HIV/AIDS AND EDUCATION IN UGANDA: WINDOW OF OPPORTUNITY?

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ABBREVIATIONS

AIC	AIDS Information Centre
AMREF	African Medical Research Foundation
ANC	Antenatal Clinic
DFID	Department for International Development
DISH	Delivery of Improved Services for Health
ESIP	Education Sector Investment Plan
FGD	Focus group discussion
FP	Family Planning
JCRC	Joint Clinical Research Centre
KABP	Knowledge, Attitudes, Behaviour and Practices
LC	Local Council
MOES	Ministry of Education and Sports
MOH	Ministry of Health
NCDC	National Curriculum Development Centre
NGO	Non-governmental organisation
NRM	National Resistance Movement
PLWA	Person Living with AIDS
PTC	Post-Test Club
PTR	Pupil Teacher Ratio
SHEP	School Health Education Programme
SMT/SWT	Senior Man Teacher/Senior Woman Teacher
STD/STI	Sexually Transmitted Disease/Sexually Transmitted Infection
TASO	The AIDS Support Organisation
UAC	Uganda AIDS Commission
UPE	Universal Primary Education
USH	Uganda shillings
UWESO	Uganda Women's Effort to Save Orphans
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

Executive Summary

HIV prevalence has been falling steadily in Uganda since 1992 and is now approximately 8%. This decline has been most noticeable in the 15-29 age groups and has been achieved through an aggressive public health campaign spearheaded by the Ministry of Health, with support and encouragement from President Museveni. The anti-AIDS activities have been co-ordinated by the National Uganda AIDS Commission. The main strategy has been to disseminate a message that emphasizes empathy and support for AIDS victims, abstinence, faithfulness in sexual relationships and the use of condoms during sexual intercourse. It has been a joint effort with national and international NGOs and religious organizations playing significant roles.

Behaviour changes have also been documented, for example:

- A two-year delay in the onset of sexual intercourse among youth aged 15-24 years
- A sharp increase in condom use from 15.4% to 55.2% among men and from 5.8% to 38.7% among women
- A drop of nearly 50% in the proportion of men and women exchanging sex for money
- Decrease in the proportion having sex with casual partners
- Increase in the proportion using condoms with non-regular partners.

However, challenges remain and a national AIDS control strategic plan is being re-launched with substantial funding from the World Bank. The Ministry of Health is negotiating with drug companies to reduce the cost of AIDS therapies. The Ministry of Education and Sports is also currently developing a strategic plan to fight AIDS and HIV infection in the education sector.

This study of the impact of HIV/AIDS on the education sector was part of a three country study (Uganda, Malawi and Botswana) and had three broad aims:

- To assess the strategies being used to educate students about HIV/AIDS in schools
- To assess the impact on students as orphans, caregivers and those infected with HIV.
- To assess the impact on teachers as educators and employees.

Carried out by a four-person team in Uganda, the study took a multi-pronged approach to the assessment:

- Interviews with stakeholders (government, NGOs and international agencies)
- Developing projections of teacher and student numbers using national demographic and educational statistics
- Survey in 10 schools (6 primary and 4 secondary) in two districts (Masaka and Jinja)
- Interviews with orphans

The study's findings and recommendations are summarised below under the three broad areas of interest.

HIV/AIDS Education

Findings

- There is very little reference to HIV/AIDS in the formal curriculum; only the last year of primary has any significant content

- Schools depend on invited guests, (MOH, TASO, AIC), outreach programmes, public education, and counselling from Senior Women and Men Teachers to provide AIDS education for students
- Student knowledge about basic facts of HIV/AIDS is good, increases with age, and varies by gender and urban/rural location. Students were unsure about some common myths, e.g. that having sex with virgins cures AIDS.
- Teachers and radio are the most commonly cited sources of information, with girls favouring teachers and boys, the radio.
- Discussion about HIV/AIDS topics between teachers and students was considered embarrassing by both sides.
- Guidance and counselling was an underdeveloped part of the school curriculum and needed guidelines and more personnel to make it effective
- HIV/AIDS was not seen as a major problem among students, i.e. students perceived that only a small proportion were HIV positive.
- Sexual harassment was generally not seen as a major problem and several schools showed evidence of strict guidelines and policies to prevent teacher/student sexual harassment. Students still felt vulnerable to members of the general public and non-teaching staff.

Recommendations

There are four strategies that can be used to improve the capacity of the education system to contribute to a decline in HIV/AIDS prevalence. These strategies are:

- Enhancing the HIV/AIDS content in the curriculum
- Improving the ability and skills of teachers to transmit this curriculum
- Developing and enhancing guidance and counselling services
- Creating an environment within schools that is hostile to sexual harassment, early sexual activity, etc.

These strategies can improve the knowledge and life skills of students and enhance their ability to avoid the behaviours that can lead to HIV infection.

Impact on Students

Findings

- Teachers and head-teachers identified increased levels of absenteeism and dropout as the principal negative consequences on students.
- Approximately 37% of the students interviewed reported having lost at least one parent. Ten percent had lost both parents.
- School interruption, i.e. having to drop out of school at one point or another, was the schooling indicator that was most affected by the loss of a parent. Thirteen percent of primary students with both parents alive had had to interrupt their schooling, but 43% of those without parents at secondary level had had to leave school at some point.
- There did not appear to be evidence of gender bias in absence from school; this had more to do with whether parents were alive and whom the student lived with.
- Personal sickness was the most common reason for being absent.
- Having a father die led to fewer negative consequences than losing a mother with respect to repetition, absenteeism and school interruption.
- School rules and regulations played a major role in causing absenteeism: children were sent away for fees, discipline, etc. This was the second most common reason for being away from school.

- Orphans reported feeling lonely, unloved, and financially deprived. They also expressed much anxiety about their future and their prospects for further education and career opportunities. Some reported anxiety about being vulnerable to HIV infection through sex work.
- Orphans reported being subject to excessive labour demands from guardians. Other students confirmed this.
- Although some discrimination against orphans was reported, students generally displayed much empathy and sympathy for their plight.
- Taking care of sick parents who later die of AIDS has a lasting impact on students.
- There was no systematic method of identifying orphans or children in need, whether material or emotional. Nor was there a general strategy for providing assistance.
- NGO assistance to orphans or with HIV/AIDS education, while useful and appreciated, was perceived as ad hoc and intermittent.
- Assistance from two major NGOs had shifted from direct subsidies to assistance directed at promoting family economic self-sufficiency
- Teachers and head-teachers felt that the number of students who were orphans would increase and this would lead to poorer quality teaching/learning environment. Students would be too poor to afford necessary school materials, and a higher proportion of them would be under psychological and emotional stress.

Recommendations

The government can enhance the training already planned for teachers and educational staff to include issues of orphan support as the evidence suggests that orphans make up a substantial proportion of students in schools. Therefore, while out-of-school programmes for orphans will be important, a comprehensive in-school approach for addressing the constraints faced by orphans must be developed.

The MOES can initiate the following:

- ✓ Explicit development of guidance and counselling guidelines covering such issues as confidentiality, ethical standards, appropriate referrals, roles and responsibilities of guidance and counselling staff, head-teachers, school management and district education officers.
- ✓ Review of the options for providing supplemental material support for orphans and other vulnerable children, in an inclusive and non-stigmatising way.
- ✓ Districts can coordinate the work of NGOs to ensure that service provision is more even.
- ✓ Districts can assist line Ministries to provide a coordinated response to the needs of orphans and other needy children, even if this is only to make assessments and identify those most in need of assistance.

NGOs can:

- ✓ Reach out more consistently and extensively to schools and educational institutions with HIV/AIDS prevention programmes

Schools can:

- ✓ Proactively reach out to communities through PTAs and school management committees to identify children in need of material and emotional support.
- ✓ Develop systematic strategies for providing assistance to needy children enrolled in schools.

Impact on Teachers

Findings

- Deaths were a relatively insignificant cause of teacher attrition.
- Absenteeism was reported to be low both by teachers and students.
- The primary cause of absenteeism was school-related duties (meetings, sports fixtures, etc.) followed by personal or family sickness.
- Official support in cases of sickness or death was meagre. Official regulations called for dismissal after 180 days of sick leave. Occasionally, District Education Offices paid for head-teachers' funeral expenses.
- On the other hand, teachers felt that the school administration was generally supportive in cases of illness and provided assistance when resources were available.
- There was very little discrimination reported against those who were HIV positive.
- Levels of morale varied from school to school and depended on conditions of work (proximity to transportation and medical services, supplementary pay, and availability of housing).

Recommendations

- ✓ Develop a corps of HIV/AIDS education specialists.
- ✓ Develop a district-based system of support (counselling, education) for teachers affected by HIV/AIDS.
- ✓ Investigate options for sickness and death benefit insurance schemes for teachers.
- ✓ Incorporate information about teacher absenteeism, sick leave into the EMIS and disaggregate death statistics by gender and age.

Role of New Government Initiatives

The government of Uganda has begun or is beginning a rejuvenated anti-AIDS programme to guard against the threat of a resurgence of the epidemic. There are two linked initiatives that govern all the sectors and two initiatives from the Ministry of Education and Sports that are relevant to HIV/AIDS. These are:

- Uganda AIDS Commission's Strategic Framework;
- World Bank's HIV/AIDS Control Project in support of the UAC's Strategic Framework.
- Ministry of Education's Strategic Plan for HIV/AIDS,
- The ongoing Primary Teacher Development and Management Plan, 2001-2003.

These initiatives already incorporate many of the recommendations above but the following areas need further development:

- ✓ Broadening the perspective of the curriculum review
- ✓ Inclusion of HIV/AIDS in pre-service education.
- ✓ Elaborating HIV/AIDS education's links to examinations, to teacher assessment, school inspection, and system management
- ✓ Introducing school-based interventions planned in the UAC framework directed at the care of orphans or the mitigation of the impact of the epidemic on both children and teachers.
- ✓ Strengthening the management of HIV/AIDS within the Ministry of Education
- ✓ Strengthening the management of HIV/AIDS within the Districts
- ✓ Developing strategies for providing technical advise and expertise at both national and district level

- ✓ Establishing support mechanisms for HIV/AIDS educators
- ✓ Establishing a budgetary base for the MOES' HIV/AIDS work within the Medium Term Budget Framework.

1. INTRODUCTION

1.1 The AIDS Crisis and Education

While HIV/AIDS is a global phenomenon, sub-Saharan Africa is at the core of the epidemic. It is estimated that African countries now account for 74 percent of new HIV infections and 78.5 percent of AIDS-related deaths in 1999 (UNAIDS, 2000). The epidemic is concentrated in the so-called 'AIDS belt' stretching from East through Central and Southern Africa where, typically, infection rates are now over 15 percent of the sexually active population. The bulk of new HIV/AIDS cases are among young people aged 15-25 and females are disproportionately affected. Although the epidemic (particularly in southern Africa) has not yet peaked, population growth rates are already appreciably lower. In Malawi, for example, results from the 1997 population census show that overall population growth rate is now only 1.9 percent per annum compared with a projected growth rate of 3.2 percent based on the 1987 census. Life expectancy at birth is a key indicator of human development. In nine of the countries with an HIV prevalence of 10 percent or more (Botswana, Kenya, Malawi, Mozambique, Namibia, Rwanda, South Africa, Zambia and Zimbabwe), it is estimated that the epidemic will cost 17 years of life expectancy: instead of reaching 64 years by 2010-2015, it will regress on average to 47 years (ibid: 7).

Despite the excellent progress made in Uganda in reducing prevalence rates, the HIV/AIDS epidemic continues to pose a threat to human resource development goals in the new context of universal primary enrolment. There is insufficient understanding of the precise implications for educational provision and a corresponding need to formulate appropriate interventions that attempt to mitigate the effects of this crisis on both the demand and supply of educational services. To date, the focus has been on providing AIDS education through community-based initiatives. However, although, community-based HIV prevention programmes have achieved significant results, the opportunity to make a lasting impression on children during their school years—before they become sexually active—has not been fully utilized.

