnership for Child Development, Imperial College, undertook a joint mission to Guyana. This fact-finding, stock-taking mission was intended to identify, in collaboration with relevant local partners, specific country needs in the education sector's HIV & AIDS response but also more broadly in the framework of school health. In particular, the final aim is to accelerate the education sector response to school health, nutrition (SHN) and HIV & AIDS at country level through improved harmonization and alignment of IDP initiatives.

A final report (Appendix 1) on the mission's outputs presented to the Ministry of Education (MoE), Guyana summarized some key priority areas that were identified by education sector stakeholders and other partners as needing particular attention. These are: (i) information and research; (ii) capacity building for planning, decision-making and coordination; (iii) continuous professional development of teachers; (iv) stigma, discrimination and human rights, including attention to cultural differences. The mission report also provided recommendations for action towards addressing these priority areas and has undertaken, in agreement with the Government of Guyana, to provide technical and financial support to the design and implementation of a series of critical actions, the first of which will be ***a rapid analysis of the current status within the education sector with regards to HIV and AIDS including impact projections based on existing data.***

With the above in mind, the UNESCO Kingston Cluster Office for the Caribbean and the Partnership for Child Development, Imperial College are seeking to contract the services of a ***Lead Situation Analysis Consultant: Education and HIV & AIDS.***

### ***Rationale***

The consultancy has the following objectives:

- To assess the effectiveness of Guyana's current and planned response to HIV & AIDS in the education sector, highlighting strengths and critical gaps through: (i) considering the response of all the education sub-sectors, (ii) concentrating on responses in priority areas, (iii) examining whether responses are appropriate to the situation, (iv) identifying gaps in the response and consider why they exist, and (v) analyzing why some initiatives are working well and why others may be failing;
- To enhance the education sector's capacity to effectively implement an appropriate response to the HIV & AIDS epidemic by providing evidence-based guidance to education sector policy makers and those responsible for its implementation;
- To work with a mathematical modeler (based at PCD) to develop (including the collection of appropriate data) and interpret impact projections of HIV & AIDS on the education sector with recommendations to mitigate against these;
- To consider how data collection and M&E systems (including broader SHN issues) can be further strengthened to finess the development of impact projections of HIV & AIDS on the education sector ;
- To integrate priorities for a comprehensive HIV & AIDS education sector response, as identified by the sector's key stakeholders;
- To consider how these priorities are linked to existing SHN initiatives and how these linkages might be expanded and strengthened;
- To develop a series of recommendations for the integration of the existing education sector Workplace Policy into a comprehensive education sector HIV & AIDS policy;
- To contribute to a stronger presence of the education sector in the Government of Guyana's multi-sectoral response to HIV & AIDS by informing the design and implementation of a comprehensive, scaled-up education programme on HIV and AIDS, as outlined in the Guyana National HIV & AIDS Strategy 2007-2011;
- To contribute to the UNESCO-led, UNAIDS Global Initiative on Education, HIV & AIDS aimed at preventing the spread of HIV through education, and to protect the core functions of the education system from the worst effects of the epidemic.

### ***Characteristics of the Consultancy***

#### **Type of consultancy**

Individual/Team

#### **Duration**

15 September–31 October, 2007

#### **Place of work**

The consultancy will require desk work in addition to travel, to Guyana as outlined in the Deliverables detailed below.

**Qualifications:**

- Post Graduate Degree in Education, Social Sciences, Development Studies, Public Health, Health Economics, or equivalent.
- At least ten years national experience in education sector policy development, planning and management.
- At least five years international experience in evaluation of the implications of the HIV & AIDS epidemic on the education sector in adversely affected countries or regions, and the design of measures to strengthen the role and capacity of the education and youth sectors in prevention and mitigation.
- Prior work experience in the Caribbean as well as in the development of education sector policies and strategic plans on HIV & AIDS would be an asset, but are not essential.
- Demonstrated teamwork capabilities. Fluency in English is required, as are good communication skills

