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Sexual Health EXCHANGE

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2003/4

Sexual health and the world of education

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SAfAIDS

Education for HIV prevention

Inon Schenker

It is striking to note what a long way forward the science of HIV prevention education has brought us. Nevertheless, we are still far from meeting the challenge of providing 95% of youth in the world with accurate, reliable, practical, non-discriminatory and comprehensive knowledge, information and skills to help them not be infected with HIV as required under the United Nation's "Millennium Development Goals".

In 1986 Dan was a six-grader in a public school in Jerusalem, Israel. I was then a "Flower Project" volunteer, teaching him and his fellow classmates a general course in health education. During one of the weekly sessions, Dan astonished me with two simple, straightforward questions: "Why is everyone now talking about this new disease – 'ADIDAS'?" "Could I die of it if my sports shoes are of a different brand?"

"AIDES", "AYDAS", "ADIDAS" – in the mid-1980s, kids and many of their parents did not even know how to pronounce the correct name of what has now become a well-known epidemic. Today, Dan is 28 years old. Fully aware of HIV/AIDS, he can tell you how HIV is spread, its origins, and how it affects the individual, families and orphans. He could advise you on voluntary counselling and testing (VCT) and how to put on a condom; he can show you how to create your own Red Ribbon and discuss with you the need to care for and protect the rights of persons infected with HIV. Dan was educated in a school system that provides education on HIV/AIDS from grade six, with repeated cycles throughout high school and compulsory military service.

But if you ask Dan discretely, he will admit that when he had sex with his new girlfriend last week, he did not use a condom, did not ask her about her previous sexual experiences or partners, or suggest mutual HIV testing. "It will never happen to me!" he would say. So have we failed Dan and his peers? Do we continue to fail them?

Many examples from around the world demonstrate how orchestrated policies, legislation, programmes and funds enable pupils, as well as teachers and managers of education systems, to protect themselves and others from being infected and to play an

Photo: Bangladesh Center for Communications Programs

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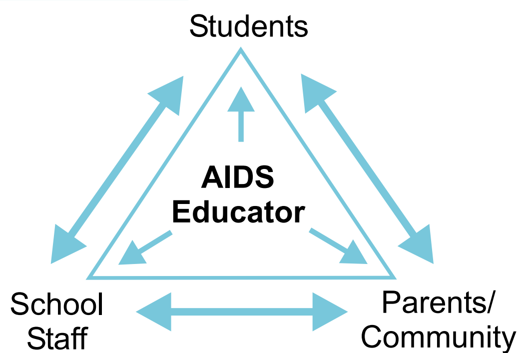

The Triangular Model

active role in prevention, care and anti-discrimination. Several of these efforts are reported in this issue of the *Sexual Health Exchange.*

How do we define success?

Success stories in HIV prevention education are published more often now than ever before. However, it is still difficult to define best practices in this area, mainly because there is not much consensus on what "success in HIV prevention education" means. Is it the inclusion of all politically correct items? Is it being blunt about sexuality? Or is it maybe just being able to demonstrate that we are reaching out to thousands of youth with some prevention messages?

Education is a long process, involving many participants and many variables to consider when we seriously evaluate its long-term effects, especially on risk-taking behaviours. The attempt to define best practices in education for HIV prevention is directly linked to reductions in HIV infection and it is therefore complicated.

The AIDS educator as a central figure

The International Bureau of Education, a Geneva-based UNESCO institute, and the International Academy of Education have published 10 principles for effective education on HIV prevention in schools by focusing on the teachers' role:[1]

1) Become an effective AIDS educator by acquiring the appropriate skills and teaching methods.
2) Develop partnerships within your school and with the community.
3) Use participatory methods that encourage active learning.
4) Encourage discussion on controversial and sensitive issues, including gender inequalities, sexual violence, premarital sexual behaviour and condom use.
5) Provide multiple sessions through multiple media.
6) Adapt teaching methods to both male and female students.
7) Be culturally sensitive to diversity in your community.
8) Reinforce local values and attitudes about unprotected sexual behaviour and introduce peer education.
9) Teach life skills as a component of HIV prevention.
10) Evaluate and monitor your progress and that of your students.

Applying these 10 principles to any given education system could be done under the "Triangular Model", a framework for developing and implementing HIV prevention education. The model puts emphasis on the well-trained AIDS educator, who is not necessarily a schoolteacher. This central figure can also be a person living with HIV/AIDS, a nurse, a medical student or a peer educator. His or her tasks are to provide comprehensive education to three key groups: pupils at school, their parents and the community at large, and school staff, as well as to facilitate communication on HIV prevention among these three groups.

What HIV/AIDS can do to education

When discussing how the education system can impact the HIV/AIDS epidemic, we also need to look at the other side of the coin and recognize that the epidemic has a tremendous impact on education systems. Even in less affected areas, the need to address HIV/AIDS and develop appropriate responses means that education systems must create new curricular units, make changes in their resource allocations, and develop new training and materials.

Education systems in countries that are seriously affected by HIV/AIDS are in danger of being weakened and disrupted. The epidemic greatly increases the scale of existing educational problems, including the possibility that the system will not be able to deliver its mandated services. Five domains most affected by HIV/AIDS are demand, supply, content, planning and the quality of education.

Education demand – As the epidemic advances, fewer families are able to financially support their children's education. There are greater numbers of sick children. Many children, especially girls, are taken out of school to care for sick relatives or to take over household tasks. Hence, HIV/AIDS has especially adverse effects on girls' education.

Photo: SWAAN – Society for Women and AIDS in Africa, Nigeria Chapter

Education supply – There is a huge loss of human resources to AIDS. Teachers and school administrators fall ill and die, or they are psychologically traumatized by family and community deaths due to AIDS, becoming unable to work. In almost all cases, HIV-positive educators remain on the payroll, draining funds that might otherwise have been used to employ substitute or replacement staff.

Education content – The content of current curricula must be reformed to reflect learning needs such as health and sex education messages, coping with illness and death in the family, non-discrimination towards people living with HIV/AIDS, gender roles and issues, and life skills. Teachers also face new demands posed by the behavioural, emotional and psychological problems brought into the classroom by infected and affected learners. The issue of sexual abuse of girls by teachers, male pupils and "sugar daddies" needs to be addressed as well. To most parents

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schools are a safe place for kids to be in. This may well not be the case in many countries where teachers and other adults are sexually abusing young girls in schools or on the way to and back from school.

Education planning – HIV/AIDS affects the planning and management of an education system at all levels: ministries, departments, agencies, and policy-makers responsible for proper planning and allocation of education resources and services.

Education quality – When the education sector cannot support AIDS-affected teachers or supply adequate replacements for those who fall ill or die, the overall morale of people working in the sector, and consequently the quality of the system, is lowered. If curricula do not provide the knowledge and skills that young people need in an AIDS-affected society, the quality of education provided to them will also decrease. In addition, among teachers in high-prevalence countries, the frequent experience of death and serious sickness in their families, communities and schools is tending to undermine their morale.[2]

It is important that we monitor the effects of the HIV/AIDS epidemic and its impact on education systems in the above domains. This will allow us to better understand the epidemic's societal implications and how to devise remedies for them. Monitoring and evaluation are no less important in investigating the effectiveness of HIV prevention education interventions. Only such studies can teach us why we fail in educating Dan and other youngsters around the world about HIV prevention and how we can improve our strategies and programmes. ❖

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1. Schenker, I. and Nyrenda, J. Preventing HIV/AIDS in Schools. Educational Practice Series, International Academy of Education and IBE, 2002.

2. Kelly, M.J. and Bain, B. Education and HIV/AIDS in the Caribbean. IIEP, Paris, 2003.

Addressing gender inequality and intergenerational sex

In many cultures and countries, gender norms shape young people's early sexual experiences. Young women are often pressured or coerced into risky sexual behaviour, while young men are encouraged to take sexual risks. In Senegal, young people aged 14-16 in focus groups agreed that a lack of respect characterizes expectations of relationships. Boys suspected girls of being primarily interested in money and other material things, while both stated that girls who refuse to have sex face the possibility of beatings or rape. For both boys and girls, these different expectations are harmful and have a negative impact on the establishment of healthy, responsible and equitable relationships.