With the adoption of an educational sector development programme in Uganda, the need for a comprehensive and detailed understanding of the actual and likely impacts of the epidemic on education is critically important. A recent study by the Futures Group (Goliber, 2000), focused on the demographic impact of the epidemic on teacher attrition and recruitment needs as well as on the size of the primary school cohort between now and 2010. The main conclusion was that the educational planners in Uganda had used projections that adequately allowed for the impact of AIDS on enrolment and consequently teacher requirements. Nevertheless, estimates of numbers of orphans and their impact on the educational system are still urgent areas for verification and investigation.

1.2 The Knowledge Base

A review of the literature indicates that little published research that specifically addresses the actual and likely impacts of the epidemic on the education sector in Uganda has been undertaken. Research on HIV/AIDS has been mainly preoccupied with examining the wider demographic and health impacts of the epidemic and, to a much lesser extent, the effects on economic growth and productivity. HIV/AIDS research in Africa has tended to focus on

epidemiology, peri-natal transmission, and assessment of knowledge, attitudes and practices (Fredland 1995).

At present, only very anecdotal evidence is available about the impact of AIDS in the education sector. There is, therefore, little more than a set of fairly basic propositions (see figure 1 below), which have not yet been systematically tested.

While a number of factors have been identified that are likely to affect the supply of or the demand for schooling adversely, no systematic attempt has been made to analyse these factors in detail and, in particular, present adequate supporting evidence.

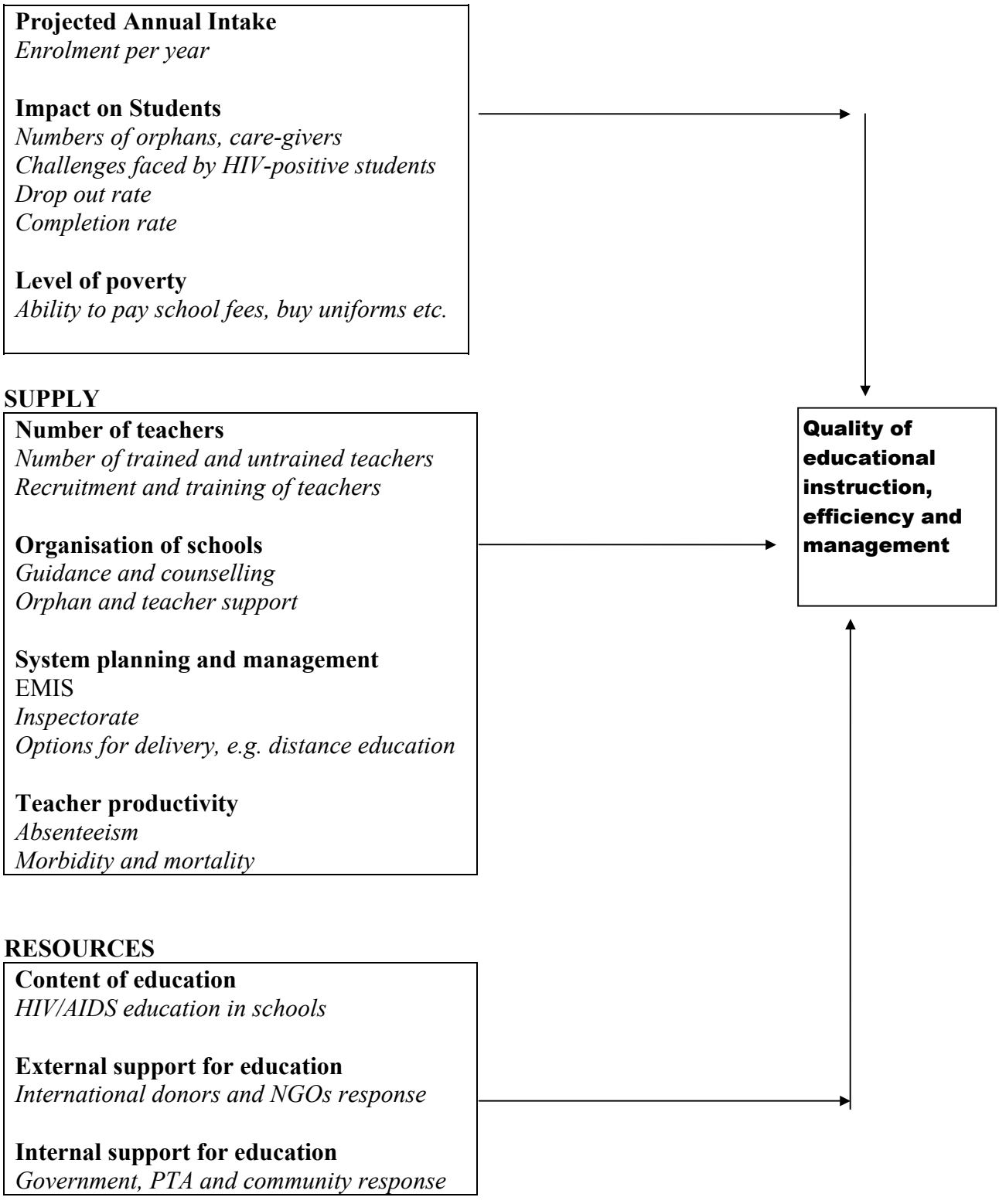
The rate of HIV/AIDS transmission has fallen appreciably in Uganda since the early 90s' and consequently the numbers of individuals becoming sick is no longer growing. However, the number of orphans will continue to grow for the next 10 to 15 years. Even though infection rates have fallen, the long incubation of the virus ensures that a proportion of teachers will continue to be HIV positive, and consequently suffer long periods of illness and eventually die.

Ensuring that the rapidly growing numbers of AIDS orphans are properly educated will be a major challenge. It is projected that in Uganda, approximately 3 million children will have lost one or both parents by 2005. Despite UPE, the age of first enrolment is likely to rise as children in HIV affected households are faced with the death of one or both breadwinners. The psychological and social disruption facing many children will require a flexible education system with the integration of formal and non-formal methods of delivery.

Girls and women are more vulnerable than men in the context of the HIV/AIDS epidemic: they have a greater susceptibility to contracting the virus in the first place (for physiological reasons), lower incomes, more limited access to health facilities, greater exposure to older partners who are more likely to be infected, and fewer entitlements to the ownership of assets or savings. The recent gains made in promoting female participation at all levels of the education system may be eroded and possibly wiped-out altogether by the demand-reducing effects of the epidemic. For example, a recent study in South-western Uganda shows that school absenteeism among girls from AIDS-affected households is significantly higher than among boys. This is mainly because girls are expected to stay at home to nurse the sick and undertake the additional tasks (both inside and outside the household). Without appropriate policy interventions, increasingly severe resource constraints in AIDS-affected households (most notably, the inability to pay school fees and meet other essential schooling expenditures) will adversely affect school enrolments, the age of enrolment and/or educational attainments for all children, especially girls.

Quite apart from access and persistence issues, learning achievements could also be adversely affected as the epidemic impacts on a rapidly growing proportion of children. At a time when governments and donors are concentrating on cost-effective measures to improve educational quality in order to encourage demand and improve persistence in schooling, it is clear that the epidemic is throwing up altogether new problems and challenges.

Figure 1 **IMPACT OF HIV/AIDS ON EDUCATION**



1.3 Study Objectives

As noted earlier, despite the potentially extremely serious impacts of the HIV epidemic on the educational development in Uganda, remarkably little attention has been devoted to this fundamentally important problem. In particular, no research to date has adopted a comprehensive analytical approach that systematically addresses all the key quantitative and qualitative impacts of the epidemic on the national education system. Such an approach should be country-comparative. Key similarities and differences in the range of educational impacts between countries as well as the effectiveness of various policy interventions can then be properly analysed. The key questions to be addressed are as follows:

- What role does the Ministry of Education play preventing HIV infections (content of the curriculum, quality of delivery, level of knowledge among students, other strategies in place to encourage positive behaviours)?
- What is the impact of the epidemic on students who are affected and to what extent does the education system, or other agency, address their needs (those who have lost parents to the epidemic, those who are nursing sick parents and those who are HIV positive themselves)?
- What impact has the epidemic had on teachers (mortality, absenteeism, etc.) and what services are in place to address their needs?
- What has been the involvement of key stakeholders, including NGOs and other government ministries?
- What interventions have been made by other organisations, both public and private, that, directly and indirectly, have tried to reduce the impact of the epidemic on the education system?
- How effective have these various interventions been in mitigating the impact of the epidemic on educational provision?
- Given current, and probable future, levels of infection, what are the likely impacts during the next 10-15 years on student and teacher numbers?

1.4 Report Structure

This report is in three parts. The first part is introductory and provides a background to the study, a description of the education system in Uganda and a brief history of the national experience with HIV/AIDS. The second part presents the research findings and the third part presents recommendations and proposals for addressing the situation. The second and third parts are organised around three central themes based on the study findings. The three themes are: prevention, impact on students and impact on teachers and other staff.

Prevention: Under this theme the current interventions by the Ministry of Education are discussed, along with the views of students and teachers about the effectiveness of these interventions.

Impact on Students: The second theme focuses on the impact on students. While the overall picture is presented, special attention is paid to three groups, orphans, caregivers and those students who are HIV positive.

Impact on teachers and school staff: This section reviews the impact of the epidemic on teachers as educators and as individuals affected by the epidemic. Projections of teacher numbers and recruitment needs under a variety of scenarios are also presented.

The discussion of each theme presents the current situation as seen by the Ministry, the respondents and other stakeholders. Where applicable, it includes national projections for the demand for and supply of educational services and the impact of the introduction of various interventions.

1.5 Team Members

The team consisted of three consultants—Karin Hyde (team leader), Catherine Barasa and Andrew Ekatan. This team worked closely with and was assisted by Mr. Yusuf Nsubuga[1], Commissioner of Secondary Education. Ms. Eunice Kyomugisha joined the core team for the data collection in the schools. Paul Kiage provided research assistance. Coding, data entry and cleaning was done by Lucy N'gang'a.

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[1] HIV/AIDS Focal Point in the Ministry of Education and immediate past Director General of the Uganda AIDS Commission

2. OVERVIEW AND CONTEXT

2.1 The Education System

Uganda's formal education system consists of primary (P1 to P7), lower secondary (S1 to S4), upper secondary, (S5 and S6), and tertiary levels (3-5 years). This structure has been in place since 1963, the result of a recommendation made by the Castle Commission. This study focused on primary and lower secondary education.

Pre-primary education, outside the formal education system, is largely concentrated in urban areas and is provided by the private sector. The Government is, however, progressively working towards full supervision of pre-primary education in order to provide some control and take on responsibility for its quality (MOES, 1999).

Primary education is central to the whole system. Some of the specific aims and objectives of primary education as outlined in the 1992 draft White Paper are to enable individuals to acquire literacy, numeracy and communications skills, and to develop and promote constructive developmental, cultural, moral and spiritual values (MOES, 1999). Over 90% of children are in government primary schools.

Some of the broad aims of secondary education as outlined in the 1992 draft White Paper on education include imparting and promoting a sense of self-discipline, ethical and spiritual values, personal and collective responsibility; instilling and promoting national unity, an understanding of the social and civic responsibilities; and, laying a foundation for further education (MOES, 1999).

Arising from the above objectives and the rapid growth of enrolment at primary level, the Government aims to increase access to, and improve the overall quality of, secondary education. Privately owned secondary schools are encouraged in order to meet growing educational demand, but have to be approved and licensed by the Ministry of Education and Sports (MOES, 1999). Transition rates between primary and secondary are relatively low and fell between 1995 and 1997 (from 41.6% to 35.8%), with the number of secondary school places being the limiting factor.

The key goal of tertiary education, according to the 1992 draft White Paper, is to train senior technical, managerial and professional personnel. The government has established the National Council for Higher Education in order to achieve this goal, and embarked on professional training and re-training programmes for tutors at tertiary level (MOES, 1999).

The government provides for the training of all teachers countrywide and requires that all teachers from pre-primary to University, be professionally trained (MOES, 1999).

Special Education is offered to children and adults who have learning difficulties due to physical or mental handicaps. The Government offers support to all institutions providing special education to enable them to operate more effectively and efficiently. The official policy on disabled children is to provide free education. Special education teachers are prepared by the Uganda National Institute of Special Education (MOES, 1999).

