

EDUCATION AND HIV/AIDS



Ensuring Education Access for Orphans
and Vulnerable Children

A Training Module



WORLD BANK



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Foreword

The Africa Regional and HD Network at the World Bank is developing a regional strategy and action program to ensure that the Bank, through its education and multi-sector HIV/AIDS projects (MAP), helps African countries systematically address the interaction between HIV/AIDS and Education. The following areas will be discussed:

- (i) Projecting the impact of HIV/AIDS on education systems;
- (ii) Mitigating the impact;
- (iii) Ensuring access to education for orphans and vulnerable children;
- (iv) The impact education should have on HIV/AIDS prevention by promoting behavioral change;
- (v) Prevention and peer counseling;
- (vi) Situation analyses.

Modules are being developed in each of the above areas. In order to project the impact of the HIV epidemic on the education system, projection models have been developed; an example is the Ed-SIDA model with its complementary training manual (World Bank, 2002). In the case of prevention and peer counseling, the key tools will be the “Education in HIV/AIDS: A Sourcebook of HIV/AIDS Prevention Programs” that is currently being developed, and other published good practices materials. This module “Ensuring Education Access for Orphans and Vulnerable Children” will assist key decision makers from client countries to reflect on the difficulties faced by children orphaned by AIDS and other vulnerable children, and on the different policy options available within the education system, and within the government and elsewhere in general. The strategy is based on building capacity within the education sectors of client countries. The implementation of the strategy will be done through the sensitization and training of a team of key stakeholders from each country at sub-regional workshops. These trainings will be followed by national seminars in each country, led by the stakeholder team. The output expected from the national seminars will be national plans of action for the education sector response to HIV/AIDS.

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
DfID	Department for International Development
Ed SIDA/AIDS	Education and HIV/AIDS
EFA	Education for All
HIV	Human immunodeficiency virus
OVC	Orphans and Vulnerable Children
MAP	Multicountry HIV/AIDS Program (for Africa)
MICS	Multi-indicator Cluster Surveys
NGO	Non- governmental organization
PRSCs	Poverty Reduction Support Credits
U.N.	United Nations
UNICEF	United Nations Children's Fund
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
USAID	United Nations Agency for International Development
WHO	World Health Organization

Introduction to the Training Module - A Road Map

HIV/AIDS-related death has claimed over 20 million lives over recent decades, and an estimated 40 million people are living with the disease today. Most of the victims are parents whose absence has left their children living under extremely difficult conditions. The recent UNICEF 'Children on the Brink' report estimates that currently, 13 million children under the age of 15 have lost either one or both parents due to AIDS. By 2010 this number is expected to reach 25 million. The number of orphans from parental deaths of all causes, is predicted to number a staggering 106 million. The future of these children is at stake, particularly as it involves their access to social amenities such as health and education services.

The numbers of such children are growing rapidly. In twelve African countries, projections show that by 2010, 15% of children under the age of 15 will be orphans (UNICEF 2002), and many millions more will be considered vulnerable, either as a result of AIDS or through other causes, principally child labor. Accompanying this crisis will be increasing psycho-social issues, issues of school attendance, and increasing poverty to name but a few. This growth increases the importance of paying attention to these children's future well-being. This module seeks to highlight the magnitude of the orphans and vulnerable children (OVC) crisis and to describe some interventions that have been implemented in developing countries to improve these children's access to education. Throughout the course of this manual we have used the term 'orphans and vulnerable children', recognizing that children orphaned by AIDS are only a fraction, albeit a rapidly increasing one, of children at risk. As the number of children orphaned through AIDS grows, many will have to turn to alternative and often dangerous employment on the streets; if we are to target this increasing proportion of children, it is important to consider all children at risk.

This module is based on an analysis of information from two kinds of sources. The first is a review of current literature on OVC and their access to basic education. The second source of information is based on a series of interviews and discussions with many people who have field experience with orphans, access to education, subsidies, and social fund issues.

The information available has many limitations and, as of yet, there is no package of established knowledge on how to intervene in favor of OVC. Even though several interventions have taken place, they are so recent that they have not been evaluated for program effectiveness and impact. Another limitation is that data on children orphaned by AIDS and vulnerable children are not systematically collected. Nonetheless, the few papers and reports that do exist offer valuable insight into the effects of HIV/AIDS on children, including data on children orphaned by AIDS and on other vulnerable children, especially with respect to their access to education.

Who is the training for and how will it be done?

This module has been developed for the training of key stakeholders within the education sectors of World Bank client countries, nongovernmental organizations, and church-based groups involved with interventions to benefit AIDS orphans and vulnerable children.

The training seeks to be as practical as possible. The literature in the Facilitators manual is identical that in the Participant's manual but contains additional exercises for the workshop at the end of each section. It will be based on concepts and ideas that the participants will have acquired from their everyday experiences or from reading the participant's module, and they will be expected to explore their views and experiences against what is contained in their module. Material is based on a participative and structured experiential approach. As the training progresses, important points should be reinforced, and the facilitator should always endeavor to draw together common themes.

The material is sufficient for a course of at least one full day. The success of the training depends on how well the facilitator prepares and introduces the course. Participants should be told what they will be doing during the course of the training and why. Because most of the work will be done in groups, the facilitator should beware of possible problems in the group process. The groups should make their presentations and then facilitator add important points that might have been forgotten.

Goals of the training

The goals of “Ensuring Education Access for OVC” training are to:

- Provide the authorities of the Ministry of Education and partners with knowledge of the magnitude of the OVC crisis in sub-Saharan Africa;
- Increase the awareness of the authorities of the Ministry of Education and other partners in client countries in sub-Saharan Africa about OVC and their access to basic education in sub-regional workshops;
- Explain the complex relationship between OVC and enrollment, attendance, and performance/achievement in school;
- Train the Ministry of Education authorities and partners in sub-regional workshops to address the issues of OVC and their access to basic education;
- Assist the key stakeholders and their partners in client countries to plan and organize national workshops to develop national plans of action for the education sector to respond to HIV/AIDS;
- Share with and learn from one another information on important policy issues that are of importance to any assistance to increase access to education for OVC.

Organization of the training module

This module is divided into five sections with corresponding workshop exercises at the end of each section.

Section 1 – Who is an Orphan, who is a Vulnerable Child, and How Many Are There?

This section presents the different definitions of orphans and vulnerable children that exist in the literature reviewed. It also explores the reasons the estimates of the numbers of children orphaned by AIDS differ, based on the different definitions.

Section 2 – The Impact of Parents' HIV/AIDS-Related Illness and Death on Their Children's Home Life

This section presents an overview of the impact of parents' HIV/AIDS-related illness and death on their children's home life. In cases of illness and death in a household, the families are made poorer, adding to the already large group of poor people in the developing countries. When parents die, children may be placed in foster families who may themselves be poor, or child-headed households may emerge.

Section 3 – The Impact of Parents' HIV/AIDS-Related Illness and Death on Their Children's Schooling

This section discusses the factors that influence access to education and surveys the impact of parents' HIV/AIDS-related illness and death on their children's enrolment, attendance, and performance at school. HIV/AIDS-related illness and death have negative impacts on enrolment, which varies from country to country and from age to age. Illness of parents affected children's attendance and performance; the impact of parents' death on their children's performance is not very clear.

Section 4 – What Has Been Done to Improve OVC Access to Education?

This section discusses the four main groups of interventions that have been undertaken in various countries with the aim of improving access to education for OVC. These interventions can be grouped into two main categories: interventions that are specific to orphans and interventions for the general population that also benefit the orphans. The section includes case histories for Burundi and Zimbabwe.

Section 5 – Key Emerging Issues and the Way Forward

This final section of the module presents emerging key issues: the definition of AIDS orphans, the increasing numbers of school-age OVC, and the relationship between orphanhood and enrolment, attendance, and performance. The section points to what still needs to be done and stresses the short-term nature of most of the interventions undertaken so far. The long-term solution to improving access to education for OVC, is achieving the goal of providing Education for All.

Appendices, workshop annexes and references follow section 5.

Workshop Warm-up

The facilitator will start the training with an icebreaker during which the participants introduce themselves.

Activity 1

Ask the participants to sit in a circle. Let each person introduce himself/herself and his or her ministry, agency, or community and describe what he or she does within that organization. He/she should also say what he/she wishes to get out of the workshop, as well as what his/her fears are. Put their expectations and fears on a transparency or flip chart and display.

Warm-up

After the introductions, start with a warm-up exercise in which everyone is involved. The aim of the exercise is to make people understand that in a group situation it is necessary to respect the views of others. Divide participants into four groups.

Materials:

On a large flip chart, draw a capital elliptical E in a bright color – call this sheet 1.

On another sheet, draw four rows labeled A, B, C, D or names proposed by the four groups of participants; and then four columns, North, South, East and West – call this sheet 2.

Methodology:

After you have divided the participants into four groups, ask them to form a square.

Put sheet 1 in the middle of the square formed by the participants.

Put sheet 2 on a board outside the square where it is visible to all participants.

Procedure

Choose any of the groups and ask them what letter they see in front of them. They should consult and ask their spokesman to call out the letter. It is written on sheet 2 under the direction they are facing –North, South, East, or West. Then ask the groups to move one direction to their right. The group that finds itself on the spot of the group that started is asked the same question. The answer is again put on sheet 2 under their initial direction (North, South, East, or West). This is continued until all four groups have taken their turn.

At the end of it all, what has been written on the board is reviewed and the groups are asked to relate the meaning of whatever is on the board to their presence for the workshop.

Discuss the reasons the training is being done, emphasizing the historical background of the training. Follow the discussion with a quick review of the HIV/AIDS epidemiology and the consequences of the epidemic:

- 25 million people have died from AIDS worldwide.
- In Kenya, for example, cumulative AIDS deaths totaled about 1.3 million from 1990 to 2000, and another 3.2 million AIDS deaths are projected between 2000 and 2010 (*can substitute another country for Kenya*).
- 16.3 million people have died from AIDS in sub-Saharan Africa.
- In 2001, 2.3 million people died from AIDS in sub-Saharan Africa.

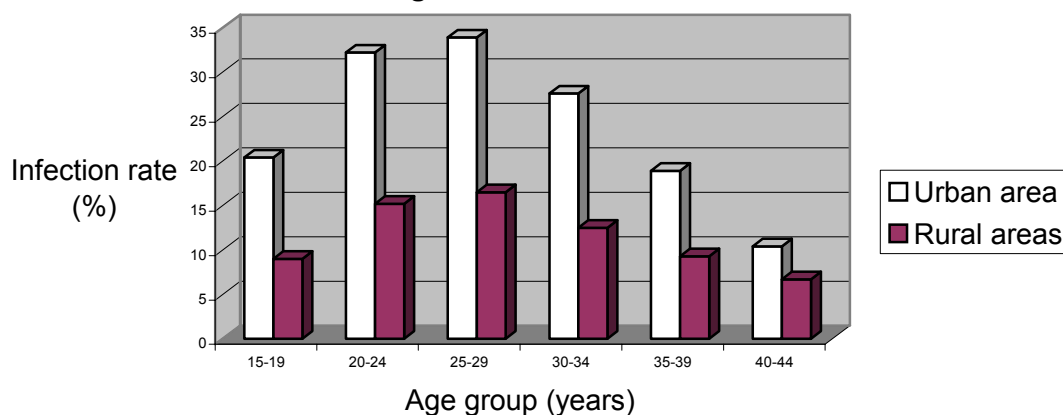
Section 1 – Who is an Orphan, Who is a Vulnerable Child, and How Many Are There?

This section presents the definitions and estimated numbers of children orphaned by AIDS. There are three main categories of children orphaned by AIDS – maternal, paternal, and double. Estimates commonly refer to maternal and double orphans; very little reference is made to the paternal orphans. Estimates differ from one author, institution, and organization to another because the numbers are inextricably linked to the definitions used; the more inclusive the definition, the higher the number of orphans. Following this, the issue of vulnerable children at large will be discussed.

Introduction

All age groups are at risk of contracting HIV, but the highest prevalence is seen in reproductive-age adults, those between the ages of 15 and 49. Within the framework of the HIV sentinel surveillance system in Zambia, a study was done in 1994 with first attendees for antenatal care during a maximum period of four months for data collection. The results indicated that the highest HIV sero-prevalence was in childbearing women between the ages of 20 and 34, especially in urban areas (Fylkesnes et al. 1997) (Figure 1.1). Similar patterns have also been reported from other countries (Bunnell et al. 1999; Mayans et al. 1997).

Figure 1.1: Distribution of HIV sero-prevalence in Urban and Rural areas in Zambia by age group of childbearing women attending antenatal clinics in 1994



Source: Data for graph adapted from Table 2 in: Fylkesnes et al. (1997), *AIDS* 11(3):339–345.

Fylkesnes, K et al, (1997) indicated that childbearing women are the key sentinel population for monitoring the HIV epidemic in the sexually active population. This system monitors trends of infection and may be considered a representative sample of the general population (UNAIDS 1999a). However there are some biases, which include the age differences between the women attending the clinics and the rest of the population. In any case, this bias can be easily adjusted (UNAIDS 1999a). It is observed that most of the people who are infected with HIV are people of child-bearing age. In the long run, some of these people die leaving children of school age as orphans.

Orphans and Vulnerable Children: Breaking down the complexity.

This paper was compiled in light of 'Children On the Brink 2002', and offers a complementary practical framework for highlighting some of the key issues surrounding orphans and other vulnerable children (OVC). While understanding that children orphaned by the HIV pandemic are ever increasing in number, it is also important to consider the other vulnerable children affected by the crisis: those who have not yet lost a dying parent but are nonetheless caring for them, or children living in a household that has fostered orphans, or fostered themselves. Children orphaned by or vulnerable due to other causes also demand attention; they may be child soldiers, prostitutes or street children to name but a few. In reality the overlap between children orphaned by HIV/AIDS and those vulnerable for other reasons is increasingly great, the categories are far from mutually exclusive. It is therefore important to adopt a holistic approach when tackling the issues of OVC and to view strategies for helping the orphans of HIV/AIDS as part of a larger framework for helping all vulnerable children.

Who is an orphan?

The term "orphan" is used and understood differently by different people. Some cultures regard an orphan as a child who has lost both parents. Others consider an orphan to be a child who has lost one parent. The *Oxford English Dictionary* (1992) defines an orphan as "a child bereaved of a parent or *usually* both parents."

Who is a child orphaned by AIDS? : Interpreting the data.

The HIV/AIDS literature tends to use three kinds of definitions; depending on which parent has been lost to AIDS; it refers to paternal, maternal, or double orphans. A *paternal orphan* is defined as a child younger than 15 who has lost a father to AIDS, a *maternal orphan* is one who has lost a mother to AIDS, and a *double orphan* is one who has lost both parents to AIDS (Deininger, Garcia, and Subbarao 2001). In the literature about HIV/AIDS, the label "AIDS orphan" mainly refers to either a maternal or a double orphan

(UNAIDS/UNICEF 1999). According to a joint report by USAID, UNICEF and UNAIDS, (2002) at a recent Reference Group Meeting, it was agreed that a child orphaned due to AIDS is “a child who has at least one parent dead from AIDS”. Data on whether a child’s mother has died and her cause of death is usually more readily available than data on the father. In the above quoted report, maternal orphans are thus defined as those children whose mothers have died, and where the survival status of the father is unknown (alive, dead from AIDS or dead from other causes) (USAID/UNICEF/UNAIDS 2002, appendix II, p31). When information about the father is available, it is possible to estimate the number of dual (or double) orphans due to AIDS, the definition being ‘a child whose mother and father have both died, at least one from AIDS’.

Whether paternal orphans should be included in the definition is the subject of controversy. Some have argued against it saying the result would be an overestimation of the numbers of children orphaned by AIDS. These people assert that some fathers abandon their children or are absent from their children’s life and might be considered dead and their children reported as orphans. Those who counter that paternal orphans should be included in the definition say that excluding these orphans results in an underestimation of the number of children orphaned by AIDS by as much as 45 to 70% (Foster and Williamson 2000).

The commonly used definition of children orphaned by AIDS: “Children less than 15 years who have lost either both parents or their mothers”, poses three fundamental problems. The first is that when a child loses its mother to AIDS and is termed an orphan, there is a risk that the father will abdicate his responsibilities to the child, especially in situations where there is a possibility of social assistance being provided to orphans. The second problem is that a father’s death can be as tragic for the child as the death of a mother. In cultures where the father’s income makes up a large share of the household income; the loss of a father is tantamount to economic death for the family: The children have lesser chances of going to school than if the mother had died because the income of the mother might not be adequate to sponsor the children. However one should not lose sight of the fact that women household heads are becoming an increasing phenomenon in many African countries and so in some instances, maternal orphanhood is just as likely to cause hardship as the paternal one. The third problem is the fact that it may give the father’s relatives incentives to claim responsibility for the child in an effort to access social assistance programs.

In the commonly used definition of a child orphaned by AIDS, it is not very clear why age 15 was chosen as the cut-off, whereas the Convention on the Rights of the Child uses age 18 (United Nations 1989). However, this age difference has implications when it comes to discussing children orphaned by AIDS and access to primary education especially in settings where children start primary school late (after the age of 8) or where there is repetition. In Tanzania for example, the official age for a child to start primary school is 7 years but delayed enrolment is widely acknowledged as a very serious issue (Ainsworth et al, 2002).

Why are there variations in the reported numbers of orphans by different authors/organizations?

The problems involved in defining an orphan make consequent predictions of the number of orphans difficult to interpret. The subsection that follows presents the numbers of OVC as reported by different authors/organizations/institutions. The figures reveal wide or marked differences. Why is it so? Box 1.1 highlights the reasons for some of the discrepancies in the data:

<p>BOX 1.1: Why the difference between the number of children orphaned by AIDS as estimated by UNAIDS and the U.S. Census Bureau</p> <p>A. Definitions of children orphaned by AIDS differ</p> <ol style="list-style-type: none">1. Some include orphans of all causes.2. The age range used differs.3. Some are cumulative, others are cross-sectional. <p>B. Different methodologies are used to project future levels.</p> <ol style="list-style-type: none">1. Different estimates are used for current levels of HIV prevalence.2. Different assumptions are made about the incubation period.3. Prenatal HIV transmission rates differ.4. Estimates for total and age-specific fertility rates5. Different estimation of the impact of AIDS on the mortality of childbearing women <p>C. Others</p> <ol style="list-style-type: none">1. Discrepancies in reporting AIDS deaths2. Stigma attached to HIV/AIDS
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The variation reflects the different definitions used by different authors. As mentioned earlier, some estimates refer to children who have lost a father, a mother, or both parents

(Hunter and Williamson 2000). Others refer only to children who have lost a mother or both parents; these definitions exclude children who have lost only their fathers (UNAIDS/UNICEF 1999). The more inclusive the definition, the higher the numbers of children orphaned by AIDS; the more exclusive, the lower the numbers. Some estimates are related only to children who are orphans because of HIV/AIDS; others include orphans from all causes (Appendix 1.2).

Different definitions consider different age ranges. One school of thought defines an AIDS orphan as a child younger than 18 who has lost one or two parents (Aspaas 1999; Foster et al. 1997). Another school of thought includes only children younger than 15 (UNAIDS/UNICEF 1999), which leaves out the whole group of orphans ages 15 to 18.

Discrepancies also arise in reporting of AIDS deaths. Many cases are not reported as such, either because the underlying cause of death is misclassified, or not understood; the latter may be especially true in situations where it is assumed that the sickness is as a result of witchcraft or a cultural phenomenon. Secondly, the stigma associated with reporting a death as being due to AIDS and the considerable proportion of cases that are not notified through formal medical channels, will lead to an underestimation of cases and thus predicted orphans. In addition, some of the data are cumulative estimates, others are cross-sectional in nature.

Most of the projections are based on mathematical models (Gregson, Garnett, and Anderson 1994). Estimates vary because of the differences in parameters used, such as fertility, HIV prevalence, incubation periods, or survival period (Bongaarts 1995; Hunter and Williamson 2000, 2000a).

