

**THE IMPACT OF HIV/AIDS ON EDUCATION SYSTEMS
IN THE EASTERN AND SOUTHERN AFRICA REGION**

**AND THE RESPONSE OF EDUCATION SYSTEMS TO HIV/AIDS:
LIFE SKILLS PROGRAMMES**

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CONTENTS

ACRONYMS AND ABBREVIATIONS	ii
EXECUTIVE SUMMARY	iii
1.0 INTRODUCTION: EFFECTS OF HIV ON COUNTRIES IN ESAR	1
2.0 HIV/AIDS AND THE EDUCATION SECTOR: AN OVERVIEW	2
HIV/AIDS is Decreasing the Demand for Education	3
HIV/AIDS is Decreasing the Supply of Education	4
HIV/AIDS is Decreasing the Management and Quality of Education	5
3.0 HIV IMPACT ON THE EDUCATION SYSTEM - THE CASE OF ZAMBIA.....	6
Conclusions on Impact of HIV/AIDS on the Education Sector	7
The Way Forward	10
4.0 LIFE SKILLS PROGRAMMES	10
4.1 Life Skills Programmes in the Region.....	13
Zimbabwe Life Skills Programme.....	14
Namibia Life Skills Programme	15
Uganda Life Skills Programme.....	16
Lesotho Life Skills Programme.....	18
Malawi Life Skills Programme	18
Botswana Life Skills Programme.....	19
Swaziland Life Skills Programme	19
5.0 CONCLUSIONS AND THE WAY FORWARD.....	20
REFERENCES.....	22
APPENDIX 1	24

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ESAR	East and Southern Africa Region
ESARO	Eastern and Southern Africa Regional Office
HIV	Human Immuno-Deficiency Virus
IEC	Information, Education and Communication
LPS	Life Skills Programmes
MOH	Ministry of Health
MOE	Ministry of Education
SHEP	School Health Education Programme
STI	Sexually Transmitted Infection
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

As a new millennium dawns, the HIV/AIDS pandemic continues to ravage the Eastern and Southern Africa Region (ESAR). The statistics are disturbing: at least 40 million people are infected with HIV in sub-Saharan Africa. Much of the impact of HIV/AIDS afflicts children and women, the primary focus of UNICEF programmes. The bulk of new AIDS cases are among young people, aged 15-25 and females are disproportionately affected. The ability of girls and women to protect themselves from HIV is constrained by their status in society.

Decades of improvements in social welfare are likely to be undermined by the uninhibited progression of the epidemic. Life expectancy in some countries has already started on a downward spiral and is expected to drop to 30 years or less in nine sub-Saharan countries by the year 2010. AIDS-related mortality has begun to eliminate the gains made in child survival over the past 20 years.

Children will be the most affected as a result of HIV/AIDS as they live with sick relatives in households stressed by the drain on their resources. They will be left emotionally and physically vulnerable by the illness or death of one or both parents. Subsequently, children who have lost one or both parents are more likely to be removed from school, to stay home to care for the sick and to be pulled into the informal economy to supplement lost income. This is especially the case for girls.

The first part of this paper describes the impact of HIV/AIDS on the education sector in ESAR and points to the fact that as a result of all these social and economic processes, the AIDS epidemic is beginning to have a serious impact on the education sector, specifically on the demand for, supply of, and the management and quality of education provided at all levels. As a result of HIV/AIDS, there are relatively fewer children needing education. Fewer children are being born because of the early death of one or both parents. Moreover, fewer parents will want to send their children to school, and there will be fewer families who are able to afford to send their children to school. Fewer students in the education system and lower demand for places in education programmes, will most probably lead to a smaller supply of facilities and places. Schools that have enrolments below a certain minimum may therefore be closed and the remaining pupils moved to other schools. Even if facilities continue to be available, there may be a lack of teachers and other personnel to provide teaching services. The quality of learning outcomes and education will be affected by several confounding factors which will emerge as the pandemic takes a deeper hold in the ESAR countries. Already, education systems have begun to experience increased problems of teacher absenteeism, and loss of teachers, education officers, inspectors, planning and management personnel. Regrettably, in the ESAR region, the impact and devastation to the education system has yet to be calculated or determined although several countries have planned such studies.

The second part of this paper describes the urgency and need for education systems in ESAR to respond to the challenges of the negative impacts of HIV/AIDS. Education systems have an essential role to play in *reversing* the very pandemic that threatens it. Young people, especially those between 5 and 14 years, both in school children and out of school youth, offer a window of hope in stopping the spread of HIV/AIDS if they have been reached by Life Skills Programmes. In the absence of a cure, the best way to deal with HIV/AIDS is through *prevention* by developing and/or changing behaviour and values.

Life skills programmes aim to foster positive behaviours across a range of psycho-social skills, and to change behaviours learned early, which may translate into inappropriate behaviour at a later stage of life. Life skills programmes are one way of helping children and youth and their teachers to respond to situations requiring decisions which may affect their lives. Such skills are best learned through experiential activities which are learner centred and designed to help young people gain information, examine attitudes and practice skills. Therefore life skills education programmes promote positive health choices, taking informed decisions, practicing healthy behaviours and recognizing and avoiding risky situations and behaviours. Research shows that these programmes do not lead to more frequent sex or to an earlier onset of sexual activities, as opponents fear. Nor do they lead young people to promiscuity.

The paper also presents an overview of the education systems in seven countries in the region that have attempted to impart life skills to children and young people. To date, there are too few life skills programmes in ESAR that are targeting children and young people with information about HIV/AIDS and that meet the criteria for minimally effective education programmes. Many countries in the region are just beginning to explore the concept of life skills and how to advocate for it to be accepted and adopted into the education system.

Working together with governments and non-governmental organizations, UNICEF and its partners need to work towards promoting rights-based, child friendly schools that are a sanctuary and provide a safe and secure environment. Furthermore, school programmes that are health-promoting - promoting both the physical and psycho-social health, as well as being cost-effective and sustainable over the long term - must be developed and put in place.

UNICEF needs to advocate for life skills programmes to be understood and accepted as a national strategy and component of all children and adolescent reproductive health programmes, for in school children and out of school youth. Working in collaboration with its partners, UNICEF should build the capacity of the education sector to design, implement, monitor and evaluate life skills programmes and related activities in all ESAR countries. This calls for a concerted effort to create an enabling environment and to develop existing capacity and capabilities through the strengthening of resources.