Education Quality: In 1998, there were 98,878 teachers in government primary schools. Of these, 33,238 (34 percent) were female. Grade 1, Grade 11 and untrained teachers constitute 12.2% of the total number of teachers. There were 5,276,209 students in primary schools. The overall ratio of students to teachers was 58:1. The ratio of students to qualified teachers (Grade III or higher) was 90:1. Generally, private primary schools have lower pupil/teacher ratios than government schools, at 32:1 and 58:1 respectively (MOES, 1999).

Those government schools with active management committees have generally tried to hire supplementary teachers directly as they regard the government limits on teacher numbers as too restrictive. These teachers, though reported to be qualified, receive lower salaries than government teachers.

There are at least four required core textbooks for English, Mathematics, Science and Social Studies. The average student per textbook ratio for all subjects is approximately 5:1. However, this masks variations between different subjects and classes. For example, the number of students sharing a Science textbook is seven compared with four for Mathematics, English and Social Studies (MOES, 1999*).*

In 1998, there were a total of 74,500 classrooms, 31,000 (42 percent) of which were incomplete. Of the complete classrooms, 25,426 (58 percent) were permanent, while the rest were semi-permanent or temporary. Those classes without classrooms are either held in the open or in other facilities, such as churches, or mosques. However, specific data on these are not available (MOES, 1999).

2.2 Government Education Policy

The education sector is governed by the Education Sector Investor Plan 1998-2003 (ESIP). ESIP arose from the need to place investment in the education sector, particularly the UPE initiative of 1997, within a planned framework that is fully consistent with the 1992 White Paper on education.

ESIP has several policy frameworks for primary, secondary, tertiary and higher education as outlined below. At the primary level, the objectives are the following:

- Clarify and reaffirm UPE policy framework
- Rehabilitate and expand classroom resources
- Expand UPE facilities to out-of-school and other disadvantaged groups
- Increase recurrent and development budget support available to UPE
- Increase efficiency in the use and deployment of primary teachers
- Deliver a sustainable curriculum including instructional materials
- Implement a sustainable teacher development programme
- Implement an Information, Education and Communication (IEC) scheme to reduce exclusion of disadvantaged groups from primary education.

The purpose of ESIP at primary level is to achieve universal access to high quality education.

The overall purpose of ESIP at secondary level is to enable an increasing number of young people to benefit from relevant secondary education of high quality. ESIP objectives for secondary education include:

- Increase access to secondary schooling to absorb increased numbers from primary schools.
- Improve the quality of secondary schooling.
- Improve efficiency of secondary school management and governance capacities.

The purpose of the tertiary (vocational) policy framework is to provide skills useful for the modernisation of Uganda and ensure productive lives for young people. The ESIP objectives for Tertiary (Vocational) education:

- Clarify Technical Vocational Education Training (TVET) policy and strategy
- Improve the quality of TVET provision
- Prepare trainees for technical advancement and for self employment
- Establish Community Polytechnics providing low-cost accessible training opportunities for primary school completers.

ESIP objectives for Higher education:

- Strengthen the management of higher education
- Develop new universities and an institute of technology
- Improve, refurbish, complete existing tertiary facilities
- Implement efficiency improvements in the tertiary sector
- Improve the quality in the tertiary sector and
- Improve equity and access in tertiary system.

The purpose of ESIP at this level is to enable more Ugandans to obtain worthwhile higher education qualifications at a lower unit cost (MOES, 1998).

Universal Primary Education (UPE) for primary school-going age (six to thirteen years) was declared in 1996 by government. The underlying principle behind UPE is to increase the literacy level in Uganda by reducing the proportion of the cost of education borne by parents and hence making primary education compulsory and free in Uganda (MOES, 1999).

The policy on UPE seeks to increase resources for primary education through increasing the overall share of sectoral allocations in the government development and recurrent expenditures budgets. The government meets statutory primary school fees requirements for a maximum of four children per family. All orphans are entitled to attend primary school under UPE. The government also undertakes to provide non-locally available building materials such as iron sheets, timber, cement and nails in addition to instructional materials and payment of teachers' wages. Parents, however, are responsible for providing writing materials (such as exercise books and pens), meals, uniforms as well as contributing labour and locally available materials for the building and maintenance of school structures (MOES, 1999).

As a result of the above arrangements, enrolment doubled following the implementation of UPE. This increase aggravated existing shortages in school facilities. A need to develop teachers' skills in the teaching of multi-aged students attending the same class and in handling large numbers of students was immediately identified (MOES, 1999).

Earlier MOES policies did not have specific strategies related to gender issues. Policy recognition of gender issues in education first emerged in the 1992 draft White Paper that noted girls' low levels of enrolment, persistence and performance. The White Paper therefore advocated making education universal and more democratic, as well as providing

increased access and equity, and making education compulsory at the primary level (MOES, 1999).

> *"Girls have equal opportunities as boys for selection among the four children and where there are both boys and girls at least two of the four shall be girls" (MOES, 1999).*

One of the policy statements from the 1992 Government White Paper and Education Policy Review Commission (EPRC) is reflected in recommendation 50 (viii):

> *"Government will allow 10 per cent free places in secondary schools for boys and girls respectively, who have genuine and convincing problems in payment of school fees... And 25 percent of the girls in P5-P8 classes throughout Uganda will also be allowed free education so as to increase girls' education."*

It also recommended the provision of basic education to all irrespective of age, sex, race, religion or region.

> *"The ESIP (1998 - 2003) strategies and targets, in the medium term, include ensuring universal enrolment of all children, including all females of primary school age. It also aims at increasing participation of females in all the education sub-sectors during the period up to the year 2003. Government pledges commitment to increasing access, equity and quality education to all."*

There is no specific HIV/AIDS policy statement from MOES. A Task Force on HIV/AIDS was formed in the second half of 2000 and is in the process of drawing up a strategic plan.

2.3 NGOs reaching out to Youth in Schools[2]

This section provides brief descriptions of the activities of NGOs providing sexual and reproductive health information and services to children and/or adolescents. The interviews focussed on the major NGOs working in this area.

The Straight Talk Foundation
The Straight Talk Foundation has influenced the sexual behaviour change of many young Ugandans. It publishes two monthly newspapers--*Straight Talk* and *Young Talk*--that reach over one million young people in primary and secondary schools.

The Straight Talk has a two-fold mission: "keeping adolescents safe" and "communication for better health" and two specific objectives:

- To increase understanding of adolescence, sexuality and reproductive health
- To promote safer sex, life skills, and child and adolescent rights.

[2] The descriptions that follow are based on interviews with staff and documentation provided by them. We were unable to gain access to any independent evaluations although several organisations claimed to have conducted such. The claims for impact must therefore be put in this context.

The *Straight Talk* newsletter was launched in 1993 with the aim of providing in-school teenagers with reliable information about sexual and reproductive health. The newsletter started with a print-run of 30,000 and immediately generated an enthusiastic response from young people and teachers. By October 1999, 155,000 copies were being printed every month. *Straight Talk* advocates abstinence and condom use as protective strategies for its readers, who are school-going adolescents and youth aged 15-24. It is supplied to all 1,400 secondary schools in Uganda (30 copies per school) and to over 400 tertiary institutions. Approximately 400,000 young people now read the publication regularly.

Young Talk was launched in February 1998, and now has a print-run of 270,000 per month. It is aimed at young adolescents, aged 10 to 14, attending primary school. It advocates sexual abstinence, but provides information about condoms whenever requested by readers. The newsletter is sent to all 12,000 primary schools in Uganda, with each school getting 15 copies. Copies are also sent to teacher training colleges.

These two sister publications tackle sensitive issues of importance to adolescents. These include physical body changes, wet dreams, menstruation, self-esteem, boy-girl relationships, masturbation, virginity, condom use, STDs/HIV/AIDS, Sugar Mummies, Sugar Daddies, pregnancy, rape and sexual harassment. Readers send in questions and receive answers from trained counsellors on a wide range of sensitive topics. There is also a counselling column.

For out-of-school youth who are literate in their mother tongue, the Straight Talk Foundation publishes editions of *Straight Talk* in *Ateso*, *Dholuo*, *Runyankole* and *Luganda*. The Foundation also runs a programme of school visits by counsellors, nurse/midwives, doctors and social development workers. It has also launched the Straight Talk Radio Show in which adolescents appear on five FM radio stations.

School Health and AIDS Prevention Programme

The African Medical and Research Foundation (AMREF) together with the Soroti District Administration started a School Health and AIDS Prevention Project in rural counties of Soroti District and within Soroti town. The project covered 95 primary schools, with an enrolment of about 120,000 children. Students are encouraged to put reproductive health problems into their "health letter-boxes". The letters are read out to the students[3] during morning assemblies, and answered on the spot by specially trained teachers. The health letterboxes are part of an innovative School Health and AIDS Prevention Programme that has helped to reduce dramatically sexual activity among primary school students.

A national survey in 1995 found that on average girls become sexually active at 16 and that 30% of girls had engaged in sexual intercourse by the age 15. In some parts of Uganda, surveys have shown that up to 62% of boys and 38% of girls were involved in unprotected sex before completing primary school. In the project area of Soroti, a survey carried out in 1994 among primary school students showed that 42.9% of the students aged 13-14 were sexually active. Boys were more likely than girls to be sexually experienced: 61.2% of boys were found to have had sex, compared with 23.6% of girls. This pattern of sexual activity clearly exposed many young people to a high risk of unplanned pregnancy, STDs and HIV/AIDS.

[3] The word 'Students' will be used throughout the report to refer to both primary and secondary levels.

Programme Strategy: The project aimed to encourage safer sexual behaviour, particularly abstinence, amongst primary school students through:

- Improved access to information about healthy sexual behaviour and strategies for positive decision-making
- Improved adolescent-to-adolescent interaction regarding information and decision-making relating to AIDS, sexuality and health
- Improved quality of the existing district education system in implementation of the school health curriculum and in counselling/advice-giving to students.

A District Steering Committee was appointed to oversee the activities of the project. It consisted of officials from the Department of Education and Health, local government personnel, religious leaders, parent representatives, youth leaders, women's organisation and staff from AMREF-Uganda. The project organised workshops to discuss health and sex education with parents, community leaders and teachers at every primary school in the project area. Teachers (Senior Woman/Man Teachers) were also trained on health education to improve their knowledge and health education skills.

The project has helped local teacher training colleges to introduce school health, AIDS prevention and Child-to-Child health learning techniques into their training courses. More influential are the weekly 'guidance and counselling sessions' run by Senior Women Teachers and Senior Men Teachers for those students in standards five, six and seven. Small groups sit under a tree to give them a chance to interact with one another in an informal atmosphere, with guidance and support from teachers whenever necessary. Students began using "health letter boxes" at school to ask questions about HIV/AIDS, STDs and other intimate matters related to sexual and reproductive issues. In addition, students went to teachers for individual counselling, advice or practical help.

In every school that was involved in the project, students started extra-curricular school health clubs whose members came together to share knowledge and experience, and to support one another in observing a healthy lifestyle. They also composed songs, staged skits and plays, and wrote poems and essays about HIV/AIDS, pregnancy and other related issues.

Information about condoms was handled cautiously. Most teachers confined themselves to providing information about the condom, without showing samples or demonstrating how it should be used. Others brought condoms to school and quietly demonstrated their use to senior students, especially those already sexually active.

After two years in operation, a follow-up survey on sexual behaviour was conducted in 1996 using a sample of students in the project area and a similar sample from a control group of schools in a neighbouring county outside the project area. The survey found that in schools involved in the project, the percentage of students claiming to be sexually active had fallen dramatically: from 42.9% in 1994 to 11.1% in 1996. Boys were still more likely than girls to be sexually active: 15.8% compared with 6.4% for girls. By contrast no significant changes in sexual behaviour were recorded among the students in the control schools.

The survey explored the reasons for this 74% decline in sexual activity. It was established that the main reason was greater social interaction between students and teachers, and among students themselves. The social interaction was not accidental but was carefully fostered by the project. The channels of communication that had been opened up between the project

and local families and communities also contributed to its success. Community leaders and parents were sensitised about the aims and activities of the project and also offered the opportunity to express their views in the local meetings. These efforts have helped parents and communities to understand and accept the project's aims and strategies.