In general, there are considerable difficulties in collecting reliable data on children orphaned by AIDS, and most of the studies tell readers very little about the enumeration methods used (Dunn, A., S. Hunter, C. Nabongo, et al. 1991). There is always a risk of either under- or over-enumeration, depending on the stated objective of the enumeration. Because of stigma attached to being an 'AIDS orphan' in most communities, many people would not like to be counted as belonging to this group. But when the end point is an intervention that will be of benefit to the child orphaned by AIDS or to their family, people tend to want to be counted among this group. Opportunistic behavior has even been known to occur, which raises the possibility of over-enumeration because people who are not orphans suddenly "become" orphans with the hope of gaining something.

Who is a vulnerable child?

The possibility that a child will be in difficult circumstances is increasing in Africa, especially as the number of risk situations increase (Subbarao et al 2001). Vulnerable children are those who belong to high-risk groups who lack access to basic social amenities or facilities. The main sources of vulnerability include HIV/AIDS and conflict. HIV/AIDS has increased the group of vulnerable children which tends to include orphans of all causes including children orphaned by AIDS, children infected with HIV, pre-orphans caring for terminally sick parents with AIDS, children in households fostering orphans, and children with disabilities. Also included are the internationally recognized categories of street children, children exposed to strenuous labor, children engaged in sex trafficking, commercial sex work and children affected by armed conflict (Subbarao et al 2001). These last categories are vulnerable and severely disadvantaged.

It has been observed in Haiti that children move in and out of various groups of vulnerability as their life circumstances change (Family Health International/IMPACT 2000). Orphanhood imposes a heavy burden on the children orphaned by AIDS themselves, but not all children orphaned by AIDS are needy or poor (Ainsworth and Filmer 2002). In developing countries there are many children who are not orphans but are equally needy or vulnerable.

As the AIDS pandemic progresses, the number of children who will be placed in vulnerable situations, either through employment or exposure to risky environments, will invariably increase. Understanding how best to reach these groups is vital. Two groups of vulnerable children have been discussed in detail in Subbarao, Mattimore, and Plangemann (2001): street children and children exposed to strenuous labor (child laborers). Many of these children are orphans as the following examples highlight:

According to Subbarao et al. (2001), there are about 1 million street children in sub-Saharan Africa. They are mostly found in conflict or in post-conflict areas. In three urban districts of Zambia it was found that the majority of street children were orphans; 37% of children had lost one parent, 19% had lost both parents and a further 2% did not know where their parents were (n=2694) (ILO, 1999). The same study found that the majority of children in prostitution in Uganda were orphans; 36% had lost one parent and 29% had lost both.

Child laborers are children of school age who have to work to earn an income for themselves or for their families (Andvig, J.S 2000) and child labor in general is widespread

in countries with high levels of poverty and high rates of unemployment. They often substitute for or supplement their parents, who may be incapable of providing for their basic needs. A rapid assessment survey in Addis Ababa, Ethiopia found that the majority of child domestic workers were orphans; 50% of children had lost one parent, and 23% had lost both (n=100) (Kifle, 2002).

How do you identify a 'vulnerable child'?

Difficulties arise when deciding how to identify a child 'at risk'. The aggregate number of children in the child labor markets in Sub-Saharan Africa is not known precisely and it is difficult to get an accurate count of children involved in child labor, as the definition often varies from country to country. A step forward has been the use of the UNICEF multi-indicator cluster (MICS) surveys (UNICEF, 2001), health and demographic surveys, and focused surveys by UNICEF and other agencies. They can identify risk in terms of malnutrition, nutrition, morbidity, death and loss of education. The MICS surveys asked about the nature of work and time spent working by children in different countries, both in informal markets such as in the home place and family businesses, and also in formal employment. Preliminary analysis shows that in more than 30 countries (covering 35% of the developing world population), close to 20% of boys and girls age between 5-14 years of age work. The figures for sub-Saharan Africa are predicted to be almost double this, with 41% of children under the age of 14 estimated to be in the labor force (Subbarao et al. 2001).

The type of child labor that is most widespread in sub-Saharan Africa is domestic labor. Its magnitude is also difficult to gauge because in most cases it is not wage-based, it is informal, and it has cultural explanations. For instance, in most countries, people in rural areas "foster" their children to relatives or friends who are better off and may live in urban areas. In most of these cases, the children are sent to relatives who are closer to schools or have access to better quality schools. In return for being accepted into these households, the children have to do domestic work there while going to school. It is also worth stressing here that a lot of children who are not orphans do domestic labor alongside their parent(s). In some cases children, especially in rural schools, do duties such as landscaping, cleaning and other school chores normally done by employed staff in urban schools.

Vulnerable children have suffered and continue to suffer considerable hardship. The challenge is to prevent this hardship escalating from an accumulation of stressful events, and to enhance the capacities of families and communities to respond to the needs of

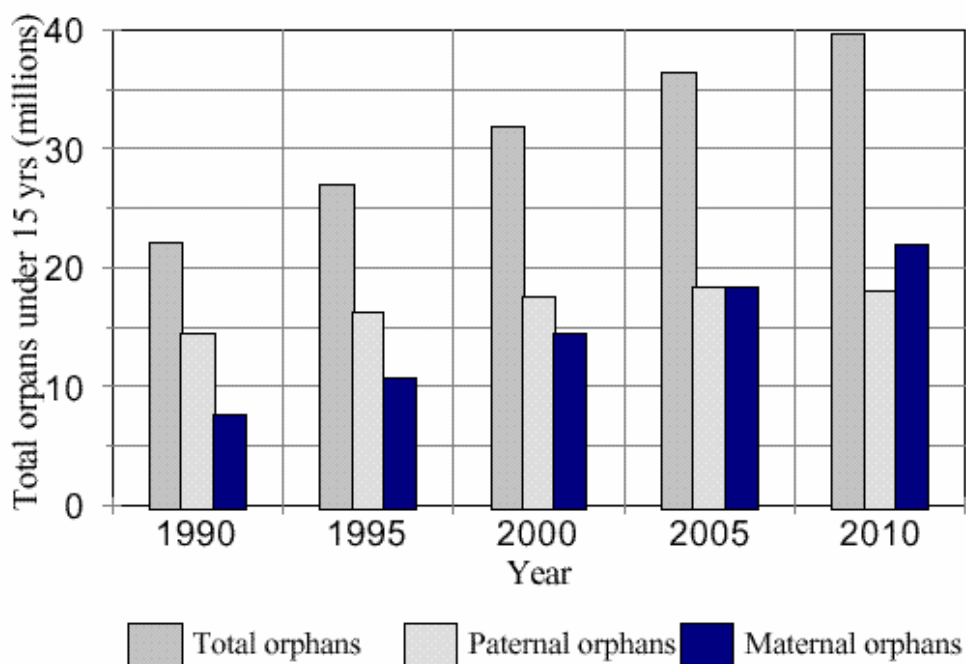
children; to make them have a sense of hope for the future, a sense of continuity and connectedness in a way that links with their economic, spiritual, health and other needs.

How many orphans and vulnerable children are there?

The numbers presented in literature vary broadly. As discussed previously, some literature present the number of orphans due to all causes including HIV/AIDS while others present only those due to HIV/AIDS (Appendix 1.2). Data on the numbers of paternal children orphaned by AIDS in many countries are difficult to collect and are of dubious reliability. Statistics about AIDS orphans tend to exclude those who have lost only their fathers to AIDS and refer only to the number of children who have lost their mothers or both parents (Ainsworth, Beegle, & Koda 2002; Deininger, Garcia, and Subbarao 2001; Hepburn 2001).

The United States of America Census Bureau presents in "Children on the Brink 2000", an estimate of 15.6 million children under the age of 15 years, with 13.6 million of these children being in 26 Sub-Saharan African countries, as being the number of children that would have lost a mother or both parents to AIDS and other causes by the end of 2000 in 34 countries heavily affected by HIV/AIDS ("Children on the Brink" 2000). It is estimated that the numbers would rise to 24.3 million by 2010 with 21.9 million of these children being from the 26 heavily affected Sub-Saharan African countries. When children who have lost their fathers are included, the numbers rise to 44 million with 40 million being in Sub-Saharan African countries (Figure 1.2). Within the 26 Sub-Saharan countries, which are heavily affected by HIV/AIDS, the percentage of maternal and double orphans due to AIDS is projected to increase from 47.2% in 2000 to 60.9% in 2005 and 69.9% in 2010 (Hunter and Williamson 2000a).

Figure 1.2. Cumulative numbers of orphans in 19 African countries for 1990–2010 (maternal orphans include those who have lost their mothers and both parents)



Source: Foster and Williamson (2000).

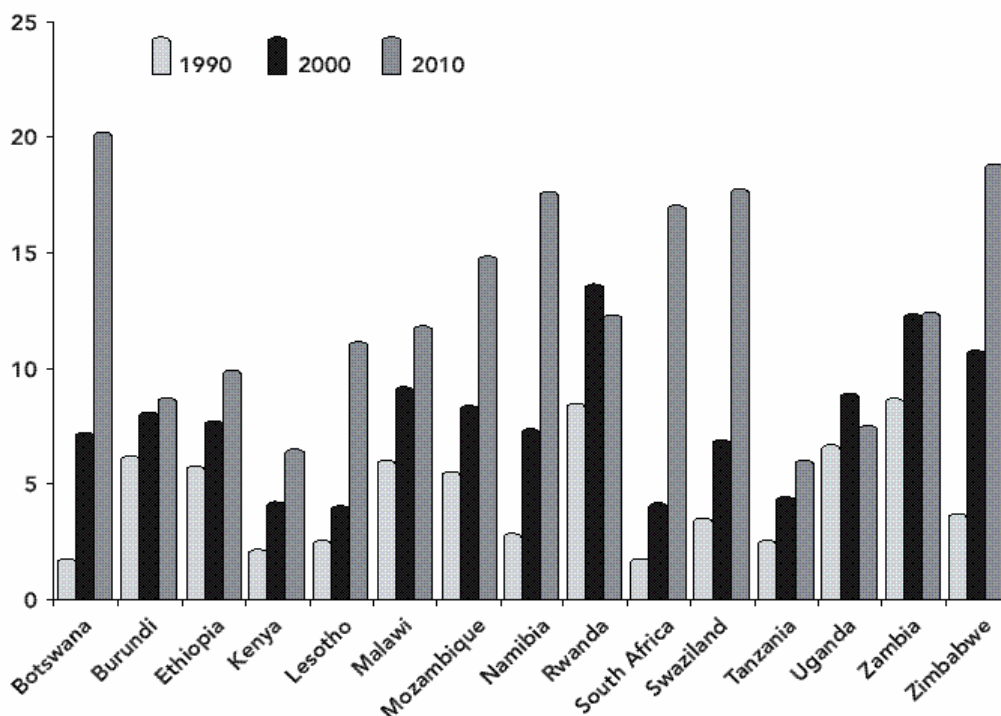
Unlike the numbers of orphans of all causes presented in “Children on the Brink” 2000, UNAIDS presents only the number of children orphaned by AIDS. UNAIDS estimates that a cumulative total of 14 million children in the world would have lost their mothers or both parents to AIDS, and it is projected that the numbers would rise exponentially in the years to come. Ninety-five percent (12.1 million) of these children are in Sub-Saharan Africa (UNAIDS 2000, UNAIDS/WHO 2001). It is estimated that the number of children orphaned by AIDS in the world will double by 2010. The UNAIDS numbers include children orphaned by AIDS who have since died and those who are no longer under 15 years of age. UNAIDS collects epidemic data from national programs but often does not use the data to make projections about the impact of the epidemic (Hunter and Williamson 2000).

To emphasize the difficulties and dilemmas of enumerating the number of children orphaned by AIDS in the world, Monk (2002) has criticized the statistical accounts of the HIV/AIDS crisis. Using field data from research carried out in Uganda and in six States of India for “*Association Francois-Xavier Bagnoud*” and using the UNAIDS estimates as well as the USAID statistics for the 34 study countries presented in *Children on the Brink 2000*, he estimates the world’s AIDS orphan population to be around 100 million by 2010 (Monk 2002). This estimate is way beyond the estimates of either UNAIDS or USAID and it includes paternal orphans as well as orphans 15 to 17 years old.

It is apparent that the rates at which children are orphaned by AIDS have increased over the years (UNAIDS/ UNICEF, 1999). Specifically, before the AIDS epidemic about 2% of children between the age of 0 to 14 years were orphaned (lost their mothers or both parents) in Eastern Africa —1.19% in Kenya, 2.44% in Uganda in the 1969 census, and 2.23% in Tanzania in the 1978 census. The rate in Kenya according to the Demographic and Health Survey remained almost unchanged until 1993 (1.8%), but it had increased to 2.7% by 1998. In Tanzania, the rate had declined to 1.96% between 1978 and 1988 before increasing to 2.8% by 1994. In Uganda it increased to 5% in 1995 and 5.7% by the 1999/2000 Household Survey. To date, the maternal and two-parent orphan rates increased in Kenya, Tanzania and Uganda by 40% – 130% since the start of the AIDS epidemic (Ainsworth and Filmer 2002). No pre-AIDS information is available for other African countries, and it is assumed that the situation in other developing countries would have reflected the prevailing mortality rate.

Projections for 1990-2010 for 15 African countries show uniformly significant increases in the percentage of orphans resulting from parents' AIDS mortality (Figure 1.3).

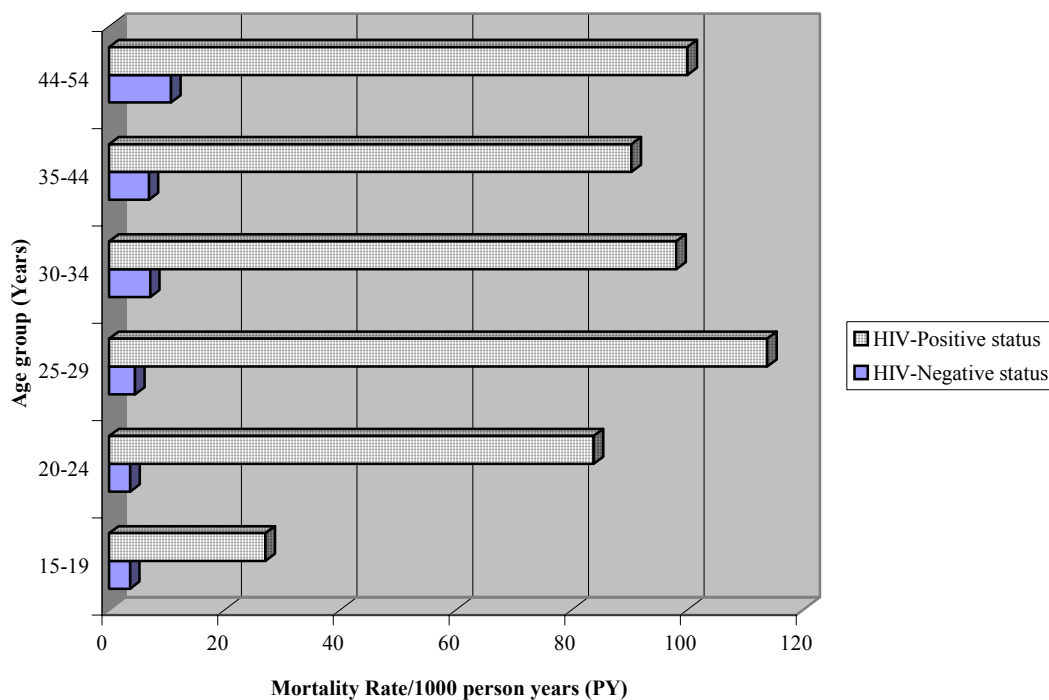
Figure 1.3. Percentage of children under the age of 15 estimated to be orphaned (maternal and double) in 2000, 2005, and 2010



Source: Adapted from World Bank (2002), Figure 2-3.

A study undertaken in Tanzania in 12 rural communities over a period of 2 years revealed far higher mortality rates in HIV-positive persons than in HIV-negative persons in all age groups (Todd et al. 1997, Figure 1.4). In Kenya, cumulative AIDS deaths from when the HIV epidemic started until 2000 were about 1.3 million; it is projected that between 2000 and 2010, another 3.2 million people would have died of AIDS (World Bank 2000). Kenya had about 323,000 maternal and double orphans due to AIDS in 1995, and the numbers are projected to increase to 2.2 million in 2010. Due to the difficulty of projecting accurately the number of orphans due to AIDS in a country, the projected numbers vary within the literature for a given country. For example, the number of orphans in Kenya for 2010 represent between 11.9 per cent (Hunter and Williamson 2000) and 17% (World Bank 2000) of the population of children under the age of 15 years.

Figure 1.4: Age-specific mortality rates by HIV status in 12 communities in Tanzania over 2 years



Source: Data for graph adapted from Table 2 in: Todd et al. (1997).

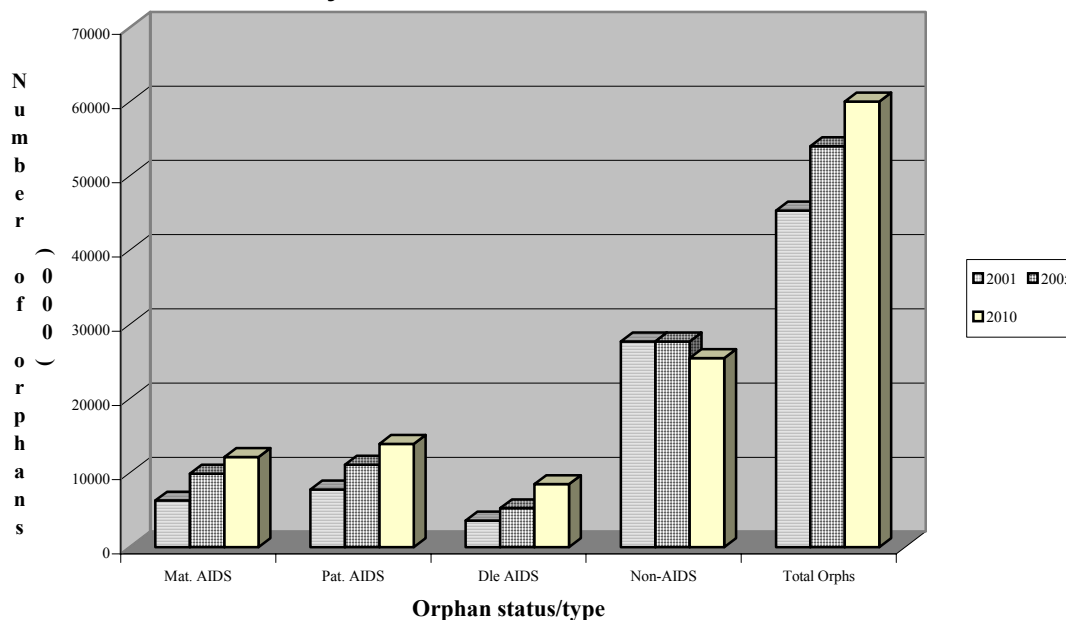
According to projections made in “Children on the Brink 2002”, in 12 African countries, by 2010 orphans will comprise at least 15% of all children under the age of 15. Figure 1.4 shows that the numbers of healthy adults that would be responsible for caring for these children are decreasing.

There are regional differences in the proportions of paternal to maternal orphans:

- In **West Africa**, paternal orphans represent 4 to 10% of school-age children. This is almost twice the number of maternal orphans. There are few two-parent orphans (Ainsworth and Filmer 2002).
- In **Eastern and Southern Africa**, paternal orphans represent about 6 to 13% of all school-age children, while the percentage of maternal orphans is similar to that in West Africa. The number of paternal orphans is three to five times higher than that of maternal orphans. This is probably related to the fact that men have higher age-specific mortality than women and that women usually marry older men. It is also observed that fewer children among the total orphaned by AIDS have lost both parents (Ainsworth and Filmer 2002).