1.0 INTRODUCTION: EFFECTS OF HIV ON COUNTRIES IN ESAR

As a new millennium dawns, the HIV/AIDS pandemic continues to ravage the Eastern and Southern Africa Region (ESAR). African countries now account globally for 70 percent of new infections and four-fifths of AIDS-related deaths. The pandemic is concentrated in the so-called “AIDS belt” stretching from East through Central and Southern Africa, where infection rates are now between 20 and 30 percent of the sexually active population. The bulk of new AIDS cases are among young people, aged 15-25 and females are disproportionately affected.

Countries in ESAR will almost certainly experience the most severe demographic effects of HIV/AIDS over the next 25-30 years after the epidemic has peaked. Decades of improvements in social welfare are likely to be undermined by the uninhibited progression of the epidemic. AIDS-related mortality has begun to eliminate the gains made in child survival over the past 20 years. Life expectancy will drop to 30 years or less in nine Sub-Saharan countries by 2010. Botswana, Zambia and Zimbabwe would have had life expectancies of 60-70 years without AIDS, but will have life expectancies of only 30 years with HIV/AIDS.¹ In Kenya and Uganda, infant mortality rates are projected to increase by 50 percent and child mortality rates to double. In Malawi, due to AIDS deaths, the 1997 population census shows that the overall population growth rate is now only 1.9 percent per annum compared with a projected growth rate of 3.2 percent in the 1987 census.

HIV/AIDS will continue to cause fundamental social and economic changes in the ESAR countries that will affect educational opportunities and the demand for labour. HIV/AIDS causes illness and death among adults in the most productive age groups. Costs to the economy of absenteeism and reduced productivity may be higher than the costs of eventual deaths. HIV/AIDS will significantly slow the growth of the labour force and will create labour shortages in several sectors including the education sector. The loss of women’s labour in the home and in agriculture will create critical deficits in food supplies. The epidemic will continue to have a profound impact on families and communities, on the availability of social services, access to health services and the rate of poverty at the household level. Children will be the most affected since they will be required to take the place of adults in the labour market, particularly in households that are highly dependent on subsistence farming.

¹ USAID, 1998, *Children on the Brink*, USAID, Washington, 1998

Unfortunately, the problems children face as a result of HIV/AIDS will have started long before their parents die, as they live with sick relatives in households stressed by the drain on their resources. Children are left emotionally and physically vulnerable by the illness or death of one or both parents, as numerous letters to newspaper editors in eastern and southern Africa already testify. Subsequently, children who have lost parents are more likely to be removed from school and pulled into the informal economy to supplement lost income. This is especially the case for girls. In a recent study in Kenya,² adolescent orphans from AIDS afflicted households in Rusinga, reported that 76.9 percent of the boys dropped out of school due to their inability to pay school fees, while girls dropped out or were withdrawn either because they were pregnant or in order to marry (58 percent). The dowry that is given when girls marry represents one less mouth to feed and an economic gain for the family. Almost 12 percent of girls were withdrawn from school because of illness in the family due to AIDS.

Strains on households and families may result in increases in child abuse and neglect, while girls already face increased pressure to marry at younger ages, again, due to AIDS. As a result of all these social and economic processes, the AIDS epidemic is beginning to have a serious impact on the education sector, specifically on the demand for, supply of and quality of education provided at all levels. Yet, in the ESAR region, the impact and devastation to the education system has not been calculated or determined, most probably due to the fact that there is little information available at the country or regional level. This paper represents a wake up call to redress the situation and has two key purposes: a) to review, synthesize and disseminate existing information on the impact of HIV/AIDS on education systems, and to suggest a way forward in the future and b) to review, analyze and disseminate available information on HIV/AIDS Education programmes in the region on Life Skills programmes focused on HIV/AIDS prevention or those which include a major component on HIV/AIDS prevention.

2.0 HIV/AIDS AND THE EDUCATION SECTOR: AN OVERVIEW

It is a well known fact that education and training are critical for long term development. Furthermore, the provision and growth of quality education is directly linked to positive economic development, emancipation and health dividends. However, HIV/AIDS is a real threat to the education sector and thus potentially to human resource-based development. HIV/AIDS has a multiple and negative impact on education. It affects three key areas at the local, district, provincial and national levels. These are:

- *the demand for education;*
- *the supply of education;*

² Johnston, T. et.al. A Profile of Adolescent AIDS Orphans. Population Communication Africa, Nairobi, 1999.

- *the quality and management of education.*

HIV/AIDS is Decreasing the Demand for Education

The pattern of *demand for education* may change due to the fact that there are fewer children to be educated. As a result of HIV/AIDS, there are relatively fewer children needing education. Fewer children are being born because of the early death of one or both parents. At the individual level, a child's opportunity for a bright future is lost or destroyed since the child may become infected or is affected by HIV/AIDS. As overall population growth slows due to HIV/AIDS, there are fewer children being born. Some of these children are born HIV + and most die before reaching school-going age. This means lower school enrollments. In Zambia, for example, primary school enrollments stagnated between 1990 and 1996 and it is estimated that this was due in part to HIV-related causes.

Fewer parents will want to send their children to school, and there will be fewer families who are able to afford to send their children to school. Such an effect on the affordability of education includes a number of issues: the direct loss of family income due to AIDS, from the illness and death of productive members of the family and the loss of income due to the costs of treatment, care and funerals. As the demand for education decreases, fewer families will be able to release children from domestic and agricultural tasks during the day, and caring for ill adults or other family members. Therefore, fewer children will be able to complete their primary school education. Furthermore, it has been estimated that in Zambia, estimates of the numbers of street children have swelled from 35,000 in 1991 to over 75,000 in 1996³, numbers of children in primary schools declined and known cases of child abuse (physical and sexual) are now beginning to be discussed in public.

Another study⁴ anticipates that in Botswana that there may be as many as 150,000 orphans by the end of this century. A 1992 World Bank study in Tanzania suggested that HIV/AIDS may reduce the number of primary school children by 22 percent and secondary school children by 14 percent as a result of increased infant and child mortality as well as lower attendance. In an-depth study conducted in Uganda on 20 students in a district hard hit by AIDS, nineteen of the students reported having been absent from school for periods ranging from five weeks to one and a half terms during the past one year. The most common responses given for absenteeism were lack of school fees and helping with the care of AIDS patients at home.

However, it is clear that declining enrolment in many countries in ESAR is already a fact of life. The lack of hard data in respect of infection rates for the school-going age population

³ Hunter, S. 1998, Orphan Programming in Zambia: Developing a Strategy for Very Young Children in Zambia, UNICEF Lusaka, 1998.

⁴ Hunter, S. 1998, Stimulating Orphan Programming in Botswana: Developing a Supportive Environment for Exploration, UNICEF Gaborone, 1998.

further makes it difficult to identify how far this decline has been accelerated by HIV/AIDS due to both reduced growth rates and the inability to take up places.