In sub-Saharan Africa in particular, girls' early sexual relationships are very likely to occur with men who are considerably older, often in exchange for money or gifts. Some poor girls exchange sex for money for school fees or to help their families. There are many accounts of teachers using their position of authority and power to talk schoolgirls into sex, in exchange for good marks or promises of marriage. These conditions significantly reduce girls' ability to negotiate safer sex and increase their chances of contracting HIV, STIs or becoming pregnant. Furthermore, if schoolgirls become pregnant, they are usually expelled, while their boyfriends will face no disciplinary actions at all.

Source: State of the World Population 2003. UNFPA, 2003, www.unfpa.org/swp/2003/pdf/english/swp2003_eng.pdf

Country Watch

Malawi

"Say No to AIDS" clubs in schools

In Malawi, with assistance from UNICEF, some 3,000 anti-AIDS clubs have been formed as part of a broad campaign to promote risk-reduction behaviours among young people. These Edzi Toto ("Say no to AIDS") clubs have a maximum of 30 pupils aged 6-18 years and are presented as an extra-curricular activity. Each club is formed after orientation of school head teachers and the training of at least two patrons, who are youthful male and female teachers. The activities themselves are run by an executive committee of club members who undergo training. Overall, about 60% of the members are boys and 40% girls, reflecting differences in school enrolment in Malawi.

Club members meet once a week in the afternoon and other pupils, as well as community members living near the school, are welcome to participate in the activities. The club's role is primarily to act as a catalyst by initiating promoting interpersonal communication on sexuality, HIV/AIDS, STIs and reproductive health issues between males and females through debates, group discussions, quizzes, drama, poetry, song and dance. Some club members are open about their positive HIV status and promote awareness about stigma and discrimination.

An evaluation conducted by UNICEF in 2000 revealed that the clubs were largely fulfilling their function. Responses to the programme by club members, teachers and parents were positive and encouraging. Several constraints were also identified, such as:

Photo: Johns Hopkins University/Center for Communication Programs (CCP)

- ❖ Not all clubs had a trained matron or patron; emphasis was put on training at least one patron per club, rather than on training one male and one female patron per club as originally planned.
- ❖ Many clubs had few or no materials available (e.g., handbook for the matron/patron, IEC materials for the pupils) nor did they have sports equipment. Several patrons complained that most of the available information materials were out-of-date.
- ❖ Most of the clubs focused on dissemination of information and too little attention was given to life skills education.

The evaluation recommendations were incorporated into the project activities. For instance, to address the lack or shortage of IEC materials, UNICEF supported the development of materials, activity manuals, and Edzi Toto caps, T-shirts and stickers. It further facilitated the distribution of recreational materials, such as footballs, chess games and books. To address the lack of attention to life skills, UNICEF supported the development of skills education, youth exchange visits, youth festivals, peer education training and training of patrons. Also, a leadership and management skills training programme for club executive committee members was introduced to prevent clubs from dissolving when patron-teachers, on whom they heavily relied, were transferred. ❖

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Special Article

Sounds of silence: selective teaching about HIV/AIDS in Indian schools

Tania Boler & Kate Carroll

An estimated 12 million young people aged 15-24 years old are living with HIV worldwide. Schools are therefore an obvious place to teach youth about the risks of HIV/STI infection. Donors, governments and civil society quickly saw the potential of school-based sexual and reproductive health education in the fight against AIDS. Lessons on HIV prevention have been incorporated into education systems in the majority of resource-poor countries. However, even when curricula contain a fair amount of attention to HIV/AIDS, there are a number of barriers that hinder communication efforts in the classroom. A study by ActionAid investigated how schools in the state of Tamil Nadu, India, implement their state-sponsored HIV/AIDS curriculum.

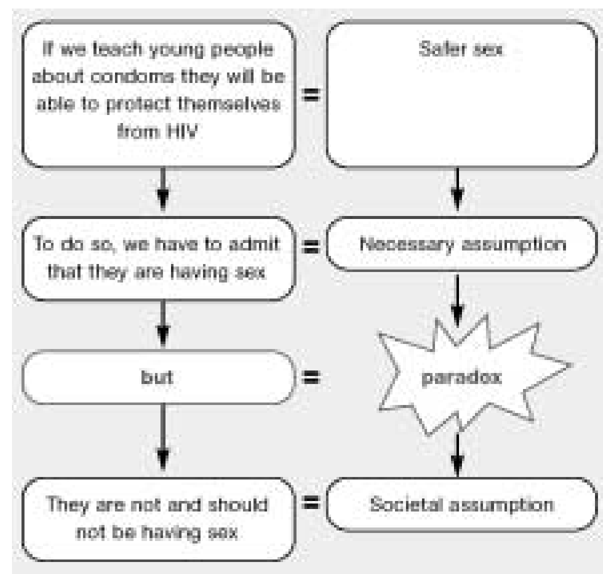
In Tamil Nadu, lessons on HIV/AIDS have been included in the syllabi for Tamil, English, botany, zoology and science. The lessons are scientific in nature, with an emphasis on issues such as the structure of the virus or disease progression. In addition, these lessons are only available to science students after Standard 10. More recently, the Total Health Programme, funded by UNICEF, has been introduced; it is much wider in scope and also includes discussion of HIV through a life skills approach.

Researchers investigated the attitudes of 3,706 teachers, pupils, parents and other key stakeholders about HIV/AIDS instruction. They found that teachers and schools play a key role in teaching young people about HIV/AIDS. Young people and their parents view the school as a trusted place to learn about HIV, believing it to be a serious problem. A large majority (87%) of teachers feel that their profession has a responsibility to teach young people about HIV/AIDS.

Nevertheless, sensitivities surrounding HIV/AIDS create gaps in communication, and in many cases, "selective teaching" takes place. This is manifested in three ways: a) entire lessons from the syllabus are not taught at all; b) HIV/AIDS lessons make no direct reference to sexual relationships; and c) communication on HIV and sexual relationships relies solely on messages regarding abstinence. For example, 95% of teachers claimed that the HIV component of the Total Health Programme was being taught, compared to only 53% of students. A male student said: *"Though we have one period per week, they never teach about health or AIDS, but use it to teach other lessons. They teach us about AIDS only when someone comes for inspection."*

Gaps in communication

It appears that teachers choose which messages to give, often relying on an overly scientific approach and avoiding any discussion about sex. Of the 92% of



students who claimed that they had received HIV education, about one-third reported never having been taught about sex. Silence about the issue of condom use or messages other than abstinence arises from tension between two societal assumptions: one assumption that young people should not, and will not, have pre-marital sex, and another that it is necessary to discuss condom use since young people do have pre-marital sex. Clearly these viewpoints are contradictory; a paradox concerning safer sex arises because both assumptions are thrust upon the educational agenda, the first by the HIV/AIDS curriculum and the second by deeply entrenched societal pressures.

The problems with such teaching are manifold. Discussion of HIV without direct reference to sex, or advocating abstinence without mentioning safer sex, cannot work. On the contrary, it binds notions of HIV to immorality, and leads to a "them, not us" attitude. This, in

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turn, leads to further discrimination of people living with HIV/AIDS. It also makes it less likely that already sexually active young people will seek advice or personalise their risk of becoming HIV positive.

Gender segregation in mixed-gender schools

The research also revealed a high level of gender segregation in the schools: male and female students in Tamil Nadu's mixed-gender schools are not only told to sit in separate parts of the classroom, but are forbidden to talk to each other. Such gender segregation distorts human relations between boys and girls. Once young people enter sexual relationships, this type of segregation hampers communication about HIV and sex. Indeed, the less interaction there is between boys and girls in other spheres of life, the more difficult it may be for both to handle sensitive issues when they do come together in a relationship.

The implication is that young people need more than knowledge – they also need the skills to apply that knowledge to everyday situations that are far removed from the classroom. In addition to skills, people need the power to leverage their sexual health rights. One critical element of ActionAid's work in both the fields of education and HIV has been to challenge ingrained gender and power relations which contribute to the rapid spread of the HIV/AIDS epidemic.