In sub-Saharan African countries, USAID/UNICEF/UNAIDS (2002) estimate that non-AIDS orphans constitute the bulk of orphans at present, but it projects that their numbers will decrease from an estimated 61% of all orphans in 2001 to 51% in 2005 and 42% in 2010 (Appendix 1.1). It estimates that many more children have lost fathers than mothers to AIDS, and it observes that fewer children among the children orphaned by AIDS have lost both parents (Figure 1.5 and Appendix 1.1).

Figure 1.5: Estimated Number of Orphans by Orphan status and year for Sub-Saharan Africa



So

Source: Data used for graph from USAID/UNICEF/UNAIDS (2002).

What are the approaches for reducing vulnerability?

There is of yet no package of established knowledge on how to intervene in favor of OVC, although the issue is now well recognized. The United Nations General Assembly's Special Session on HIV/AIDS in June 2001 represented an important turning point in the global response to HIV/AIDS. The *Declaration of Commitment*, issued by member states at the Special Session, outlines specific goals and targets in the areas of prevention, care, support and treatment of HIV/AIDS. For OVC, the goals stated:

By 2003, develop and by 2005 implement national policies and strategies to: build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS including by:

- *providing appropriate counseling and psychosocial support;*
- *ensuring their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children;*
- *to protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance*

In addition, by 2005, significant progress will be made in implementing strategies to:

Strengthen family and community-based care including that provided by the informal sector, and health care systems to provide and monitor treatment to people living with HIV/AIDS, including infected children, and to support individuals, households, families and communities affected by HIV/AIDS..." (UNGASS 2001, §§ 65, 66)

Churches and secular NGOs have long intervened, but on a small scale, and sometimes at relatively high cost and intensive use of skilled staff. The World Bank has funded some pilot programs, notably in Eritrea, Zimbabwe and Burundi, but for the most part the results are not yet known. There is also much debate on the criteria to use in targeting vulnerable children. In order to shift the paradigm away from external change agents and encourage the OVC issue to be community driven and answered, we need to explore ways in which communities themselves, define the index of vulnerability and subsequently prioritize their response to children that they are most concerned about. The answer will vary depending on the country and the context. Some countries are largely rural and traditional and the extended family system functions well. Others rely more on a community based approach. Ethiopia for example, has a history of family and community placement of children that were institutionalized in orphanages following the famines of the 1980s. The situation regarding OVC differs both within and between countries; for example, some countries have high numbers of street children while others have more child soldiers.

Some intervention strategies that have been used on small scale programs are listed below and these are discussed in further detail throughout the manual. This list is designed to prompt further discussion surrounding OVC intervention strategies.

- Child placement to households, small-scale 'community' houses and orphanages;
- Support to foster families through cash transfers, food aid, grant for revenue generating projects, and micro-credit;
- Education subsidies through payment of primary school fees, distribution of uniforms, textbooks and other materials;
- Vocational education or informal skills training for adolescent orphans;
- Psycho-social groups to deal with trauma and depression;
- Advocacy of the rights of orphans and other vulnerable children to inherit land and other property.

Other sources of funding for intervention are available. One tool for intervening in favor of OVC is, for example the Multisectoral HIV/AIDS projects (MAPs). Other possibilities are to intervene through Poverty Reduction Support Credits (PRSCs), social funds, or general health and education credits. Debate arises regarding the MAP: should the MAP fund a specified set of interventions on behalf of OVC, or should it respond to applications for interventions?

Workshop Exercises

Objectives of this section

At the end of this section, participants will be able to:

- List the goals of the training
- Define an OVC
- State the estimated number of OVC in sub-Saharan Africa and provide reasons for the different estimates
- List the factors that influence access to education by OVC
- Discuss the different people with whom OVC live and the different implications of this situation to the well-being of the households
- Discuss the impact of HIV/AIDS on children's schooling and home life

Activity 2

Participants should discuss the material in section 1 of this manual.

Section 2 – HOME LIFE: The Impact of Parents' HIV/AIDS-Related Illness and Death on Their Children's Home Life

HIV/AIDS affects the household and the extended family as well as the home life of children orphaned by AIDS. This section assesses the impact of parents' HIV/AIDS-related illness and death on households, extended families, and children's home life. Because of illness in a household, family financial resources decline, and psycho-social and physical support for the children is lacking. In case of illness, children become caregivers for the sick and for younger siblings. In case of death, families become poorer; the children may be placed in foster care with extended family members, who themselves might be poor; in many cases, the children are cared for by their grandparents. Sometimes as a result of a parent's death, the household is headed by a child, or the children are taken to orphanages.

The impact of HIV/AIDS related illness and death on the household and the extended family

Households and extended families that have patients suffering from HIV/AIDS-related illnesses are often severely constrained, both economically and socially. The constraints include a decline in their financial resources, malnutrition and stunted growth, loss of value systems, discontinuation of education, delinquency, and crime, and in many places have to deal with the stigma associated with the disease. Some of these impacts are presented in Box 2.1.

Box 2.1: HIV/AIDS impact on households and extended families

Decline in the family's resources: A sudden decline occurs with either death or illness. As the family takes steps to mitigate the impact of the decline on the household, one or more of the following may occur in, for example, an agricultural family:

- The household members are forced to work long hours in their fields.
- The land being cultivated is reduced in accordance with the reduction of human resources.
- Food crops are substituted for cash crops that require much labor.
- The harvest has a poor yield because weeding has been delayed.
- In the worst case scenario, the family may have to abandon its farm completely.

Decline in the health status of the family:

When fewer household members are available to work on the land or the parents are unable to work or earn income, the food available to the household is reduced, and the nutritional status of the family members declines as a result. In such circumstances, households may do the following:

- Stick to one or two easily available staple foods, which might not be nutritional.
- Reduce the number of meals or portions available to family members, and particularly children.
- Sell most of what they produce to buy other essential things—Medicines, for example.

Households with AIDS patients commonly experience a decline in productivity. A household with an AIDS patient spends, on average, between 11.6 and 16.4 hours a week on agriculture, compared with 33.6 hours for a non-AIDS-affected household. A shift occurs in the pattern of work; family members that were previously employed in income generation for the family need to be increasingly at home to care for the sick. In a household in Tanzania where one person was sick, 29% of labor was spent on AIDS-related matters. When two people were devoted to caring for the sick, 43% of labor time was used (Kelly, 2001). The disappearance of households altogether is unfortunately a common consequence of an AIDS-related death. In Zimbabwe, 65% of households where a deceased female had lived no longer existed after her death (Kelly, 2001).

Because the infected individual is unable to work, the financial resources of the household decline and part of the resources that are available are used to provide care to the sick person (Ainsworth and Rwegarulira 1992; Gilks et al. 1998); this leaves fewer resources available for school fees, purchase of textbooks, and childcare. In Côte D'Ivoire, studies in urban areas have shown that when an adult in a family has AIDS, average income falls by between 52 and 67%, while expenditure on health care quadruples (UNAIDS/UNICEF 1999); as a consequence, a household with an AIDS patient spends twice as much on medical care as one without such a patient (Kelly 2001). Another study in Côte D'Ivoire found that the costs of health care for persons with AIDS accounted for about 80% of the health budget of the household and amounted to 8.4% of the household's total consumption. The cost of health care for other members of a household with an AIDS patient accounted for only 2.2% of total expenditures, compared with 5.6% in non-AIDS households by Bechu (1998).

Impact on the child

AIDS is substantially increasing adult mortality in most developing countries (Boerma, Nunn, and Whitworth 1998). There is due concern about what happens to the general well-being and to the education of OVC. Some of the main impacts on the child are summarized in Box 2.2:

Box 2.2. Impact of HIV/AIDS-related death on a child's home life

Increased	Reduced
Poverty	Access to food
Household responsibility	Access to health services
Psychosocial distress	Access to school
Vulnerability to abuse, child labor, sexual risk	Material goods such as clothes, supplies
Stigma and isolation	Guidance, protection, and love from adults
Hunger, malnutrition	

Source: L. Gilborn (2001).

HIV/AIDS not only affects households with children orphaned by AIDS, it also affects the children living with HIV-positive parents or relatives. This group of children serves as an indicator for the future orphan burden. The exact number is unknown and most countries do not even have estimates. Like the children who have lost their mothers or both parents, this group of children is discriminated against, lacks basic health care and education, experiences physical and psychosocial stress, and they have little or no social and economic support. The children are frequently young: the mean age of orphaning is only 6.2 years (Mugabe, Stirling & Whiteside, 2002) and they are forced to take on responsibilities far beyond their years, not only caring for other siblings but also for their parents - the ones they look to for love and support. An adult AIDS patient, requires increasing help with everyday activities which is expected from the child, but also suffers from frequent opportunistic infections such as uncontrollable episodes of diarrhea, in conjunction with the slow debilitating effects of the HIV itself - the responsibility for caring for them frequently falls entirely on their young children. The psychological demands and effects on the child must not be underestimated (Kelly, 2002).

The infectious nature of HIV means that if one parent dies of AIDS, it is likely that the other parent is also infected; the child has to face the traumas of watching one parent die tragically whilst all the time knowing that the course will soon be repeated. Once left alone, orphanhood becomes an enduring condition that accompanies a child into adulthood. A child requires continued loving care and support throughout its childhood; for orphans, the lack of a parent figure exacerbates the social, psychological and spiritual problems attached with growing up. In addition, and a pertinent issue for the forthcoming years, is how a lack of parenting will impact on their performance as parents of the future generation (Kelly, 2002).

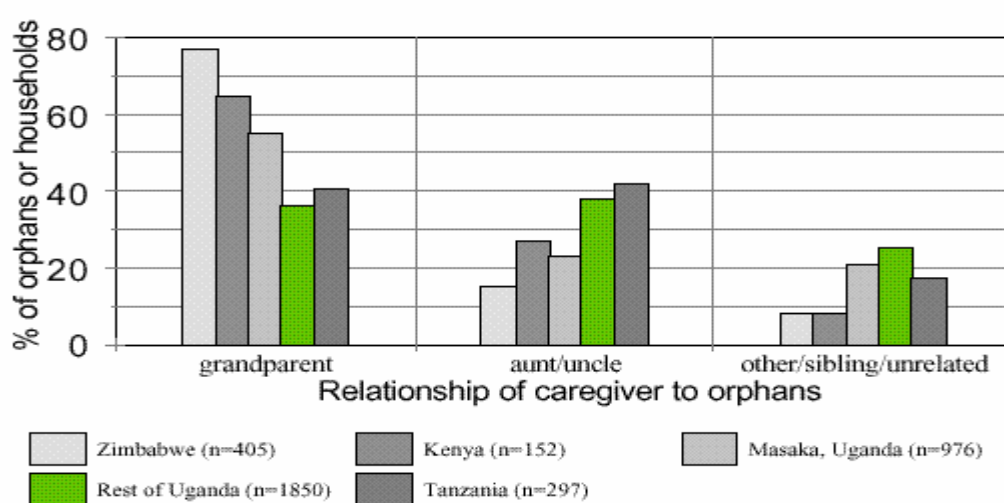
The illness or loss of a mother or both parents can affect a child in many ways that differ from country to country, depending on the culture, legal system, and family structure.

Orphans, especially girls, have a higher probability of being sexually abused and forced into prostitution as a survival strategy. In any case, most of these children are discriminated against and lack basic health care, education, and economic and social support. The nutritional status of the child deteriorates and OVC have an increased risk of stunting and malnourishment (Barnet and Blakie 1992); it has been observed that food consumption drops by 41% in a household with a family member who has AIDS (UNAIDS/UNICEF 1999).

Who cares for OVC?

The choice of who will care for an orphan, within the extended family, depends on the family's circumstances, and it varies from country to country, and even from village to village in some cases. Where the extended family system still exists, orphans are often cared for by relatives (Ntozi et al. 1999), often moving between different families. Foster and Williamson (2000) observed that foster care of orphans is most often provided by elderly grandparents with little or no assistance from other family members. Their findings are illustrated in Figure 2.1, which highlights who children are looked after by in four African countries. Summarizing results from studies carried out in Uganda, Zambia, and rural Tanzania it was noted that 32% of grandparents in Uganda, 43% in Tanzania, and 38% in Zambia were caring for orphans. Other members of the extended family also provided care for orphans, as was seen in Zambia, where 55% were cared for by the extended family (Deininger et al. 2001).

Figure 2.1. Relations of caregiver to orphans in four countries



Source: Foster and Williamson (2000).

With the increasing numbers of parents dying from AIDS, there are fewer adults of parenting age to care for the children left behind. The burden of care falls increasingly on other children and elderly people. This situation is sometimes made worse by the reluctance of relatives to provide foster care for the orphans, by the death or illness of relatives, or by the lack of contacts between orphans and relatives (Foster et al 1997; Aspaas 1999). In some cases, the relatives are willing but are simply unable to shoulder the additional burden of foster children. Older orphans cared for 11% of the orphans in Zambia and 10% in Tanzania. Most foster care households are unable to regularly provide extra food and clothing. To make ends meet, the children are expected to work, and therefore they may not attend school regularly or may drop out of school completely.

Fostering is a deep-rooted practice in Africa, in the form of kinship systems and family networks that provide social safety nets for children, not just orphans, for reasons including continuity for the youngster and to strengthen family relationships. Deininger et al (2001) observed that in Uganda between 1992 and 2000, the incidence of fostering increased, even for children younger than 6, even though the incidence of HIV/ AIDS had been declining in the same period. The numbers of households having foster children also increased, from 5% in 1992 to 15% in 2000.

In rural Tanzania, child fostering was found to be very common, and 34.2% of all children under the age of 18 were not living with one or both biological parents. 42% of all households had fostered a child (Urassa et al. 1997). These numbers point to the risk that poor households, especially in rural areas, that are taking in foster children may not be able to accommodate the ever-increasing numbers of children orphaned by AIDS, considering the limited resources available to them. It has also been observed that there is a higher concentration of children orphaned by AIDS in rural than in urban areas. One reason for this concentration is the fact that when people are sick with HIV/AIDS-related illnesses, the tendency is for them to move back to their villages, where their parents and relatives are (Aspaas 1999). Another reason might be related to the fact that a higher proportion of the population live in rural areas, so much so that even if the infection rates are higher in the urban areas, the absolute numbers in rural areas might be higher. When parents die in the rural areas, the orphans may remain in the village with either the grandparents or other family members or migrate to towns and become street children.

From the point of view of the OVC, being placed in a fostered environment can cause considerable stress. Often they have no say as to where they are to be placed, and may be separated from their siblings and their community, at a time when they are most in need

of their support (Kelly, 2002). In the majority of cases the fostered orphans are treated with fairness and love, but the receiving households are often poor, and the addition of orphans puts more strain on their limited resources. In these cases inequalities may arise in the allocation of resources between children, and orphans are often the first to suffer when resources are scarce.

What is the economic impact of fostering?

Deininger et al (2001) presented changes in real per capita expenditure and income based on results from 1300 panel households in Uganda that had a foster child below the age of 14 years. When considering children of school age (7 – 14 years), significant differences between households with and without foster children were observed. The addition of a foster child to a rural household would reduce per capita consumption and income. This has implications for the economic well-being of its members as these households invest significantly less than those without foster children (Table 2.1). Using an econometric approach, Deininger et al. (2001), found that a household that initially had two children would be worse off were it to take in a foster child, but it will not be worse off if the third child is that of the occupants. Taking in orphans can bring economic hardships to the household, and if the orphans have to work and contribute economically to the well-being of the fostering family, they are likely to drop out of school. Some resentment on the part of the foster family has been documented; in a survey in Lusaka, only 56% of 13-18 year old orphans said they were well-treated (FHI/SCOPE OVC, 2002).

Table 2.1. Growth of per capita expenditure and income for households receiving foster children

Fostering	Change in real per capita expenditure	Change in real per capita income	Rate of Investment
Received foster child less than 14 years old in 1992–2000			
No	4.91%***	8.34%**	2.40%**
Yes	2.95%	5.81%	1.88%
Received foster child 7 to 14 years old in 1992–2000			
No	4.80%***	8.12%**	2.41%***
Yes	2.84%	5.98%	1.71%
Total sample	4.42%	7.70%	2.27%

Note: All rates are mean annual growth rates

** Significant at 5%; *** Significant at 1%

Source: Deininger, Garcia, and Subbarao (2001).

Taking orphans to orphanages is always the last resort, especially because the cultural, community, and family norms still support fostering within the community (Urassa et al. 1997). Orphans are taken to orphanages only if there is no family or community member prepared to care for the orphaned child and there is no child in the household old enough to care for the other siblings. Orphanages take the orphans away from their communities and cultures and bring them up in ways that may not be the same as in the orphan's culture, and it is often difficult for the child to adjust to life outside when they leave the institution (Kelly, 2002).

From an economic point of view, orphanages are very expensive. For example, it costs between \$300 and \$500 a year to maintain a child in an orphanage in Ethiopia (Bhargava and Bigombe 2002), and can be up to fifteen times more expensive than community care (World Bank, 2001). Similarly, orphanages only have the capacity to cater for a small fraction of the children in need of care (Kelly, 2002). Notwithstanding the above, orphanages have been perceived in Uganda to provide orphans with a higher standard of living than that provided by relatives. This is probably related to the fact that orphanages spend more money on the orphans than relatives do. Children in orphanages were more likely to be attending school than orphans living elsewhere, though it must be stressed that most of these orphanages are found in urban areas (Ainsworth and Rwegarulira 1992). Furthermore, there are not many orphanages available, probably related to low demand and high running costs. The situation is made worse by the fact that orphanages prefer toddlers/infants as opposed to the school age group we are dealing with here.

Kelly highlights that orphanages offer a temporary solution while orphans are waiting to be housed with families elsewhere, and also for abandoned children. Given the scale of the OVC problem in Africa, orphanages can only hope to offer a partial and emergency response to the crisis. Other measures are needed in the long term. A third option and one that is developing in many parts of Africa is that of children's villages. The children live with relatives, but attend the school during the day where they are fed and receive a basic education and basic health care. In Zambia for example, the centers are run by widows, who have lost their husbands through AIDS.

Workshop Exercises

Impact of HIV/AIDS on home life of children

Give each participant a copy of Annex 2.

Instructions for Activity 3

In groups, discuss the following:

What impact has loss and illness from HIV/AIDS had on the families and communities? (Look at Elizabeth's mother's story and draw from your personal experiences). What might some of the long-term effects be on enrollment, attendance, and performance of children in school?

Choose a person to write all of the responses down on a large sheet of paper for everyone to see.

Instructions for Activity 4

Divide into small groups.

Think of a child in your community who has experienced the loss of a parent due to HIV/AIDS.

What types of problems did the child face as a result of the parent's illness and subsequent death? When thinking of problems, refer to the problems faced by the family in the Child's Story 1– "Orphan-Headed Household" – provided to participants (Annex 1).

Be sure to look at the child's physical, developmental, spiritual, and emotional needs when considering this question.

Have one person in each group record the group's findings.

When all the groups are finished, have each report its findings to the larger group.

At the end of the presentations, the facilitator makes a summary of the main points. Some of the points the facilitator could raise after the presentation and comments by participants are presented in Annex 3.

Section 3 – SCHOOL LIFE: The Impact of Parents’ HIV/AIDS-Related Illness and Death on Their Children’s Schooling

This section reviews the factors that influence access to education and the impact of parents' HIV/AIDS-related illness and death on their children's schooling. Illness and death within a household has an impact on enrolment, attendance, and performance of a child at school. When there is an illness or death in the household, the available financial resources tend to be used to care for the sick or for funerals, thus reducing resources allocated for children's schooling. The outcome is either a delay in enrolment (in most cases) or no enrolment at all. Attendance at school also declines, especially as the children have to work and care for the sick parents. Performance suffers as a result of absenteeism and a lack of parental care and support.

Introduction

Education for All (EFA) is a compelling goal for all nations (UNESCO 2000). It improves both the lives of the children and the economic and social well-being of countries. A child who has access to quality primary schooling and who knows how to read, write, and do basic arithmetic has a solid foundation for continued learning throughout life. Education gives children a better chance for a full, healthy, and secure life.