In late 1998, the project was expanded to cover all 213 primary schools in Soroti District and 154 schools in the neighbouring District of Katakwi – a total of 367 schools with a total enrolment of 192,000. The social interaction approach adopted by the project has since been incorporated into the curriculum of the two teacher training colleges which supply most of the new teachers for the two districts.

The Mobile Farm School Project

In August 1998, with funding from Caritas Norway, the Kitovu Mobile Programme (an off-shoot of Kitovu Hospital in Masaka) started a "Mobile Farm School" project for orphaned teenage school dropouts. The project, which operates at ten different centres (school or community buildings), is currently training about 400 young people (70% boys and 30% girls) in agricultural skills. In addition to the agricultural curriculum, the Farm Schools deal with sensitive issues such as sexual behaviour, AIDS, orphan-hood and relations with guardians. These issues are addressed both within the formal curriculum and through counselling.

All students participate in HIV/AIDS awareness and behaviour change classes. They are also able to meet with counsellors who help them cope with their emotional and social problems. At the Farm Schools, the students undergo counselling once a month. In the first year, counselling is mostly on an individual basis. At the start of the second year, most students form peer-counselling groups, to help one another understand and cope with their problems. There are reported to be encouraging signs of behaviour change, especially in communities where the Mobile Programme is active.

Student Partnership World-Wide (SPW)

SPW is a youth focused education charity committed to giving young people a central role in the development process.

SPW recruits, trains and deploys young volunteers, from Uganda and from overseas, to work on programmes in rural communities. These programmes are designed to give other young people the life-skills to tackle the everyday problems of environmental degradation and poverty. By mobilising young people into development-focused groups, the programmes add a new non-formal dimension to the school system and thus promote community participation.

SPW volunteers' ability to interact with their peers in rural communities of Uganda with a commitment to helping them improve their lives, make them powerful role models and agents of change. SPW education volunteers have worked in 34 schools in Kapchorwa, Kamuli and Mbale districts. They:

- Raise awareness among young people about issues that affect their lives (including HIV/AIDS).
- Empower young people, especially girls, to make decisions for themselves.
- Set up Youth Clubs as a focus for young people's active involvement in community development. The Youth Clubs are attached either to schools or to existing community-organisations, bringing together motivated young people. Through the clubs, the youths

identify peer leaders and teachers who will keep the clubs active after the placement terms are over.

- Teach life-skills within the curriculum. As permanent support for the informal network of Youth Clubs, SPW is planning the construction of a model Youth Development Centre to provide resources and specialist life skills training.
- Organise event days, demonstrations and workshops to raise awareness and transfer skills.
- Run co-curricular activities such as drama by Aids Information Centre, sport, music and art in schools.
- Conduct non-formal education in the villages addressing issues on HIV/AIDS/STIs, hygiene and sanitation and adolescent reproductive health problems.
- Ensure wider-community support for youth-led activities.
- Raise the profile of young people in development and environmental work

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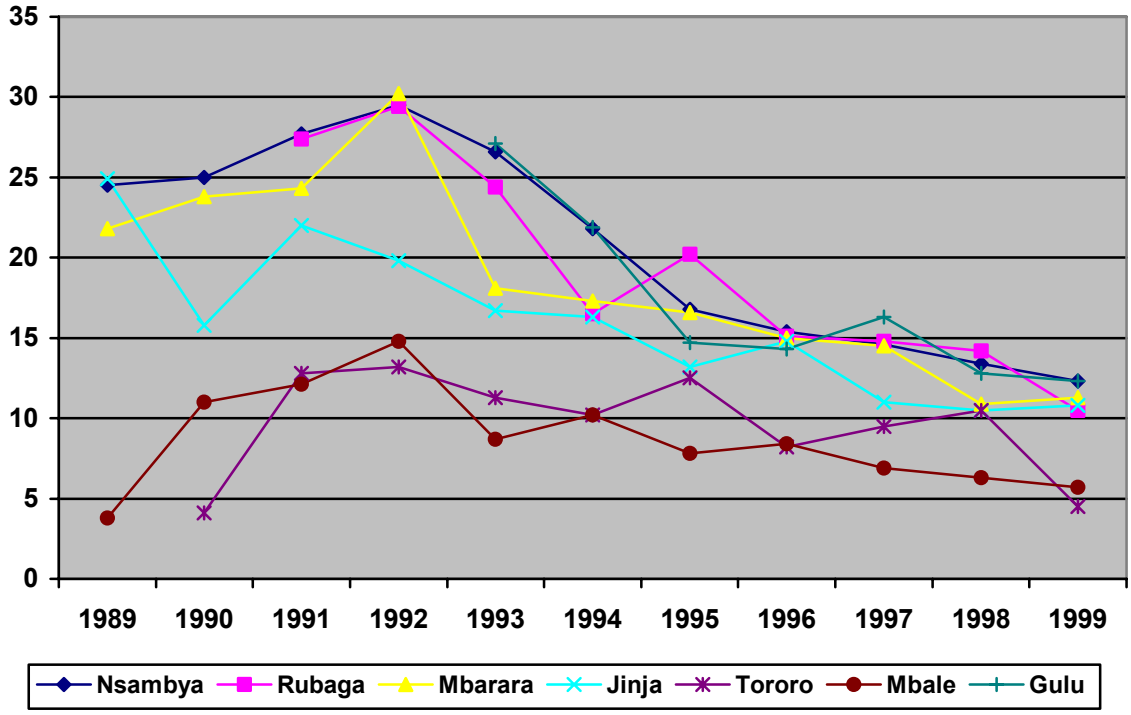
3. HIV/AIDS—the challenge and the response

3.1 The Experience of HIV/AIDS in Uganda

In this chapter an overview of Uganda's experience with HIV/AIDS is presented along with brief descriptions of key programmes, NGOs and innovations that are generally credited with contributing to progress against HIV/AIDS.

In the mid 1990s surveillance reports from the Ministry of Health indicated that HIV prevalence was beginning to decline in Kampala and other urban areas.

Fig 2: Infection Rates at ANC Sentinel Sites



Eventually, evidence also came in from rural areas that the decline was apparently countrywide. Even St. Mary's Hospital Lacor in Gulu (Gulu in the chart above) has documented a decline in prevalence despite its location in a war-torn district. Figure 2 illustrates the historical rise and decline in the prevalence rates from antenatal clinics in the main sentinel sites.

By the late 1990s there was also firm evidence of significant changes in sexual behaviour, especially among young people and further declines in HIV prevalence were reported from different parts of the country. Researchers in Uganda believe that these declines in HIV prevalence are linked to changes in sexual behaviour, which were made possible in part by the openness that has characterised Uganda's national response to the HIV/AIDS epidemic.

The first evidence of changed behaviour was published in the international journal *AIDS* in 1997 in an article based on a 1993 study (Asiimwe-Okiror et al, 1997) that reported:

- A two-year delay in the onset of sexual intercourse among youths aged 15-24 years. Among girls, the median age increased to 16.6 years and to 17.4 years among boys.
- A sharp increase in condom use: from 15.4% to 55.2% among men, and from 5.8% to 38.7% among women.
- A drop of nearly 50% in the proportion of men and women exchanging sex for money.
- A 9% decrease in casual sex in the previous year among male youths aged 15-24.

The June 2000 edition of the Ministry of Health's *HIV/AIDS Surveillance Report* indicates that positive changes in behaviour have been sustained (table 1). A 1998 KABP survey in six districts provided evidence for very high levels of awareness, increases in levels of knowledge of protection from HIV/AIDS, increases in ever condom use and condom use in non-regular or casual partnerships. While no additional delay in age of sexual initiation was reported, it had remained at the previously recorded level.

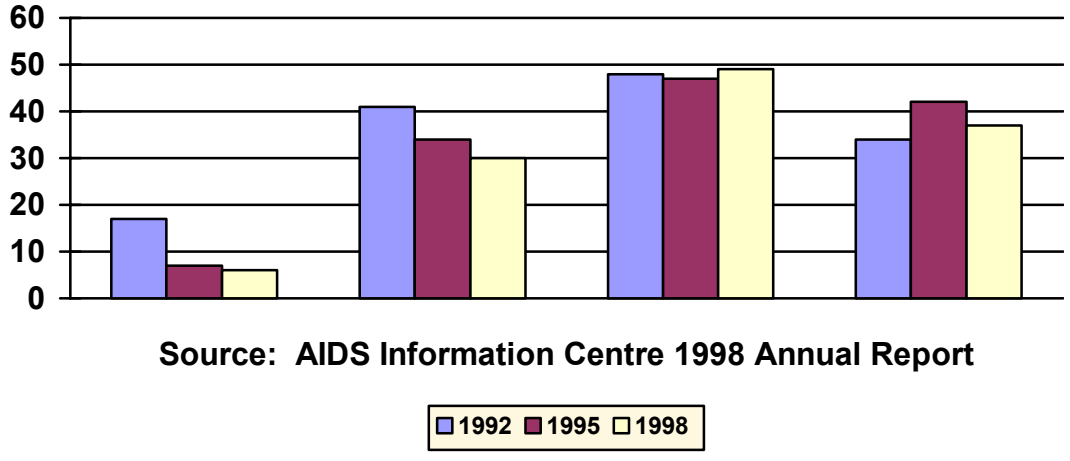
Table 1: Comparison of Population Based KABP Findings, 1995 and 1998

	Kampala		Jinja		Lira		Soroti	
	1995	1998	1995	1998	1995	1998	1995	1998
Knowledge of preventive practices	84.2	87.5	80.0	86.1	**72.1**	**87.4**	85.8	86.2
Reported non-regular sexual partners	14.1	13.7	7.8	7.0	7.5	5.4	**11.4**	**6.4**
Reported condom use with non-regular partners	**57.6**	**76.0**	**34.3**	**66.7**	14.3	13.8	14.3	18.0

Source: Ministry of Health HIV/AIDS Surveillance Report, 2000.

As indicated above, HIV prevalence in Uganda has been falling since the mid-1990s, and nowhere has the decline been faster than among young people. Growing numbers of Ugandan adolescents, especially those still attending school, are having sex at a later age. Those adolescents who are sexually active are adopting condom use faster than other sections of the population.