***Scope of Work:***

- In collaboration with the local situation analysis consultant, review documentation on current thinking on the appropriate response of an education sector of a country with a HIV & AIDS epidemic at the 1.5-3% prevalence rate, and reports documenting the current response of Guyana's education sector to the epidemic at all levels.
- Develop a strategy with the local consultant (and in collaboration the Government of Guyana and its current partners in the response of education – including partners in other sectors, UNAIDS cosponsors, the CARICOM Secretariat, Teachers Training Institutions and NGOs) based on information gathered in (i) above to identify what further information might be needed to obtain a complete picture of the current situation.
- Prepare a report that evaluates the effectiveness of Guyana's current response and its plans for the immediate future, highlighting strengths and critical gaps, and outline parameters of a policy development and strategic planning exercise for the sector, citing best practices from countries with similar experiences. The report should also include the projections developed of the impact of HIV & AIDS on the education sector (including current and potential implications for Guyana).
- Based on this final report and in collaboration with all education sector stakeholders develop a series of recommendations to be included in the policy development process.

***Output/Deliverables*****Detailed Work Plan & Process**

- Preparation of key background documentation:  
Preparation and submission of a paper identifying the components of the final report and a short overview of documentation received from the local situation analysis consultant with a preliminary analysis indicating gaps and areas to be further examined in country by **September 28, 2007**.

- Scheduling and confirmation of key informant interviews: Preparation (in collaboration with the local situation analysis consultant) and submission of a schedule of key informant interviews (based on gaps identified in 1a above) during the country visit for final agreement by UNESCO and PCD by **October 5, 2007**.

### **Country Visit to Guyana**

- Field visit to Guyana from **October 13 to 20, 2007**. The country visit will include:
  - Meetings with key informants (as outlined in 1b above) to fill in information gaps identified in 1a above.
  - Development of a series of recommendations for development of the education sector specific, comprehensive HIV & AIDS Policy based on the updated situation analysis.
  - Facilitation of a two-day technical meeting with education sector stakeholders to discuss and finalise the recommendations.

### **Finalisation of Report**

- Report finalised by **October 26, 2007** comprising: i) HIV situation analysis for the sector; ii) strengths, weaknesses and critical gaps of the current education sector response; iii) recommendations for future action; iv) recommendations for the policy development and strategic planning.

**Final Report, including policy recommendations, submitted to MoE senior management and development partners by October 31, 2007.**

### ***Supervision and Coordination***

The consultant/s will be supervised by the Education Programme Manager at UNESCO Kingston Cluster Office for the Caribbean and the Coordinator, Partnership for Child Development, Imperial College. The consultant/s will also work with a mathematical modeler (based at PCD) on the development of the impact projection and relevant M&E issues. At the Ministry of Education, Guyana the consultant/s will work in close collaboration with the Coordinator for HIV & AIDS Education and in particular, the local situational assessment consultant, in the execution of the assigned tasks. In addition, the consultant/s will coordinate with the Ministry of Health, Health Sector Development Unit and the National AIDS Programme Secretariat.

# APPENDIX B

## List of Stakeholders Interviewed and Schedule

### Final Schedule for Situational Analysis Consultants' Visit to Guyana

*Mr. Michael Beasley and Ms. Mohini Venkatesh  
October 15–22, 2007*

Team arrives at Cheddi Jagan International Airport at 08.40 Hours on  
Caribbean Airlines Flight BW 461

Met on arrival by Dereck Springer, Local Consultant

Arrives at Cara Suites at approximately 10:30 Hrs

|                                 | Time      | Agency                              | Contact Person(s)  | Location   |
|---------------------------------|-----------|-------------------------------------|--|--|
| <b>MONDAY, OCTOBER 15, 2007</b> |           |                                     |  |  |
| X                               | 12:00 Hrs | Side Walk Cafe                      | <b>Working lunch</b> with Dereck Springer and Sharlene Johnson, HIV & AIDS Focal Point   | Middle Street (3 doors East of Cara Suites)              |
| X                               | 13:30 Hrs | Ministry of Education               | <b>Ms. Nicola Warrinna</b> , Senior Statistician<br>Tel: 223-7900 (Ext. 239)   | 26 Brickdam, Georgetown                                  |
| X                               | 14:00 Hrs | Ministry of Education               | <b>Ms. Jacqueline Simon</b> , Personnel Officer<br>Tel: 225-4422   | 21 Brickdam, Georgetown                                  |
| X                               | 14:45 Hrs | National AIDS Programme Secretariat | <b>Ms. Bendita Latchmansingh</b> , Epidemiologist<br>Mr. Bernard De Souza, M&E Officer<br>Mr. Nicholas Persaud, Coordinator, Treatment & Care<br>Tel: 227-8683 or 226-5371 | Hadfield Street & College Road, Wortmanville, Georgetown |
| X                               | 16:00 Hrs | UNFPA                               | <b>Ms. Patrice La Fleur</b> , Liaison Officer<br>Tel: 226-4040   | UNDP Office, 40 Brickdam, Georgetown                     |