Education benefits nations because it is a major instrument for economic and social development. In particular, at the basic level (primary and lower secondary), it is a major contributor to the reduction of poverty. It increases the productivity of labor, improves health, and enables people to participate fully in the economy and the development of their societies. In the world today, a child who is not educated is disadvantaged in terms of income, health, and opportunity. Children whose parents suffer or die from HIV/AIDS-related illness are among the group of vulnerable children who have the highest risk of being excluded from or denied access to education.

In discussions of the international strategy to operationalize the Dakar Framework for Action on EFA, it has been stated that the international and bilateral partners at the national level should “support the diversification of education opportunities to ensure that access to learning opportunities is sufficiently flexible to respond to the demands that HIV/AIDS

places on children and their families, and to meet the special needs of children orphaned by AIDS” (UNESCO 2002).

The HIV pandemic is severely hindering the opportunities for OVC to attend school and receive the education so vital for a fulfilled life. The highest HIV/AIDS prevalence is seen in adults of parenting age with the mortality impact occurring at ages 20-44 years for women and 25-44 years for men (Boerma T.J., Nunn A.J., et al 1998). HIV/AIDS-related illness and death reduces the numbers of parents who are 20 to 40 years old (Todd, J. et al., 1997) and who would otherwise be expected to support their children in school.

As discussed in section 2, when a parent dies from AIDS, the result may be a decline in the household's financial resources because the number of income earners in the household is reduced. Less money is available therefore, to pay for school fees or to purchase textbooks, and the children themselves may have to work to help support the family or foster family. In the long term, the education of the child suffers. The probability of orphans going to school regularly, or at all, is limited. In Uganda, the chance of a child orphaned by AIDS going to school is reduced by 50% compared to a non-orphan, and those that do go to school spend less time there (World Bank 1995).

However, any strategies to assist children in gaining access to education should not be directed only to children orphaned 'biologically' by AIDS but at all vulnerable children (Children on the Brink, 2002). With an increase in the number of OVC, an accompanying rise in childhood psychosocial and physical problems can be expected. In addition absenteeism among children who are heads of households and those who help to supplement family income can be expected to rise. School enrolment and attendance rates are expected to decline (UNAIDS/UNICEF 1999; Coombe 2000).

The section that follows looks at the factors that may influence access to education and then discusses the impact of parents' HIV/AIDS-related illness and death on children's schooling.

What are the factors that influence access to education?

Most parents regard sending their children to school as an investment. They consider that schooling will increase the earning power of the child once they become adults and that the child will in turn provide for their own needs when they are old and unable to work. However, a multitude of factors operate that constrain a child's enrolment and attendance at school. Some of these factors have a strong influence on children orphaned by AIDS or children in households with adults suffering from HIV/AIDS-related illnesses. There are

many barriers to education that may affect everybody to differing degrees, such as poverty and distance from the school, but specific barriers exist for OVC, in addition to these, such as stigmatization, a lack of a permanent residence etc.

A review of the factors that influence whether a child goes to school in Tanzania by Ainsworth et al (2002) highlights the following, divided into general and OVC specific barriers:

General barriers

- **The income of the household (either personal or borrowed).** Parents incur education-related costs. When they are poor, meeting these costs is difficult. HIV/AIDS increases the poverty level of families, so they lack the money to pay for schooling.
- **The availability of schools,** especially secondary schools, near the household. Schools are few and far away in most rural areas in sub-Saharan Africa. Parents, especially those in rural areas that are not sensitized enough to the value of education, do not like to send their children, especially girls, to distant places for schooling.
- **The quality of the education** provided in the schools. Poor quality education is exacerbated by the death and illness of teachers due to HIV/AIDS. This results in either a replacement teacher who may not be as well qualified or in the worst scenario, the loss of a teacher. Classes may have to join together to compensate for the lack of teaching staff. Parents in Tanzania have indicated that overcrowding is one of the reasons children are not enrolled early (Ainsworth et al. 2002).
- **Death or illness of the teaching staff.** The illness or death of a teacher deeply affects children because teachers are very much part of the affected community. It is vital to care for the caregivers; teachers must be counseled themselves in addition to learning how to counsel pupils.
- **Lack of incentives to send a child to school.** Given the high level of unemployment in most developing countries, parents may consider sending their child to school as a waste of limited resources.
- **Lack of importance attached to education.** The incidence of deaths from HIV/AIDS among young people is high in many areas, and parents may feel that spending limited resources on schooling is not worth the investment if the child is likely to die.

OVC specific barriers

- **The cost of schooling** (fees, cost of uniforms, textbooks, etc.). A poor household will have little or no money to cover these costs. If HIV/AIDS-related illness has made a family member unable to work, the funds available must be used to pay for treatment.
- **The opportunity cost of schooling for the child.** When there is illness in the household, the child may need to work at home and take care of other siblings and the sick person in the household. The opportunity cost of children's time becomes very high.
- **Stigmatization and discrimination of children orphaned by AIDS.** This arises in most cases from a fear of infection coupled with a lack of understanding of the disease. School may become less appealing for the child. Unfortunately, the teachers and other pupils may not be sensitive to the needs of the OVC and as a result these children may drop out of school.
- **The parents' assessment of the child's ability to cope.** When an adult in the household is ill, the income of the household may decrease limiting available money for food. Malnutrition may ensue and lead to other health problems. The child may be kept at home due to its own ill health.
- **The child's emotional reactions.** The child may withdraw, feel shame or dwell on their impending situation once a relative is suffering or has died from HIV/AIDS. Their concentration and work at school will suffer.

OVC Enrolment, Attendance and Performance at School

The presence of AIDS in a household will have an impact on the school enrolment, attendance, performance, or achievement of children for several reasons. Details are presented in the subsections that follow.

Enrolment

As discussed previously, the presence of AIDS within households strains the finances available and increases poverty. Education of the children in the household suffers and children may be enrolled late or not at all. The increasing numbers of OVC will pose a challenge for the achievement of the goals of EFA and may lead to increasing poverty for the OVC when they reach adulthood.

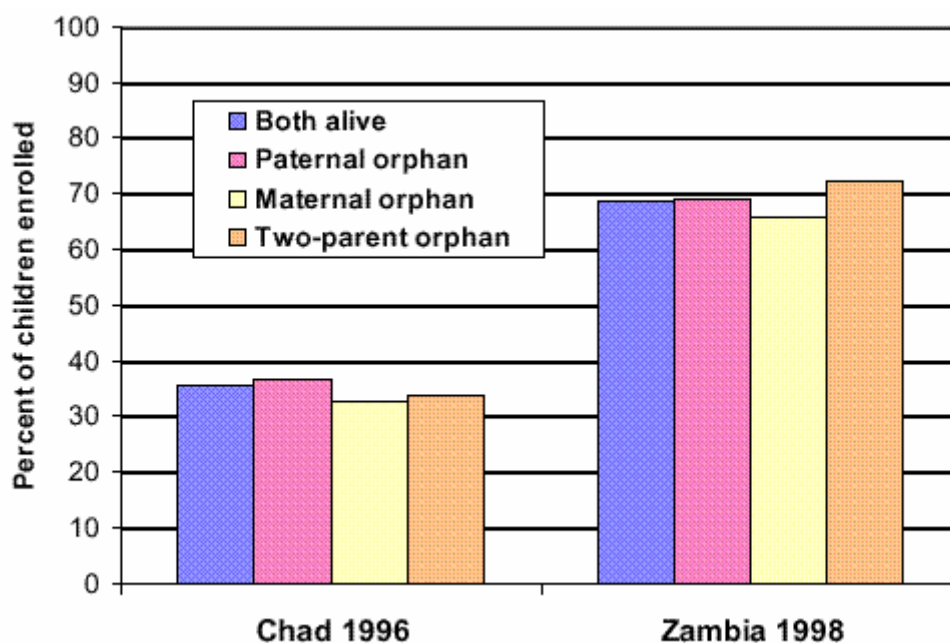
There are many factors influencing, and most importantly in this context, hindering the enrolment process of a child in school; frequently OVC experience even greater barriers. In some sub-Saharan African country settings, there is a substantially lower enrolment rate for

orphans compared to non-orphaned children. However, this is not always the case; enrolment of OVC varies both within and between countries, and also depends on the orphan status, whether the orphan has lost a single parent or both.

Orphan status

In a preliminary analysis of the Living Condition Monitoring Surveys (LMS) and Demographic and Health Surveys (DHS) in 28 countries (22 of which are in sub-Saharan Africa), Ainsworth and Filmer (2001) observed, for example, that in the Chad DHS of 1996 and the Zambian LMS of 1998, there were no significant enrolment differentials by orphan status (Figure 3.1).

Figure 3.1. Countries with no significant enrolment differentials by orphan status



Other studies analyzed, such as the 1993 Benin DHS and the 1998 Kenya DHS, showed a lower enrolment rate for all orphans than for children with two parents alive (Figure 3.2). When compared with enrolment rates for children with two parents alive, the Burkina Faso DHS of 1993 showed lower rates for both maternal and dual orphans (Figure 3.3), but the DHS for Mozambique in 1997 and Ghana in 1998 showed lower rates only for double and paternal orphans (Figure 3.4).

Figure 3.2. Countries with lower enrolment for all orphans

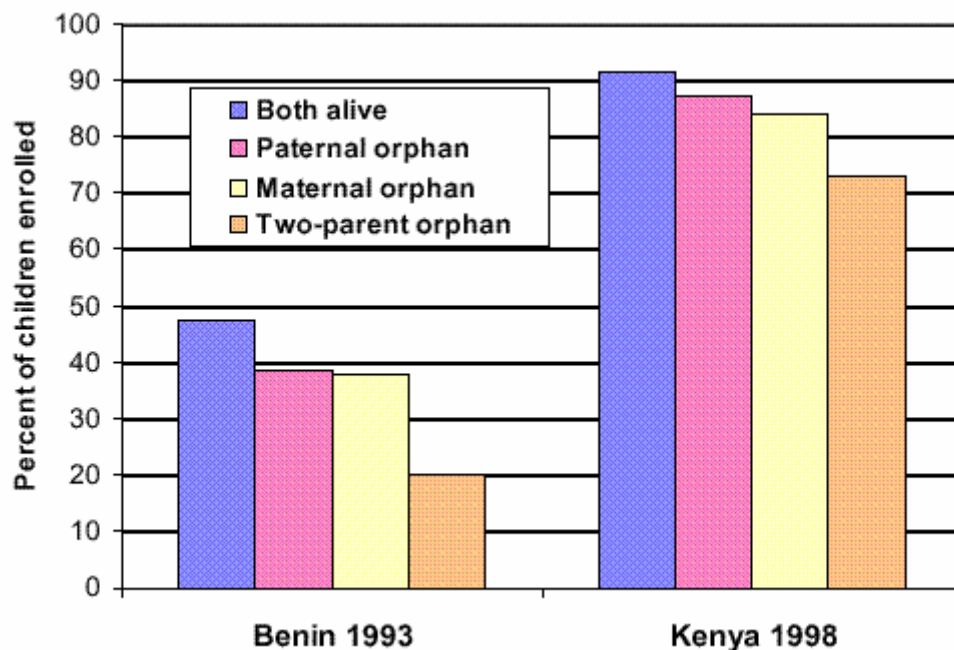


Figure 3.3. Countries with lower enrolment for maternal and two-parent orphans

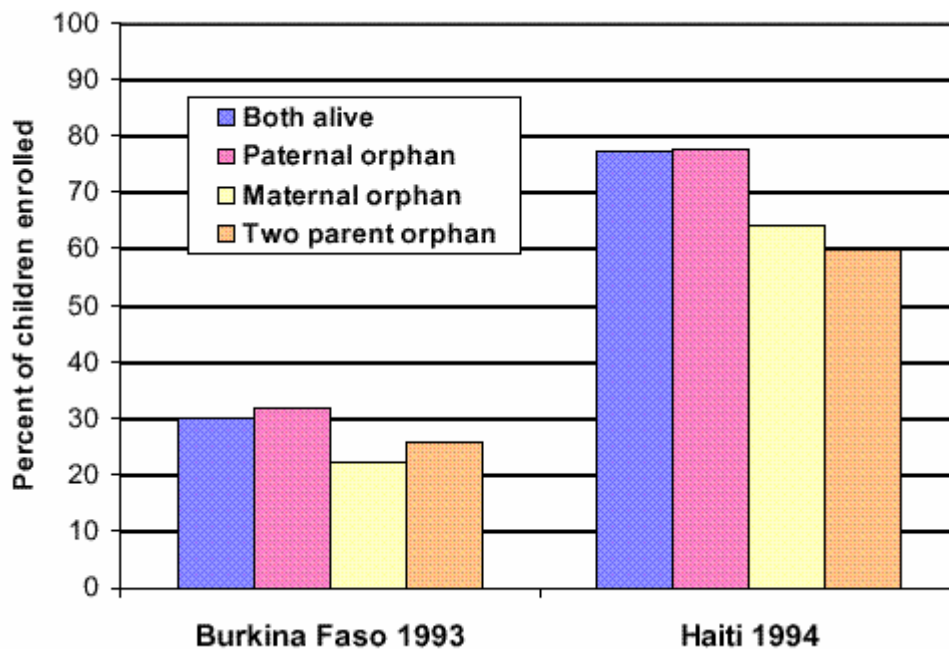
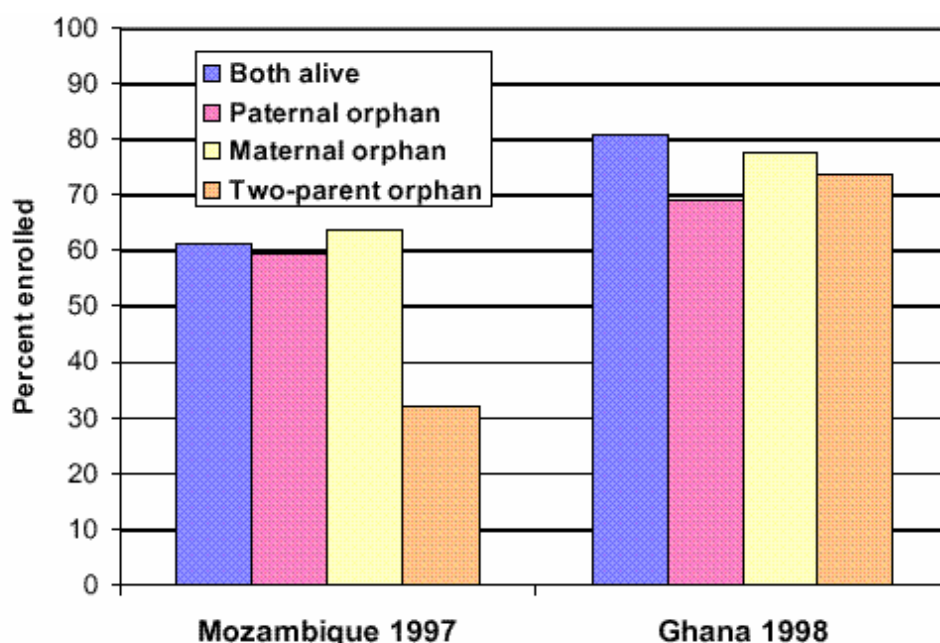


Figure 3.4. Countries with lower enrolment for two-parent orphans or paternal orphans

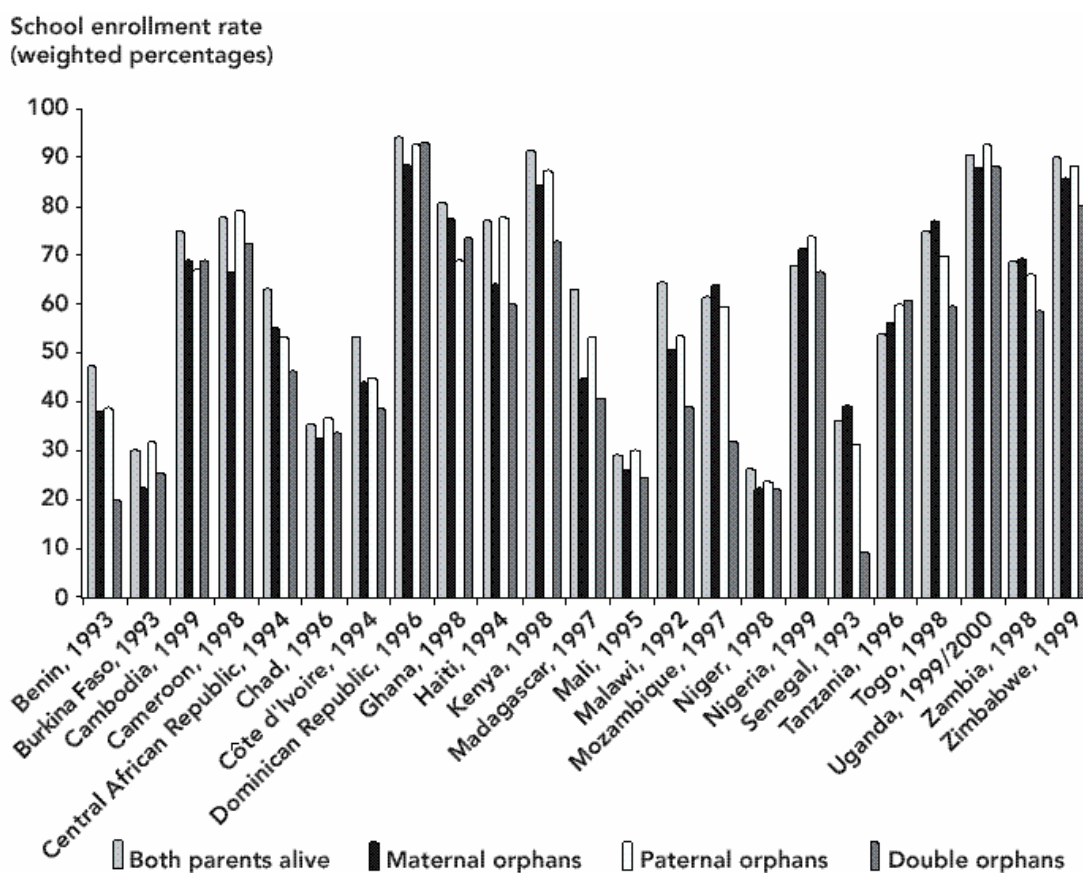


Sources for Figures 3.1–3.4: Ainsworth and Filmer (2001). Calculations done by the authors from DHS and LSM (Zambia) data.

UNICEF collected data on more than 10,000 children in Burundi and found that the proportion of children in school who have lost both parents is significantly lower than the proportion of children with one or both parents alive (Deininger et al. 2001). This finding was confirmed by DHS in six African countries undertaken in the early 1990s. The observations made by Ainsworth and Filmer (2001) illustrate that the degree of underenrolment varied from country to country with orphans not always having lower enrolment outcomes.

In a recent analysis of 23 countries, 21 of which are in Africa, the World Bank found that double orphanhood affected enrolment in most but not all countries (Figure 3.5). However, the majority of OVC are not double orphans.

Figure 3.5. Average school enrolment by orphan status of children ages 7 to 14 in selected countries and years

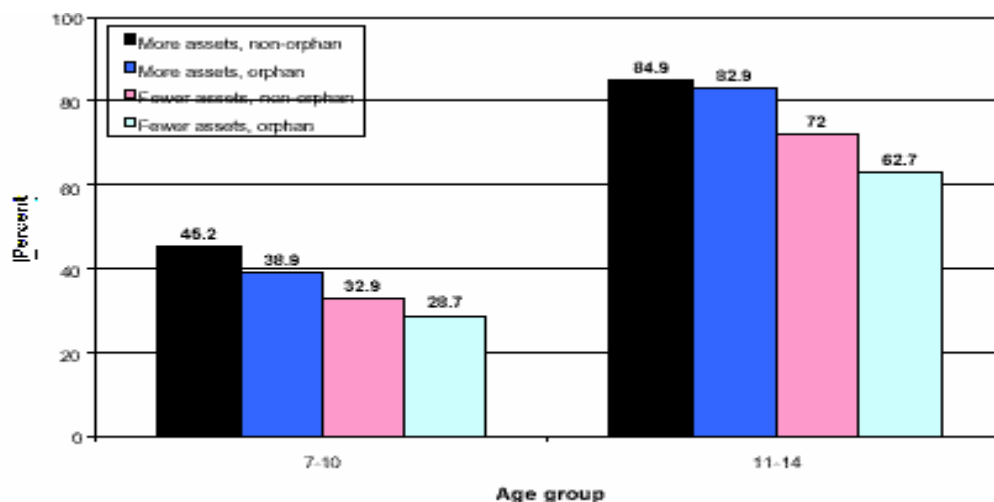


Source: World Bank (2002).