Fig 3 Trends in HIV Rates Among Female First Time Testers



Source: AIDS Information Centre 1998 Annual Report

Fig 4 Trends in HIV Rates Among Male First Time Testers

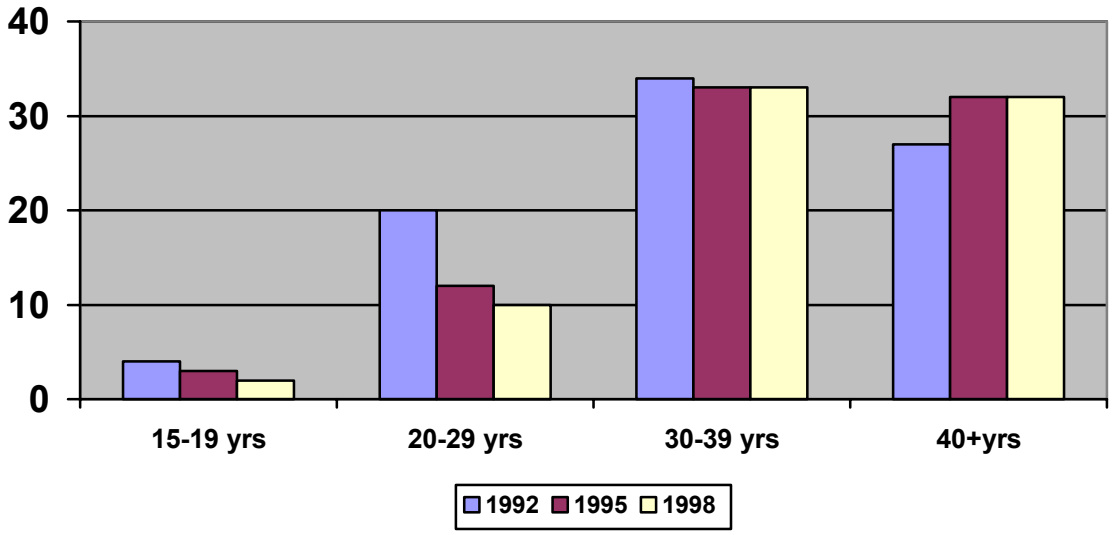
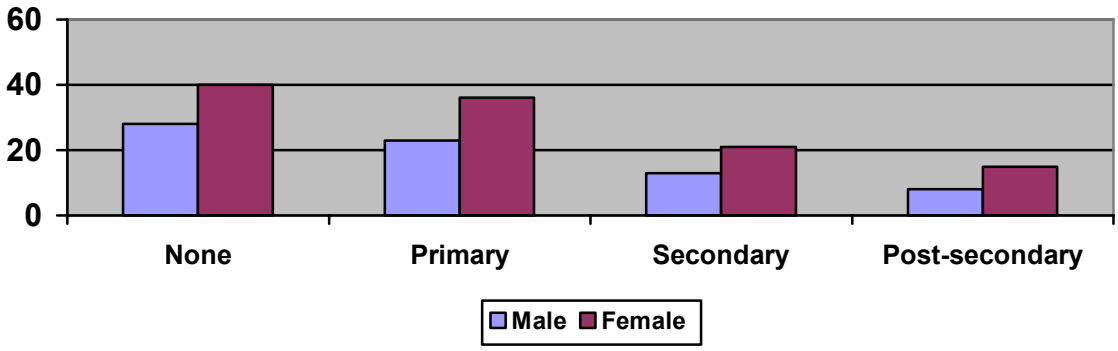


Fig 5 HIV Seroprevalence by Education Level



Moreover, some young people who were sexually active at an early age have decided to abstain until they are older (Kaleeba et al, 2000).

Figures 3 – 5 are based on the results of HIV testing done by the AIDS Information Centre[4] on 400,000 clients between 1990 and 1998. They illustrate a reduction in prevalence among the younger age groups and suggest that education reduces the likelihood of being HIV positive.

Uganda's achievement in responding to the challenges of the HIV epidemic has been a joint effort; government, individuals, NGOs, community groups and religious organisations have all played important roles. Many foreign NGOs have provided aid, either through their own field programmes at the community level (e.g. Concern, Lutheran World Federation, Redd Barna, World Vision) or indirectly via local NGOs and community groups (e.g. ActionAid, Caritas Norway, Oxfam, *Médecins Sans Frontières*). Much of their success would not have

[4] See below for more information on AIDS Information Centre.

been possible without the environment created by a government that had put AIDS control and prevention at the top of its agenda for many years.

High Level of Political Leadership, openness and Government Action

When the National Resistance Movement (NRM) came to power in 1986 after a five-year guerrilla war, the problems facing Uganda were immense. First and most urgent was the task of reconstructing an economy brought to its knees by two decades of conflict, neglect and mismanagement. The government was completely bankrupt, inflation was rampant, smuggling was widespread and the parallel "black" market dominated trading. Public health services, schools and colleges had deteriorated into a state of near destitution. In addition, NRM had to cope with ongoing insecurity problems in the Northern and Eastern parts of the country, where rebels challenged the authority of the new government.

President Museveni decided to make AIDS a national priority and urged Ministry of Health officials to think boldly about the new health challenge. In October 1986, the Uganda Government established an AIDS Control Programme within the Ministry of Health—the first of its kind in the world. The government then organised an international donors' conference in Kampala to garner financial support for AIDS prevention and care activities. Impressed by the Ugandan government's frank admission of the seriousness of the epidemic, 21 international donors attended the conference and pledged immediate support for HIV/AIDS prevention and control programmes in Uganda.

At home, the President almost invariably referred to the menace of AIDS in his speeches as he toured the country. Using colourful images and earthy humour, he challenged his audiences to avoid reckless sexual behaviour likely to spread AIDS. The First Lady, Mrs. Janet Museveni supported her husband in campaigning against AIDS. She went further, urging people to support families, affected by AIDS, especially HIV-positive women and orphaned children who had lost their parents to AIDS. She lent her support in particular to the organisation, Uganda Women's Effort to Save Orphans (UWESO), which was originally founded to assist war orphans but quickly expanded to include those orphaned by AIDS.

With the realisation that the fight against HIV/AIDS needed a more global approach, the Uganda AIDS Commission (UAC) was set up in 1990 and AIDS Control Programmes launched in the line ministries. There has been much accomplished by these institutions including:

- Development and distribution of guidelines for AIDS prevention and control
- Increase in the number of personnel trained to plan, implement, co-ordinate and undertake research related to HIV/AIDS
- Ongoing multi-sectoral approach to planning HIV/AIDS activities
- Establishment of national and regional networks related to HIV/AIDS for PHAs, Law and Ethics, Youth, Traditional Healers and AIDS Service organisations
- Establishment of a legal framework for co-ordinating the national AIDS control programme
- Establishment of research institutions related to HIV/AIDS such as the National Blood Bank and Joint Clinical Research Council (Republic of Uganda, 2000)

In combating HIV/AIDS, NGOs and community groups have adopted an approach that combines both care and prevention by training large numbers of community-level volunteers

who have a caring and preventive role in HIV/AIDS work. They are generally known either as community AIDS workers or counselling aides. They usually do home visiting, counselling, provide information, help to clarify misunderstandings and generally act as a link between the community and the health services.

The STDs/AIDS Control Programme

By 1990, the AIDS Control Programme established within the Ministry of Health in 1986 had achieved a great deal. Most people in Uganda had at least heard of AIDS, due largely to mass media campaigns and mobilisation of health workers, NGOs, community groups and volunteers throughout the country. Measures had been taken to ensure safe blood supplies, an epidemiological surveillance system was in place and counselling and testing had begun in some hospitals. In addition some government agencies, such as the Ministry of Defence, had started their own HIV/AIDS control programmes.

The strategies promoted by the STD/AIDS Control Programme can be summarised as follows:

- **Epidemiological surveillance**: The programme is responsible for tracking the course of the epidemic, particularly by recording the number of reported AIDS cases, the results of anonymous testing of pregnant women at the antenatal clinics in different parts of the country and the number of STD cases reported by health facilities. This information is published in regular reports.
- **Health Education**: The programme advocates abstinence, mutual faithfulness and condom use as the main methods of HIV prevention using all the available mass media, public campaigns and interpersonal communication.
- **Care and Support:** The programme has trained thousands of health personnel in HIV/AIDS counselling and related skills, and has also trained volunteers as community AIDS workers, counselling aides and peer educators.
- **Condom distribution**: The programme is the sole importer of condoms for free distribution to health facilities throughout the country.
- **Clinical Care**: The programme provides drugs for STD treatment and trains health personnel in the syndromic management of STDs and also provides health facilities with drugs for the treatment of the most common opportunistic infections associated with HIV.
- **Voluntary Counselling and Testing (VCT)**: With funding from the Norwegian Government, the programme is implementing a VCT pilot project in two districts. The programme aims to extend VCT to all towns and rural areas that do not yet have adequate access to such services. This has helped to promote safer sexual behaviour.

The AIDS Support Organisation (TASO)

TASO is one of the most influential NGOs in the fight against HIV/AIDS. Formed in Kampala in 1987 by a group of 16 volunteers, including 12 people with HIV/AIDS, TASO has contributed to promoting openness about HIV/AIDS through its concept of "Living Positively with AIDS". TASO adopted this approach as an antidote to the fear, denial and stigma that were paralysing the community response to the HIV epidemic in Uganda at the time.

The TASO slogan of "Living Positively with AIDS" is a call to everyone in society, infected or not infected. It calls on those infected to live responsibly with the HIV infection and to face up to the infection as a starting point; to recognise their responsibility to society, the responsibility to retain the amount of virus they have in their blood, and not to spread it

around to others; to look after themselves better; and to remain actively involved in society. It also calls upon the rest of the community to support people infected with HIV. It calls on the uninfected or those who don't know that they are infected, to accept people with AIDS, to recognise that one cannot catch AIDS through casual contact. Acceptance of people with HIV/AIDS within the community is a very important starting point for dealing with the problem.

TASO supports people with HIV/AIDS through counselling, nursing and medical care and material and social support for families affected by the epidemic. TASO encouraged those who tested HIV-positive to inform at least one other "significant " person, such as a family member or close friend of their sero-status. This became known as "shared confidentiality" i.e. openness about one's HIV-positive status within a limited circle of trusted people. This had the effect of opening up channels for care and support and helping to promote positive living. People talked openly about their HIV-positive status and this reduced the stigma attached to AIDS. This had a powerful educational effect on other members of the community, which in turn contributed to HIV prevention in Uganda.

AIDS Information Centre (AIC)

AIC provides counselling and advice for those already infected and affected by HIV/AIDS and promotes the adoption of healthy lifestyles. AIC operates main branches in Kampala, Jinja, Mbale and Mbarara. Currently, AIC offers:

- Voluntary and anonymous HIV Counselling and Testing (VCT). This service is offered daily (except on Sundays) at a minimal fee. In the provision of VCT services, confidentiality is upheld, no certificate of clients' results is given and counselling is a pre-requisite for HIV testing.
- Rapid syphilis testing and on-site treatment for those testing positive is also offered.
- Syndromic detection and management of other STDs. All clients who consent to take the HIV test are also screened for syphilis. However, those clients interested in testing for syphilis only also benefit from this service. Those who have syphilis are treated with their sexual partners at a fee.
- Condom education and distribution.
- Information about family planning (FP). All clients who come to AIC receive information, education and counselling on FP. Counsellors and reproductive health volunteers help clients make informed decisions about which methods to use. AIC provides clients with pills, condoms, spermicides, injections and referrals for the other methods. Pregnancy tests are also done at no cost.
- Tuberculosis education and referrals. Information and counselling on TB is given to all clients who seek VCT services.
- Psychosocial and medical services through the Post Test Club.
- Food supplementation and peer support through the Post Test Club.
- Special services for discordant couples.
- The Philly Lutaaya Initiative, with HIV-positive clients "going public" to advocate for VCT and behavioural change.

The Post Test Club/ Philly Lutaaya Initiative (PTC) is a voluntary association for clients tested for HIV irrespective of their test results. Members who test HIV positive and are willing to 'go public' to share their personal experience with HIV/AIDS, form the Philly Lutaaya Initiative. PTC members distribute free condoms provided by the Ministry of Health.

AIC is in the process of decentralising its HIV counselling and testing services to enable it to reach 16 districts. The North and Northeast districts of Uganda have been particularly poorly served by HIV/AIDS prevention and diagnostic services. With the support of European Development Fund (EDF), AIC has developed a five-year proposal to expand availability of counselling and testing services in these areas.

Contribution of UNICEF

HIV/AIDS and adolescent development have been important areas of intervention in the previous two Government of Uganda-UNICEF Country Programmes. In the new Country Programme (CP), HIV/AIDS is a 'priority among priorities'. Interventions are focused on prevention of HIV and other sexually transmitted infections (STIs) in young people, the prevention of teenage pregnancy, and the interruption of HIV transmission from mother-to-child, linked to the empowerment of women to take control of their sexual and reproductive life.

UNICEF's involvement in the development of Life Skills Education[5] has been extensive. One important aspect of this initiative is to equip students and adolescents with life skills that will enable them to deal effectively with the demands and challenges of everyday life. The objective is to develop skills among young people in the areas of interpersonal relationships, self awareness and self esteem, problem solving, effective communication, decision-making, negotiating sex, maintaining chastity, resisting peer pressure, critical thinking, negotiation, formation of friendships and empathy.

Drug Access Initiative

UNAIDS HIV drug access initiative in Uganda is aimed at providing wider access to HIV-related drugs in the country. In June 1997 the government, in collaboration with the UNAIDS theme group, decided to pilot an HIV/AIDS drug access initiative for PLWAs in Uganda, without compromising the HIV/AIDS prevention strategies and priorities. Uganda joins three other developing countries, namely Ivory Coast, Vietnam and Chile, in this initiative. The major areas of work are: new anti-retroviral and patented drugs for the prevention and treatment of opportunistic infections, other sexually transmitted diseases and other AIDS related illnesses. Several treatment centres, including Nsambya, Mildmay, Mulago and JCRC, are currently participating. Approximately 900 patients have benefited from the anti-retroviral drugs. Price reduction for drugs and laboratory-monitoring tests have been negotiated with more than four companies. Various IEC materials have been developed and distributed. The training of medical personnel in communication and counselling is currently underway.