Examining gender inequality and its effect on communication in sexual relationships is essential in any educational approach that truly aims to change sexual behaviour. The challenge is to find constructive ways to work with men as well as women, and boys as well as girls, to address the wider gender and power issues that affect communication within (sexual) relationships.

Tackling the culture of silence

Apart from the social and cultural constraints that exist in teaching about HIV/AIDS, there are a number of obstacles faced by teachers that are symptomatic of a wider crisis in education. Efforts in the classroom are severely hampered by oversized classes, overstretched curricula – 52% of teachers said that they did not have enough time to teach about HIV/AIDS – and a lack of training opportunities and learning materials. For example, 54% of teachers report never having been on a training course. A female teacher complained: *"We do not have enough time to teach about HIV/AIDS as we are already burdened with enough workload. We are always in a rush to complete the syllabus."*

There are also many positive features in the educational system in Tamil Nadu, and these should be drawn upon when considering improvements. Advantage should be taken of pre-existing systems of knowledge transfer such as encouraging religious leaders to take a more positive role – all sectors of society should be involved to ensure that communication on HIV/AIDS is accurate, open and positive.

Teachers should also be given the confidence that parents support school-based HIV/AIDS education. Many teachers (36%) believe that parents would not

Photo: WHO Photolibrary

approve of HIV/AIDS education in schools, while in reality only 4% of parents do not approve. A large majority of parents, 87%, said that they wanted their children to be taught about HIV/AIDS in schools. Increased communication between parents and teachers also has the benefit of allowing an increased flow of information between the school and community, expanding the range of education.

Furthermore, HIV/AIDS education should be locally relevant so that the risks related to HIV/AIDS can be personalised. This can be achieved if HIV/AIDS education moves away from its scientific focus. Learning materials should stimulate children to understand the human side of HIV so they can connect the issue to real life. Innovative and participatory forms of learning are important to achieve this – and efforts are needed to ensure that exam-focussed systems allow sufficient space and give recognition to such approaches.

If the educational system is to be an effective vehicle to prevent the further spread of HIV/AIDS, improving the basic functioning of the system is a prerequisite. A massive injection of resources is needed in order to support teachers – not just for teaching about HIV/AIDS, but to ensure some degree of quality education for all.

It takes special skills to talk about sex and a life-threatening disease, especially in countries where sex and HIV are linked to immorality. These obstacles can be overcome but not by assuming teachers can gain these talents from a book: it will take a very different type of training and learning process for them to acquire the necessary skills. More than anything, it is about communication. On this foundation, the culture of silence can begin to be tackled in schools. ❖

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The information presented in this article is drawn from the ActionAid report The Sound of Silence, Difficulties in Communicating on HIV/AIDS in Schools (see page 16).

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Research Notes

A snapshot survey on HIV/AIDS education experiences in South Africa

Heinrich Heinrichs

Education will continue to play a predominant role in the fight against HIV/AIDS. Many schools in South Africa understand this and have developed specific strategies to address the issue. In 2002, the Western Cape Education Department and the German Agency for Technical Co-operation (GTZ) commissioned a survey at eight urban secondary schools to identify best practices and lessons learned in order to make these findings available to all Western Cape schools. The schools chosen for the survey were known to have programmes on HIV/AIDS in place and to reflect South African cultural diversity and social backgrounds.

To obtain different points of view, principals, teachers and students were interviewed separately. Semi-structured open interviews allowed new topics to come up during the interviews. Eight principals and eight life skills or counselling teachers were interviewed. The number of students interviewed varied from school to school, ranging from 3 to 10 and totalling 55.

The results of the study were published in the booklet *If you love this country, you will do something about HIV/AIDS. A snapshot survey of HIV/Aids education in eight Western Cape high schools.* The study does not claim to be representative or comprehensive; it was designed to collect qualitative data that was unavailable before. We called it a "snapshot survey" because we, so to speak, took snapshots of the good practices in selected schools. The main best practices identified by the eight schools were:

- An HIV/AIDS school policy, which should at the least include guidelines for preventing transmission and for supporting those living with HIV/AIDS
- Peer education, for instance in school-based health centres
- Where possible, health clinics on school premises
- Out-of-class activities, such as sexuality camps
- Linking with external agencies, such as NGOs
- Invitation of people living with HIV/AIDS as guest speakers
- Using parents as lay counsellors
- Using creative and participatory tools to stimulate learning
- Integration of issues around HIV/AIDS into other learning areas.

The most interesting findings were that both teachers and students were eager to see integration of HIV/AIDS into learning areas other than life skills and that out-of-class learning venues, such as sexuality camps and school health centres, were perceived as successful.

Integration of HIV/AIDS into different learning areas

Life skills education is included in the new South African curriculum, Outcomes Based Education (OBE), and already starts in grade 1. Issues around HIV/AIDS are integrated and play a predominant role in the syllabus. OBE does not prescribe content but leaves room for the teacher to integrate topics relevant to the students.

For example, in Cape Town, the grade 8/9 maths curriculum deals with the interpretation of graphics, expressing data through graphs and basic statistics. Mathematics therefore provides a good opportunity to examine data on the development of HIV/AIDS over the last years and to compare prevalence rates at the national and international levels. In Soweto, teachers integrated teaching material on HIV/AIDS provided by the Science Education Centre into grade 11/12 biology workshops for 16-17 year-old students. Workshops about HIV/AIDS were held and the knowledge gained was subsequently tested in the classroom; the workshops were considered very successful.

The science curriculum for grades 8/9 emphasizes scientific thinking and "hands on" work. In this context, there are many possibilities to investigate condoms in a scientific way, e.g., by examining safety by leaving a condom blown-up for a couple of days. At several schools, teachers piloted activities and materials about the immune system; acceptance was high, with both teachers and students greatly enjoying the lessons using the new materials.

Integrating HIV/AIDS into learning areas across the curriculum is advantageous: HIV/AIDS becomes an everyday life issue that is no longer separated from the "normal" subjects such as science, mathematics and biology. The major challenge is how to introduce the teaching techniques that teachers need to use these new materials. South African teachers are rarely used to learner-centred teaching, which is essential for any lesson concerning HIV/AIDS or related issues such as life orientation and behaviour change. It is therefore highly recommended that teacher development focus on teaching skills to develop learner-centred lessons. When teaching these lessons, teachers have no chance to fall back on old teacher-centred habits, because these lessons simply did not exist before.

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Out-of-class programmes

In co-operation with external service providers, school health centres were set up in some schools. The school provided a room and service providers trained students to become peer educators, who could give other students educational materials and other specific information. These peer education projects were perceived to be effective. The most interesting and promising aspect was that although boys did not attend the school health centres as much as girls, boys consult male peer educators. For example, one male peer educator said that boys very rarely asked him for advice in school, but they visited him at home in the afternoon to ask questions about sexuality and HIV/AIDS.

Experience with sexuality camps for grade 10 female students was also good. Girls are sent to these camps for a couple of days where they can learn and speak about sexuality with external staff. All girls enjoyed this time very much and reported gaining a lot. They felt it was important to discuss sexual issues without interference from parents and teachers since this made it possible for them to speak out freely without fearing consequences. No doubt it would make a tremendous difference to develop and implement sexuality camps for boys, too.