| <b>Time</b>                        | <b>Agency</b>   | <b>Contact Person(s)</b>   | <b>Location</b>  |
|------------------------------------|---|--|--|
| <b>TUESDAY, OCTOBER 16, 2007</b>   |   |  |  |
| X 08:30 Hrs<br>Split               | Ministry of Education   | <b>Ms. Genevieve White-Nedd</b> , Chief Education Officer<br>Tel: 225-6329   | 26 Brickdam, Georgetown  |
| X 08:30 Hrs<br>Split               | Guyana Teachers Union (formerly Association)  | Mr. Colwyn King, President<br>Tel: 2270403 or 226-3183   | GTU Office Woolford Avenue, Georgetown   |
| X                                  |   |  |  |
| X 09:15 Hrs                        | US Centers for Disease Control and Prevention, Global AIDS Program Guyana (CDC GAP) and USAID | <b>Dr. LaMar Hasbrook</b> , Country Director<br>Tel: 223-0859/79<br><b>Ms. Julia Rehwinkel-Roberts</b> , Health & Nutrition Officer, USAID<br>Tel: 225-7315 (Ext. 4362)    | <b>Meeting will be held at CDC Office</b><br>44 High Street, Kingston, Georgetown, DDL Building, 4th Floor<br><b>Please walk with photo ID</b> |
| X 11:00 Hrs                        | PAHO/WHO  | <b>Mr. Enias Baganizi</b> , HIV& AIDS Advisor<br><b>Mrs. Renee Peroune</b> , Health Promotion Advisor<br>Tel: 225-3000   | 8 Brickdam, Stabroek, Georgetown   |
| 12:00 Hrs                          | L U N C H   |  |  |
| X 13:15 Hrs                        | Education for All Fast Track Initiative (EFA-FTI)   | <b>Mr. Edward Jarvis</b> , Hinterland Coordinator<br>223-7900  | Ministry of Education, 26 Brickdam, Georgetown   |
| X 13:15 Hrs                        | Ministry of Education<br><b>Mohini Venkatesh</b>  | <b>Ms. Nicola Warrinna</b> , Senior Statistician<br>Tel: 223-7900 (Ext. 239)   | 26 Brickdam, Georgetown  |
| X 14:30 Hrs                        | UNICEF  | <b>Ms. Michele Rodriques</b> , Programme Officer, Education<br>Tel: 225-8105   | 72 Brickdam, Georgetown  |
| X 15:30 Hrs                        | Ministry of Amerindian Affairs  | <b>Mr. Michael Abraham, HIV &amp; AIDS Focal Point</b><br>Tel: 223-7285  | Thomas & Quamina Streets, Cummingsburg, Georgetown,  |
| X 16:15 Hrs                        | UNAIDS  | <b>Dr. James Guwani</b> , M&E Advisor<br>Tel: 225-1580   | CIDA Support Secretariat, 56 Main & New Market Streets GTown   |
| X 18:30 Hrs                        | Ministry of Education   | <b>Ms. Sharlene Johnson</b> , HIV & AIDS Focal Point   |  |
| <b>WEDNESDAY, OCTOBER 17, 2007</b> |   |  |  |
| X 09:00 Hrs<br>Split               | Cyril Potter College of Education   | <b>Ms. Myrtle Fanfair, Principal</b><br>Tel: 222-4441  | Turkeyen, East Coast Demerara  |
| X 09:00 Hrs<br>Split               | Francois Xavier Bagnaud (FXB) Treatment & Care  | <b>Dr. Tom Minior</b> , Country Director<br>Tel: 225-1068-9  | Barrack & Duke Streets, Kingston, Georgetown   |
| X 10:15 Hrs<br>Split               | Caribbean Community (CARICOM)   | <b>Ms. Valarie Taylor</b> , Senior Project Officer, Education<br>Tel 222-0001-0075 (Ext. 2752) or 220-9652   | Caribbean Community Secretariat, Turkeyen, E.C. Demerara   |
| X 10:15 hrs<br>Split               | National AIDS Programme Secretariat<br><b>Mohini Vanketesh</b>                                | <b>Ms. Bendita Latchmansingh</b> , Epidemiologist<br>Mr. Bernard De Souza, M&E Officer<br>Mr. Nicholas Persaud, Coordinator, Treatment & Care<br>Tel: 227-8683 or 226-5371 | Hadfield Street & College Road, Wortmanville, Georgetown   |
| X 11:15 Hrs<br>Split               | National Centre for Education Research Development (NCERD)                                    | <b>Mr. Mohandatt Goolsarran</b> , Director<br>Tel: 225-6723  | 3 Battery Road, Kingston, Georgetown   |