Age of the child

The impact an AIDS death in a household has on enrolment also depends on the age of the child—whether the child is young (7 to 10) or older (11 to 14), and also on the wealth of the household and on which of the parents dies. Figure 3.6 presents the results of household surveys carried out from 1991 to 1993 in Tanzania (Ainsworth et al. 2002). The survey revealed a lower enrolment rate for children aged 7 to 10 than for those aged 11 to 14 regardless of the wealth status of the household. This is explained by the fact that households may have delayed school enrolment to allow the young children, ages 7 to 10, to cope with the death. For those in the 11 to 14 age group, the enrolment rate was unchanged, although it is not known whether attendance may have been disrupted.

Figure 3.6. Enrolment rates by age, orphan status, and household assets, Kagera, Tanzania, 1991–1993

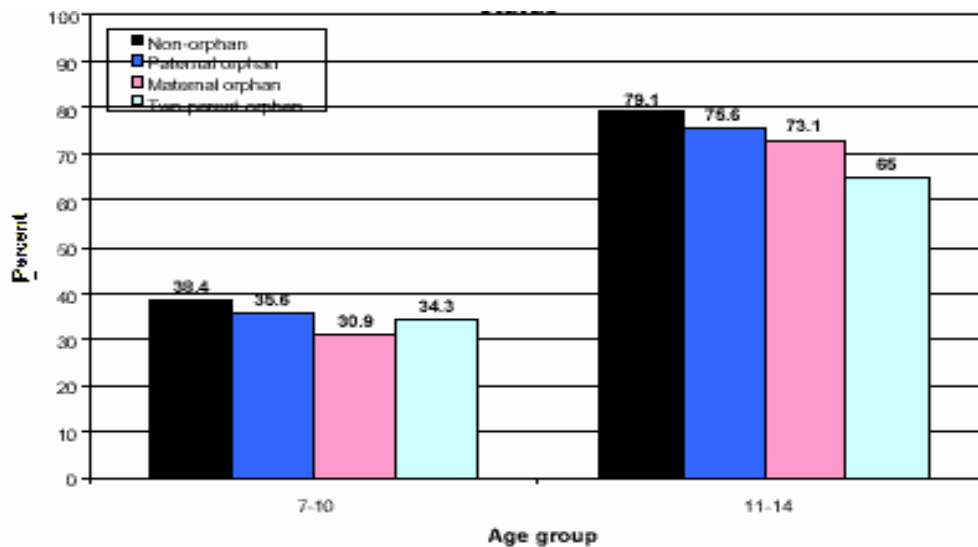


Source: Ainsworth, Beegle and Koda, 2000 (Adapted from Figure 9)

Within the same survey, it was found that in a household with a maternal death, the enrolment rate of children ages 7 to 10 is lower than that of children of this age group in a household with no female adult death (Figure 3.7). Mothers are closer than fathers to their children and support them in their schoolwork, and therefore their absence will have a more negative impact (Ainsworth et al. 2002; Oulai and Carr-Hill 1993).

A child’s likelihood of enrolling at school increases with increasing levels of maternal education. The effect of maternal death on the enrolment of children aged 11 to 14 is smaller because the children have already been going to school for some time by this age. Unless there are other economic or social reasons for them not to enroll, they are more likely to continue going to school than younger children who need extra care and guidance during their initial years at school. This difference in enrolment between the ages highlights the impact that a female adult death can have on the enrolment, and therefore education, of children ages 7 to 10. On the other hand, the death of a male parent appears to have little effect on either school enrolment or attendance (Ainsworth et al, 2002; Oulai & Carr-Hill 1993). This is understandable on the provision that his death does not present an economic barrier to the child’s schooling.

Figure 3.7: Enrolment of children 7 – 14 years of age and orphan status in Tanzania



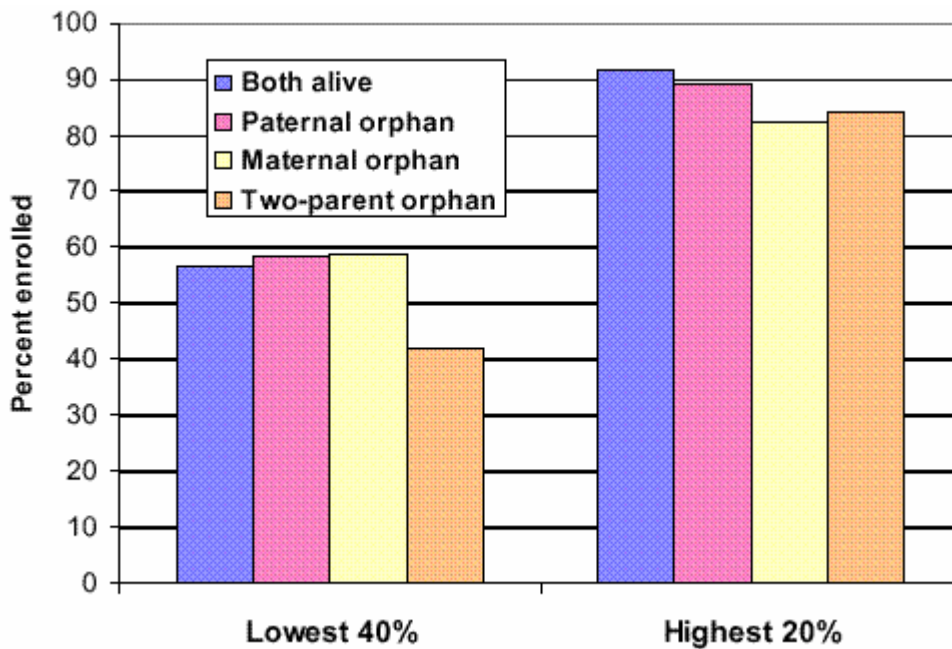
Source: Ainsworth, Beegle and Koda, 2000 (Adapted from Figure 8)

Household wealth

Following the death of an adult, children in poor households often experience delayed enrolment, compared to those in more affluent households who show no delay. In Kagera in Tanzania, orphans aged 7 to 14 in poor households had lower enrolment rates than non-orphans (Ainsworth, Beegle, and Koda, 2002) (Figure 3.6). It is common practice in Tanzania for parents to delay the enrolment of their children in school. Fewer than 75% of children are enrolled, and this is not usually because families are unable to pay, as enrolment rates are low even in households given monetary assistance, but rather for a variety of other reasons. These include the poor quality of primary education, the location of the household with respect to the school, and additional chores that children perform; for example in rural areas often more help is needed for farming, especially from the boys.

Many of the reasons that prevent orphans from attending school are the same as those that prevent poor children from attending school. Figure 3.8 shows the results of the 1998 analysis of the Living Standard Measurement study of children in Zambia, and highlights that children from lower income households were less likely to enroll at school, regardless of their orphan status. This may be related to the amount of work they have to do at home, which prevents them from going to school. Among children living in low income households, double orphans were around 15% less likely to have enrolled at school compared to either single parent orphans or non-orphans.

Figure 3.8. Enrolment rate by orphan status in Zambia, lowest and highest income quintiles (1998)



Source: Ainsworth and Filmer (2001).
(Calculations done by the authors from LSM data).

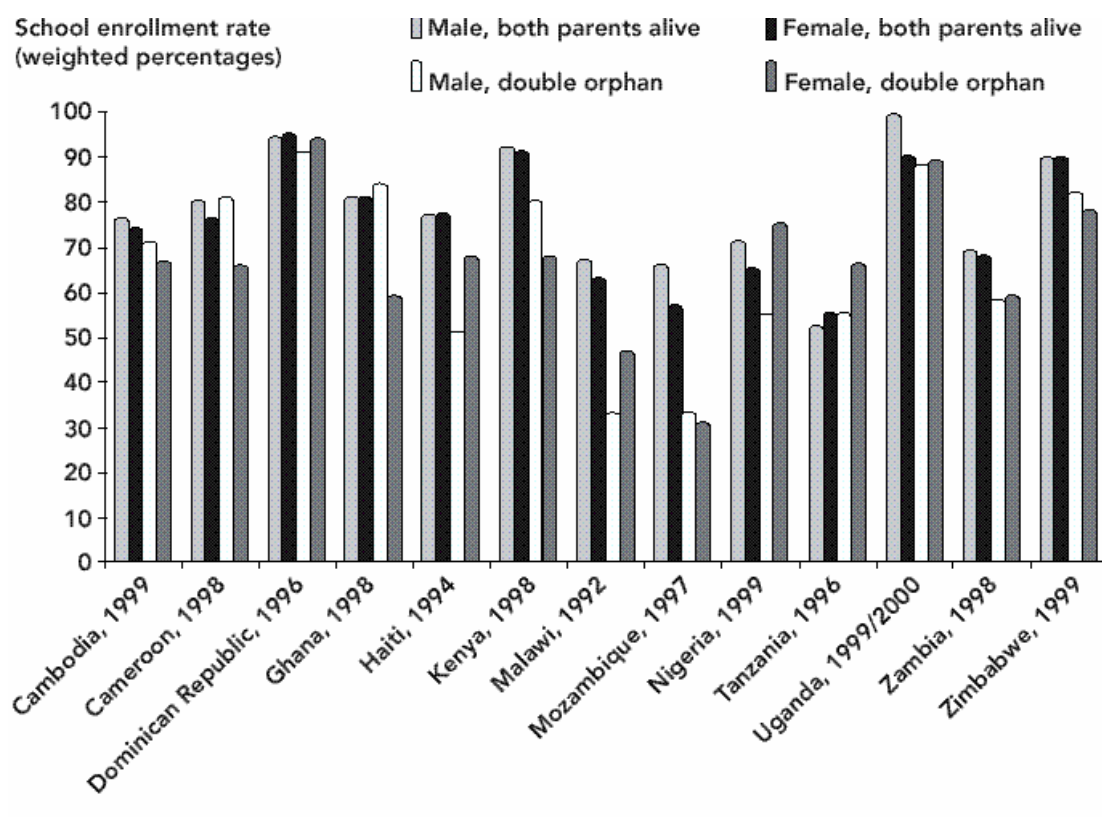
Country Examples

During an initial survey in Uganda in 1992, foster children were found to be disadvantaged in accessing primary and secondary education. In contrast, the 1999 survey revealed a marked increase in enrolment in both primary and secondary schools for all children, and little difference between foster and non-foster children (Deininger et al. 2001). This increase in enrolment is attributed to the implementation of the 1997 Universal Primary Education (UPE) policy in Uganda, which made primary education free to four children per household. The payment of school fees was abolished, publicity campaigns were launched, and communities were mobilized within the framework of the UPE program to aid parents or households that could not otherwise afford to send their children to school (Deininger et al. 2001). The status of the foster children was not revealed, but it was assumed that because Uganda had a high HIV sero-prevalence at the time, most of the foster children would have been children orphaned by AIDS.

In Zambia, a survey found that 32% of orphans were not enrolled in urban areas, compared to only 25% of non-orphans. In rural areas, this figure was much higher with 68% of orphans not enrolled, compared to 48% of non-orphans (UNAIDS/UNICEF 1999). However, the survey made no mention of the general level of enrolment in Zambia.

Gender gaps in enrolments have also been observed among orphans and non-orphans, and the pattern is not consistent. In most developing countries, many more male children are enrolled than female children (World Bank 2002). More double male orphans than double female orphans are enrolled in school in Ghana, Kenya, Mozambique and Cameroon. In countries such as Nigeria and Tanzania however, female double orphans have a higher enrolment rate than their male counterparts (World Bank 2002) (Figure 3.9).

Figure 3.9. School enrolment rates of male and female orphan children aged 7 to 14 for selected countries and years



Source: World Bank (2002), Ainsworth and Filmer (2001)

Attendance

When an adult in the household suffers from HIV-related illness, the children are required to take on new responsibilities such as domestic chores, care-giving to other children in household and income-generating activities. In most cases, the children, especially girls, not only have to work to supplement the household income, they are also called on to care for the sick parent. It is often difficult for an OVC already in school to continue without interruption, and as a consequence regular or seasonal absenteeism is common. The cycle is self-propagating, and the more time a child is absent from school the more they fall behind. Unfortunately, this frequently results in the child having to drop out of school.

In a survey carried out in Uganda in 1999, when children 13 to 17 years old were asked if the illness of their parents had any impact on their education, 26% said their school attendance had declined (Gilborn et al. 2001). In Kenya, it was found that 76.9% of boys dropped out of school due to an inability to pay fees. The expenses of being at school are often hard to meet, such as the additional costs of uniforms and textbooks. In the Kenya study, 12% of girls were found to have been withdrawn from school as a result of AIDS-related illness in the family (Johnston et al. 1999). In another study carried out in the Luwero and Tororo districts of Uganda in 1999, 81.3% of parents with HIV said that when they were sick, they needed assistance with farming or gardening, cooking, fetching water and firewood, going to health center or collecting medicine, food shopping, looking after livestock, and selling goods. This assistance is provided mostly by children, siblings, and brothers-in-law (Gilborn et al. 2001).

In another study, carried out in Rakai in Uganda involving 20 pupils (10 boys, 10 girls, 10 orphans, and 10 non-orphans), Shaeffer (1994) cited a report by Anne Katahoire, that "Nineteen of the pupils reported having been absent from school for periods ranging from five to fifteen weeks during the past year. The most common responses given for absenteeism were lack of school fees and helping with the nursing of AIDS patients at home. All other household members including themselves were reallocated to caring for the patient or patients... pupils (especially girls) were required to take turns at home nursing the sick and helping out on the farm, especially with the decrease in farm labor in the homes. Most pupils indicated that they had to work on the farms in order to raise money for fees and to grow food to eat".

The psychosocial traumas associated with caring for a dying person and the ostracism, discrimination, and stigma suffered by children as a result of infection or HIV/AIDS in the

family coupled with a fear that they may also be infected, makes children unhappy in the school environment, and often less likely to attend.

Performance

Although there is a lack of direct empirical data on the impact of HIV/AIDS-related death in a household on the performance of children in school, one can infer from the difficulties the children orphaned by AIDS face, either in child-headed households or in foster homes that they might perform poorly in school. An extensive international student achievement test within the framework of the Third International Mathematics and Science Study was recently undertaken in about 40 countries with representative samples of students. To minimize the problems of comparing student achievements across countries, cultures, and languages, the survey was conducted in close association with the International Association for the Evaluation of Educational Achievement, which has 40 years' experience with international comparative studies on educational achievement (Wößmann 2000). The results indicate that students in the middle school years living with both parents performed better than others in mathematics, and boys performed better than girls. Students in geographically isolated communities performed worse than those in urban areas. Children in schools where parents play a part in curriculum development were better performers. Following from this study, it could be concluded that in a situation where parents were sick with HIV/AIDS-related illness, their participation was not possible, and this would have a negative impact on the performance of their children in school.

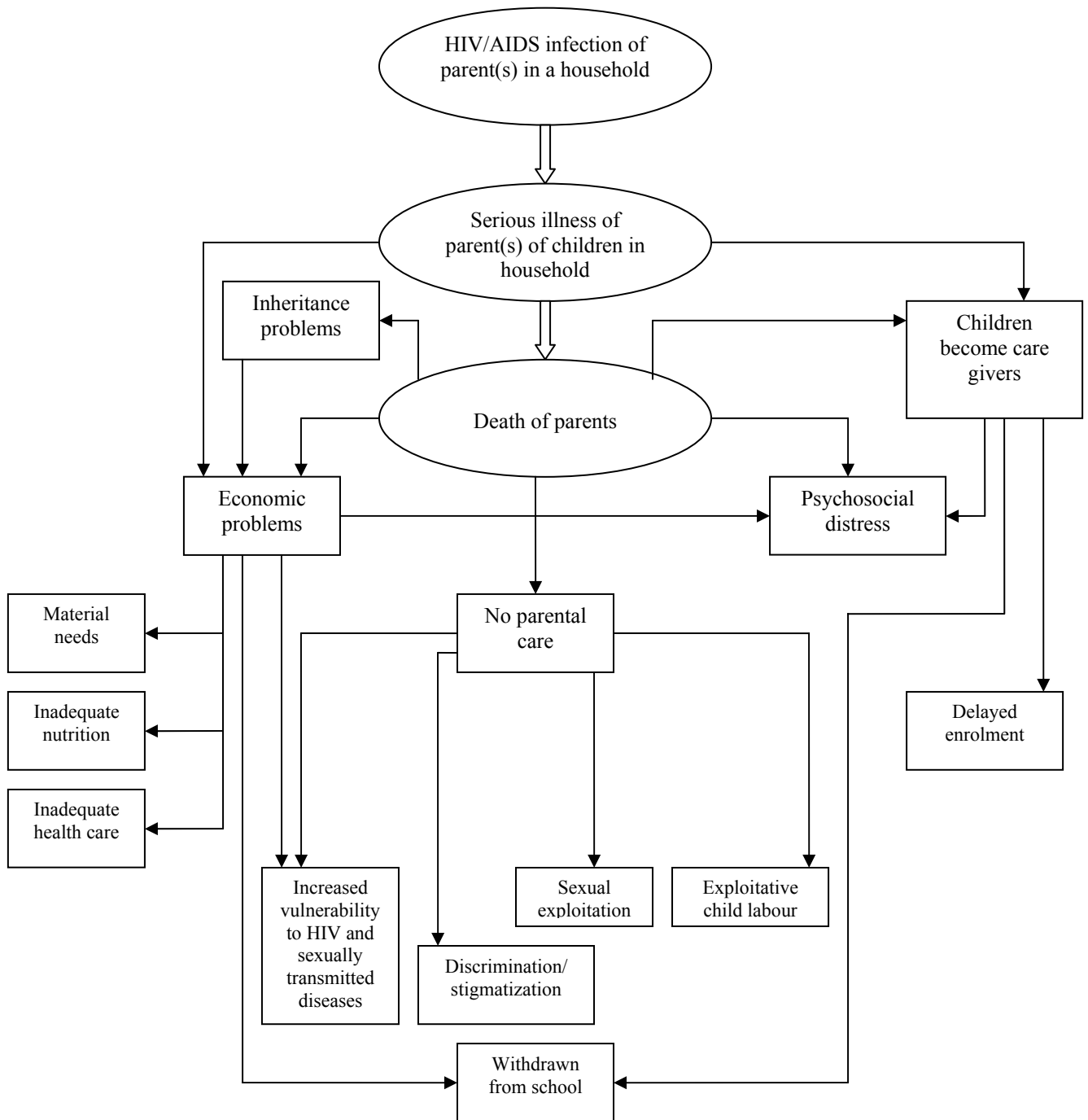
Discussing the results of a study addressing the psychosocial impact of HIV/AIDS in Lusaka, Webb (1997) says that "children of sick parents are significantly more likely to show behavior which is depressive in nature rather than that which is anti-social. Once a child is bereaved this behavior is exacerbated." When HIV-positive parents were interviewed about what psychosocial concerns they had about their children, they listed access to education, food, and the basic necessities for survival (Gilborn et al. 2001).