A crucial role to play for schools

Schools in South Africa have understood that they have a crucial role to play in the fight against HIV/AIDS. The principals, teachers and students interviewed are very aware of the disease and have already started to face the pandemic using various strategies that work well in their respective environments. However, it should be noted that a best practice at one school will not necessarily be the same at another school since success very much depends on a school's health-promoting environment. The following conclusions can be drawn:

- Support from external service providers is crucial. The reasons are manifold: service providers are specialized and more experienced than teachers; students have problems being open with their teachers; teachers do not have the skills to handle certain student problems.
- Students want to know more about HIV/AIDS and sex, but are often not satisfied by teachers' answers. Many students complained that the only lessons they received were about what to do and not to do, about good and bad behaviour, while what they needed was factual information about HIV/AIDS. Teachers therefore need training on HIV/AIDS that includes not only knowledge but also issues regarding attitudes and behaviour.
- HIV/AIDS should not only be taught in life skills lessons, but rather be included in every learning area, be it mathematics, science, biology, languages, etc. This helps make it an integral part of life that is not separated from "normal" school life. Teachers generally have good ideas on how to deal with HIV/AIDS in various learning areas. These ideas should be collected, put in the right format and be made available to teachers at other schools through teacher development initiatives.
- The study showed clearly that young people want to get involved in HIV prevention and take responsibility, but they do not always know how. Both out-of-class programmes and integration of HIV/AIDS into different learning areas give them the opportunity to learn more about the issue. But preparing students to deal with HIV/AIDS can be somewhat different for boys than for girls. For instance, boys might benefit from sexuality camps as well, but at the moment these are not offered to them. Finding ways to get boys and young men more involved in HIV prevention is a major challenge for the future. ❖

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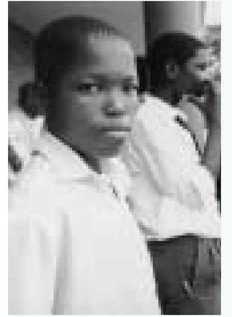
Photo: Patrick Coleman, CCP

Programme Feature

Schoolchildren against AIDS – a national contest in Lithuania

Saulius Caplinskas & Loreta Stoniene

Lithuania has seen the lowest HIV prevalence of all Eastern European countries, where injecting drug use is the main mode of HIV transmission. This is mainly due to HIV prevention activities. Since the foundation of the Lithuanian AIDS Centre (LAC) in 1989, the country has witnessed more open discussions about HIV/AIDS, sexuality, gender issues and drug use. Since 1991, LAC has been implementing the government's national HIV prevention programme. One of its activities for young people is the project "Schoolchildren against AIDS", a national competition for students 15-18 years old that started in 1999.

This project is focused on World AIDS Day and is based on the principle of interdisciplinary cooperation between event organizers and the Ministry of Education and Science, youth centres, public health specialists, journalists, volunteers, teachers, and students. The main goals are to inform young people in secondary schools about HIV/AIDS, involve them in prevention activities, make them aware of the consequences of high-risk behaviour, and stimulate them to form positive attitudes towards people living with HIV/AIDS (PLWHA).

When the project first started, it was considered an innovative initiative in the country. The competition starts at the individual school level: teams of five students compete with other teams to show their

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knowledge about HIV/AIDS and their creative abilities. Each team gathers a group of fans who support them during the competition. Performances take place in large halls, where up to 500 spectators can watch the contest.

Contesting to gain knowledge

In most schools, three to five teams prepare a presentation, design anti-AIDS promotion messages for clothes, take a knowledge test, and make a video-clip about HIV/AIDS. A jury rates the teams' performance on each of these tasks. Experience has shown that the judging committee works best when it includes people from different fields, for example, a doctor, a producer, a student, and a teacher. The maximum number of points that can be received is 20 for the knowledge test, 10 for the video-clip and presentation and 5 for the message designed for clothing.

The winning team from each school moves on to the second round at the district level. District winners move on to the third round for each of the six zones in the country. The fourth and final round is at the national level and takes place around World AIDS Day (1 December). The whole programme of four rounds takes around three months. Several incentives have been created for participants and their teachers. The winning team is granted a one-week trip to Sweden (sponsored by ECAD – European Cities against Drugs – and UNDP), where team members visit HIV prevention programmes, share experiences and communicate with peers. Second and third prize winners are granted a trip with the same purpose to another European state or the Lithuanian capital Vilnius.

Prevention of HIV/AIDS and drug use

Every year the project attracts more participants. It started with teams from some 250 schools in the first year to some 700 schools in 2003 (about 70% of Lithuanian secondary schools). Some 10,000 young people participated in the 2003 programme, including contestants and spectators. An evaluation survey in 2002 among 189 participants of the third round showed that 86% felt that their knowledge about HIV/AIDS had greatly increased; 94% claimed that they were more aware of the health consequences of unsafe sex and drug use. Moreover, 84% said they had become more tolerant towards PLWHA, 77% had improved their relationship with teachers and 86% with their parents. More girls (62%) than boys filled out the questionnaire, reflecting the male- female participation ratio.

Another evaluation survey in 2003 with third-round participants (61% girls) showed that almost half of the students had participated in the competition more than once. This indicates that they find the initiative stimulating and interesting. The great majority of participants (96%) evaluated the project positively and 78% believed that participating in such an activity encourages them to become more actively involved in HIV prevention efforts. The over 150 organizers (local authorities, youth centres, public health centres, teachers etc.) stated that the idea of the competition is wonderful and that the programme proved to be a useful tool in the prevention of HIV/AIDS and drug use.

Lessons learned

Since the start of "Schoolchildren against AIDS", the project has reached many students and teachers with information on HIV/AIDS and drug use. The main lessons learned are:

- A competition combining knowledge tests and creative thinking is a useful tool to convey HIV/AIDS messages through young people themselves and it reaches many people. However, the form and tasks of the competition must be changed after 4-5 years in order to avoid repetition and lack of ideas.
- In the beginning, there was some confusion as to what was expected of the participants because the tasks were not clearly described. In order to standardize tasks in all rounds, the book *I Want to Know Everything about AIDS* was prepared for organizers and participants. A web page was also created; it includes information about the project and provides a chat room to facilitate communication between the students even when the competition is over.
- Multi-sector cooperation has proved to be successful. LAC generates ideas, youth centres organize the rounds of the competition, editors create scenarios, medical specialists and educators arrange knowledge tests, journalists inform society, young volunteers help to organize the event, etc. The participation of the Ministry of Education and Science ensures not only easy access to information, but also encourages the inclusion of the project in education and prevention strategies and school plans, and entitles teachers to draw more attention to HIV/AIDS and drug use.
- Through the active participation of youth in the contest, society and media attention can be attracted to HIV/AIDS. In our case, this led to private sector interest to support the project, for instance by donating presents.

The project has lived up to our expectations. Schools in almost all Lithuanian districts (currently 50 out of 60) participate in the contest. The students, teachers and organizers regard the competition as interesting and stimulating. There are no hard data on the initiative's effectiveness in terms of reducing HIV prevalence among young people. However, a recent study by the European School Survey Project on Alcohol and Drugs (ESPAD) showed that experimentation with illegal drugs among 15-16 year-olds in Lithuania has stabilized at about 15-16% over the last four years.

LAC is determined to continue this project. The video clip component of the competition has proved to be very good; in 2003, the best one was broadcast by two TV channels. This element of the project will therefore be expanded. ❖

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Senegal

Revitalising school life through Anti-AIDS Clubs

In many countries, sexual and reproductive health education is implemented in schools by integrating sex education, information on HIV/AIDS and gender issues in a multidisciplinary programme called Family Life Education (FLE). Such curricula offer a mix of biology, home economics, and health, civic and moral education. It is felt that by integrating the topics of sexuality and sexual behaviour into a multidisciplinary programme, it is easier to address these issues in a conservative environment.

Since 1994 the Senegalese NGO GEEP (Group for the Study and Teaching of Population Issues) has been carrying out an FLE programme in secondary and tertiary schools in cooperation with the Ministry of Education and with support from UNFPA. The objective is to provide information on sexual and reproductive health, including gender issues, STIs and HIV/AIDS. One component of the programme comprises FLE clubs called *Clubs EVF*. Each club is run by 15 young peer educators who are supervised by a collective of 5 teachers. Over the last 10 years, some 3,000 adolescents have been trained to be peer educators, and 140,000 children have been reached, representing 40% of all secondary school students. One-third of the peer educators are girls.

In addition to social and educational activities organized by the clubs for the school population and – sometimes – outside audiences, the peer educators at some schools also operate youth orientation and information centres. At these centres, students can discuss personal problems with the peer educators and receive advice about sexual and reproductive health issues.