| Time                 | Agency  | Contact Person(s)   | Location  |
|----------------------|---|---|---|
| X 12:00 Hrs<br>Split | Health Sector<br>Development Unit                                   | Mr. Keith Burrowes, Executive Director<br>Tel: 226-2425                     | East Street, North<br>Cummingsburg, Georgetown                      |
| X 12:30 Hrs<br>Split | Guyana HIV & AIDS<br>Reduction and<br>Prevention (GHARP)<br>Project | Dr. Navindra Persaud, Director, M&E<br>Tel: 231-6317 or 231-6311 (Ext. 258) | 44 High Street, Kingston,<br>Georgetown, DDL Building,<br>1st Floor |
| X 13:30 Hrs<br>Split | Ministry of Health<br>Adolescent Unit                               | Dr. Marcia Paltoo, Director, Adolescent Health Unit<br>Tel: 223-7354        | Ministry of Health, Brickdam,<br>Georgetown                         |
| X 15:00 Hrs          | Health Sector<br>Development Unit                                   | Mr. Patrick Mentore, Coordinator, Line Ministries<br>Tel: 226-2425          | East Street, North<br>Cummingsburg, Georgetown                      |

#### THURSDAY, OCTOBER 18, 2007

|                      |  |   |  |
|----------------------|--|---|--|
| X 09:30 Hrs          | Guyana Teachers' Union<br>(HIV & AIDS Training)  | <b>Ms. Lesline Collins</b> , Representative<br>Tel: 661-7546  | GTU Office, Woolford Avenue,<br>Georgetown           |
| X 10:30 Hrs<br>Split | National Bureau of<br>Statistics                 | Mr. Lennox Benjamin, Chief Statistician<br>Tel: 225-6150  | Brickdam, Georgetown                                 |
| X 11:00 hrs<br>Split | Ministry of Education<br>Inspectorate Department | Mr. Herbert Grandison, Assistant Chief<br>Education Officer<br>Tel: 225-7000  | 68 Brickdam, Georgetown                              |
| 12:00 Hrs            | <b>L U N C H</b>                                 |   |  |
| X 13:00 Hrs          | Ministry of Education                            | <b>Honourable Dr. Desrey Fox</b> , Minister in<br>the Ministry  | Minister's Office<br>26 Brickdam, Georgetown         |
| X 13:30 Hrs          | Ministry of Education                            | <b>Honourable Dr. Desrey Fox</b> , Minister in<br>the Ministry<br><b>Ms. Sharlene Johnson</b> , HIV & AIDS Focal Point<br><b>Ms. Shirley Innis</b> , Member Ministerial Committee<br>on HIV & AIDS<br><b>Mr. Dereck Springer</b> , Local Consultant | Boardroom<br>26 Brickdam, Georgetown                 |
| X 16:00 Hrs          | Ministry of Culture,<br>Youth & Sport            | <b>Mr. Carl Brandon</b> , Director of Youth &<br>Community Services<br>Tel: 226-7144  | 71-72 Main Street, South<br>Cummingsburg, Georgetown |