Preliminary estimates in some circles report that in Zambia, Swaziland and Zimbabwe, the number of children or primary school-going age will be more than 20 percent lower than pre-HIV/AIDS projections by 2010 and a high percentage of these will be orphans with very limited resources and incentives to enter the system. The Ministry of Education, Swaziland suggests that in 1999 the number of 6 year olds was 6 percent lower than it would have been in the absence of AIDS. The same study estimates that by 2016, there will be 30 percent fewer 6 year olds and 17 percent fewer 18 year olds.

HIV/AIDS is Decreasing the Supply of Education

HIV/AIDS is decreasing the *supply of education*. Currently, there is little hard data about the impact of HIV/AIDS on the decreasing supply of education. Schools that have enrolments below a certain minimum may be closed and the remaining pupils moved to other schools. Fewer students in the education system and lower demand for places in education programmes, will most probably lead to a decreased supply of facilities and places. New solutions such as the introduction of multi-grade teaching, might tax the current capacity of affected school systems which are unprepared for new responses to the situation.⁵

The *supply of education* will also be affected by issues of finance. Since enrolment is declining, so will be the number of financial supporters of the system whose contributions are essential for such things as chalk, books, school maintenance and supplementary allowances for teachers. Thus, the absolute investment in education will be less than anticipated. Ministries of Education in the region will be provided with an ever smaller piece of the national budget as the demand increases for funds to the health and other sectors which are more directly associated with the pandemic.

Declining numbers of teachers

Even if facilities continue to be available, there may be a lack of teachers and other personnel to provide teaching services. It is clear that the number of trained teachers is decreasing. Teachers who are infected may try to transfer to another area or, once visibly ill, abscond and disappear. In Zambia, the number of teachers dying from AIDS is greater than the output from all teacher training colleges. The Ministry of Education reported that 680 teachers (2.2 percent) died in 1996. The number is expected to rise to approximately 2000 a year by the year 2005. This is 5-6 teachers dying per day.⁶ In one of Kenya's eight provinces, it is

⁵ The Impact of HIV/AIDS on Education: Report of an IIEP Seminar, UNESCO, Paris, 1993

⁶ Kelly, M.Prof. The Inclusion of an HIV/AIDS Component in BESSIP, Lusaka, 1998.

reported that as many as 20-30 teachers die each month from AIDS of a total of all teachers. There is also evidence to suggest that teachers may be at higher risk from HIV than other groups since they have higher incomes than other people in rural areas and therefore greater mobility which is a known HIV risk factor.

In Namibia, the incidence of HIV infection among teachers is likely to be well above that for the population as a whole, which is currently between 20 and 25 percent.⁷ By 2010, therefore, at least 3500 serving teachers may have died in Namibia, but this figure could be as high as 6500. In Mozambique, nearly 3.1 percent of all Mozambican children under the age of 15 years are estimated to be HIV+. About 14 percent of all children will be living in a family affected by HIV/AIDS. They will help care for sick adults, and may contact TB. Many girls will be forced out of school to provide care, or replace the labour of sick and dying adults. On the whole, there will be fewer students to educate. However, the reality of it is that there will also be fewer educators and managers who will be able to attend school and manage the system.

HIV/AIDS is Decreasing the Management and Quality of Education

The quality of learning outcomes and education will be affected by several confounding factors which will emerge as the pandemic takes a deeper hold in the ESAR countries. Already, education systems have begun to experience increased problems of teacher absenteeism, and loss of inspectors as well as teachers, education officers, planning and management personnel. There will be a less qualified teaching force, as trained and experienced teachers are replaced with younger and less well trained teachers. It is quite apparent that as AIDS continues to take its toll, there will be schools with no head teachers and no inspectors of schools. This has a negative impact on the education system's ability to plan, manage and implement policies and programmes.

The school itself may also be affected by the psychological effects of having infection, illness and death in its midst. There is likely to be discrimination, ostracism and isolation in the classroom and school of those pupils and teachers who are infected or ill or are members of affected families. Teachers may face the suspension of social and health benefits and/or dismissal from the system. Pupils may face formal suspension by the system or be pressured to leave school if they have not already been pushed or dropped out.

In conclusion, the statistics are as staggering as they are frightening and they are impacting on the quality of education. It is impossible to overemphasize or exaggerate the scope and complexity of challenges faced by children affected by HIV/AIDS and by the families, communities and governments responsible for them. One of the most urgent responses to this tragedy should be to build the capacity of children to support themselves by enabling children to stay in school and acquire not only vocational skills but life skills. Although the

⁷ HIV/AIDS and the Education Sector Strategic Plan: Paper prepared for the Education Sector Strategic Plan First Annual Review Meeting, Maputo, 1999.

primary and most traditional role of the school is to equip children with literacy and numeracy skills, the school will be expected to take on a new, and perhaps daunting role, of equipping children with survival skills.

3.0 HIV IMPACT ON THE EDUCATION SYSTEM - THE CASE OF ZAMBIA

As mentioned earlier in this paper, there are few systematic attempts or studies in ESAR that have reported on the impact of HIV on the education system. There is an overwhelming lack of data from countries in the region that document the current situation regarding the impact of HIV in the education sector. However, Zambia is one exception.

In Zambia, the HIV/AIDS crisis is not a new problem. The disease first manifested itself in the early 1980s. It has now grown to such proportions that in late 1997, it was estimated that the adult prevalence rate was 19.9 percent with prevalence rates being about twice as high in urban areas than in rural areas.⁸ This means that among those Zambians now over the age of 15, one out of five will probably die at a young age from this disease, mostly over the next 3-10 years. Were prevalence to continue at present levels, then 50 percent of all newborns would eventually die from AIDS, some in infancy, others in adulthood, but all from AIDS rather than other diseases.⁹

Nowhere will the impact be greater than in the education system. There will be no future for many children in Zambia where, at present prevalence rates, half will die before their 15th birthday because of AIDS. Only large scale behavioural change will alter this bleak situation. Education is the only agency that can address itself to this with the group of children between 5 and 14 years, who are generally HIV free.

HIV/AIDS has already affected *the demand for education* since there is evidence which suggests that there has been an actual decline in primary school enrolments between 1990 and 1996 in Zambia.¹⁰ Moreover, there has been an increase in the number of dropouts and a decline in school completion rates. A fall in pupils-through lower enrollments or non-continuation- will lead to a decrease in the number of classes and schools. Of greater concern is the large number of orphans. In 1996 it was reported that there were almost half a million orphans. Other estimates suggest that there could be almost three times this number by the year 2000. This undoubtedly will have an impact on determining educational infrastructure and other human resource requirements and will lead to policy implications such as some schools having to close for lack of children and teachers and other being nearer the communities they serve.