An evaluation in 2003 showed that the establishment of FLE clubs led to a revitalisation of school life. Students and teachers alike were very satisfied with the activities organised and the information provided by the clubs. Another review by the World Bank team that published the *Education and HIV/AIDS Sourcebook*[1] showed that the programme has met the majority of benchmarks proposed in the sourcebook. ❖

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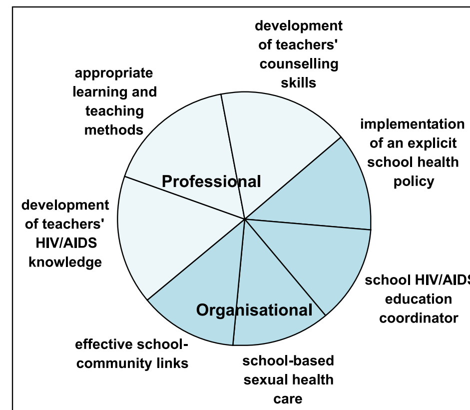
1. All programmes described in this book were benchmarked against criteria that the UNAIDS Inter-Agency Task Team for Education considers to be sound programming practice. *Education and HIV/AIDS: A Sourcebook of HIV/AIDS Prevention Programs,* World Bank 2003 (see also page 16).

Namibia

Health-promoting school environments for HIV/AIDS education

A strong health-promoting school environment is a requirement to facilitate behavioural change through school-based HIV/AIDS education interventions. Such an environment has two dimensions: an organisational and a professional one (see Figure). The combination of both dimensions defines the strength of a school's health-promoting environment for HIV/AIDS education.



A health-promoting environment for HIV/AIDS education

A model developed by the University of York (United Kingdom) was tested in 42 Namibian senior secondary schools catering for students aged 12 to 20 and representing just under half such schools in the country. The study showed that only 7% of schools had a strong support structure in place. On the organisational level, nine schools had none of the four aspects related to the organisational dimension in place, i.e. no coordinator, no policy, no health care and no community links. Twenty-eight had an HIV/AIDS coordinator only, and 6 more also had an official school health policy. On the professional level, teachers in 18 schools received no training on HIV/AIDS, teaching methods and counselling skills at all. In only three schools, were the teachers fully trained in all three aspects.

When both dimensions were combined, 7 of the 42 schools (17%) lacked a health-promoting environment to support HIV/AIDS education while only 3 (7%) had a strong support structure in place. The majority of schools (64%) were in the basic to intermediate level. Surprisingly, there was no difference in strength of health-promoting environment between schools in rural and in (peri)urban areas. There was a difference however between small and large schools: small schools had considerably stronger environments than very large schools with over 1000 pupils. ❖

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A more detailed account of this study can be found in B. Campbell and F. Lubben, The provision of a health promoting environment for HIV/AIDS education: the case of Namibian senior secondary schools. In: *International Journal of Educational Development,* 23, p. 529-542, 2003.

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Programme Feature

Youth in Action for Life – a peer education programme in Peru

Carmen Murguía Pardo

With an adult HIV prevalence rate below 0.1%, Peru is a low-prevalence country. The government estimates that about 76,000 of the country's 27 million inhabitants are living with HIV/AIDS. Nevertheless, given the relatively low levels of sex education, limited condom promotion, high levels of risky behaviours and higher prevalence in surrounding countries, there is a potential for further spread of the epidemic. The Youth in Action for Life programme combines efforts of pupils, teachers, community structures and health-care providers aimed at educating young people about their sexual and reproductive health and rights.

While Peru has a National Sex Education Programme, it currently lacks political support and the resources needed to appropriately implement it nationwide without ideological restrictions imposed by a conservative wing in the Ministry of Health – especially in the areas of sexuality and sexual and reproductive health. Teachers are not trained to provide sex education in the classroom or to respond to adolescents' needs and concerns, and health services are not youth-friendly. Added to these problems is the traditional lack of interest by planners and decision-makers in adolescents' participation, which is reflected in HIV/AIDS interventions. Gender differences, which place adolescent women at an even greater disadvantage in adopting safe sexual behaviours, also represent an obstacle to addressing the AIDS epidemic.

Youth in Action for Life

Jóvenes en Acción por la Vida (Youth in Action for Life) is the name chosen by young people in Peru, Brazil and Colombia for a programme of HIV prevention in schools in which they play an active part. The programme is sponsored by Save the Children UK and the European Union. The partners in each country are the Institute of Education and Health (IES) in Peru, Gapa-Bahia in Brazil, and Ser Humano in Colombia. The programme began in November 2001 and has a three-year time frame. In Peru, Youth in Action for Life is carried out in the capital, Lima, and in the city of Chimbote, reaching adolescent students aged 12-18 years in 14 public schools, as well as out-of-school youths aged 19-24 years in peripheral urban districts.

Youth in Action for Life working on a newsletter

The programme's main venue is the school and its central strategy is peer education. Youth guides chosen by their peers receive training and ongoing support provided by a group of teachers. These "teacher companions" also receive training for their task. A third key player in the programme is the health professional, because one important role of the youth guides is to refer their peers to health-care services, where they receive counselling and specialised attention in areas related to sexuality. Using brochures and educational games, theatre and socio-cultural activities, HIV prevention is the central focus of the school youth guides' work. Their work, however, is not limited to school. Rather, they seek to mobilise the entire community to work together to stop the epidemic. They sensitise authorities at the local level (the school principal, mayor, director of the health-care establishment) and the central level (government officials) to respect and defend the rights of young people. They created and monitor a special zone on the IES website called "Punto J" ("J Spot") which advocates changes in adolescent sexual and reproductive health.

Filling the Daypack

To date, 385 male and female youth guides have received training and support from 40 trained teachers. They are organised in a network that will enable them to support one another in carrying out their activities beyond the project's time frame. The guides have reached approximately 6,000 of their peers in- and outside school. They are equipped with educational materials to help them in their work, as well as information that they can distribute to their peers and to teachers, parents and authorities, which have been designed and validated with their help. "Llenando la Mochila" ("Filling the Daypack") is the name given to the main educational material they have produced. It consists of a set of simple guides to inform their peers about STIs, HIV/AIDS, gender issues and sexual and reproductive rights.

Youth guides have carried out a participatory needs assessment in their communities to identify the main health problems, including those related to sexual health. After presenting the results at a public event, they designed action plans to address the priority problems identified. In the current project period, they are being trained to obtain information from the health and education sectors, putting into practice their rights under a new Peruvian law that guarantees citizens access to information from the public sector. A group of peer educators is also being trained in Internet communication skills to improve and monitor the "Punto J" website.

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More self-confident

A baseline evaluation was carried out at the beginning of the project, and an evaluation will be done at the end. Although we must await the final results, we know from observations and discussions with peer educators that the programme has made a significant impact on their personal lives and on the way in which their peers and adults view them. They say that they have more self-confidence and are more able to express their ideas and opinions. Their relationships with their parents, teachers and other adults are more open, and they feel good because their peers see them as leaders and the community values their role as peer educators.

Teacher companions, meanwhile, feel closer to the adolescents and feel fewer taboos in talking about issues related to sexuality. They are willing to listen to adolescents without judging or censoring them. Health-care providers indicate that one of the project's most important accomplishments lies in the way the adults and young people work together and the joint work of the health and education sectors. While we do not yet have figures showing an increase in the number of adolescents using health services as a result of the programme, we know that health-care personnel have reached more than 4,000 adolescents through mobile counselling services and educational fairs, answering their questions and providing assistance in the areas of sexual and reproductive health.

Lessons learned

Lessons that we have learned so far include:

- HIV prevention must be part of comprehensive health-care programmes for adolescents and must be connected with community development to help reduce the number of cases in the adolescent population. Results are weak if there is no interconnection between the school, health-care establishments and other community organizations.
- The peer education strategy works well as long as it is based on participation and recognises adolescents as persons with rights. To be successful, however, work must be done simultaneously with adults and youths.
- Capacity building among adolescents must include skills that will enable them to serve as partners in dialogues with authorities and to take an active role in oversight of and advocacy for their own health and development.
- More solid institutional foundations are needed for youth participation in school, as is a sustained strategy for empowering adolescents in the school so that the school provides an environment conducive to fostering sexual and reproductive health and HIV prevention.
- Creative, innovative educational materials, tools and strategies are needed that are based on the adolescents' own proposals and initiatives and respond to their needs and concerns.
- Programmes for adolescents require creating opportunities for intergenerational evaluation in which adolescents, teachers and health professionals have more horizontal and democratic relationships that respect differences of age, gender and life choices. This fosters truly participatory processes in health issues.
- Last but not least, we have learned that it is difficult to address the issue of adolescents' sexual and reproductive rights in practice. The community does not admit that people in general – much less adolescents – have inherent rights related to their sexuality. This suggests the need for programmes to promote sexuality in its broadest dimension, going beyond the focus on risk. This means recognising desire and pleasure as inherent dimensions of sexuality and connecting this view, in people's understanding, with human rights and sexual and reproductive rights.