#### FRIDAY, OCTOBER 19, 2007

##### STAKEHOLDERS' WORKSHOP

Venue: Guyana National Commission for UNESCO

Robb & Oronoque Streets, Bourda, Georgetown

|           |   |   |
|-----------|---|---|
| 08:30 Hrs | Workshop Registration                     | Dereck Springer, Local Consultant                           |
| 09:00 Hrs | National Pledge                           | Led by Sharlene Johnson, HIV & AIDS Focal Point             |
| 09:00 Hrs | Welcome                                   | Sharlene Johnson, HIV & AIDS Focal Point                    |
| 09:05 Hrs | Brief Remarks                             | Honourable Dr. Desrey Fox, Minister in the Ministry         |
| 09:15 Hrs | HIV & Education:<br>International Lessons | Michael Beasley, Partnership for Child<br>Development (PCD) |
| 09:30 Hrs | HIV & Education:<br>El SIDA Model         | Mohini Venkatesh, PCD                                       |
| 10:00 Hrs | Education Sector<br>HIV & AIDS Response   | Sharlene Johnson, HIV & AIDS Focal Point                    |
| 10:30 Hrs | <b>BREAK</b>                              |   |

| <b>Time</b>                                   | <b>Agency</b>  | <b>Contact Person(s)</b>                                    | <b>Location</b> |
|---|--|---|-----------------|
| <b>10:45 hrs</b>                              | Principal Challenges:<br>–Coordination<br>–HIV & AIDS within<br>the wider school health<br>context<br>–Monitoring & evaluation<br>–Training & dissemination<br>of information and<br>appropriate communication<br>–Decentralization<br>–Community involvement<br>& education | Michael Beasley, Partnership for Child<br>Development (PCD) |                 |
| <b>12:00 Hrs</b>                              | <b>LUNCH</b>   |   |                 |
| <b>13:00 Hrs</b>                              | Discussion: group<br>and plenary   | Michael Beasley and Mohini Venkatesh                        |                 |
| <b>14:15 Hrs</b>                              | Next Steps:<br>–Education strategic<br>plan<br>–Policy development   | Dereck Springer   |                 |
| <b>15:00 Hrs</b>                              | Close  | Sharlene Johnson  |                 |
| <b>SATURDAY, OCTOBER 20</b>                   |  |   |                 |
| Consultants will determine activities, of any |  |   |                 |
| <b>SUNDAY, OCTOBER 21</b>                     |  |   |                 |
| Michael and Mohini Depart Guyana              |  |   |                 |

X—Confirmed appointments

# APPENDIX C

## Methodology and Data inputted into the Ed-SIDA Model

### **Overall Approach**

The Ed-SIDA model combines an epidemiological model, using UNAIDS processes to project the course of the HIV epidemic, and an education planning model, using standard education planning tools to project teacher supply needs for a given set of education parameters.

### **Model description**

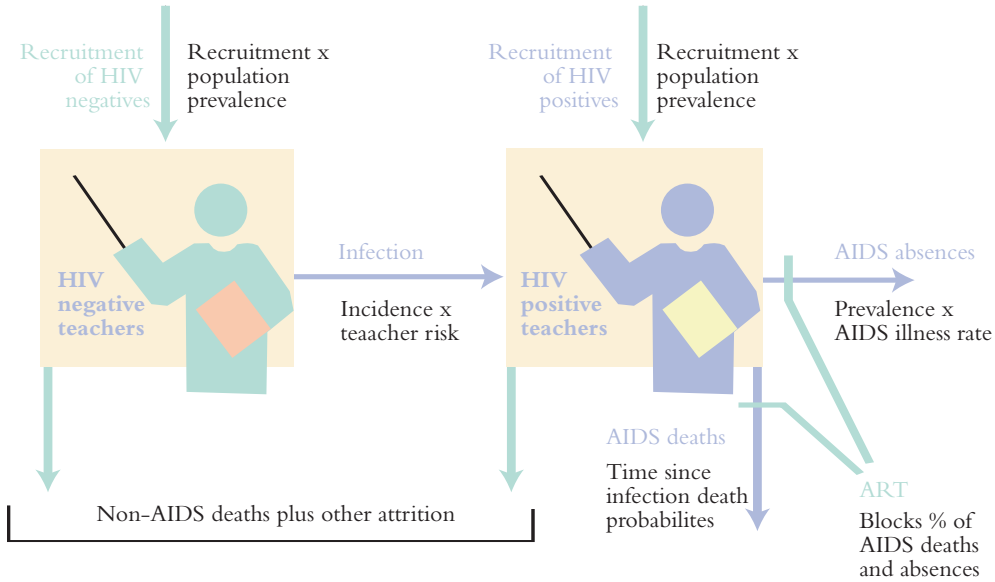
The model used has been developed from that described in Grassly (2003). It enumerates the processes which affect the number of primary school teachers in each country. Costs are then applied to these processes and scenarios examined to generate cost estimates in various circumstances. The structure of the new model is illustrated in figure 10. This model allows for the exploration of the addition of care and support for teachers, and the probability of death is based on age, gender and expected time since infection.