⁸ Kelly, M. Prof. *The Inclusion of an HIV/AIDS Component in BESSIP*, Lusaka, 1998.

⁹ Ibid.

¹⁰ Ibid.

The Zambian MOE has reported that HIV/AIDS has also affected *the supply of education*. In 1996, 2.2 percent of the trained teachers died. Furthermore, the many trained teachers who are still surviving are finding it increasingly difficult to provide uninterrupted teaching services because they are too ill to do so.

Losses through death and sickness has already affected education officers, inspectors, college lecturers, finance officers, planning officials and other management personnel in the education sector. It is likely that 20 percent of MOE personnel are HIV+¹¹.

A reduced *supply of education* may also stem from lack of support and finance from heavily affected communities and/or government. As both have competing demands for resources, funds for maintaining facilities and places, let alone building new ones, may be very limited.

Other aspects of education, including the content, process and role of education have also been affected. The primary school curriculum is being changed to include psycho-social life skills and teachers will have to be trained to adopt new facilitation roles. In Zambia it has been suggested that due to the large and burgeoning orphan population, the curriculum will have to incorporate work-related training skills to enable orphans to look after themselves and their siblings. The school calendar, time and dates may need to be reorganized to accommodate the income-generating needs of orphans.

Kelly further suggests that it is the primary schools that are the principal channel through which messages about HIV/AIDS can reach Zambia's window of hope, the 5-14 year olds. These children must be empowered to internalize age-appropriate information about AIDS and demonstrate that they have learned this. They must be supported in forming personally held values and attitudes that will enable them to behave in ways that will protect them from risky behaviour. This means the schools will have to take on a more explicit role in behaviour formation and teachers will have to play a more active role in facilitating .

Conclusions on Impact of HIV/AIDS on the Education Sector

The scenario from Zambia is being replicated in every country in ESAR to a greater or lesser extent. Some countries are worse off than others in the region. The current HIV/AIDS pandemic is a problem that dwarfs all other problems in the region. As a result of HIV/AIDS, fewer children may need education because the birth rate will decline following the early deaths of potential parents. The transmission of HIV from mother to child, which is estimated to occur in 30 percent of cases where the mother is HIV+ will increase infant and child mortality and further reduce the numbers of children entering school.

¹¹ Ibid.

Kelly reports that in general, there will not be a fall in the absolute number of children in Zambia, but rather the rate of increase will decline¹².

Fewer children enrolling in schools:

In situations where schooling requires households to pay for education, fewer children and their families will be able to afford it, because of the direct loss of family income from AIDS-related illness and death, and costs of care and funerals. Moreover, children who have been taken in or live in extended families or in polygamous families, where more children require resources for schooling, will not be provided with money by the less productive remaining adults.

More children leaving school early:

However, it is not just the lack of financial resources that will keep children out of school. Even if children enter school, their chances of them completing their education are slim. This is due to the fact that many children will need to work or care for sick adults. They may also be ostracized, discriminated against and suffer from stigma when it is known that their family members have HIV/AIDS. Some children who are HIV + will also be too ill to attend school. Finally there is a perception that investment in education will not give returns due to premature mortality.

Gender gaps:

HIV/AIDS is already increasing educational disparities between girls and boys because girls are removed from school to look after and care for siblings and relatives, to substitute for the productive work of other family members or to save the costs of school fees. Moreover, girls may be forced into early marriage, as they are pushed out or try to escape from overcrowded extended families.

Increased danger for girls:

Evidence also suggests that men seek younger and presumed uninfected partners. Therefore, some parents want daughters removed from what they perceive as a dangerous school environment in terms of risk of infection from teachers, school boys, school workers, such as cooks and subordinate staff and outsiders who are allowed into the school. Some parents think that family life or sex education which is taught in schools puts their daughter at risk, since a knowledge about sex education may make them promiscuous.

Increasingly difficult to teach children:

It will become increasingly difficult for education to reach children, especially those defined as being in “difficult circumstances.” AIDS exacerbates problems of poverty, disinheritance, migration, orphanhood, child abandonment, psychological trauma,

¹² Ibid.

ostracism, discrimination, physical and sexual abuse - the very conditions which create such children.

Evidence indicates that a major problem with the HIV/AIDS epidemic is the rapidly increasing population of orphans. Research points to the fact that orphans have higher mortality rates, are likely to be less well nourished, may be overworked by their guardians and lack proper supervision, care and school or vocational training. Such problems may be aggravated if the child is uprooted from family and community, either through outright orphanhood or because of the often enforced migration of widows and their children. Such circumstances are resulting in increasing numbers of abandoned, exploited and unschooled street children. Schooling for orphans is an unexplored and new issue which needs to be addressed.

HIV/AIDS will affect *the supply of education* in the region through deaths of personnel, school closures, and reduced budgets for education and reduced capacity of households to contribute to financing schools. Teachers and other education personnel receive higher incomes which enhances greater mobility and consequently places them at greater risk. Furthermore, teachers and other education personnel may be posted to areas away from their families which results in high risk behaviour leading to HIV infection. After the initial incubation period of the disease, there will be absenteeism caused by illness, the need to tend to the sick and attending funerals, loss of staff due to increased mortality, and transfers from or refusals to be posted to heavily affected areas. Sick leave for Ministry personnel becomes a financial burden to governments since they are entitled to pay for up to one year.

At school and community level, as extended families grow, available income decreases while more financial resources are needed for illness and death; thus less money is contributed by the community to the school. At the level of the education system, funds may be required for health-related personnel costs such as treatment and care of staff, insurance, and death benefits. There will be a greater need for training and paying replacements of affected personnel (who may still be on the payroll) and on implementing an effective AIDS education programme.

At the same time, increased funds will be required for new clients and roles which the education system may need to adopt scholarships for orphans, teacher training in counselling, new curricula in life skills education, and new school-based programmes in income generation. The Ministry of Education, however, may receive a diminishing proportion of the national budget as demand for resources increases from other sectors.

The quality of education is being impacted by the HIV/AIDS epidemic. This has resulted in a less-qualified teaching force, as experienced teachers are replaced with younger more inexperienced ones.

The special needs of children who are infected and are in school will need to be considered alongside the development of positive attitudes that negate discrimination, stigma and

isolation of students and teachers who are infected or ill or who have families where somebody is ill or has died from AIDS.