HIV Voluntary Counselling and Testing

Voluntary Counselling and Testing (VCT) has emerged as an important aspect of the fight against HIV/AIDS. Meaningful interventions can be of benefit to the individual and the community only when people know their sero-status, even before the onset of clinical signs and symptoms. The rationale for the HIV Voluntary Counselling and Testing strategy is to encourage safe sex practices to ensure prevention and positive living for those already infected. Since the introduction of the VCT strategy considerable progress has been made. For example, many people have adopted safer sexual practices and this has saved millions of

[5] Working UNICEF/MOES definition: Life skills are the strategies or abilities one uses to get along with one's own personality, one's friends, family, the society and the environment as a whole. These strategies empower young people to interact as effectively as possible with the society in which they live. (UNICEF/MOE. nd. Life Skills for Young Ugandans: Manual for Trainers and Facilitators of Out-of-School Youth. Kampala).

loved ones who would have been inadvertently infected, as can be seen in the growing proportion of discordant couples. Through VCT many people in Uganda with HIV/AIDS have entered the continuum of care much earlier and can live longer productive lives in the community.

Religious Organisations/Leaders

Religious leaders in Uganda are highly respected. Therefore, they can play a pivotal role in determining how individuals, families and whole communities respond to the challenges posed by the HIV epidemic.

Catholic, Protestant and Muslim hospitals and health centres have played leading roles in providing medical care, counselling and social support to people with HIV/AIDS in Uganda. The Catholic hospitals at Nsambya (in Kampala) and Kitovu (in Masaka District) were the first to develop home-based care programmes for people with HIV. These were soon followed by many other church-based hospitals and health centres.

In 1993 the Church of Uganda started the Church Human Services AIDS Prevention Programme (CHUSA), which has promoted an open and positive dialogue between church leaders and the public health workers, leading to important changes such as liberalisation of church policy regarding condom use. In Namirembe Diocese, Kampala, the Church of Uganda runs an integrated health programme consisting of the following components: reproductive health; HIV prevention and AIDS care; nutrition and immunisation; and hygiene and sanitation. The programme is based on local church structures and works through a series of clubs in four different age groups:

- **Sunday schools and primary schools**, using the Child-to-Child approach
- **Young people**, using a Youth-to-Youth approach
- **A post-test club**, consisting of people -mostly aged between 20-30 who have been tested for HIV, some of whom have tested positive
- **Parents**, through a positive parenting programme, which helps spouses to improve their relationship skills with each other, and also to develop better communication with their children.

The Islamic Medical Association of Uganda (IMAU) has implemented HIV awareness and prevention programmes "Family AIDS Education and Prevention through Imams" (FAEPTI) involving religious leaders and community groups in 11 districts and the city of Kampala. IMAU teaches the Islamic community the basic facts about HIV/AIDS, behaviour change, safer sex and principles of communication and counselling. In Kampala, IMAU initiated a different approach. The project trains not only religious leaders from local mosques, but members of the Christian churches and local government councils. The project also developed an HIV/AIDS education programme for youth at Muslim schools. The Madrasa AIDS Education and Prevention Project started in 1995 with 350 schools in the District of Mpigi and Kamuli.

In Kampala, the Kamwokya Christian Caring Community (Strategies for Hope) has developed from a small church-based group into a fully-fledged NGO providing a wide range of services and support to people and families affected by HIV/AIDS.

The open declaration that Uganda was affected by AIDS required considerable political courage. Apart from the high level political encouragement of openness, Uganda's

achievement in responding to the challenges of the HIV epidemic is due in large part to the work of NGOs, community groups and religious organisations, who have quietly extended the conventional boundaries of openness in the fight against the HIV/AIDS epidemic.

3.2 Fighting AIDS—The Message

One of the keys to success in the Uganda experience has been the 'message'. There has been a gradual evolution in the type of messages that have been used in the media campaign to fight AIDS.

The original messages against AIDS were fear-based—AIDS kills. These messages, on radio, TV, posters, leaflets and booklets as well as by word of mouth, succeeded in raising levels of awareness, but may have contributed to stigmatisation (Kaleeba et al, 2000). Realising this, those responsible for the media campaigns began to use new messages stressing compassion, solidarity and hope. This helped reduce the stigma and created an environment in which HIV positive individuals began to feel able to tell family and, most importantly, sexual partners, about their status.

Currently, the dominant message is one that seeks to empower people and promote empathetic attitudes towards those infected. It emphasises:

- That individual actors can take responsibility for their own actions and thus avoid getting the HIV virus
- That apathy and fatalism can be countered
- That anyone of any age or condition could become infected with HIV
- That through positive living, it is possible to live for ten years or more after contracting the virus and to remain healthy for extended periods through good nutrition, avoidance of stress and prompt and aggressive treatment of opportunistic infections

Revised AIDS messages

- Give love and care to people with AIDS
- Do not point fingers at people with AIDS
- People with AIDS need your care and compassion
- Caring is sharing
- If you have AIDS do not despair

Kaleeba et al, 2000.

The IEC unit within the STD/AIDS Control Programme is mandated to screen and approve all IEC materials and messages designed for distribution to the general public (STD/AIDS Control Programme (IEC Unit), nd). They are also expected to make recommendations for revision whenever the materials are deemed inappropriate.

The current objectives are:

- To provide the necessary information and skills needed to prevent further spread of STDs and HIV
- To advocate for abstinence from sexual intercourse until marriage for the youth
- To promote voluntary HIV testing and counselling among sexually active people and before marriage
- To promote mutual faithfulness between/amongst sexual partners
- To promote consistent and correct condom use

- To promote early and appropriate STD treatment-seeking behaviour
- To advocate 'positive living' among people living with HIV and AIDS
- To advocate for care and support of the infected and affected persons
- To promote Family Planning Services to people living with HIV/AIDS to reduce vertical transmission
- To facilitate better planning and management of IEC activities by districts
- To strengthen capacity at national and district levels.

The Unit has identified numerous categories, by age, gender, occupation and location, and suggests a range of strategies for reaching them. For children from 5 to 19, the objectives are to promote abstinence, delay of sexual initiation and the correct and consistent use of condoms. The recommended strategies include education through the school system, life skills education, and need for training in self-defence, visits by community members to schools, educators, recreation programmes, etc.

3.3 The condom debate

The Uganda government was initially sceptical about the practicality of condom use in HIV prevention and the first government AIDS control materials did not advocate condom use. A government booklet entitled *Control of AIDS* (1989) stated bluntly: "The government does not recommend using condoms as a way to fight AIDS". It explained that condoms were not readily available everywhere in Uganda and that those available were unreliable, that many people did not use condoms correctly, and that condoms gave people the false impression that they were safe from AIDS. Most religious leaders and many politicians, President Museveni and his advisers included, were at first opposed to the condom strategy. However, by the end of 1991, the policy began to change. With over one million Ugandans infected with HIV and the figures rising steadily, the government concluded that abstinence and mutual fidelity would not be enough to control the epidemic. New information presented to the government by the international agencies such as the WHO and USAID demonstrated how condoms could help to cut the number of new HIV infections. The President reluctantly agreed that condom promotion should quietly and discreetly go ahead, accompanied by education about condom use.

By the mid-1990s, the tide had turned decisively in favour of condom promotion. Two social marketing organisations launched the *Lifeguard* and *Protector* brands and began to intensify condom promotion through the mass media, including government-owned outlets that had hitherto been reluctant to carry condom advertisements. In response to the increasing public demand, the Ministry of Health began importing large quantities of condoms for free distribution through health institutions. By the end of the decade, an estimated 50 million free condoms were distributed annually. Although condoms were widely available from pharmacies, drug stores and small retail outlets, the demand for free condoms at hospitals and health centres far outstripped the supply, leading to shortages and complaints from would-be users.

Over a period of six years, the official government policy on condom use as a means of HIV/AIDS prevention in Uganda had moved from outright opposition, to quiet acceptance, and finally to active promotion accompanied by education. The Ministry of Health, as the technical arm of the government, now vigorously promotes condoms by issuing guidelines on their promotion, distribution and use.

Although religious leaders tend to view condom use as a matter of individual conscience, it remains an issue about which Ugandans are quite ambivalent.

3.4 Continuing Challenges

The knowledge about HIV/AIDS that is transmitted to the community has been sufficient to convince significant numbers of young women and men to postpone sex or practise safer sex. They are, however, not yet being equipped with the skills to carry these positive behaviours into the long-term formalised relationships (marriage and cohabitation) that are more complex and seem to be unrelated to the decision-making and negotiation skills of their youth that are focussed on promoting abstinence. Safer sex within marriage, particularly the use of a condom except when trying to become pregnant with a partner who is known to be HIV negative, brings up issues of trust that few couples are able to confront and resolve.

As the graphs on sero-prevalence over time indicate (Figures 3 and 4), there has been little if any movement in the HIV prevalence levels among those over 30. For both men and women these levels have remained high and stagnant since 1992. It is the young (15-29 age group) who have shown evidence of changed behaviour. Any additional decline in overall prevalence must depend on downward shifts in the over 30 age groups, as the overall prevalence levels have remained stagnant since 1997. These figures are suggestive of several continuing challenges.

The first is that the existence of a pool of individuals with relatively high levels of sero-prevalence poses a constant danger of an upward trend in overall prevalence levels. There is continuing concern among many in the health sector that a dangerous complacency is setting in, aided ironically, by the continued success of medical services in Uganda in treating HIV positive patients so the well-known ravages of the syndrome are much less obvious among those with full-blown AIDS.

The second challenge is that some important gender issues, especially with respect to condom use, faithfulness and openness between spouses, are far from being resolved. As one stakeholder remarked: "We have not yet solved the problem of maintaining safe sex practices, once individuals become sexually active." This is particularly an issue for poorly educated women in rural areas. A small number of well-educated Kampala women may be able to refuse to have sex with their husbands without condoms[6], but they are very much in the minority.

Medically, the fight against HIV/AIDS has primarily been one of aggressive treatment of opportunistic infections[7]. The cost of AIDS treatments and the relative poverty of the country have meant that only a very few have been able to take advantage of the recent advances. In December 2000, the monthly costs for double therapy of anti-retrovirals are between $214 and $321 while those for triple therapy were between $379.5 and $602 per month. Therefore, a patient would need about USH20 million per year[8].

The MOH and the manufacturers of AIDS drugs have agreed to cut the costs of the anti-retrovirals by 40-68% for the double treatment and 24-70 % for the triple treatment. As a

[6] Personal communication, NGO official.
[7] Personal communication, AIC official.
[8] Source, The New Vision, The Monitor

result about 1500 patients can now afford the drugs. Even with these price cuts, these drugs are still out of reach of the vast majority of HIV positive patients. The Ministry of Health is still pushing for further reductions as well as exploring cheaper sources from pharmaceutical firms in developing countries.

Each year 10,000-20,000 children are born HIV positive and the MOH is intensifying efforts to provide Nevirapine to expectant mothers suspected of being HIV positive.

4. METHODOLOGY

4.1 Introduction

This study is part of a three-country project, the other countries being Botswana and Malawi, where similar issues are being addressed although within quite different contexts. Notably, the Uganda situation represents one in which the epidemic is past its peak and the levels of prevalence now hover around 9-10 percent (Republic of Uganda, 2000). In Malawi, the prevalence levels are similar to those of Botswana, 20 – 30 percent but the context in Malawi is one of much greater resource constraints.

The whole project was co-ordinated by three lead consultants who each had primary responsibility for one country[9]. The composition and funding of the team varied from country to country. To maximise the benefits of cross-country comparison there was a single proposal that set out the basic principles of the investigation and all team members met in Uganda in February and October for initial and final workshops. At the initial workshop, a common strategy was developed, identifying the type of information and classes of respondents to be interviewed as well as guidelines for administration of the school survey. Instrument drafts were also developed and pre-tested in country. Necessary modifications were made following these pre-tests. The final workshop was used for reviewing country findings and identifying lessons learned for inclusion in a final overview report.