Let's talk about sex

Strengthening the advocacy strategy

The peer education strategy used by the programme and the component for strengthening the capacities of health providers is being adopted by the Adolescent's Health and HIV/AIDS Prevention Programme carried out by the Ministry of Health in partnership with the German Agency for Development Cooperation (GTZ) in various parts of the country.

The current political situation and backsliding in the health sector in the area of sexual and reproductive health has spurred civil society to take a more important role in setting up task forces and other advocacy groups to defend the gains that have been made in this area. As a result, the Youth in Action for Life Programme has had to strengthen its strategy for advocacy with authorities.

The third year of the project will focus on strengthening the advocacy strategy aimed at raising the awareness of local, regional and central-level authorities about adolescent sexual and reproductive health needs and urging them to take immediate action. As part of the strategy, the programme is currently preparing to launch a campaign to promote adolescent sexual and reproductive rights. The first stage of the campaign will be kicked off in San Juan de Lurigancho, Lima's largest marginal urban district, which is home to 30,000 adolescents. It will later be expanded to the other districts in which the programme is carried out.

The campaign will be launched in conjunction with the health and education sectors and the local government. Three posters have been designed and validated by the adolescents. They depict the faces of young people who are participating in the project and offer messages about prevention to the public. The campaign will include placing billboards in strategic public places in the district, as well as the massive distribution of T-shirts, pins, caps and stickers in the community.

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More information about IES: Sexual Health Exchange 2001/1, www.kit.nl/ILS/exchange_content/html/2001_1_7.asp

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Special Article

Sexual violence in schools: breaking the silence

Fiona Leach & Pamela Machakanja

Over the past decade or so, schools have been viewed as a primary place for educating young people about HIV prevention and safer sex. However, many schools are in fact sites of high levels of sexual violence, most of it directed at girls, who we know are particularly vulnerable to HIV infection. Young people engage in sexual activity at an increasingly early age and if schools tolerate an environment that condones male aggression and intimidation, then they are encouraging rather than discouraging high-risk sexual behaviour and contributing to the spread of the disease rather than to its reduction. Regular media reports and recent research provide evidence that sexual violence is commonplace in schools, at least in sub-Saharan Africa; it may well be pervasive elsewhere. There is therefore an urgent need to break the silence around this issue.

Sexual violence is any sexual act or attempted sexual act using coercion, threats or physical force. In schools, this may involve sexual harassment, aggressive or unsolicited sexual advances, assault, forced sex or rape. Male pupils and male teachers are usually the perpetrators, and female pupils disproportionately the victims. In addition, in the vicinity of schools, adult men ("sugar daddies") may seek out schoolgirls for sex in exchange for money or gifts. Some girls may enter relationships with male pupils, teachers or other adults willingly but others who are under pressure to pay school fees, buy books and uniforms, or simply to survive, may be pushed into dependent and potentially exploitative liaisons.

It has long been recognised that violence against children, including sexual abuse, is a global concern. It exists in the home, the community and the workplace. Yet there is reluctance to admit that it also exists in schools and other institutions caring for children and that, most shockingly, some violence is perpetrated by teachers, who are supposed to be figures of respect and authority. Pervasive violence in society unfortunately prepares young people to expect and accept it as a part of everyday life, including at school.

What forms does sexual violence take in schools?

On a daily basis, the greatest threat of sexual violence in schools is to girls who receive sexual advances from older male pupils. Sexual advances by teachers may be fewer in number but they are more shocking because of the abuse of trust involved. Such behaviour by teachers offers a dangerous role model to male pupils and has a negative impact on both pupils and parents; a single case in a community may discourage parents from sending their daughters to school. Although female pupils are most frequently the targets of sexual violence, it may also be directed at male pupils, female teachers and those who have same-sex preferences. Some forms of sexual violence are specific to certain cultures, e.g., acid attacks on girls in South Asia or jack rolling (gang rape) in South Africa.

Photo: Edward Reilly, Lutheran World Relief

Sexual violence is only one form of school-based violence; others include bullying, corporal punishment (widespread in many countries even when officially banned), verbal abuse, and psychological and emotional abuse (such as denying a pupil access to resources or support, threatening exam failure or beatings). Most types of violence have a gender dimension and so schools become a breeding ground for potentially damaging gendered practices that remain with pupils into adult life. This is a violation of a child's right to an adequate education in a safe environment, as enshrined in the UN Convention on the Rights of the Child.

Much of the violence experienced in schools involves males affirming their dominance over females, for example, a boy cornering a girl, touching, pinching, groping, and shouting obscenities to demean or humiliate her; a male teacher touching a girl's breasts while pretending to read her exercise book in class, ordering a girl to come to his office and then molesting her. For many girls, this invasion of their private space is an unavoidable part of school life. In some instances, teachers offer girls higher grades in exams in exchange for sex.

Why does it exist in schools?

Sexual violence originates in the imbalance in power between males and females and in socially accepted views of what constitutes male and female behaviour. The school is a prime site for the construction of male and female identity and at this formative age, adolescents can learn that masculine identity is associated with aggressive, dominant behaviour and feminine identity with submissive, dependent behaviour. And so boys act out their beliefs of what it means to be male, while girls learn to make themselves attractive to boys.

Pupils who do not conform to accepted gender behaviour may be bullied or attacked. The peer culture plays an important role in this socialisation process. Peer pressure may require that older boys aggressively demand girls' attention since their status in the group may depend on having one or more girlfriends and competing over girls. If a girl turns a boy's proposal down, she may well risk being assaulted or subjected to sexually explicit

verbal abuse. In this way young people are encouraged, and sometimes forced, into sexual relationships, often with multiple partners. This pressure to conform influences sexual practice and so serves to increase young people's exposure to the risk of HIV infection, other STIs and unwanted pregnancy.

Male teachers who exploit the advantage of their sex and their authority by having sexual relations with pupils are rarely expelled from the teaching profession, even if they get a schoolgirl pregnant; some are merely transferred to another school. Other teachers often choose to ignore what is going on, heads are reluctant to report the matter because of the burden of a bureaucratic investigation, and pupils and parents are either intimidated or lack information about how to make a complaint. High levels of apathy among officials and a reluctance to believe pupils who make allegations are contributory factors. To complicate matters, not all parents, teachers and girls disapprove of teachers or older men having sexual liaisons with schoolgirls, whether for economic or cultural reasons.

Where violence is allowed to flourish and is not discouraged by disciplinary action, it becomes an integral and institutionalised part of school life, something "normal" or "inevitable". Indeed, many teachers view aggressive and intimidating behaviour by boys as part of "growing up" and not to be taken seriously. By tolerating violence, the authorities are implicitly sanctioning its practice.

What can be done?

Only an imaginative holistic approach – bringing together teachers, parents, pupils, education officials and civil society – can make schools safe environments for schoolchildren. All aspects of the culture of violence need to be tackled, whether it is sexual violence and abuse, excessive corporal punishment or bullying.

In particular, Ministries of Education need to take greater responsibility for tackling the issue in schools. If perpetrators are prosecuted firmly and quickly, this sends a clear message that violence will not be tolerated. At the same time, corporal punishment and bullying need to be stamped out, as there are clear connections with sexual violence. Training courses need to provide trainee teachers with strong messages about professional and ethical conduct and available sanctions. The South African government has set an example by recently passing legislation banning sexual relations between educators and learners. In the United Kingdom, such relations are a criminal offence, even if the learner is over the age of consent and in the USA schools can now be held liable in cases of sexual harassment.

Within the school, efforts also need to be made, both through the curriculum and through school management and discipline, to encourage more collaborative relationships between pupils and between teachers and pupils. Acknowledging that school-going adolescents engage in sexual activity, reporting cases of teachers' sexual misconduct and eliminating the negative role model that this provides to boys may also lay the ground for teaching about sexual health in a more constructive environment.