The Way Forward

HIV/AIDS is a real threat to the education sector and thus potentially to human resource-based development. Education will become increasingly random as illness, absenteeism and death invade the schools. Policy makers and planners at national and district levels need current and accurate information about the demographic and other types of impact of HIV/AIDS in their countries. The first step therefore is to collect information about the pandemic in order to plan appropriate policies, investments and interventions. Better data collection and analysis will allow for better monitoring of the changing pandemic. Urgent attention should be given to conduct studies on the impact of HIV/AIDS on the education sector in the region. The World Bank initiative in collaboration with the Futures Group in four countries is a welcome step in that direction (Appendix 1). Kenya, with support from UNICEF, is also planning to conduct an impact study.

Because the HIV/AIDS pandemic is constantly evolving, monitoring its effects provides essential information to guide policy and programme development. Systems that regularly collect and disseminate information on health and socio-economic impact of HIV/AIDS on families and children are particularly important. Accurate information is essential for targeting assistance to children in the most seriously affected areas. The next step then would be to identify appropriate response actions and develop strategies and interventions aimed at keeping children alive, in school and in good health. There is an urgent need to get more AIDS-affected children into school, or into alternative and specially supportive basic education programmes. Schools and communities need to be assisted to establish mechanisms to trace and track children who are not in school and then get them enrolled. Both parents and teachers, as well as other ministry personnel need to be sensitized about the 'safeness' of AIDS affected children. UNICEF and its partners need to work towards promoting rights-based, child friendly schools that are a sanctuary and provide a safe and secure environment. Furthermore, school programmes that are health-promoting both in the physical and psychosocial sense, as well as being cost-effective and sustainable over the long term must be developed and put in place. One such example of a new supportive mechanism is the introduction of life skills programmes in schools.

4.0 LIFE SKILLS PROGRAMMES

Education systems must respond to the challenges of the negative impacts of HIV/AIDS. But more than this, education systems have an essential role to play in *reversing the very pandemic that threatens it*. Young people, especially those between 5 and 14 years, both in and out of school youth, offer a window of hope in stopping the spread of HIV/AIDS if they have been reached by Life Skills Programmes. In the absence of a cure, the best way to deal with HIV/AIDS is through *prevention* by developing and/or changing behaviour and values.

As they mature and become sexually active, more young people face serious health risks with too little factual information, too little guidance about sexual responsibility, few skills about how to protect themselves from adult coercion, and too little access to youth friendly health services. The help that young people need to avoid these risks varies.

Some young people are not yet sexually active. They need support and skills to postpone starting sex. Some suffer from sexual abuse and they need protection and care, particularly at this critical time when there is a threat of death from AIDS. Some start sex before marriage and change sexual partners several times before they marry. They need help to either abstain from sex or use condoms to prevent pregnancy and STIs. Life skills programmes is one way to offer the *information and skills* that young people need to deal with these issues.

There are five key psycho-social aspects that are included in life skills programmes which aim to influence health and social behaviour. These areas are:

- Self-awareness (self-esteem) and empathy
- Private communication and interpersonal relationships
- Decision making and problem solving
- Creative thinking and critical thinking
- Coping with emotions and coping with stress

Life skills programmes aim to foster positive behaviours across this range of psycho-social skills, and to change unacceptable behaviours learned early, which may translate into inappropriate and risky behaviour at a later stage of life. Life skills programmes are one way of helping children and youth and their teachers to respond to situations requiring decisions which may affect their lives. Such skills are best learned through experiential activities which are learner centered and designed to help young people gain information, examine attitudes and practice skills. Therefore life skills education programmes promote positive health choices, taking informed decisions, practising healthy behaviours and recognizing and avoiding risky situations and behaviours.

Life skills programmes provide a variety of exercises and activities in which children do something and then process the experience together, generalizing about what they learned and ideally, after much practice in the programme, attempt to apply it to future real life situations. Life skills therefore help young people to deal effectively with the demands and challenges of everyday life and to respond to the difficulties encountered in everyday life. They help children become socially and psychologically competent and to function confidently and competently with themselves, with other people and with the community.

One of the most important skills young people need to acquire is the ability to analyze situations, the behaviour of individuals, and the consequences of their own actions, *prior to engaging in those actions*. They also need to learn how to *avoid certain situations*. They need to understand what risky behaviour entails and *how to manage or avoid risky situations*.

Life skills programmes, family life education, and/or reproductive health programmes for children and young people often face opposition from parents, religious and community leaders and from some youth themselves who do not understand that they are at great risk. Research shows that these programmes do not lead to more frequent sex or to the earlier onset of sexual activities, as opponents fear. Nor do they lead young people to promiscuity. Recent research in Kenya suggests that family life/sex education programmes yield significant and positive adolescent reproductive health benefits and behaviours¹³. These findings about the behavioural change effectiveness of family life/sex education programmes are virtually identical to findings in other sub-Saharan countries, including Ghana and Ethiopia. Impact evaluations of such programmes concluded that young people ***do not engage in sex earlier or in more frequent sexual intercourse***. In some cases, the information and skills acquired by young people ***help them to delay the initiation of sexual activity***.

Life skills programmes provide an opportunity to address other social issues that young people encounter in their daily life. Sexual abuse and violence are serious problems that transcend racial, economic, social, ethnic and regional lines. Violence is frequently directed towards females and youth, who lack the social and economic status to resist or avoid it. Adolescents, children and young women and girls in particular experience increased abuse in the form of domestic violence, rape and sexual assault, sexual exploitation and/or female genital mutilation.

Violence against women is a widespread problem in ESAR. Surveys conducted in Uganda reveal that 46 percent of women report regular physical abuse. In Tanzania it is 60 percent, in Kenya it is 42 percent and in Zambia it is 40 percent.

In a study in South Africa, 40-47 percent of sexual assaults are perpetrated against girls age 15 or younger. Abuse takes place in both urban and rural environments. Studies conducted in a city in Zimbabwe found that half of reported rape cases involve girls less than 15 years of age and that girls are most vulnerable to sexual abuse by male relatives, neighbours and school teachers. Also distressing is that for one out of 10 young women the first sexual encounter occurs under force, threat or coercion. In a survey conducted by the Zimbabwe National Family Planning Council (ZNFPC), 16 percent of the women reported having forced sex.

In a study in South Africa, 30 percent of girls report that their first sexual intercourse was forced. In rural Malawi, 55 percent of adolescent girls surveyed report that they were often forced to have sex.

Violence has a significant impact on the health and life expectancy of women. Domestic violence can have long term psychological effects. Children in abusive households also suffer from the effects of violence, whether or not they are physically abused.

¹³ Johnston, T. ed. Ukweli: The Need to Know Newsletter, Nairobi, 1999.

Yet another study in Uganda suggests that both boys and girls can be targets for sexual abuse. In one district, 31 percent of school girls and 15 percent of boys reported having been sexually abused, mainly by teachers. Consequently parents and guardians will continue to keep their sons and daughters away from school unless the situation can be turned around and parents can be convinced that schools are a safe environment.