During data collection in the schools, the project was faced with a double challenge--trying to get respondents to open up and discuss very sensitive topics surrounding HIV/AIDS within a context, i.e. primary and secondary schools, not generally considered relevant to sexually transmitted disease. As a consequence, an indirect approach was utilised, with every effort being made to obtain information on the 'social' symptoms of HIV/AIDS rather than the medical symptoms. Therefore, the focus was on indicators of orphans (number, problems and coping strategies); teacher morbidity and mortality; and knowledge of and related behaviour change with respect to HIV/AIDS. As discussion on these issues proceeded, it usually became clear to the respondents what the connection was. Discussions and interviews, particularly with teachers, were preceded by a clear indication that the information provided would be anonymous.

To promote anonymity, respondents were asked not to identify himself or herself or any other person as being HIV positive or suffering full-blown AIDS. Further, no names were recorded on the instruments, not even that of the school.

The study took a three-pronged approach. The first was the interviewing of key informants in the education, health, social work, financial and population sectors; the second was a two-week long school survey in ten schools. The third prong was the collection of national level statistics on the education system, on prevalence rates and on mortality levels and rates.

This study was an interactive one: Because HIV/AIDS is viewed with strong emotions by almost everyone, the process of data collection often spurred extensive questioning of team members by respondents. The team needed to respond to questions, concerns voiced by students, teachers and head-teachers. This usually consisted of providing information or merely being supportive as respondents voiced their concerns about their job security, about

[9] One lead consultant worked in both Botswana and Uganda.

contracting the virus, that they may have already been infected, or about living and working with people who were HIV positive. Occasionally, it was necessary to provide counselling to both students and teachers.

4.2 School survey

The schools were selected randomly among schools of a certain size in the district with the assistance of the DEO. In each district one urban and one rural secondary school was chosen. One of the secondary schools was a girls' only school. The primary level mix was one urban and two rural from each district. The districts selected, Jinja and Masaka, were among those with the highest recorded levels of HIV infection. A team member visited each school the week before fieldwork started to alert the school and brief the head teacher or deputy head teacher on the data collection exercise.

The team spent a day in each of 10 schools: six primary and four secondary schools in the two districts. During the day semi-structured interviews were held with the head-teacher and with members of the school management team to obtain their views of the impact of HIV/AIDS on their school, trends in numbers of orphans, levels of teacher deaths and sickness, sexual harassment, etc. These interviews were conducted in English.

Teachers were interviewed in several ways. All teachers (up to 40) were given a questionnaire that asked for basic background information and their views on a range of issues related to HIV/AIDS and education through a five-point rating of a series of statements. Up to 10 teachers were randomly selected for face-to-face interviews with team members. Then between four and 12 teachers (depending on the number of teachers available after the interviews) were randomly selected for participation in a focus group discussion. Interviews and discussions with the teachers were conducted either in English[10] or Luganda.

Forty students (from P6 and P7 or S1 to S4) were randomly selected for a group-administered questionnaire. Twelve to 16 students from the same classes were selected for a focus group discussion. In primary schools, the focus group included children from P4 and P5 and both the discussion and the questionnaire groups were gender balanced. Luganda speakers administered both sets of instruments to all students.

The focus group discussion facilitator utilised sets of statements that participants were asked to categorise under 'agree', 'disagree' and 'not sure'. All the statements portrayed negative situations, for example "HIV/AIDS is a big problem in this school" or "Boys in this school are fearful and anxious about their safety". They were asked to further categorise the statements they 'agreed' with into 'not bothered', 'dislike a little' and 'dislike a lot' as a way of indicating strength of feeling. This was done as a group (either one or two depending on the number of participants) and the group was required to adopt a consensus position. Explanations of the rationale for the categorisations adopted then formed the basis for the discussion. Statements were translated into Luganda for the primary school students.

A small number of focus group interviews were held with orphans. Two of these were at a primary school and three more were held under the auspices of agencies that provided

[10] There was one rural primary school in Masaka where the teachers' focus group discussion was conducted in both English and Luganda because of the language constraints of the respondents.

support to orphans. This was a less formalised procedure. The original plan was to interview an orphan group in each school surveyed. In the first few schools visited, the school administration was hesitant about identifying and singling out a group of orphans. However, the first discussions were held within a school and the children appeared to suffer no ill effects. Later group discussions were held among children who already belonged to orphan groups, to minimise any distress that might be caused by singling them out.

A team meeting was held every day to review and assess the data collected from each respondent or set of instruments. This triangulation was particularly important because of the nature of the study. Resistant respondents, who denied the existence of sexual harassment[11], were present in almost every school. Fortunately, there were also very open respondents in almost every school and the children, in particular, were extremely happy to discuss their concerns and issues.

The instruments with a list of the statements used in focus groups are in appendix 1.

Table 2: Distribution of Instruments and Respondents

Instrument	Primary	% Female	Secondary	% Female
Head-teacher	6	33.3	4	25
School Data Sheets	6		3	
Senior Management Team	6		4	
Teacher Interviews	43	54	37	32
Teacher Focus Groups	6		4	
Teacher Questionnaires	60	55	81	32
Student Questionnaires	241	50	153	58
Student Focus Groups	6		4	
Orphan Focus Groups	5			

4.3 Stakeholder Interviews

Systematic sampling for the stakeholder interviews would have been extraordinarily difficult; there are approximately 2000 NGOs in Uganda dealing with different areas of HIV/AIDS. Consequently, the big agencies were identified first and then a snowball strategy was used to identify other stakeholders. In other words, interviewees were asked to provide names of agencies working in the same area. The emphasis was on agencies working on AIDS education, particularly for young people, and care of orphans. Conversations were held with the major institutional actors in the area of HIV/AIDS, namely the Ministry of Health's AIDS Control programme, the Uganda AIDS Commission, TASO (the AIDS Support Organisation), the AIDS Information Centre and UWESO (Uganda Women's Effort to Save Orphans). Whenever possible, every effort was made to interview agencies both at headquarters and in the field.

[11] There was never any denial that HIV/AIDS was affecting the school.

Conversations were held with the major donors in the education sector, namely the World Bank, DFID, UNICEF, as well as UNFPA and USAID (through the DISH project). A complete list of stakeholders interviewed is in appendix 2.

Discussions were held with personnel at both the central and district level in the Ministries of Education and Sports, Gender, Labour and Social Development, and Health.

4.4 Modelling

An important component of the project was the inclusion of projections of student and teacher numbers. Information from the Uganda Bureau of Statistics (projections of single year age groups) and data and targets from the Ministries of Education and Sports and Health and the AIDS Information Centre were input into an Excel worksheet based on the UNESCO model for cohort analysis. Assumptions about the probable trajectory of the prevalence of HIV infections were then used to estimate the probable impact on the education sector. In 1994/5 the Ministry had conducted a similar exercise with respect to teacher requirements in preparation for UPE. These Ministry projections were compared with the results from this study of explicitly modelling the impact of HIV/AIDS. Full documentation is provided in appendix 3.

4.5 Lessons Learned

This is the first study that has attempted to assess the impact of HIV/AIDS on the education sector using data collected directly from the field. A number of other reports have been published (Kelly, 1999; Gachuhi, 1999; Coombs, 2000; Carr-Hill, 2000, etc.), all of which provided insightful and valuable groundwork for this study, but they were meta-analytic in their approach, extrapolating to the education sector from studies that have been done in the health and macroeconomic sectors. These extrapolations were complemented by anecdotal data. Consequently, both the findings and the methodology used in this study can be regarded as groundbreaking.

The research strategies used here were innovative in at least two respects. *The first was in the strategy of going directly to head-teachers, teachers and students to discuss the impact of HIV/AIDS on them both as individuals and as members of institutions*—this has never been done before. The second was the strategy of *getting respondents to discuss the most sensitive issues by directing the questions at their perceptions of their environment (classroom, school and community) rather than more directly at themselves*.

The process of data collection was itself illuminating and several lessons were learnt that could help strengthen other research and project work in the same area.

Although Uganda has the reputation of being very open about sexual matters, it became clear that this was only in comparison with other countries. Although respondents were generally knowledgeable about transmission of the virus itself, there was some resistance to any discussion that went beyond the general facts. Particularly, the use of three different data collection methods (questionnaire, interview and focus group discussion) was very useful with teachers. Students generally responded very well to the group discussion format.

Once any initial reticence was overcome, the team was struck by the way in which respondents welcomed the opportunity to discuss issues that had been taxing them. Some of

these were ethical: What should be done about a student who is believed to be HIV positive and known to be sexually promiscuous? Others needed help in personal decision-making: How do I get my partner to use a condom at the right point during sexual intercourse? I think my partner died of AIDS and although I am healthy now, should I be tested? Some were practical: Where is the nearest site at which I can get tested for HIV? On numerous occasions, post-interview discussions lasted 30 minutes or more.

Strengths: The indirect approach and the use of trend analysis ultimately proved to be very useful entry points in the data gathering and analysis. The mix of instruments and the general approach was felt to be appropriate and yielded much interesting information with the combination of qualitative and quantitative techniques.

Data Gaps: Some data was unavailable for a variety of reasons. This included complete and unambiguous information on numbers of orphans and whether they were experiencing problems in school and a clear and systematic record of sick leave taken by teachers.

Weaknesses: The study took place three years after the implementation of UPE. The effects of UPE were clearly dominating gross measures of educational participation. Therefore, unambiguous conclusions about the impact of HIV/AIDS on student participation or teacher effectiveness and deployment were impossible to obtain.

Another major weakness was sample size. The attempts to access supplementary funding to double the sample size were fruitless. Therefore, although the results are generally robust and the evidence from the various sources was consistent, estimates of phenomena like the proportion of school children that is orphaned cannot be considered either firm or nationally representative.

The scope of the study was unwieldy, particularly given the limited resources available, and this ultimately caused delays in completion.

Omissions: As data collection proceeded, it would have been useful to be able to assess community reaction to certain of the strategies being proposed to deal with HIV/AIDS in schools, or to cross-check the reported views of parents. A notable example relates to whether and under what conditions condoms should be distributed in schools. In addition, the views and experiences of out-of-school adolescents were not sought. Some issues only emerged during the study, like reasons for absenteeism among students and their relationship to living arrangements or a more detailed investigation of students' sources of information on HIV/AIDS.

Another area where much further research is needed is about young people: more information about their schooling experience, their sexual behaviour, living arrangements and the amount of disruption they are subject to, and the coping strategies they use.

5. Preventing HIV Infection Among Students

HIV/AIDS education among the young remains a key component in the battle against the spread of the infection. As universal primary education becomes an established reality in Uganda, the role of the school in inculcating skills, attitudes and knowledge in the age group below 15 will become even more crucial. There is simply no other institution that has the access and the organisation to provide a coherent programme of HIV/AIDS education to this age group.

To assess the current situation, students were asked about their knowledge, sources of information, quality of teaching of HIV/AIDS topics, as well as their views of the extent of behaviour change. This information was gathered both through the questionnaire and the focus group discussions. Similar areas were investigated through the teachers' instruments. There was in addition a review of the primary education syllabus and the Uganda Certificate of Education syllabi.

Within schools there were three main strategies that had been used to provide HIV education:

- Explicit instruction in the curriculum
- Guidance and counselling sessions
- Extra-curricular events like club meetings and visits by TASO, the AIDS Information Centre and other NGOs.

5.1 HIV/AIDS Education in Schools

The Ministry of Education has sponsored at least three activities designed to focus on HIV/AIDS prevention. The first was known as the School Health Education Programme (SHEP) and was started in 1986 in recognition of the role schools could play in the mitigation of the epidemic. Eventually this school based programme consisted of two components - one contained within the primary health education syllabus (AIDS and STD prevention) and the other within the family life education syllabus (human reproduction, parenting skills, moral and ethical values, etc.).