Long before the death of a mother or both parents, children in a household with a member having AIDS start suffering and experiencing fear and anxiety. They take on some of the functions originally performed by the household member, such as household work, looking after younger siblings, going to the farm, and working to supplement household revenue. Taking on these functions produces stress in the child. The child also exhibits depression and anxiety over the suffering of the person who is ill (Black 1998; Forsyth et al. 1996; Hunter and Williamson 1997, 1998; Williamson 2000b). When such children do continue to go to school, their performance may decline. Discussing the psychosocial support for

children affected by HIV/AIDS, one study found that due to the unresolved psychological trauma, school performance of children is negatively affected by HIV/AIDS (UNAIDS 2001a). A study in Uganda in 1999 on the impact of parental illness on a child's performance revealed a decline of 27.6% among children ages 13 to 17 (Gilborn et al. 2001). Such a decline, can also be linked to the fact that children may intermittently have to drop out of school to cater for the affairs of the household, including the care of the ill family member. In the situation where the parent is too sick to actively participate in the affairs of the school or the children's educational development, it becomes difficult for the children to concentrate even if they do continue in school. Parents who are ill are often unable to help their children with homework or supervise them at home. Both in the short and long terms, the children's performance or achievement in school will be negatively affected.

An overall view of the barriers to enrolment faced by OVC is shown in Fig 3.10.

Figure 3.10. Barriers to preventing OVC from enrolling at school and continuing with their education.



Source: Adapted from Foster and Williamson (2000); Williamson (2000b)

Workshop Exercises

Impact of illness and death of an adult in a household on children's schooling

The participants are asked to work in their country groups.

Instructions for Activity 5

Participants are divided into country groups.

What do you know about the impact of HIV/AIDS-related illness and death in a household on children, especially as it relates to enrollment, attendance, and performance/achievement in school?

Each country group selects someone to write the list of impacts on a flipchart. At the end of the time allocated, each country presents its work. Common themes are written on another flipchart.

The facilitator then adds any points that the participants have left out and summarizes the impact illness and death have on home life, enrollment, attendance, and performance (further points are highlighted in Annex 4).

Because very little has been done so far to support children when they lose a parent or parents, emphasis should be put on the psychosocial impact.

The session continues with a discussion of the psychosocial impact of HIV/AIDS on families and communities (Annex 5).

Section 4 – What Has Been Done to Improve Access to Education for OCV?

This section presents the different strategies that have been implemented to increase access to education for OVC. Some of the strategies are specific to children orphaned by AIDS, and others are for all children in general but they also benefit children orphaned by AIDS. Case histories of projects in two countries to illustrate how funds flow from the donor or the government to the beneficiaries. It describes how interventions are monitored and evaluated. It concludes with a discussion of issues related to the targeting of assistance to children orphaned by AIDS—should assistance be given to the children orphaned by AIDS or to foster families/relatives? Should assistance be for the children orphaned by AIDS or for all vulnerable children, and should assistance be provided directly?

Introduction

Efforts have been made to mitigate the impact of HIV/AIDS-related illness and death on children's access to education. As of yet, no consistent picture is emerging to indicate that OVC have less access to education or poorer attendance, but it is clear that poor children have less access and poorer attendance than rich children.

In some countries, local community groups and nongovernmental and church-based organizations have recognized the negative impact of HIV/AIDS on children's education and well-being, and have begun to take concrete action. Most of the interventions in favor of OVC and their access to education are fairly recent and have not been evaluated yet for program effectiveness. This section discusses some of those interventions.

Strategies to improve access to education

Many interventions can be implemented for OVC to enable them to gain access to education (Deininger, Garcia, and Subbarao 2001; Hepburn 2001). Hepburn (2001) has discussed these interventions and grouped them into four categories (see Appendix 1.3).

- Subsidization of school-related costs—for example, payment of school fees;
- Restructuring of the traditional educational delivery system—for example, provision of community schools;
- Indirectly increasing access to education—for example, by providing community- and home-based care for children;

- Improving the quality of education—for example, through curriculum revision, teacher training, and provision of basic equipment.

Some of the interventions in these categories are specific to OCV while others serve to benefit all children. They are regrouped and elaborated as presented in Box 4.1 as follows:

Box 4.1. Interventions to improve access to education

OVC -specific interventions

- Subsidization of school-related costs – school fees and provision of scholarships and/or school vouchers;
- Income-generating schemes;
- Community- and home-based responses;
- Teachers taking on psychosocial and work counseling;
- In-kind support to schools admitting orphans and vulnerable children;

General population interventions

- Abolition of tuition fees;
- Operation of community schools;
- Increased capacity of teacher training colleges to increase the number of teachers;
- Revision of curriculum to include teaching of vocational and life skills;
- General improvement of quality of education;
- School feeding programs.

OVC - specific interventions

1. Subsidization of school-related costs and provision of scholarships

As discussed in previous sections, the costs of tuition, textbooks, uniforms, and other fees hinder the access of many OVC to education. One of the most common strategies used to overcome this barrier is to reduce or eliminate some of these costs. These reduction interventions include the provision of scholarships or subsidies to households, to help them cover the costs of books, stationery, and school clothing. They can represent substantial incentives for households to send vulnerable children, including orphans and particularly girls, to school. In some cases textbooks have been provided free of charge to schools, made available through textbook rentals, or sold at subsidized rates.

In many developing countries in sub-Saharan Africa, education systems are under funded and schools have to mobilize their own resources. This is often achieved by requesting that parents fill in the funding gaps through Parent-Teacher-Association levies. Intervention strategies can help families meet these additional schooling costs. The direct provision of some of these school requirements, as a means of increasing accessibility of education for OVC, is being proposed for Zimbabwe and Burundi and is discussed in the case histories, later in this section (Gouvernement de la République du Burundi 2002, unpublished; Government of Zimbabwe 2001, unpublished).

In Brazil, it was observed that school attendance increased when the *Bolsa Escola* program was introduced. The program aimed to reduce child labor and encourage families to send their children to school by providing cash grants to families with children aged 7 to 14. Attendance at school was a criterion: To qualify as a beneficiary for the grant, the child had to attend school for a minimum number of days a month (90%). It was observed that the rate at which children in beneficiary households were promoted to the next grade was 80%, compared with 72% in non-beneficiary households. It was also observed that a higher proportion of children from the beneficiary households enrolled in school at the right age (Guilherme, Nadeem, and Gustafsson, 2000).

The *Progresá* program in Mexico is implemented by the federal government and is a scheme of supplying educational grants and monetary support for the acquisition of school materials. It uses geographic targeting to select the poorest municipalities and then means testing in the chosen locality to select the beneficiary households. Beneficiaries of the program are chosen after a household survey has been carried out. The size of the grants change with the school grade and gender of the child; a greater incentive is given to girls to

attend school and children in a higher class in a school will get a higher grant than one in a lower class. Grants are awarded to mothers every two months during the school year, and all children between the ages of 7 and 18 are eligible. To receive the grant, parents must enroll their children in school and ensure regular attendance (i.e., students must have a minimum attendance rate of 85%, both monthly and annually) (Guilherme et al, 2000).

After analyzing data collected in the *Progres*a program, and controlling for community, household and school characteristics, Guilherme et al. (2000) observed that the enrolment rate was 2.2% higher (baseline of 92%) in program regions compared to the control regions. The program had a substantial impact on enrolment, increasing the proportion of pupils both continuing and returning to education from 61% in 1998 to 82% in 1999. The scheme was not ideal however in the eyes of the community; they were dissatisfied at not being more involved in the selection of beneficiaries (Adato et al. 2000).

In Latin American countries, some local authorities have provided school subsidies and funded the education of girls. Considering the number of OVC in sub-Saharan Africa and the limited resources available, this approach may not be feasible. Sustainability in the African region might not be possible without continuous external support. In Burundi, for example, it is estimated that the subsidy package would cost \$148 per family per year (Subbarao, Mattimore, and Plangemann 2001) and it would be difficult for Burundi to fund this on its own. One possibility for increasing the chances of sustainability might be to provide funds to families for income-generating projects (Donahue 2000).

Targeting orphans with assistance for school-related costs assumes that their low rates of enrolment are related only to their inability to pay. This is unlikely to be the case for reasons discussed in previous chapters. Having to care for a sick parent, poor quality schools and distance between the home and school and other factors also have a negative impacts on school enrolment. In a survey of 62 schools in Tanzania, school officials cited financial difficulties as being the least important reason for children being absent from school (Oulai and Carr-Hill 1993, p. 18). Improvement in the whole education system might be more appropriate to increase enrolment among all children equally.

2. Income-generating schemes

Foster households often need financial assistance in order to be able to send the OVC they are caring for to school. Microfinancing and providing funds for income-generating schemes have been implemented as strategies for improving their economic status (Donahue 2000). Income-generating schemes have been undertaken in countries such as

Uganda and Eritrea. Their effectiveness, however, depends on follow-up training and marketing support (Deininger et al. 2001). Where income-generating schemes have been implemented, sometimes the returns are small in relation to the effort and resources invested (UNAIDS/UNICEF 1999). Care must be taken to ensure that the income-generating scheme does not require the children to provide labor instead of going to school, and also that the child has enough time to study outside school.

The foster households can also be given a targeted conditional transfer of cash, but this might not be sustainable unless the government is prepared to contribute substantially. In some cases, foster households have been given loans to enable them start a small income-generating business. Donahue (2000) and Hepburn (2001) have found that microfinancing, which has been undertaken in several African countries, helps the household to maintain or increase income and reduces its vulnerability to financial loss. Most of the microfinancing credit or loan schemes target women because they are more likely to repay the money and also more likely to use the income for the benefit of the household, including the OVC (Williamson 2000a). In a vulnerable children's project in two local government areas in Benue State in Nigeria, 250 households with orphans and vulnerable children are receiving support through income-generating activities and microcredit schemes, and 350 OVC are receiving education and vocational training (USAID 2001, pp. 30–31).

3. Community- and home-based responses

After the extended family, the community is an OVC next safety net. Actions at the community level have been important in the prevention and control of HIV/AIDS as well as in catering to the needs of orphans and children whose parents are suffering from HIV/AIDS-related illnesses (Hunter and Williamson 2000a). A community in this case represents people who have something in common and who are prepared to act together in their common interest, for example, a women's group, a church group, or a cooperative of workers. These groups focus on orphan monitoring and the psychological needs of OVC and provide assistance in community schools and community day care centers (Gilks et al. 1998).

As indicated earlier, when a parent is sick with HIV/AIDS or dies the education of the OVC suffers. The community can devise methods of identifying those households in need and children not attending school, and their reasons for not doing so. The community will need to be mobilized to assist the OVC with activities in the home so that the child has enough time to attend school. Such activities include support with household chores, helping with crops and tending animals, and providing home-based care for the sick parent. In

Zimbabwe, the Chief Charumbira Community-based Orphan Care program in Masvingo Province formed in 1994, uses volunteers through the village committees to ensure that OVC attend and remain in school. The volunteers have taken on some of the household chores to enable the children to attend school, and village committees asked community members to contribute for the payment of school fees (UNAIDS/UNICEF 1999). In Nigeria, the River State Enhanced Care of Orphans project has provided care to 500 households with OVC. Plans are underway to assist 300 more caregivers and enroll 300 additional orphans in schools (USAID 2001, p. 29).

The community can also serve as advocates for the orphans in communication with the parents/relatives, the Ministry of Education and the school in order to solve some of the problems that prevent children, especially OVC, from being enrolled in school. Community and national-level advocacy campaigns were used successfully in Zambia to waive enrolment fees for orphans for one year (USAID, UNICEF, and SIDA, cited by Hepburn 2001).

4. Psychosocial and work counseling by teachers

Many of the OVC who stay on in school lack the material and psychological support they need for success. In many cases little is done to assist the OVC psychosocially, often for some of the following reasons (Sengendo and Nambi 1997):

- Teachers lack the ability to identify psychological and social problems.
- It is culturally accepted that children do not have emotional problems.
- There is little knowledge of how to handle the problems if they are identified.
- The psychological problems are not always very obvious.
- Information on the nature and magnitude of the psychosocial problems is not adequate.

To respond to the psychosocial needs of children orphaned by AIDS, efforts have been made to train teachers in counseling skills as well as methods of promoting social integration for grieving and isolated children and classroom management strategies to minimize stigmatization of OVC (Gilborn 2001). If counseling is to be incorporated as an integral part of a teacher's duty, there will be a need to review their workload. School teachers will have to devote most of their time to counseling related to psychosocial trauma and how to stay in school. There is usually no additional income for teachers who take up counseling and this makes it difficult to recruit interest. It will be important to explore possibilities of other community figures who could perform this role, such as counselors,

community leaders and semi-professional teachers trained in life skills and communication. Pilot programs looking at this are underway in Zimbabwe and Tanzania (UNAIDS 2001a).

For OVC that do not attend school, community leaders' and parents' support groups should be formed and parents trained in counseling so that they can talk about their situation with their children. Support groups for the children can also be established. In Uganda, a child survival project supported by USAID and implemented by "The AIDS Support Organization (TASO)" has already trained 22 teachers, and 55 more school teachers are being trained in counseling during 2001–2002 (USAID 2001, p. 44). The following table highlights some of the social psycho-social issues that the counselors should be aware of when helping OVC.

BOX 4.2. Psycho-social issues that the counselors should be aware of regarding the child:

- Worry about their future, usually in silence
- Fear they are infected
- Feel different from other children
- Lose opportunities—such as for an education
- Watch parents suffer and die
- Lose others as well—uncles, teachers, siblings
- Change homes, sometimes more than once
- Lack adult love, guidance, and protection
- Incur teasing, isolation, gossip, and even neglect and abuse

These circumstances can lead to:

- Shame
- Withdrawal
- Depression
- Grief and sadness
- Fear and anxiety
- "Acting out" – often misunderstood

5. Support to schools that admit OVC

As mentioned earlier, in most developing countries there is always a funding gap in the education sector. Admitting OVC who are unable to contribute to school funds is always very difficult. In an effort to improve the quality of education, some projects have attempted to overcome this constraint by donating materials needed by a school on condition that the school admits a certain number of orphans without enrolment fees (Hepburn 2001). Zimbabwe has implemented this strategy. The organizations providing the assistance are also involved in the physical infrastructure renovation. This is quite expensive however, and difficult to sustain. It also might not prevent schools from seeking more funds from the parents to compensate for the enrolment fees not received from the orphans. However, although expensive, it is an intervention that provides benefits not only to the orphans but also to all the children who attend the school.

General Interventions

1. Abolition of tuition fees

Abolition of tuition fees is an example of a general intervention that is beneficial to all children including OVC. In an effort to increase enrolments, a number of countries have put in place Universal Primary Education (UPE) policies, which abolish the payment of tuition fees at the primary level. For example, Uganda's UPE policy abolishing the payment of fees for the first four children in a family, increased enrolments fivefold within a year. This policy covers all vulnerable groups, not just children orphaned by AIDS (Tumushabe, Barasa, Muhanguzi, and Otim-Nape 1999). Malawi also abolished fees, and saw an associated rise in enrolment despite the costs of uniforms, books, and the other levies that were still in place (Kadzamira, Chibwana, Chatsika, and Khozi 1999). Zambia, on the other hand, still charges fees, but orphans are eligible for subsidies (Kasonde-Ng'andu, Chilala, and Imutowana-Katukula 1999). In Indonesia, Tanzania, and Kenya, enrolment has increased substantially following abolition of primary school fees for all children (Lockheed et al. 1991, p. 162). However, the education sectors are not adequately funded, so most schools still require that families cover some school-related costs. Furthermore, the governments are unable to keep pace with the increased enrolment resulting from the abolition of the fees. This has resulted in poorer-quality education. In Kenya, the government abolished the payment of fees and the enrolment of poor children increased. Unfortunately, they had not planned how to recoup the lost revenue from fees and schools began to levy other types of charges to cover their costs; the cost to parents increased, and the enrolment of the poor declined in due course (Lockheed et al. 1991).

2. Operation of community schools

Another strategy that has been used to improve the access of OVC to schools is to increase coverage so that schools are available to children living in areas outside the those covered by the formal education system. Children whose education was interrupted can also gain access to a general education program outside the traditional channel. Community schools have been created to respond to the problem.

Community schools are established by local community members and sometimes supported by nongovernmental organizations (NGOs) and churches. These schools do not charge fees, nor do they require that children wear uniforms. They sometimes adjust their timetable to local needs and use volunteer teachers. The drawbacks are that the quality of education using volunteer teachers may not be optimal and the teachers can leave if they find a better job elsewhere. Also, the donor can reclaim the buildings at any time for other purposes. Sustainability in such cases is doubtful. Community schools implement the same curriculum used in the public schools, though modified. They also concentrate on those things that affect the quality of life in the community and may offer more vocational courses. Tanzania has had community schools since the late 1970s (Ministry of Education 1980), not because of orphans but because of a need to make education relevant to the needs of the community. In Zambia, more than 200 community schools have been opened in far-away remote areas where there are no government schools (World Bank 2002).

3. Increased capacity of teacher training colleges to increase the numbers of teachers

Access may also be hindered by the absence of teachers in the classrooms. HIV/AIDS also has claimed the lives of many teachers and when teachers are ill with an HIV/AIDS-related illness, they may be absent from school for long periods. More than 30% of teachers in parts of Uganda and Malawi are HIV positive (Coombe 2000). A review of the situation in six African countries reveals high rates of infection and death from AIDS among teachers. Of the teachers who died in the Central African Republic between 1996 and 1998, 85% were HIV positive. In Kenya, the number of teachers' deaths resulting from AIDS rose from 450 in 1995 to 1,500 in 1999 (Gachuhi 1999). Projections of the current situation indicate that Zimbabwe will lose about 2.1% of its teachers, Zambia 1.7%, and Kenya 1.4% in the 2000 to 2010 period (World Bank 2000). These projections have serious implications for the supply of teachers in schools and attainment of Education for All (EFA) goals (Kelly 2001).

Countries that have already lost a large number of teachers have had to take immediate action to replace the dead or absent teachers. Many have relied on hiring of temporary,

untrained teachers or retired teachers. In Botswana, it is reported that 12% of teachers are temporary and untrained (World Bank 2002). Efforts to increase the supply of teachers in the long term include increasing the numbers of entrants into teacher training colleges based on strategic planning models. Meanwhile, other strategies such as employing untrained or retired teachers in the community or peer tutoring are being used. Another strategy that is not HIV/AIDS-specific but that goes a long way toward increasing the supply of teachers, is to raise the training capacity of teacher training colleges and consequently their output. For example, Guinea increased the output of its teacher training colleges tenfold and shortened the duration of teacher training courses. In The Gambia, training output of the teacher training college increased threefold. It is also reported that Zambia has doubled its teacher training college output (World Bank 2002, p. 38).

The Mobile Task Team on HIV/AIDS and Education, based in South Africa, supported by USAID, is working with governments in Malawi, Namibia, and Zambia to model teacher supply needs based on the current situation of teachers and the prevalence of HIV/AIDS in these countries. The Education and HIV/AIDS initiative (ED-SIDA/AIDS), supported by the World Bank, the Department for International Development, the International Institute for Educational Planning, and the Partnership for Child Development, are also working with Ministries of Education in ten African countries (Benin, Burkina Faso, The Gambia, Ghana, Guinea, Niger, Nigeria, Senegal, Togo and Zambia) to project the numbers of teachers that will be needed in both low- and high-prevalence scenarios in order for these countries to meet the EFA targets.

4. Revision of curriculum to include teaching of vocational and life skills

Schools need to address work-related technical and vocational training earlier in the curriculum. Children orphaned by AIDS are no longer “parented” (Ntozi et al. 1999), and will therefore need support to do most things on their own. They will need practical numerical and literacy skills to survive economically and socially after they leave school. These are skills related to work and income generation, as well as life skills dealing with key psychosocial factors (Gachuhi 1999). A revision of the curriculum will therefore be necessary to ensure that these skills are taught. Some programs have attempted to revise the curriculum to include vocational subjects and the development of life skills. However, efforts have to be made not to overload the curriculum and note has to be taken of the fact that the children being taught might be too young to understand the implications of the acquisition of vocational skills. It is perceived that by enabling primary school graduates to work, this revision in the curriculum will increase the benefits of primary education and serve as an incentive for some households to send their children to school.

5. Improvement of quality of education

Ainsworth et al. (2002) found that some of the reasons for delayed schooling in northwestern Tanzania are overcrowding in schools, low returns from primary schooling, limited opportunities for secondary schooling, and opportunity costs of the children's time. The same study (p. 23) also found that the factors likely to reduce delayed enrolment and drop-out rates at the primary level include better access to secondary schooling, reduced overcrowding of classes, better quality of physical facilities, and higher teacher-student ratios. In other cases, there are no post-primary education opportunities within a reasonable distance from home.