The threat of social stigma prevents young women from speaking out about rape and abuse. In Zimbabwe, rape cases are sometimes settled out of court when the perpetrator either pays compensation to the girl's father or pays a bride price and marries the girl to avoid bringing public attention and shame to the girl and her family.¹⁴ However, forced or early marriage of young girls to older males leaves girls with little or no economic or social power, since girls do not have the opportunity to return to school or to go for some type of training.

Poverty coerces many young people of both sexes into early sexual activity for money. These young people usually have little bargaining power or negotiation skills. In their sexual relationships and may be unable to protect themselves from pregnancy and STIs by using condoms. In ESAR, young girls frequently report that their early sexual experiences were coerced. Young women are vulnerable to coercion into sexual relationships with older men. A study of female adolescents in Kenya revealed that 50 percent of the girls admit receiving gifts in the form of money, ornaments and clothes from their partners when they engaged in sex for the first time.¹⁵ In Uganda, 22 percent of primary school girls anticipate receiving gifts or money in exchange for sex. Some adolescents also report engaging in sexual activity because it is pleasurable.

In conclusion, it is clear from the above discussion, that there are many reasons why boys and girls engage in early sex. Poverty and being coerced are two key reasons.

4.1 Life Skills Programmes in the Region

Learning for life in the 21st century requires equipping children with a basic education in literacy and numeracy as well as the more advanced, complex skills for living that can serve as a foundation for life, enabling children to adapt and change as do life circumstances. Nowhere is this more critical than in sub-Saharan Africa.

While there have been various attempts to impart life skills to children and young people in ESAR, to date there is no consensus on the definition, scope and methods for including life skills education in the school curriculum. This may account for the reason why the

¹⁴ Njovana E. Watts C. Gender violence in Zimbabwe: A Need for Collaborative Action. *Reproductive Health Matters*, 1996; (7) 46-52.

¹⁵ Njau,W and S.Radeny, *Sexuality among Adolescents in Kenya*, Nairobi, Kenya, Association for the Promotion of Adolescent Health, 1995.

implementation of life skills programmes have been sporadic and why some countries have yet to start such programmes.

The following section of this paper presents some examples of life skills programmes and activities in school systems in ESAR.

Zimbabwe Life Skills Programme

In Zimbabwe, which has one of the highest AIDS prevalence rates on the continent, the Ministry of Education and Culture took a bold step and began to offer a school-based HIV/AIDS and Life Skills Education Programme for schools in 1992. The AIDS Action Programme for Schools targets students and teachers from Grades 4-7 in all primary schools and Form 1-6 in all secondary schools. It is a separate subject on the timetable. AIDS Education is compulsory in all primary and secondary schools, and tertiary institutions. HIV/AIDS information is also integrated in relevant subjects. The AIDS Action Programme for Schools has helped to bring the HIV/AIDS problem in Zimbabwe out into the open for discussion.

The goal of Zimbabwe's AIDS Action Programme for Schools is to effect attitudinal and behaviour change amongst pupils in order to reduce the risk of HIV infection. The Programme aims at developing pupils' life skills such as problem solving, informed decision making, and avoiding risky behaviour. Participatory methods and experiential learning processes are expected to be used to teach life skills.

Zimbabwe's AIDS Action Programme for Schools has a number of important achievements to its credit. Over 6,000 schools are now teaching the prescribed curriculum, using high quality materials that have been produced and introduced into the schools. All national, regional and district Education Officers have received training through the programme and more than 2,000 teachers have received in-service training in the use of not only specific AIDS education materials, but also of participatory life skills methods generally. At the tertiary level, more than 5,000 teacher trainees have begun similar training in teacher training colleges.

An effective research and monitoring component has been built up and the data generated from this system have been used to effect mid-course adjustments in the Programme. The Programme has drawn on resources from within the existing education system and its managers have demonstrated a readiness to assess their problems and make corrections as needed. The Programme has the full support of the Government and others, including the churches.

In an evaluation conducted in 1995, it was found that only one third of the teachers had received any in-service training and were unfamiliar with experiential learning and participatory methods. Moreover, many teachers felt embarrassed to handle sensitive topics related to sex and HIV/AIDS.

According to the substantial experience in countries around the world¹⁶, life skills programmes are more effective when teachers:

- explore their own attitudes and values and establish a positive personal value system;
- establish an open and positive classroom climate;
- place education about STIs/AIDS within the context of a general programme on personal development, health and living skills;
- use a positive approach which emphasises awareness of values, assertiveness, and other relationship skills, decision-making and self-esteem;
- apply teaching about STIs/AIDS to situations with which students identify.

The Zimbabwe programme was the first of its kind in ESAR and although there is a need for longer initial training and more days for refresher courses for teachers, the programme has tried to incorporate some better practices, including strengthened teaching training, and has set a good precedent for others in the region.

Namibia Life Skills Programme

The Ministry of Education and Culture, with UNICEF assistance has focused initially on life skills training for 15-18 year olds for school youth after and outside school. *My Future is My Choice* is an HIV risk reduction intervention. By December, 1998, more than 21,000 young people had passed through an intensive peer education effort, and an additional 30,000 were planned to be reached in 1999. It appears that the programme reduced adolescent sexual risk behaviour.

¹⁶ UNESCO (1991). Some of the successful and exemplary AIDS education programmes highlighted in this report include those from the Philippines, Australia, Canada, and Uganda.

This effort has not only filled a void in Namibia, but it has also created a demand for similar training targeting youth ages 10-14 years. The Namibian Catholic Bishops Conference has joined the initiative to combat HIV/AIDS.¹⁷

The Namibian Ministry of Education and Culture has made progress in incorporating an HIV prevention framework throughout the primary and secondary school curriculum. The curriculum sends very direct and clear messages with regard to both abstinence and condom use. The primary and secondary school syllabus reinforces the issue of HIV prevention at frequent intervals from fifth to tenth grade in the Life Sciences Curriculum and in the Population Education Curriculum. Nearly all Namibian youth are in school up to grade eight and therefore most youth are reached by the school programme.

However, it has been reported that some teachers are uncomfortable with AIDS materials and do not wish to teach it. Many are still lecturing instead of using participatory methods.¹⁸ Furthermore, it has been suggested that many 15-18 year old youth, especially high risk youth, feel disenfranchised by the formal school system and therefore are not likely to be responsive to risk reduction messages presented in a school setting.¹⁹ In conclusion, there is need for mobile teams to reach young people where they are. The programme has been able to successfully reach almost 51,000 young people out of a total national population of about one and half million. There are plans to start a similar programme for children between 10-14 years of age.