The epidemiological model provides country-specific epidemiological projections of HIV prevalence, incidence, and AIDS deaths. The UNAIDS projections used which output these values for each gender and five-year age group, and give high, low, and medium estimates. The education model is a national planning tool for which education data were provided by the Guyana Ministry of education.

### **Incorporating age and gender patterns**

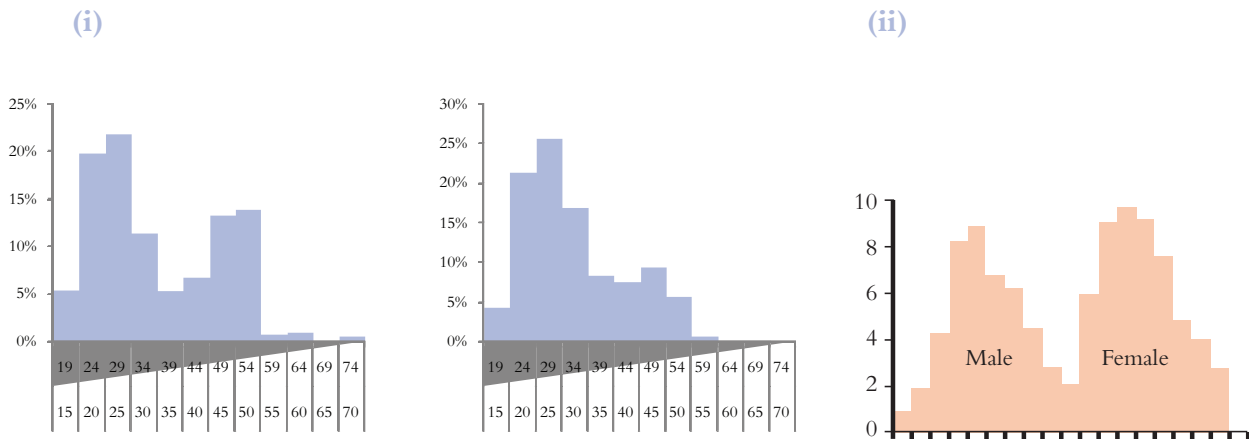
Age- and gender-specific HIV prevalence and AIDS death rates were obtained using UNAIDS methods. The age and gender profile of teachers was then used to predict the HIV prevalence and AIDS death rates among teachers. Figure 11 shows age profiles from Guyana. It is apparent that there are marked differences between the age distributions of male and female and teachers. It is also apparent that there are differences between the age distributions of HIV infection by gender. The age distribution of HIV infection is applied to the age distribution of teachers along with the HIV prevalence and teacher relative risk of being infected to produce the number of teachers living with HIV and/or AIDS.

**FIGURE 13 Processes in the model of impact on HIV and AIDS on education supply. All prevalence, incidence, and death probability estimates are made using UNAIDS methods and are age-, gender-, and year-specific.**