6. School feeding programs

School feeding programs have been implemented as a strategy for reducing the cost of education to parents, as incentives for them to send their children to school, and also as a way of improving the nutritional status of children attending school. In situations where children in areas of food scarcity and /or walk for long distances to school and food is not provided, the effect on cognition, short-term memory, verbal fluency, and ability to concentrate is negative (Janke, 2001).

School feeding and take-home rations serve as an incentive (feeding) and a reward (take-home ration). They raise school enrolment and attendance and lower dropout rates. Enrolment and attendance rates significantly increase at the start of the school feeding program and then level off. Dropout rates decline too, but not as much as the enrolment and attendance rates increase. Food assistance of this nature provides an income transfer for households that have high opportunity costs for children's labor. The size, composition, and frequency of delivery of the rations should be sufficient to address the opportunity costs of the targeted families. One drawback is that children are attracted to school not by education but by the food, and enrolment and attendance fall when feeding programs stop. On the whole, school feeding programs do not necessarily improve nutrition and school performance. To sustain long-term educational benefits, it is advisable to plan school feeding programs for at least 10 years and that they should not stand alone but involve local stakeholders (Janke 2001).

School feeding programs are operating in several countries, particularly in areas of food scarcity. For example, in Ethiopia a school feeding program operates in areas that were affected by drought and suffering from food insecurity. It is reported that the program had a significant impact on enrolment, drop-outs, and performance. Similar programs exist in

Côte D'Ivoire and the northern regions of Ghana. The programs have encouraged parents to send their children to school, and they may also result in improving health and performance at school.

Case histories—Burundi and Zimbabwe

Burundi

In Burundi, assistance is targeted to all children who have lost one or two parents and who are younger than 16. This is to avoid singling out the children orphaned by AIDS. Because resources are limited, it is usually impossible to target all the orphans nationwide. Certain provinces and communities are chosen based on the number of orphans, the security situation, the existence of an agency to execute the project in the community, and the presence of a community development committee. Due to difficulties in targeting all OVC, priorities are set based on the assumed needs of the child. First priority is given to double orphans who have no assistance; Second are children in refugee camps who are separated from their parents. Third are either paternal or maternal orphans with no assistance from the living parent. Fourth are maternal or paternal orphans living in very poor foster families (Gouvernement de la République du Burundi 2002, unpublished).

The communities are actively involved in the identifying the beneficiary OVC. In each community, the agency that has been chosen to assist the OVC holds a meeting with the whole community and produces a list of orphans who need assistance. In the case of children in refugee camps, the United Nations High Commissioner for Refugees is responsible for providing the list of separated children who need to be assisted with schooling. It is worth stressing that in some cases, Ministries of social welfare already have lists of orphans that may not be complete, but that can serve as a starting point.

Assistance for orphans is provided directly to the school through the executing agency in the community, which has the responsibility to ensure that the beneficiaries attend school regularly. If the assistance is for uniforms, textbooks, and school equipment, the executing agency is responsible for buying and distributing them to the beneficiaries (Figure 4.1).

In a situation where orphans need to be fostered, especially orphans from refugee camps, the executing agency contracted will ensure that the members of the extended family foster the orphans in the priority groups first. When it is not possible to get someone from the extended family, the orphans are fostered to families that are capable of paying the school fees. For a child-headed household, assistance is provided to make the household

economically viable. It is worth stressing here that assistance is provided only to the orphan, and not to all children in the fostering household. Income-generating projects have also been established to raise the income levels of families to enable them buy textbooks and uniforms for the other children in the household. The family that is assisted will have to contribute 20% of the cost of the income-generating project in kind or in cash. This is to ensure that dependency is not created, that the family values the project, and that it does not see the project as a grant. Experiences from the field indicate that income-generating projects at the community level do not provide enough revenue, in relation to the efforts and resources invested, to enable a foster family to provide for members of the household in addition to the orphan. The inability to assist the rest of the children in the household, risks creating conflicts and jealousy between the other children and the orphan being assisted.

Zimbabwe

The situation in Zimbabwe is quite different from that in Burundi. Zimbabwe has a Basic Education Assistance Module, which assists with school fees for an estimated 426,000 vulnerable children aged between 6 to 19 years. This module is part of the Enhanced Social Protection Project funded by the International Development Association. The module is nationwide and is available for children in all primary and secondary schools except “Elite” schools (Government of Zimbabwe 2001, unpublished). The project is estimated to cost \$6.8 million annually.

Assistance is provided only to children who have problems with tuition fees, building funds, and levies. Children who can be assisted are divided into three categories:

- i) children in school failing to pay or having difficulties in paying fees or levies;
- ii) children who have dropped out of school because of economic hardship;
- iii) children who have never been to school because of economic hardship but are of school age.

No mention is specifically made of children orphaned by AIDS as it is believed that those in need of assistance will be captured in one of the three categories.

The process to identify needy children for assistance is government-oriented and bureaucratic. An elected Community Selection Committee, using guidelines provided by the project, calls for, receives, and vets applications for assistance for children in the community at both the primary and secondary levels. Sometimes Ministries of social welfare already have lists of orphans, though they may not be complete. The executing agency and communities hold meetings, at which a list of orphans who need assistance is produced (Government of Zimbabwe 2001, unpublished). The community selection

committees select the beneficiaries and forward the list to the District Education Officer, who in turn forwards it to the Project Monitoring Unit. This unit then pays the required fees, levies, and building funds into the bank account of the schools in which the beneficiaries are found (Figure 4.1).

The process is very cumbersome and confusing. The government has many other programs that might be providing assistance to children, but ways to avoid duplication are still to be explored. Continued assistance to a child depends on attendance and has nothing to do with academic performance. This may result in pupils going to school without really learning anything. An element of performance should have been involved in any evaluation of the need to continue assistance to a child. Identification of the target groups to be assisted will be cumbersome, requiring considerable numbers of documents to prove that the child concerned has had difficulties paying their fees or that they have not enrolled because of economic hardship. The involvement of the local authorities and the Ministry in the implementation of the project is a cause for concern. Though the selection of the beneficiaries is done by the community selection committee, at times there may be the possibility that the political class and the power brokers in the communities exert pressure on members of the committee to award benefits to children they know or children who do not qualify for assistance.

Most of the interventions in favor of OVC and their access to education are fairly recent and have not been evaluated for program effectiveness. But it has been observed that decentralization to the community level and getting the communities to participate actively in developing the list of orphans to benefit from the assistance is very important. This involvement makes it difficult for opportunistic behaviors to succeed, especially because the community members know who is an orphan and who is not. It also ensures against the moral hazard of fraudulent use of funds for undeserving recipients and families. To make this approach work, appropriate targeting mechanisms need to be in place. However, there might still be need for some external mechanism to check the possible setbacks that can result due to internal community politics.

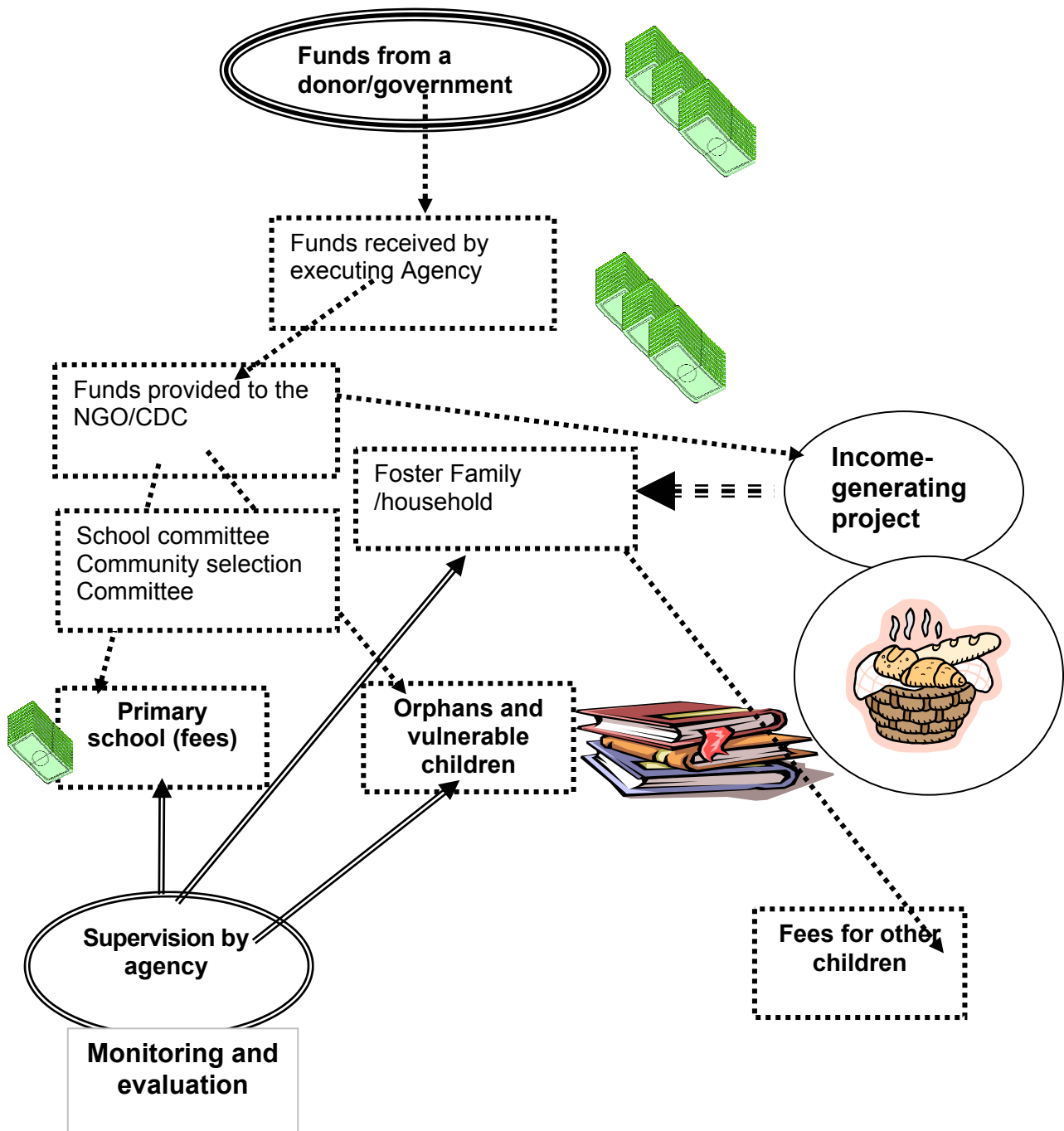
How are beneficiaries targeted, and what are the financial assistance mechanisms?

In the face of limited resources and the growing population of OVC, difficult decisions will need to be made about targeting resources where they are most needed and avoiding giving assistance to children or families that do not really need it. If the aim is to assist all vulnerable children, efforts are needed to ensure that all OVC are included, even though the result may be that some children are assisted who really do not need the assistance. It

may become too time consuming to define eligibility indicators and police the assistance needed to ensure that only those who qualify are assisted. It is recommended that the communities that should be targeted are those where the impact of HIV/AIDS is greatest, and the ability of families to best meet the needs of their children is lowest. Furthermore, children and families that have been identified by residents as being most vulnerable, should be targeted with assistance (Hunter and Williamson 2000a). The targeting method chosen will depend on the country's circumstances and the nature and intensity of the problem faced by OVC.

The following diagram illustrates possible pathways to provide funding for OVC:

Figure 4.1. The flow of funds for assistance to OVC



Targeting only the foster families might result in opportunistic behaviors, where suddenly children become “orphans” while their parents are still alive— households foster children whose parents are alive and claim they were orphans. The assistance reaching the individual orphan might not be sufficient if it is shared between all the children in a household. Yet the counter argument would be that if one were to assist the OVC alone, other children in the household would feel resentful, and this may cause conflict within the

household. To avoid this, the household should be given the possibility of assisting all the children, but this is only possible if the household income increases.

If the aim is to encourage fostering of orphans, foster households can be targeted with both direct subsidies (cash transfers) and indirect subsidies (such as tuition fee waivers and food supplements). Tuition fee waivers are preferred because they are easy to monitor to ensure that they benefit the orphan. There are ways to minimize problems of leakages; the whole community can be overseen by NGOs; church groups can identify the households and OVC to be assisted, and the assistance for the OVC can be provided in kind (Gouvernement de la République du Burundi 2002, unpublished).

How are interventions to be monitored and evaluated?

Monitoring

All the assistance that is provided to the OVC, to the foster family, and to any school is to ensure that OVC have access to school. It will therefore be necessary to follow up to ensure that the OVC are effectively gaining access to school. Monitoring can be done on a quarterly or annual basis. For the quarterly and annual monitoring, it is proposed that the following be monitored at the school and community levels by the school, the executing agency, community development committee, or community selection committee as the case may be:

Quarterly Monitoring

- Total number of pupils in school by grade and sex at the beginning and end of term;
- Number of beneficiaries in school by grade, sex, and purpose of assistance at the beginning and end of term;
- The regular presence of the OVC in school – attendance records of beneficiaries;
- The amounts of funds provided to each school for each child by purpose for payment;
- Verification that the orphan does not work full time;
- Verification that the orphan is not physically abused.

Annual monitoring

- The economic situation of the household fostering the orphan;
- The condition of the OVC – anthropometric measurements.

Data should also be collected for non-orphans as well as for OVC to enable a comparison to be made in order to determine the impact of the assistance to the OVC. Monitoring will be made easier if the required data is built into the existing Ministry of Education data

systems. It is expected that the data collected at the community level will be presented to the executing agency responsible for the implementation of the assistance program, who in turn, will aggregate it for onward transmission to the Ministry of Education.

Evaluation

Processes have been put in place to identify the beneficiaries and these processes will need to be evaluated. It is proposed that this evaluation be done by an external agency. The following indicators may be used on an annual basis:

Process

- The process by which the beneficiaries were/are identified (satisfaction with the process of identifying and selecting beneficiaries);
- Focus group discussions with the beneficiary orphans to find out how they are being treated by the foster household and whether they perceive the assistance provided to be making access to education easier for them.

Impact

- Enrolment rates;
- Repetition rates for the orphans in school;
- The rate of movement from year to year;
- Percentage of orphans in full-time education
- Rate of absenteeism from school
- Nutritional status of the orphans compared with the other children in the household

Workshop Exercises

Objectives

At the end of this section, the participants will be able to:

- Describe the different mechanisms available to assist AIDS orphans and vulnerable children to ensure that they have increased access to education
- Describe the disadvantages and advantages of targeting assistance to either the AIDS orphan or the household or the community or the other children in a fostering family/community
- Describe how those to be assisted are chosen and who makes the selection
- Explain why it is necessary to improve the access of AIDS orphans and vulnerable children to education
- Define monitoring and evaluation and discuss the indicators that should be used in a program to provide assistance to AIDS orphans and vulnerable children
- Analyze and comment on a country program to assist AIDS orphans and vulnerable children

Each participant should be given a copy of Annex 6.

Instructions for Activity 6

Divide into small groups (not necessarily country groups).

Think of a child in your community who has experienced the loss of a parent due to HIV/AIDS. What types of interventions would you propose for this family to ensure that the children attend primary school? Review “A child’s story 2: orphan-headed household.”

How would you go about providing this assistance? Will it be provided to all the children in the village or only to the orphans? Will the assistance be given to the school directly or through the orphans or community members? Give reasons for whatever you think should be done. How will you monitor and evaluate the program?

Be sure to look at the child’s physical, developmental, spiritual, and emotional needs when considering this question.

Have one person in each group record the group’s findings. When all the groups are finished, ask each to report its findings to the larger group.

Practical country case histories

Activity 7 Practical Country Experiences

Divide the participants into two groups. Give one group the operation manual from Zimbabwe, and give the other group the manual for Burundi. Have each group prepare a presentation.

In the larger group, the two groups present their work and make comments about the projects (targeting, selection, bursary mechanism, management of funds, sustainability, monitoring and evaluation, etc.).

The facilitator then summarizes, taking into consideration the various policy issues presented in Annex 7 and the general principles in Annex 8.

Identification and targeting of orphans and vulnerable children and other policy issues:

The following points should be discussed if they were not covered in Activities 6 and 7:

- What are the most effective ways to channel funds to schools/beneficiaries?
- What roles do communities and community committees play in providing assistance to AIDS orphans and vulnerable children?
- Is it better to do targeted conditional cash transfers or support the foster family?

Other important policy issues are presented in Annex 7 for discussion.

Activity 8 Monitoring and evaluation of interventions to improve access to education

Discuss how participative monitoring and evaluation can be done. Emphasis should be placed on qualitative methods.

Section 5 – Key Emerging Issues and the Way Forward

This section discusses some key issues about the access of OVC to education. These include::

- *The need to reach a consensus on the definition of orphans and vulnerable children;*
- *The increasing numbers of school-age children who are orphaned by AIDS;*
- *The relationship between orphanhood and enrolment, attendance, and performance at school;*
- *The need to achieve Education for All (EFA)*

The section ends with a discussion of how to proceed. It stresses that whatever has so far been done to improve access to education can only be seen as short-term interventions. In the long-term, it will be necessary to achieve the goal of EFA. It is emphasized that assistance should be provided to all vulnerable children including orphans and according to need, rather than only targeting children orphaned by AIDS.

The key emerging issues:

Some key issues are emerging in discussions of access to education of OVC. Among these issues are the following:

- ***The need to reach a consensus on the definition of orphans and vulnerable children;***

There is potential for confusion in the definition of OVC. This had resulted in conflicting figures for children orphaned by AIDS in the world in general and in sub-Saharan Africa in particular. For an important issue such as this, consensus is needed on the definition. From a policy perspective it is more appropriate to talk of OVC, given the stigma associated with AIDS in many countries and the difficulties involved in discerning the cause of death of parents. There is a need for incidence studies of orphans over time to enable nondiscriminatory interventions. Given the difficulties involved in distinguishing children orphaned by AIDS and orphans from other causes, community based approaches are likely to be most useful when identifying OVCs.

- ***The increasing numbers of school-age children who are children orphaned by AIDS;***

It is clear that the number of OVC is increasing due to AIDS and conflict. The numbers of school-age children who are orphaned by AIDS are increasing at a time when the traditional coping mechanism is under strain from the high adult mortality. The psychosocial implications of orphanhood are not clear to many people in the education sector. There is a need to verify whether teacher counseling and community education can be of any assistance in dealing with the psychosocial issues faced by orphans.

- ***The relationship between orphanhood and enrolment, attendance, and performance at school;***

Unless immediate action is taken, the numbers of OVC who have little or no access to education will significantly increase. As a result, the socioeconomic development of most countries will stagnate for many years to come. Policies that raise enrolment among the poor will both raise enrolment among OVC and provide poor children with tools to prevent HIV infection as they move into adulthood (Ainsworth & Filmer, 2002). So far, not enough has been done to ensure OVC are enrolled sufficiently early, stay in school, and do not drop out. More research is needed to find novel and effective solutions to the problems of access to education for OVC. In addition, improved documentation of approaches is also required in order to share successful experiences.

There are some small promising pilot projects that are providing care and assistance to OVC. In some cases the assistance has included access to education (USAID 2001). Communities and families are doing much to care for children orphaned by AIDS by providing foster care for them, but they will be increasingly unable to cope with the ever-growing numbers of children orphaned by AIDS in sub-Saharan Africa.

- ***The need to Achieve EFA***

In situations where there are financial barriers to OVC access to education even if subsidies are in place, there is still the problem of levies to consider, such as Parent-Teacher Association levies. Universal Basic Education, for example, abolishes school fees but still leaves in place the levies, which can be a barrier to access for poor families. There is therefore a need for countries to target the OVC depending on the situation in their education sector. Achieving "Education for All" appears to be the most appropriate solution to the problem of education access for OVC.

What is the way forward?