Uganda Life Skills Programme

In the early 1990s, Uganda had a comprehensive School Health Education Programme (SHEP) which provided health information to pupils, although the intention had been to also change behaviour. An evaluation of the programme in 1994 revealed that the curriculum had indeed been successful in raising knowledge about health issues, but it reportedly had little impact on attitudes and values and no discernible impact on health practices.

¹⁷ UNICEF, CP Medium Term Review, p.7, 1999.

¹⁸ Stanton, Bonita, HIV Prevention Efforts in Formal Curriculum of Ministry of Basic Education and Culture: Targeting Youth 10-14 Years of Age in Namibia, Maryland University, p.2, 1999.

¹⁹ Ibid. p.3.

It was pointed out that behaviour and practice needed to be targetted more effectively. The study therefore led to the development of a Life Skills Programme and recommended using experiential and participatory methods. In 1994 the programme was launched with a national sensitization seminar for senior policy makers, opinion leaders and NGO representatives. Baseline surveys were conducted in primary and secondary schools followed by the development of life skills reference manuals for teachers. Another reference manual for training out of school children and youth facilitators was also developed. Primary teachers' college tutors were trained in 1997/8.

In a one year trial using the WHO-UNESCO in-school Life Skills Manual in Masaka district in Uganda, a curriculum and materials were developed. Some 100 primary and 32 secondary school teachers were trained. A control group of schools was included as well. One key feature of this programme was to do a pre and post test on knowledge, attitudes and practices related to STI/HIV/AIDS and sexual behaviour. This trial was part of an overall IEC intervention in the district. Following the intervention, it was found that there was no significant difference between the control group and the intervention school for the following reasons:

- Teachers were not confident to carry out experiential learning activities such as role plays and therefore reverted to more conventional teaching methods.
- Teachers avoided teaching sensitive topics such as those on or those that referred to condoms for fear of losing their jobs and due to religious affiliations.
- Since it was not an examinable subject and not on the curriculum, it was not perceived to be important.
- The teachers said they taught about 70 percent of the life skills lessons officially included on the timetable, while the pupils claimed they only taught about 30 percent of the lessons.

Some lessons learned from this intervention point to the need for a more concerted effort to ensure that life skills programmes are developed with an agreed upon methodological approach and strategically placed in the curriculum with the commitment of all players. There is need to enlist the support and cooperation of inspectors and local authorities. Teachers require *skills* and confidence to facilitate experiential learning activities in life skills lessons.

Currently, effective advocacy has created a supportive environment for life skills education and plans are under way to develop a better designed curriculum, sufficient and sustained training and basic but essential teaching materials to bring life skills education effectively into primary and secondary schools. Life skills will be infused in health/science as the carrier

subject.

The Ministry is now in the process of developing a curriculum, designing training approaches and writing teaching materials, to bring life skills education into schools. The initial focus is on the primary schools.

Lesotho Life Skills Programme

Lesotho has integrated some HIV/AIDS and STI information in such subjects as health and physical education in the primary school curriculum and in the biology curriculum in secondary schools, although the subject is not compulsory in all schools. In an assessment conducted by Chendi,²⁰ the life skills programme is intended to equip the youth with life skills to enable them to deal effectively with the demands and challenges of everyday life. However, on closer examination of the content of the curricula, it is heavily biased towards knowledge, with very little curriculum content or time during lessons on the requisite skills and attitudes for behaviour development and/or change. Moreover, head teachers have not received training on life skills and many teachers state that they lack the confidence to handle such sensitive topics. In conclusion, while a certain amount of activity is taking place, the coverage is unknown and the methods are ineffective with the exception of those that are implemented by a few NGOs.

Malawi Life Skills Programme

In Malawi, where 15-25 percent of urban youth are infected with HIV, and girls are 3 to 4 times more likely to be infected than boys, the Ministry of Education implemented a life skills syllabus for Standard 4 children in primary schools in 1997. Regrettably, about 2 percent of children drop out after Standard 1 and most pupils terminate their education, and therefore remain unreached, and leave school after Standard 4. The syllabus attempts to equip learners with skills such as decision making, problem solving, effective communication, assertiveness and conflict resolution, among others. However, due to the design of the programme, it is unlikely that there will be any significant behavioural change, since the findings indicated the lack of appropriate teaching and learning methodologies for effectively learning skills related to safe behaviour. Standard classroom modes of assessment are identified in the syllabus. Chendi's²¹ assessment of the Malawi Life Skills Education Programme revealed the urgent need to train teachers, to develop additional materials for use in all classes in primary and secondary school in all districts in the country – and importantly the need to develop participatory learning practices in schools. To date, there is scant information on the impact the life skills programme is having in reducing the incidence and prevalence of STIs, unplanned pregnancies and young people's ability to engage in risk free behaviour.

²⁰ Chendi, Helen, HIV/AIDS Life Skills Programmes in Lesotho, Unpublished, 1999.

²¹ Chendi, Helen, HIV/AIDS Life Skills Programmes in Malawi, Unpublished, 1998.

Botswana Life Skills Programme

A 1998 Sentinel Survey conducted at ante-natal clinics at nine sites in Botswana, indicated that out of 4194 pregnant women tested over a twelve week period, 1614 were found to be HIV positive and about 13 percent of these were less than 20 years old.²² This is a clear indication that young people and especially women are engaging in unsafe sex. Consequently in 1998, the Ministry of Education developed a policy on HIV/AIDS Education with the following guidelines:

- HIV/AIDS education must be integrated into the curriculum and should be made compulsory at all levels of education:
- It is the responsibility of all staff involved in education to participate in HIV/AIDS education since the disease has social, economic, scientific, demographic and moral implications.
- Schools, in cooperation with the local health authorities, should involve parent teacher associations and the community in AIDS education. There should be links between the school and the community on this issue.

The Ministry of Education has infused life skills across the curriculum in secondary school subjects such as development studies, biology, religious education, integrated science, and social studies and especially focusing on the Guidance and Counselling programme to work on skill development. Nevertheless, AIDS education is presented as one-off lessons, taught as biomedical facts to be learned for a test by teachers who are uncomfortable discussing the topic. Teachers lack participatory methods to ensure effective learning and there is little understanding of the important role life skills plays in the development of young people.²³

Swaziland Life Skills Programme

The Life Skills Programme in Swaziland is still in the planning stages and has taken a different approach. It appears as though there is no clear cut policy as yet regarding the infusion of HIV/AIDS in the curriculum. However, it is incorporated in several interventions including care of orphans, activities for out of school youth and school based AIDS education. *Despite*

²² Molobe, Ennie and Tanya Salewski, Education for Citizenship: Life Skills in the Botswana Classroom, Paper presented at the 1999 BOLESWA Symposium, 1999.