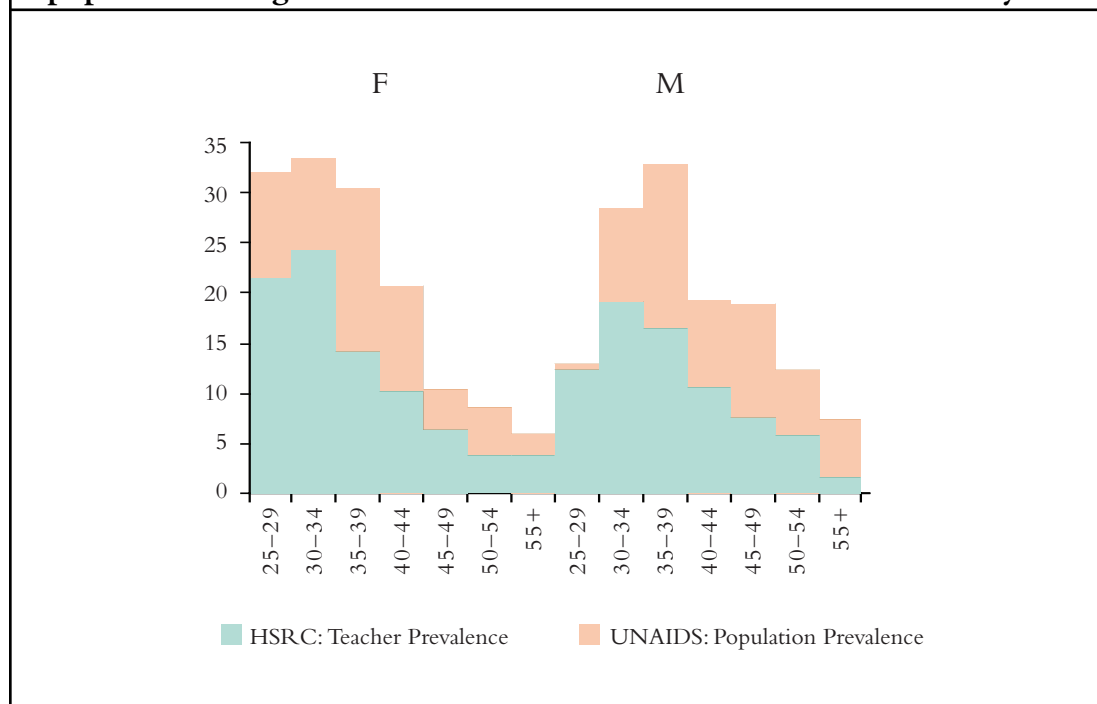


**FIGURE 14**

- (i) Age distribution of teachers employed in Guyana, 2005, by gender input into the model
- (ii) Typical age distribution HIV infection, by gender



**FIGURE 15 HIV prevalence by age and gender in a large sample of educators in South Africa in 2004 and that estimated for the general population using UNAIDS methods for South Africa in the same year.**



The available data on HIV age-distribution are for the population as a whole, and not for teachers specifically. The best and only data available on age-infection profiles in teachers are from a study in South Africa (Shisana et al. 2005). The relative risk of teachers being infected with HIV is calculated from this study, as described in figure 12.

Teachers had on average 56 percent of the prevalence of the general population. The shape of the prevalence-age distribution is similar in educators and in the general population, which lends credibility to projections based on these distributions. The peak age of infection among male teachers is slightly lower in educators than in the general population, and male educators ages 25-29 have an almost indistinguishable prevalence to that of the general population. This may indicate that young male teachers are engaging in behaviour just as risky as the general population

## Historical data, 1980-2006

Teacher numbers and pupil teacher ratios were determined from a pre-epidemic start date of 1980 until 2006 using data made available by the UNESCO Institute of Statistics. Where data were unavailable for one year, values were estimated to increase or decrease linearly between bounding years. Where data from boundary years (1980 or 2006) were unavailable, data were estimated to be equal between 1980 and the first year with available data, or between 2006

**TABLE 15 Primary school data input into the model. All data shown except where stated are from the most recent available year. Data were input into the model for all years available.**