Teachers need to take responsibility for listening to both boys and girls and engaging them in constructive dialogue. Sex education and guidance and counselling as school subjects should be used to create a deeper and more positive understanding of what it is to be female or male and to promote notions of negotiated and responsible sex. In this, men and boys need to be seen as part of the solution and not just the problem.

Using songs and theatre to address sexual violence in schools

Photo: Patrick Coleman, CCP

Zero tolerance towards violence

Schools that offer examples of good practice are those that do not tolerate any form of violence, that offer a more open and supportive environment for pupils, especially girls, where discipline is imposed without resorting to physical punishment, and where expectations of both teacher and pupil behaviour are high. These are usually schools that openly espouse democratic values; they often initiate forms of pupil representation such as student councils, and offer opportunities for pupils to have their voices heard and their complaints addressed.

Such schools are rare in the developing world. It is noticeable that most innovative work with young people to challenge dominant gender relations and to encourage them to change unsafe sexual behaviour has been done by NGOs and not by schools. The work of DramAidE, Soul City and the Storyteller Group in South Africa stands out.[1] Traditional teaching methods provide information and knowledge but do not provide a forum for questioning existing gender roles, identities and practices, and for developing more constructive and consensual relationships. Instead, participatory approaches are required. Activities involving drama, media, art, poetry and storytelling have all been shown to be particularly effective, as has the use of peer educators and peer counsellors. Schools need to learn from such initiatives. ❖

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More information: An Investigative Study of the Abuse of Girls in African Schools, Fiona Leach et al, 2003 (see page 16).

1. DramAidE is an AIDS, life-skills and sexuality education programme aimed at schoolchildren and teachers, www.und.ac.za/und/dramaide; Soul City is multi-media health promotion and social change project, www.soulcity.org.za; and the Storyteller Group uses comic stories as a tool to explore the gendered dimensions of violence within adolescent relationships.

Research Notes

Do we need special programmes to keep orphans in school?

Deon Filmer & Martha Ainsworth

One result of the AIDS pandemic is that the number of orphans is increasing in many countries. As education is of paramount importance for a child's chances to escape poverty and learn how to live a healthy life, it is necessary to make sure orphans have the same access to education as other children. Concern that school-aged orphans will drop out of school or will never enrol has prompted calls for governments to subsidize their schooling. Incentives offered include free textbooks, uniforms, waiving of school fees, free medical care, and supplemental feeding. However, are these programmes targeting orphans only really necessary? The results of a study conducted by World Bank in 2002 indicate that this very much depends on the circumstances in each country.

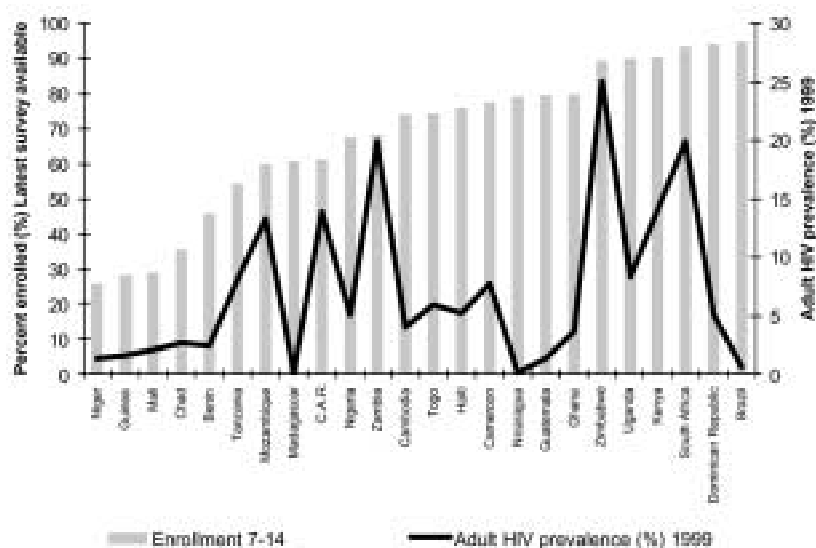
An estimated one in eight children under 15 years in Africa has lost one or both parents, about a third of them due to AIDS.[1] Enrolment of orphans in schools might be lower either because their guardians cannot afford the costs of schooling, they are needed for income-generating or other economic activities, or their guardians have less interest in the welfare of children who are not their own.

But the extent to which orphans are under-enrolled relative to other children and the reasons for their non-enrolment have not been systematically reviewed. It is not clear, for example, whether orphaned children are worse off than other equally poor children – therefore requiring a targeted intervention linked to their special needs – or whether the impact of becoming an orphan is to swell the already large group of poor or uneducated children. According to the World Bank, of at least 67.5 million primary-aged children not in school worldwide in 1997, 58 million were living in low-income countries (31.5 million in South Asia and 25 million in sub-Saharan Africa). It is not known how many of these are orphans.

The study

A quantitative study using data from 28 developing countries in Africa, Latin America, the Caribbean and Asia conducted by the World Bank examined the relationships between orphan status, poverty and school enrolment among children 7-14 years old and, for a few countries where data permitted, among those aged 15-17 years. We wanted to find out whether orphans have lower enrolment rates than non-orphans and how this was related to overall enrolment and to poverty. Orphans were defined as children who have lost one or both parents due to any cause (the cause of parent deaths is not identified).

The data came from settings where the prevalence of both HIV and orphans is relatively high (e.g., Cambodia, Uganda and Zambia) or low (e.g., Brazil, Madagascar and Nicaragua), as well as from low- and middle-income countries. The purpose of this range was to understand how country circumstances affect the results.



Relation between enrolment rates and HIV prevalence

Are orphans under-enrolled?

The relationship between orphan status, poverty and school enrolment was diverse, reflecting different background levels of income, schooling, and adult mortality in the countries studied. In more than half of the countries, the most recent data showed that children in poor and non-poor households were equally likely to be orphans, while in the remainder, poor children were more likely to be orphans than were non-poor children. However, in all countries, children in poor households had significantly lower enrolment rates than children in non-poor households.

In 20 countries, e.g., Kenya and Benin, at least one group of orphans (maternal, paternal or two-parent) had significantly lower enrolment than did non-orphans; in two countries (Nigeria and Tanzania) at least one orphan group had significantly higher enrolment. In six countries there were no enrolment differences between orphans and non-orphans. However, once the child's poverty status was taken into account, the differences in enrolment rates between orphans and non-orphans often disappeared (seven countries) or persisted only among the poor (four countries) or the non-poor (three countries).

Not all orphans are under-enrolled

In the six countries where both poor and rich orphans were under-enrolled in schools, the size of the gap in enrolment between orphans at the bottom and the top

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of the income distribution was larger than the gap between orphans and non-orphans within the income group. In almost all countries, the gap in enrolment between female and male orphans among those 7 to 14 years old was similar to the gap between girls and boys with living parents, indicating that girls' enrolment is not disproportionately affected by becoming an orphan.

These findings suggest that under-enrolment of orphans – to the extent that it is observed – is often related more to their economic situation than to their orphan status. Enrolment gaps between orphans and non-orphans that persist after controlling for poverty are likely due to factors specific to being an orphan – such as psychological trauma or discrimination by guardians – that will probably not be affected by policies such as subsidized school fees and uniforms.

Implications for interventions

In countries like Benin, Burkina Faso, Chad, Guinea, and Senegal, average enrolment rates for all children were less than 40% and even children with living parents from the top of the income distribution had low enrolments. This points to fundamental issues in the availability, quality, or demand for schooling that constrain enrolment of all children, whether or not their parents are alive. Policies to subsidize orphan enrolment may have minimal effect on their welfare unless these larger issues are addressed.

In the group of countries with moderate overall enrolment rates, there are often very large gaps between enrolment of poor and non-poor children. The most disadvantaged children are the poor, including poor orphans. Policies to reduce the poverty gap in enrolment will contribute significantly to raising enrolment among the neediest orphans without any orphan-specific targeting, as was shown in the Dominican Republic, Kenya, and Uganda.