²³ Ibid, p. 24.

these efforts, the impact of these interventions has been negligible.

It has been reported,²⁴ that in the School Based HIV/AIDS and Population Education Programme, (SHAPE), implemented by CARE, HIV/AIDS is handled in a rather haphazard manner and may or may not be taught, depending on the commitment of the head teacher as well as the ingenuity of the teacher who has been trained by SHAPE.

In a few schools, HIV/AIDS is taught as a separate lesson and in others it is infused into the curriculum. Yet in other schools, it is taught only if the teachers have time. Therefore, in conclusion, there is no clear policy as yet, coverage is quite low and the intervention has been sporadic and, as a result, generally ineffective, due to the methodology used.

5.0 CONCLUSIONS AND THE WAY FORWARD

Young people need life skills programmes that learn and respond to their needs, earn their trust, go where they are and speak their language, that is, the language of youth and children. These programmes must start early, because many young people are initiated into sex early, either voluntarily or are forced into sex and violated at an early age. Lessons learned from life skills programmes in general point to those programmes that have done best when they win support by working with parents, local and religious leaders, remove policy barriers and change service provider's prejudices. Other lessons learned indicate the need to enlist children and young people in programme design and delivery, tell young people specifically what they need to do, and help them to rehearse the interpersonal skills to avoid risks. Finally, it is crucial to link information and advice with services, offer role models that make safe behaviour attractive and invest enough-for long enough- to make a difference.

Specific experience in ESAR has shown that

- stand-alone life skills programmes or having one lesson a week entirely separate and on its own, or a special lesson within a subject like health education or biology, ***have a better chance of succeeding than those that are infused in the curriculum.***
- Life skills programmes are successful when they use participatory methods and experiential learning techniques.
- To date, there are too few life skills programmes in ESAR that are targeting children and young people with information about HIV/AIDS and that meet the criteria for minimally effective education programmes.

²⁴ Chendi, Helen, HIV/AIDS Life Skills Programmes in the Kingdom of Swaziland, Unpublished, 1998

Many countries in the region are just beginning to explore the concept of life skills and how to advocate for it to be accepted and adopted into the education system. Working together with governments and non-governmental organizations, UNICEF needs to advocate for life skills programmes to be understood and accepted as a national strategy and component of all children and adolescent reproductive health programmes, for in school children and out of school youth. Working in collaboration with its partners, UNICEF should build the capacity of the education sector to design, implement, monitor and evaluate life skills programmes and related activities in all ESAR countries. This calls for a concerted effort to create an enabling environment and to strengthen human resources. The time to act is now.

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APPENDIX 1

STUDIES ON HIV/AIDS IMPACT ON THE EDUCATION SYSTEM

Draft

STUDIES ON HIV/AIDS IMPACT ON THE EDUCATION SYSTEM

Draft

Country	Studies completed	Studies planned	Comments/Source of info	Agency/ies
Botswana		Impact assessment on education sector	<i>Country Visit Dec 99</i>	USAID
Burkina Faso		Impact on education sector	Under consideration	UNDP
CAR	UNICEF/UNDP '99	Impact on teachers and students	Funded by UNICEF/UNDP	UNICEF/UNDP
Côte d'Ivoire	UNICEF '97 '98	Impact on teachers and students Same format as CAR study	Funding sources not clear UNICEF/UNDP/WB/UNAIDS?	UNICEF/UNDP (?)
Kenya		Impact on education sector Planned January 14-February 4, 2000 Demographic impact of epidemic on projections for teachers and school-age children	Under consideration <i>Bert Voetberg - email 22 Oct. 99</i>	UNDP World Bank
Malawi		Toolkit in MOE Impact on education sector One core researcher and 2 national researchers	<i>Brad Strickland - email 12 Oct. 99</i> <i>Email from Nicola Swainson to Des Cohen 18/11/99 - requested draft proposal from Des on Nov. 26</i>	USAID Rockefeller Foundation
Mozambique	-	Impact study under consideration Planning study	MMB - email to JL 21/10/99 UNICEF info MINED planning with Irish Aid (Carol Coombe, contacting Alan Whiteside, Natal Univ, Durban); MINED, Prov. Directorates, WHO, WB, bilaterals, UNICEF agreed on need for a study	UNDP
Namibia		Suggested impact assessment study	<i>Brad Strickland memo of 9 July</i>	USAID
South Africa		Ongoing Technical person to work w/ MOE Planned '99	<i>Brad Strickland - email 12 Oct. 99</i> UNICEF info HIV/AIDS UN Theme Grp Wkplan <i>Need more info</i>	USAID UNICEF

Swaziland	Hunter Sectoral study '99	Impact on education sector Rapid Assessment in Ed Aug 99	Under consideration <i>Country Visit Dec 99</i> <i>UNICEF info</i> HIV is a crosscutting issue in UNICEF SITAN for new CP 2001.	UNDP UNICEF
Tanzania		Impact on education sector Interest expressed by country	Under consideration	UNDP
Uganda		Planned January 10-21 2000 Demographic impact of epidemic on projections for teachers and school-age children Impact on education sector One core researchers and 2 national researchers	<i>Bert Voetberg - email</i> <i>22 Oct. 99</i> <i>Email from Nicola Swainson to Des Cohen – requested draft proposal from Des on Nov. 26</i>	World Bank Rockefeller Foundation
Zambia		Suggested impact assessment study “Earmarked” “Socio-economic and quality aspects of the impact on the education sector” Planned November 15-December 3 Demographic impact of epidemic on projections for teachers and school-age children	<i>Brad Strickland memo of 9 July</i> <i>Bert Voetberg - email</i> <i>22 Oct. 99</i> <i>Bert Voetberg - email</i> <i>22 Oct. 99</i>	USAID World Bank World Bank
Zimbabwe	-	Planned: 99-Impact of HIV/AIDS on Ed System; Impact of HIV/AIDS and LS ed Prog 2000 “earmarked” “Socio-economic and quality aspects of the impact on the education sector” Planned December 6-17 Demographic impact of epidemic on projections for teachers and school-age children	UNICEF info <i>Bert Voetberg - email</i> <i>22 Oct. 99</i> <i>Bert Voetberg - email</i> <i>22 Oct. 99</i>	UNICEF World Bank World Bank
Global		Ongoing HIV/AIDS impact on education sector	<i>Janne Lexow - email to Sheldon Shaeffer,</i> <i>20 Oct. 99</i>	NORAD - Norway

20 Studies Planned in 11 countries
Nov 26 1999