| Data   | Value           |
|--|-----------------|
| Age and gender distribution of teachers <sup>a</sup>               | F 50-54 M 50-54 |
| Age and gender distribution of recruited teachers <sup>a</sup>     | F 20-24 M 20-24 |
| Age and gender distribution of teachers leaving <sup>a</sup>       | F 50-70 M 50-70 |
| Number of teachers   | 4185            |
| Female teachers  | 86%             |
| Background attrition rate  | 8%              |
| School-age population  | 88450           |
| Net enrolment  | 89%             |
| Gross enrolment  | 132%            |
| Relative risk of teacher infection                                 | 56%             |
| HIV prevalence (UNAIDS medium estimates for 2005)                  | 2%              |
| Probability of AIDS death in HIV-positive women aged 40-44 in 2000 | 14%             |
| Reduction in mortality due to ART                                  | 93%             |
| Reduction in absences due to ART                                   | 90%             |
| Proportion of HIV-positive teachers needing ART                    | 20%             |
| Access to ART by those who need it                                 | 20%             |
| Substitute teacher salary <sup>b</sup>                             | \$1,371         |
| Teacher training cost <sup>b</sup>                                 | \$1,475         |
| Death benefits <sup>b</sup>  | \$1,728         |
| Cost of ART <sup>b</sup>   | \$1,038         |
| Cost of VCT <sup>b</sup>   | \$15            |

a. Peak five-year age band(s).

b. Costs are US\$, 2007 equivalent.

and the last year with available data. From 2000-06, age and gender profiles for teachers are available. Before this date, they were presumed to be equal to those in 2000. Recruitment and attrition data were available from 2000 to 2006. Prior to 2000, the attrition was initially set at the value given in appendix 2, and first the recruitment was varied until the number of teachers calculated by the model equalled the number of teachers given by UIS in that year. If there was a drop in teacher numbers which could not be accounted for by zero recruitment, the attrition rate was increased until the calculated and observed numbers of teachers were equal. The UIS-collected number of teachers was not therefore entered into the calculations directly, but was used to adjust recruitment and sometimes attrition rates so that the model produced the observed number of teachers. The actual data entered are listed in table 3.

***For years for which no data are currently available, 2007-2015***

Rates of recruitment and attrition were kept at the most recent values, thus maintaining the trends in teacher numbers (approximately constant for primary school teachers, and an increasing number of secondary school teachers). Age distributions were maintained at 2005 estimates and HIV data were projected using UNAIDS models. Costs were discounted for the future at 3 percent per annum.

## **Estimating costs**

Cost data to estimate the economic impact of HIV on education were sourced from the WHO (cost of ART), World Bank (GDP), and the Ministry of Education and teacher training institute (teacher salary, costs of absenteeism, and death benefits).

Costs were converted to 2007 equivalent using a rate of inflation of 3 percent. For future and past years, they were then discounted at a rate of 3 percent. If costs were unavailable for a country, a neighbouring country's costs were then scaled on the relative GDP per capita and subsequently discounted at 3 percent.





# APPENDIX D

## Emerging Best Practice in Education Sector Strategic Planning for HIV and AIDS

(Quoted from the EduSector AIDS Response Trust for the development of an Education Sector Strategic Plan on HIV & AIDS in Jamaica in 2007)

- The Education Sector Strategic Plan should be firmly located within an enabling legislative, policy and regulatory framework. Where such an enabling environment is not sufficiently manifest, the Policy and Strategic plan needs to address the development of such an environment.
- The Policy and Strategic Plan should be developed and owned by, and should cover the entire education sector, not only the Ministry of Education. Teacher unions and associations, other staff unions, private providers of education, NGOs, representative bodies, tertiary institutions etc. are some of the key role players to involve. Where more than one ministry has responsibility for education, ministries should collaborate in developing a single plan for the entire sector. Where ministries of education carry additional mandates (Typically Sport, Youth or Culture), the needs and contributions of these areas should be included in the policy and strategic plan.
- The Policy and Strategic Plan, in its scope and breadth, should comprehensively cover all levels of the education enterprise, Early Childhood Development to Tertiary Education, TVE, non-formal and even informal education provision.
- In order for the Education sector to contribute fully to the national response to HIV & AIDS, Ministry-wide participation and ownership is required, including from the political and administrative heads of the Ministry.
- The Education sector response to HIV & AIDS should target all learners/students in the sector, but also all teachers and other non-teaching staff.
- The Education sector efforts should address the full cycle of the HIV & AIDS, i.e, prevention; treatment, care and support; and impact mitigation, as well as dealing with HIV & AIDS as a workplace issue.
- While many ministries of education are largely dependent on development assistance to support their strategic work in HIV & AIDS, it is essential that the Ministry signal its ownership and prioritization of the issue through the allocation of some of its own resources in support of these efforts.