Many people within the education sector do not see a role for it in mitigating the impact of HIV/AIDS on children in general and OVC in particular. HIV/AIDS has been perceived

primarily as a health problem. To muster the resources to assist OVC when it comes to access to education, political commitment is needed. To persuade the authorities to increase their commitment to the cause of OVC requires adequate data.

The scale of the OVC crisis is overwhelming the ability of the countries of sub-Saharan Africa to deal with it. The financial resources needed to tackle this crisis are such that a single organization or country cannot raise them. Consequently, coordination is necessary at the community, national, and international levels during planning and implementation of activities and in the delegation of tasks. At a time when the available resources are increasing, coordination becomes even more imperative to focus efforts and avoid duplication. Partnership with the communities, parents, and local leaders is a necessity, as are discussions with international organizations to support both the governments and communities. Notwithstanding the above, programs from outside should supplement, rather than replace, existing community programs.

The discussion of the various interventions in Section 4 referred to mitigating the impact of HIV/AIDs in the short term. On a long-term basis, the achievement of Education for All is a necessity. It will therefore be necessary that all countries, especially those of the sub-Saharan Africa region, make efforts to work toward the achievement of the goals of Education for All (EFA) (Gachuhi, D. 1999; UNESCO 2000; UNESCO 2002 and World Bank 2002), which is a policy that can play an important role in the reduction of the spread of HIV/AIDS and by implication a reduction of the number of orphans.

Workshop Exercises

Activity 9 **Evaluation of the module**

Review the objectives of the module. Verify that they have all been met. Are there any suggestions as to how these objectives can be better met?

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APPENDICES

Appendix 1.1. Numbers (in thousands) and percentages of the different AIDS orphan types

Year	Maternal children orphaned by AIDS	Paternal children orphaned by AIDS	Double children orphaned by AIDS	Non-children orphaned by AIDS	Total
2001	6,278 (13.9%)	7,770 (17.1%)	3,579 (7.8%)	27,698 (61.1%)	45,3257 (100%)
2005	9,927 (18.4%)	11,125 (20.6%)	5,240 (9.7%)	27,732 (51.3%)	54,024 (100%)
2010	12,166 (20.3%)	13,910 (23.2%)	8,497 (14.2%)	25,470 (42.4%)	60,043 (100%)

Source: USAID/UNICEF/UNAIDS (2002).

Appendix 1.2. Estimated number of orphans by country for 2000

	(a)	(b)			(c)	
	Maternal+Die AIDS	Maternal+Die AIDS	Paternal All causes	Maternal other causes	Total All causes	Total All causes
Angola	98000	-	-	-	-	701000
Benin	22000	14650	184595	136382	335627	286000
Botswana	66000	37852	57231	7210	102293	98000
Burkina Faso	320000	148104	398713	178116	724933	769000
Burundi	230000	113965	283864	118142	515971	508000
Cameroon	270000	111950	310972	142482	565404	708000
CAR	99000	95232	216926	80798	392956	245000
Chad	68000	-	-	-	-	417000
Comoros	-	-	-	-	-	-
Congo	53000	23729	86388	27301	137418	180000
Cote d'Ivoire	420000	314161	685668	246840	1245669	905000
DR Congo	680000	447110	735064	1063397	2245571	2733000
Djibouti	7200	-	-	-	-	30000
Equatorial Guinea	860	-	-	-	-	19000
Eritrea	-	-	-	-	-	199000
Ethiopia	1200000	1061305	2832207	1255955	5149467	3839000
Gabon	8600	4316	25001	16139	45456	47000
Gambia	9600	-	-	-	-	47000
Ghana	170000	28398	330558	242057	601013	759000

	(a)	(b)			(c)	
	Maternal+Die	Maternal+Die	Paternal	Maternal	Total	Total
Country	AIDS	AIDS	All causes	other causes	All causes	All causes
Guinea	30000	-	-	-	-	377000
Guinea Bissau	6100	-	-	-	-	60000
Kenya	730000	377789	669191	169731	1216711	1659000
Lesotho	35000	14362	40896	19753	75011	137000
Liberia	31000	-	-	-	-	165000
Magadascar	2600	-	-	-	-	644000
Malawi	390000	273336	521181	153085	947602	937000
Mali	45000	-	-	-	-	602000
Mauritania	-	-	-	-	-	-
Mauritius	-	-	-	-	-	-
Mozambique	310000	252715	911437	347558	1511718	1274000
Namibia	67000	33161	68992	21923	124076	97000
Niger	31000	-	-	-	-	565000
Nigeria	1400000	564682	2556175	1526734	4647591	5421000
Reunion	-	-	-	-	-	-
Rwanda	270000	129404	515180	292107	936691	613000
Senegal	42000	-	-	-	-	402000
Sierra Leone	56000	-	-	-	-	299000
Somalia	-	-	-	-	-	-
South Africa	420000	358593	705766	218852	1283211	1528000
Sudan	-	-	-	-	-	1190000
Swaziland	12000	18932	41245	14814	74991	59000

	(a)	(b)			(c)	
	Maternal+Die	Maternal+Die	Paternal	Maternal	Total	Total
Country	AIDS	AIDS	All causes	other causes	All causes	All causes
Togo	95000	33908	94700	42119	170727	224000
Uganda	1700000	585809	1294735	473520	2354064	1731000
United Rep. Of Tanzania	1100000	426300	924084	182700	1533084	1928000
Zambia	650000	429124	677599	133293	1249816	874000
Zimbabwe	900000	3430.1	595686	486586	1066702	1018000
Sub-Saharan Africa	12100000	6449884	16701676	7215124	30366684	34294000

KEY:

(a) Maternal and Double orphans due to AIDs (UNAIDS 2000)

(b) Maternal, double orphans due to AIDS,
paternal orphans of all causes, maternal orphans of all other causes
than AIDS and Total orphans due to all causes

(Hunter and Williamson 2000a)

(c) Total orphans due to all causes (USAID/UNICEF/UNAIDS 2002)

Appendix 1.3: Initiatives attempting to increase primary education access for orphans and vulnerable children

Subsidizing school-related costs

- Provision of scholarships and/or school vouchers
- Suppression of enrollment fees
- In-kind support for schools admitting orphans and vulnerable children

Restructuring traditional education delivery system

- Operation of community schools

Indirectly increasing access to education

- Provision of community and home-based care
- Development of income-generating schemes
- Establishment of school feeding programs

Improving educational quality

- Training of teachers to take on psychosocial and work counseling
- Revision of the curriculum to include teaching of vocational and life skills
- General improvement of the quality of education

Source: Adapted from A. Hepburn (2001).

Annex 1.

A Child's Story 1. A story of an orphan-headed household

My name is William. I am a young boy. My parents died three years ago. I live in Gikongo village with my two sisters and brother in this hut. It is the same hut that we used to live in with my parents. It was hard when my parents died. They were both sick for a long time and none of us knew what was going on, so we were afraid. We didn't know what would happen to us when they were gone. When they were sick, everything around the house stopped because most of our time went to caring for them. As a result, the family got poorer and poorer and we had to sell off some of our possessions to get money to pay the hospital bill. We stopped going to school.

Now my elder brother (16 years) does not live with us anymore. He lives in a nearby town. He is working at a maize mill, but he comes to see us almost every day. He brings some money to help us get by. He has just bought two goats to help us. He also repaired the hut. My eldest sister (15 years) looks after us. We try and help around the house. In the morning, she makes sure that we have something to eat before we go to school. This is when there is food in the house. Only my younger sister Kathy and I go to school. My younger brother Peter left school last year because he did not have a good pair of shorts. Even now with the "new" pair he has, he still does not go to school.

He wanders around the village trying to find some odd jobs he can do, so that we can have some money to survive on. But this is not easy. After school, Kathy cooks food for all of us. She also goes to the river to fetch water and wash the clothes.

Sometimes, we boys wash our own clothes. After that, she washes the dishes, and then helps our elder sister with any household chores that are needed. If she is not needed, then she does her school work or goes to play with her friends. Early last year, she used to have to look after our baby sister, but she died. My brother and I also help our sister around the house. Usually we sweep the outside yard or work in the small garden we have. When things are bad, we rent our piece of land to people in the village so that we can use the money for other things, but then we don't have enough food.

We have two uncles who live close by, but they do not help us. On rare occasions, they may help us with some money when we have had no food for some days. If we

have any problems, usually they do nothing to help even if we go to them. Often, it is our neighbors who help us. If we are sick, they may give us some medicine, and if they do not have any, they may take us to the traditional healer, or the hospital. Most of the time we go to the traditional healer because the hospital is too far away, and we have no one to go with. If we do go, there is usually no medicine, and we do not have money to buy medicine. There is a mission hospital, but they charge for treatment, and we do not have the money, so we go to the traditional healer. Sometimes he treats us for free, or our neighbor pays him. If it is not a serious illness we use herbs to get better. Most of the time it is our eldest sister who takes care of us when we are sick. If we get very sick, then she and my eldest brother decide what to do.

Life is hard. We do not have parents like the other children, and have to do everything by ourselves. We have to repair the hut when it is falling apart, try and find odd jobs to get money to buy clothes and live, and most of the time we bathe without soap. We just go to the river and wash. We go hungry most of the time, especially if we cannot find casual labor for the day. My younger brother Peter has left school so that he can find odd jobs around the village. At least that way we are able to eat and buy clothes, but even though he has left school, work is not easy to find. Sometimes he tries to hunt for birds, but he usually doesn't catch any.

Our biggest challenge is to survive. But even if this is so, most of all we lack our parents' care. Most of our friends are orphans. This is better because when we are playing with other children, they always have their parents' backing. But we have no one. When we have all been playing happily, the other children go home to their parents, but we only have ourselves to go to. When I sit alone, I dream of becoming a teacher or a businessman. Sometimes I wish that I could be a craftsman. I could at least weave mats, or build huts. My brother Peter would like to be a bus conductor. Even though we boys suffer, I think that it is the girls that suffer most. We boys can stand up for ourselves, but the girls cannot. They just have to take what people do to them. Kathy has some problems at school because the kids call her an orphan all the time and she has no one to come home to and complain because there is nothing we can do. We are all orphans. So like us, she has friends that are orphans too. She is good at playing 'jingle,' and enjoys herself.

Sometimes she plays hopscotch, and chicken in the den. We boys like to play football and mess around in the water at the river. But life is not so easy. In the evenings, especially on the weekends, we sit around and sing songs. Sometimes we sing songs that are on the radio, but most of the time we sing church hymns, more like in a choir. But we miss having our parents, because they could do all of these hard things for us, but most of all they could tell us stories in the evening. I dream of my mother sometimes. The last time I dreamt of her, she was coming home from town with a basket on her head, and I was running to meet her joyfully, but then I woke up. My brother Peter also dreamt of her another time. She was standing in a garden near the house singing hymns, but she did not come to the house. He also woke up. We miss our parents. Now all we can do is dream.

Annex 2

Elizabeth's mother's story

My husband died in hospital early last year, so there was no time to go to the traditional healer. When he was sick, everything around the house stopped because most of our time went to caring for him. As a result the family got poorer and poorer and we had to sell off some of our possessions to get money to pay the hospital bill. He did not have a younger brother, and his relatives did not want to support me, so my children and I moved back here. I have two daughters and a son. Elizabeth is the oldest and has left school because her uncle cannot support her any more and we cannot get a transfer. She helps me with household work around the house, and early in the morning, she works in the garden.

Life has not been easy since my husband died. Look at my hut; it is falling apart. I will have to find some piecework so that I can buy the poles and grass for the roof. That way the men in the village can repair the house. I do not have a job, so when we need clothes, food, and other necessities I go out and work on other people's gardens. Sometimes Elizabeth helps me. The money I get from this I use to buy what we need. When my children are ill, I take them to the traditional healer, who sometimes treats them for free. The hospital is too far away. I need transport money to get there and back, so I only take them there when they are seriously ill.

At the moment, things are very difficult, so we only have one meal a day. I usually make sure that we eat late in the afternoon so that my children are full at least when they go to bed. Elizabeth is almost a woman and may get married. If this is her wish to do so, I cannot stop her. At least her husband will support her. In the past, we were able to control these things. Girls were allowed to get married at the age of 15 or 16 and would attend initiation ceremonies so that they are given advice on our culture. But today these children mature so fast we cannot stop them. They only get initiated after or when they are getting married. It's a shame, but with all the troubles, these days parents do not have much say.

Annex 3. Summary effects on children of parents' AIDS-related illness and death

Increased

Poverty
Household responsibility
Psychosocial distress
Vulnerability to abuse, child labor, sexual risk
Stigma and isolation
Hunger, malnutrition

Reduced

Access to food
Access to health services
Access to school
Material goods, such as clothes, supplies
Guidance, protection, and love from adults

Source: L. Gilborn (2001).

Annex 4. Impact of parents' HIV/AIDS-related illness on children's school attendance and performance

- Drop out of school because there is little or no money for school fees
- Must care for the other siblings
- Must take on more household responsibilities
- Must stay at home to care for the sick parent (especially applies to the girls)
- Experience psychosocial trauma
- Reduce performance because of absence from school
- Miss parental care and support

Annex 5. Psychosocial issues for AIDS orphans and vulnerable children that the teacher should be aware of:

- Worry about their future, usually in silence.
- Fear they are infected.
- Feel different from other children.
- Lose opportunities, such as for an education.
- Watch parents suffer and die.
- Lose others as well: uncles, teachers, siblings.
- Change homes, sometimes more than once.
- Lack adult love, guidance, and protection.
- Incur teasing, isolation, gossip, and even neglect and abuse.

These circumstances can lead to

- Shame
- Withdrawal
- Depression
- Grief and sadness
- Fear and anxiety
- “Acting out” – often misunderstood

Source: L. Gilborn (2001).

Annex 6

A Child's Story 2 – Orphan-headed household

My name is Rwugantamazam, and I am 18 years old. I have three sisters and two brothers. My eldest brother does not stay with us. He moves about doing odd jobs and comes every once in a while to give us some money. My eldest sister is married. She is 20 and comes every day to see if we have food. She only got married late last year. Felicia (16), Mary-Anne (14), Andrew (12), and I live together. All three of them go to school. I left school because there was no money for school fees. My eldest brother also left school because of the same problem. My father built this house we are living in, but he died before he could finish it. My father died in 1995 and my mother died the following year. My eldest sister is the one who took care of them during their illness.

Our relatives did not want anything but the property. They used to tell us that we would suffer once our parents were dead. My eldest sister was clever. When she saw things were bad, she hid most of the furniture at a neighbor's house so there was nothing for them to take. We still have most of this furniture. When my mother died we went to live with our grandmother but they were so cruel to us. They still wanted the furniture and they wanted this house. My sister argued with them every day about this. In the end, we decided to go and live on our own in the same house they wanted. In the first few months, things were not easy. My uncle came almost every day trying to get us to sell the house or give him the house, but my sister and brother argued with him. No, they do not help us. We are on our own.

We face many problems. We lack food, clothes, and school fees. School fees are a real problem. Even when we work hard there is no way we can stay in school because we do not have enough money to pay for school. We have to pay RWF500.00 a month. Mary-Anne has just written her standard eight exams and is worried. She does not know if she has passed, and she does not know how she is going to find a place in a secondary school. She has big dreams. She wants to go to university to get a diploma in tourism. She wants to visit all the countries she has learnt about.

Felicia does not care what she does. She just wants to get any job that can be found or run her own business. Andrew wants to become a pilot, but the teacher keeps

complaining about his poor behavior in school. He is never paying attention to what is happening in class. Andrew always complains because he does not have tea in the morning any more. I guess he does not understand that times are hard. This is not the only meal we go without. Sometimes we do not have food at all. When we do eat, it is usually maize meal and boiled vegetables with salt. On days when we can say we have had a good meal then, it is maize meal and fish. This is rare.

I have to look after these three. The care I give them cannot match the one my parents gave us. I wish our parents were still alive. Every morning I wake up and try and think of ways of getting a meal. When our clothes are looking worn, I have to think of ways to get us some. I know my sister got married so that she could get away from these problems. At least she tries to share with us the little she has, but she does not have much. Maybe one day I will be lucky and work in an office, but with the way things are, I don't think I will get to do that.

When we are sick, we look after ourselves. I usually take them to the hospital by bicycle. It is the best I can do. We all have friends but do not have too much time to spend with them because we have work around the house. The girls work around the house while Andrew works in a shop in the market during the weekend. I look for work every day so that we have food. We have closed off one side of the house and let that out so that the rent from there helps us. Most of the people here are nice to us, but some of them tell us to get out of their sight because we are orphans. This is hurtful, but what can we do? There is nothing we can do because we are orphans after all. We really miss our parents, especially when there is nothing to eat. We used to dream of our parents for a long time, but nowadays we don't.

Sometimes we sit and chat about them and what we used to do with them. I remember that my father suffered a lot during his illness, but he wasn't sick for a long time. His relatives were so happy that he was sick, it was horrible. Even though they treated him like this, he left a will leaving some money for my grandparents, but they still do not treat us nicely. I really wish our parents were alive. At least they would know what to do.

Annex 7. Policy issues of interest for discussions

Targeting of beneficiaries

- What are the policy objectives?
- Which groups have compromised access?
- Has it been decided which group will be offered assistance? Are the targets AIDS orphans, all vulnerable children, or the poor in general?
- What groups must be included?
- How do you identify the target group?
- What targeting mechanisms should be used to reach them?
- What is the role of the community?
- Do cultural conditions allow for introduction of assistance to this group? What are the cultural and economic implications?

Mechanisms for assistance

- What type of assistance is required by the target group?
- What are the best ways to channel funds to schools/beneficiaries?
- How are the payments made?
- Is assistance to be equal for everyone, or should it be in relation to need?
- What is the role of community committees?
- What is the role of teachers and the school administration?
- What best practices have worked elsewhere?
- Are cash transfers the most cost-effective route?
- Has a mechanism been agreed on for deciding entitlements?
- Have checks been made for possible overlap with services available from other donors or providers?
- What role have relatives or foster parents to play in all this?
- Are there frameworks/laws and enforcement procedures to support the assistance?

The mix of interventions

- What is the role of school feeding? Is it sustainable?
- Which of the education, health, nutrition, and psychosocial interventions should be combined to best support the AIDS orphans and vulnerable children?

- How about school health support, such as deworming?

Implementation and governance mechanisms

- How will the fund be operated?
- How will funds be governed? Is there sufficient independence from government?
- How can moral hazards be avoided, such as fraudulent use of funds for undeserving recipients and families?
- Is the infrastructure adequate to ensure that funds will reach those truly in need?

Sustainability and financing aspects

- How can these activities be sustained?
- What is the role of partnerships?
- Is it feasible to register and collect contributions from community members?
- What is the relationship government departments and agencies – what are the roles of the different players?
- Is it known how much money would be needed to achieve the objectives?

Enhanced monitoring and evaluation

Has a needs assessment been done?

- How can this program be monitored?
- How can participatory techniques be used to determine beneficiaries' assessments?
- Are structures in place to monitor and regulate the program?
- Do existing administrative structures/procedures offer mechanisms for monitoring and evaluation?

Annex 8. Principles to guide programming for orphans and other children affected by HIV/AIDS

1. Strengthen the protection and care of orphans and other vulnerable children within their extended families and communities.
2. Strengthen the economic coping capacities of families and communities.
3. Enhance the capacity of families and communities to respond to the psychosocial needs of orphans, vulnerable children, and their caregivers.
4. Link HIV/AIDS prevention activities, care, and support for people living with HIV/AIDS and efforts to support orphans and other vulnerable children.
5. Focus on the most vulnerable children and communities, not only those orphaned by AIDS.
6. Give particular attention to the roles of boys and girls, men and women, and address gender discrimination.
7. Ensure the full involvement of young people as part of the solution.
8. Strengthen schools and ensure access to education.
9. Reduce stigma and discrimination.
10. Accelerate learning and information exchange.
11. Strengthen partners and partnerships at all levels, and build coalitions among key stakeholders.
12. Ensure that external support strengthens, and does not undermine, community initiative and motivation.

Source: J. Williamson (2001).