In countries like Brazil, the Dominican Republic and Zimbabwe, where overall enrolment rates are high even among the poor, orphan enrolment differentials are likely related to problems specific to being an orphan, some of which may not be school-related. The reasons need to be carefully explored: policies that subsidize fees or school uniforms for orphans only may not be effective in reducing this gap while potentially transferring funds to orphans who might otherwise already be enrolled.

Concerns

A general conclusion from this study is that orphan status in most countries is not a good targeting criterion for "traditional" programmes aimed at raising enrolment rates, like providing textbooks, uniforms, school fees, medical care, or supplemental feeding for free. Also, it is likely that the benefits being channelled to orphans are things that other children or other household members lack. This might be a reason for some households to take in orphans for opportunistic reasons, which is not always in the children's best interest. Policies and programmes aimed at improving the welfare of the poorest households will help the poorest children, including the poorest orphans, without creating incentives to redistribute children in ways that may adversely affect their welfare. On the other hand, interventions linked solely to the special needs of orphans (for example, grief counselling or health services for HIV-infected children) are unlikely to invite opportunistic responses.

Poor orphans have less access to education than non-poor children

Photo: Eric Vance

Further, the impacts on child schooling before parents and other adults die of AIDS – when there is a sick adult who must be cared for and for whom many resources may be spent for medical treatment – also deserve attention. In Uganda, older children (13-17 years) in households with a sick parent had lower school attendance (80%) than did children in the same age group whose parents had already died (89%).[2] Older two-parent orphans reported that their attendance improved after moving in with a guardian following the parent's death. In Tanzania, children attended primary school fewer hours before an adult death than after.[3] By focusing exclusively on outcomes after a parental death, programmes may be neglecting larger impacts before the death that might be mitigated through short-term support for households with terminally ill adults. ❖

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More information about this study can be found in: Ainsworth, M. and Filmer, D., Poverty, AIDS, and Children's Schooling: A Targeting Dilemma, Worldbank, 2002 (see p. 16).

1. USAID, UNICEF and UNAIDS. *Children on the Brink 2002: A joint report on orphan estimates and program strategies.* USAID 2002.
2. Gilborn, L., Nyonyintono, R., Kabumbuli, R. and Jagwe-Wadda, G. *Making a difference for children affected by AIDS: Baseline findings from operational research in Uganda.* Horizons Program/Population Council and Makerere University 2001, www.popcouncil.org/pdfs/horizons/orphansbsln.pdf.
3. Ainsworth, M., Beegle, K. and Koda, G. The impact of adult mortality and parental deaths on primary schooling in Northwestern Tanzania, *Journal of Development Studies* 2004 (forthcoming).

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- On the issue of sexual violence and sexual abuse in schools the following recent sources are available:
  - *Beyond victims and villains. Addressing sexual violence in the education sector.* The Panos Institute, 2003 (56 p.): www.panos.org.uk/PDF/reports/Beyond%20Victims.pdf. Hardcopies: The Panos Institute, 9 White Lion Street, London N1 9PD, UK. Fax: +44-20-7278.03.45, e-mail: judym@panos london.org.uk, web: www.panos.org.uk
  - *An Investigative Study of the Abuse of Girls in African Schools.* F. Leach et al, DFID Education Research report No 54, 2003 (208 p.): www.dfid.gov.uk/Pubs/files/investudyafrica_edpaper54.pdf
  - *Unsafe Schools: a literature review of school-based violence in developing countries. USAID, 2003 (158 p.):* www.dec.org/pdf_docs/PNACU253.pdf (also contains extensive list of internet resources)
  - *Scared at school: Sexual Violence Against Girls in South African Schools.* Human Rights Watch, 2001 (138 p.): www.hrw.org/reports/2001/safrica. Order hardcopy ($10): Publications Department, Human Rights Watch, 350 Fifth Ave, 34th Floor, New York, USA. Fax: +1-212-736.13.00, http://store.yahoo.com/hrwpubs/scaratschool.html

- World Bank publications (accessible through www.schools andhealth.org):
  - *Education and HIV/AIDS: A Sourcebook of HIV/AIDS Prevention Programmes,* 2003 (396 p). Online available in English, French and Portuguese. Hardcopies (English only): Education Advisory Service World Bank: 1818 H Street NW, Washington DC 20433, USA, e-mail: eservice@worldbank.org
  - *Education and HIV/AIDS: A Window of Hope,* 2002 (104 p.)
  - *Education and HIV/AIDS: Ensuring Education Access for Orphans and Vulnerable Children – A Training Module,* 2002 (101 p.)

- UNESCO publications:
  - *Helping teachers select suitable materials on HIV/AIDS.* UNESCO Bangkok, 2002 (104 p.): www.unescobkk.org/ips/arh-web/resources/aids/hiv_aids.pdf. Hardcopies: P.O. Box 967, Prakanong Post Office, Bangkok 10110, Thailand.
  - *HIV/AIDS & Education, A Strategic Approach.* International Institute for Educational Planning/UNESCO, 2003 (71 p.): http://unesdoc.unesco.org/images/0012/001286/128657e.pdf. Hardcopies: 7-9 rue Eugène Delacroix, 75116 Paris, France, e-mail: information@iiep.unesco.org
  - *Towards an African Response: UNESCO's Strategy for HIV/AIDS Education in Sub-Saharan Africa (2002-2007),* 2002: www.dakar.unesco.org/pdf/vih_sida_strategicplan.pdf
  - *Preventing HIV/AIDS in schools.* I. Schenker and J. Nyirenda, International Bureau of Education, Educational Practices Series, 9, 2002 (31 p.): www.ibe.unesco.org/International/Publications/EducationalPractices/EducationalPracticesSeriesPdf/prac09e.pdf

- Other resources:
  - *Preventing HIV/AIDS, STI and Related Discrimination: An important responsibility of Health-Promoting Schools.* WHO, 1999 (56 p.): www.unicef.org/lifeskills/gshihiv.pdf
  - *Guide to Setting Up Health and Life Planning Clubs in Schools.* Action Health Incorporated, 2001 (75 p.): www.actionhealth inc.org/publications/hlpc_guide.pdf
  - *The sound of silence – Difficulties in communicating on HIV/AIDS in schools.* ActionAid, 2003 (54 p.): www.actionaid.org/resources/pdfs/soundofsilence.pdf
  - *The impact of the HIV/AIDS epidemic on the education sector in sub-Saharan Africa. A synthesis of the findings and recommendations of three country studies.* P. Bennell, K. Hyde, N. Swainson, Centre for International Education, University of Sussex Institute of Education 2002 (117 p.): www.sussex.ac.uk/usie/cie/aidssynpublished.pdf
  - *Poverty, AIDS and children's schooling: a targeting dilemma.* M. Ainsworth and D. Filmer, World Bank Policy Research Working Paper, 2002 (41 p.): http://econ.worldbank.org/files/18719_wps2885.pdf
  - *Reducing HIV Infection Among Youth: What Can Schools Do? Key Baseline Findings from Mexico, South Africa, and Thailand.* Horizons Program et al, 2001 (32 p.): www.popcouncil.org/pdfs/horizons/schoolsbsln.pdf
  - *The Role of Education in Promoting Young People's Sexual and Reproductive Health.* I. Warwick and P. Aggleton, Safe Passages to Adulthood, Thomas Coram Research Unit, Institute of Education, University of London, 2002 (38 p.): www.socstats.soton.ac.uk/cshr/pdf/guidelines/educationreport.pdf

- Useful websites:
  - HIV/AIDS Impact on Education Clearinghouse, coordinated by the International Institute for Educational Planning/UNESCO: http://iiep.tomoye.com/ev.php
  - Insights (ID21 specials, Institute of Development Studies), Special Issue "Conspiracy of silence? Stamping out abuse in African schools", 2001: www.id21.org/insights/insights-gv-special/index.html
  - ID21 Gender Violence in Schools web pages: www.id21.org/education/gender_violence/index.html
  - UK Consortium on AIDS and International Development website – Education, Schools & HIV/AIDS Bibliography: www.aidsconsortium.org.uk/educationbibliography.html
  - Eldis Education Resource Guide: www.eldis.org/education
  - Schools and Health: www.schoolsandhealth.org

Alll resources are accessible through our website: www.sexualhealth exchange.org

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