The SHEP curriculum covered the following areas: growth and development; changes during adolescence; reproduction; family planning and contraceptives; abortion; socio-cultural attitudes and beliefs; STDs/HIV/AIDS; responsible sexual behaviour; sexual harassment and abuse; marriage/parenthood; common childhood illnesses and immunization; anti-social behaviour; hygiene; pollution; water sources and protection; environmental sanitation; first aid; primary health care; bacterial, viral and fungal diseases; food and nutrition; exercise, rest and recreation; family; and relationships.

However, an evaluation in 1994 suggested that while the curriculum was successful in promoting knowledge, it was not having any discernible impact on behaviour. A second major problem was that the teachers' embarrassment and inappropriate methodology were presenting barriers to effective teaching of attitudes that would lead to behaviour change. Consequently, SHEP was abandoned. However, some of the lessons learnt included making it a non-examinable subject; using a life skills approach, putting emphasis on developing teachers' abilities to use participatory methodologies and making the language of instruction flexible (O'Donoghue, 1995).

An attempt was made to move intensively into life skills training with support from UNICEF.

After approximately three years, an evaluation of the life skills initiative suggested that none of the activities had succeeded in reaching the classroom. Resources had gone into developing teachers' aids, but the effect on student knowledge or behaviour was uncertain. The life skills initiative has recently been re-vitalised and more effort is being put into changing the behaviour of students. There are ongoing discussions with the Uganda National Examinations Board on a strategy for assessing student behaviour change.

5.2 Formal Curriculum

A new primary education curriculum was introduced during 2000. The subject of Integrated Science has been organised into eight themes of which three; Human Health, the Human Body, Community-Population and Family Life, are relevant to HIV/AIDS education. The coverage of HIV/AIDS is surprisingly sparse; it is first mentioned under the Human Health theme in the second term of P7, in other words just before the student leaves primary school. The module deals with:

- Causes, modes of transmission, signs and symptoms, effect on individual prevention and control and
- Necessary life skills, behaviour change clubs.

The teacher is asked to point out non-sexual modes of transmission and encourage the development of survival life skills (NCDC, 1999).

There are a number of missed opportunities; for example the curriculum discusses hygiene in the context of caring for the sick and elderly and other 'weak' community members but there is no direct reference to HIV/AIDS. It would seem likely that a significant proportion of Ugandan citizens will have cause to be involved directly or indirectly in the care of an individual with HIV/AIDS and the lack of reference to it in this context is extraordinary. Similarly breast-feeding and nutrition is also to be presented, again without reference to mother-child transmission or the role that good nutrition can play in living positively with AIDS.

The new syllabuses for the Uganda Certificate of Education[12] that guide instruction at the secondary level contain no references to HIV/AIDS in biology, health sciences, Christian or Islamic Religious Education, even in the presentation of human reproduction or population growth.

At secondary level the biology syllabus is being reviewed to incorporate recent advances in knowledge of HIV/AIDS and the links between HIV/AIDS and the environment. This new syllabus is expected to come into effect in about two years time and will benefit those students currently in P.6[13]. The new syllabus will be incorporated in a combined biology and health education (a new subject that has been introduced at O-level). Health education was formerly called health sciences but with the new emphasis, it has been renamed. All students at O-level will have to pursue either Biology or Health education and these will be examinable at the national level. Because the current syllabus presents HIV/AIDS simply as an STD, the new syllabus will also include the social components such as stigmatisation and the psychological impact on people affected in one way or another. Health education will exhaustively discuss HIV/AIDS, traditional and religious attitudes and how they intersect with HIV/AIDS, for example, support for the sick, alcoholism, etc.

[12] Team was not able to obtain a copy of the old syllabuses by the time of this draft.
[13] Personal communication from NCDC official.

Teachers interviewed in this study (both individually and in the focus groups) felt strongly that they were not well prepared to teach sexual and reproductive health topics, either professionally or culturally. There were suggestions that the curriculum in primary teacher training colleges should be revised to raise the profile of this subject. The treatment in the school curriculum was regarded as too shallow and too exam-oriented. However, most felt it was their duty but would like more guidance and assistance in presenting the material in an age-appropriate way. There were those who came from regions where girls and boys still experienced some culturally prescribed seclusion and traditional sexual education at puberty as preparation for marriage. These teachers found the curiosity and occasional questions from young students (P2 to P5) (for example, about the lengthening of the clitoris) particularly challenging and embarrassing. Teachers find such questions quite difficult to answer without discouraging the children or making them lose confidence in them as teachers. All teachers felt there was a dire need for better teaching aids for sexual and reproductive health topics, including HIV/AIDS education.

In one secondary school teachers expressed strong views about the perceived passivity of the Ministry of Education in this regard. It was felt that the MOES had left all responsibility for AIDS education to the Ministry of Health and failed to develop a clear curriculum on sex education. In their view, any objections from the community about discussing such topics with their children should be dealt with through constructive engagement with prominent cultural leaders.

There was also a general, but not universal, consensus that the topic should start earlier than P7.

Parental attitudes to the topic being taught in school were seen as mixed. Views depended on parents' cultural background as well as their level of education. The teaching of sexual and reproductive health topics appeared to be more of an issue in rural than in urban schools. There were some complaints that the home environment was not conducive to teaching students to be abstinent and delay sexual initiation; for example, one teacher in a secondary school complained that parents encouraged their daughters to think of their bodies as commodities that could be exchanged for cash or material rewards. Another teacher at the same school was of the opinion that parents did not exercise enough control over their children:

> *"Schools might try to control children but there is too much liberty at home. Children attend weddings and films the whole night as well as discos. Parents need sensitisation on the dangers of such liberty. If parents become serious then AIDS can be controlled to some extent (sic)*."

5.3 Student Knowledge

Student knowledge of HIV/AIDS is good although there were areas where improvement was called for. On the questionnaire they were asked to indicate whether the statements below (see table 3) were true or false[14]. In general, knowledge improves with age; the higher the class, the less likely were the students to respond incorrectly.

[14] The table gives the percentage of respondents who gave the wrong answer, so a low percentage is a positive sign.

There was good knowledge on such questions as whether or not one could contract HIV through unprotected sex or sharing writing materials; on mother-to-child transmission of HIV; whether traditional healers could cure AIDS and whether condoms reduce the probability of transmission. For two items, unprotected sex and curing of AIDS by traditional healers, none of the S4s got it wrong. Two items in particular indicated confusion or lack of knowledge on the part of the students; namely—whether one could identify an HIV-infected person on sight and whether one could get infected through blood donation. Although a decreasing proportion tended to get these questions wrong as they grew older, a significant percentage of the S4s still got the question wrong, 31% and 37.9% respectively. Not quite as serious were the results from two other statements that dealt with common myths; that sex with a virgin could cure AIDS and that only immoral people got AIDS. Although a third of those in P6 got these wrong, by S4 only a small percentage did (13.8% and 10.3% respectively).

The last two columns of table 3 compare boys and girls. Girls were more likely to know that having sex with virgins did not cure AIDS; that the AIDS virus could be passed to unborn children and that one could not get AIDS through sharing writing materials. Boys on the other hand were more likely to be familiar with the preventive role of condoms, and somewhat less likely to believe that one could get infected with HIV from a toilet. There seems to be a tendency for each gender to be more knowledgeable about facets of HIV/AIDS that more directly impinge on it: an indication that perceived relevance plays a role even in retention of HIV/AIDS knowledge and suggests that gender-specific strategies might be necessary to optimise learning in this area.

Table 3: Student Knowledge of HIV/AIDS, Percentage Wrong By Class and Gender

Statement	P6	P7	S1	S2	S3	S4	Boys	Girls
Having sex with virgins helps cure AIDS	35	15.9	23.7	25.0	28.9	13.8	30.6	18.1
Using condoms help prevent AIDS	23.1	17.1	8.3	15.6	23.7	6.9	13.9	20.6
There is no cure for AIDS	30.2	17.6	7.9	6.3	13.2	10.3	16.9	19.3
You can get AIDS by donating blood	71.4	75.9	56.8	54.5	40	37.9	60.3	64.6
AIDS virus can be passed to unborn child by mother	11	10.2	8.1	19.4	18.9	10.3	16.9	7.7
One can tell someone has AIDS by looking	67	58.7	64.9	43.8	47.4	31	65.2	49.5
One can get AIDS through unprotected sex with infected person	18.3	8.3	5.3	3.1	10.5	0	10.7	8.5
It is possible to get AIDS from a toilet	32.3	17.9	23.7	25	10.8	20.7	17.5	25.5
Only immoral people get AIDS	38.3	33.1	25	21.2	18.4	10.3	27.8	29.6
One can get AIDS by sharing writing materials	27.1	12.7	5.6	9.1	5.3	3.4	18.9	9.6
Some traditional healers can cure AIDS	13.3	5.9	2.6	6.1	2.6	0	8.8	6.5
N	113	118	38	33	38	29		

Urban/rural differences: There were marked differences on certain items depending on whether students were enrolled in urban or rural schools (see table 4). These differences were not always to the detriment of rural students. Urban students were more likely to believe that HIV could be passed through blood donations, that it would be possible to get AIDS from a toilet and that some traditional healers could cure AIDS.

Table 4: Student Knowledge of HIV/AIDS, Percentage Wrong By Location

Statement	Urban	Rural

Having sex with virgins helps cure AIDS	17	29.5
There is no cure for AIDS	14	21
You can get AIDS by donating blood	47.0	30.2
AIDS virus can be passed to unborn child by mother	7.1	15.5
It is possible to get AIDS from a toilet	27.6	17.8
Some traditional healers can cure AIDS	10.2	3.8

Table 5: Most Useful Source of Information about HIV/AIDS
Note: Students named up to three sources

	Boy	Girl	Primary	Secondary
Teachers	15.6	18.3	21.6	15.6
Radio	18.4	17.8	19.5	20.0
Newspaper	7.9	11.2	7.5	14.9
Church	2.1	1.8	1.3	3.3
Hospital	14.8	13.9	18.3	11.6
TV/Movies	8.7	9.1	8.8	11.3
Friends	3.4	8.3	4.3	9.2
Home/Parents	10.0	14.9	13.6	13.4
Posters	1.1	1.9	2.4	0.5
Relatives	1.1	2.6	2.2	1.7
Other	0.6	0.0	0.4	0.7

When asked about the source of this knowledge, teachers and the radio were the most common source. For boys and secondary students the radio had the edge, while teachers had the edge for girls and primary students. The hospital and the home/parents were third or fourth for all categories. Newspapers were generally the fifth most common source for boys and secondary students. TV/movies were of approximately the same level of importance as newspapers. However, 60% of the sample was from rural areas and access to both newspapers and TVs would be difficult for those students. Teachers were an important source of information for rural students.

Girls were somewhat more likely than boys to identify parents as a useful source of information. Friends were more important for girls and for secondary students than for boys and primary students. The church was of low priority for all.

In the focus groups both teachers and students reported that there was considerable embarrassment in discussing sexual and reproductive health topics in the classroom. Even when the subject was supposed to be taught, teachers were reported to be 'shy' about going into any detail. For the students, they did not want to be seen as being too interested in sexual topics or to be quizzed about where they got their information. In the focus groups both boys and girls were more likely to agree that HIV/AIDS topics were not taught well. From the questionnaire, secondary students were less likely (24.4%) than primary (63%) to agree with the statement that AIDS topics had been taught well.

From the questionnaire, there were sharp differences between primary and secondary students in the degree to which they felt they received adequate information on HIV (see table 6). While almost half of the primary students felt they had not obtained sufficient

information and advice; less than 20% of the secondary students agreed. Rural students were more likely to feel that they received adequate information than urban students.

Table 6: Statement Responses, Student Questionnaire—HIV/AIDS Teaching					
		Boys	Girls	Primary	Secondary
Students do not get all the information and advice they need about AIDS	d	39.4	43.1	30.5	57.6
	ns	22.9	22.3	21.5	23.8
	a	37.7	34.6	48.0	18.6
Students talk freely to teacher counsellors about HIV/AIDS	d	29.4	31.5	25.9	37.1
	ns	31.7	21.0	24.7	28.5
	a	38.9	47.5	49.4	34.4
Students changed sex behaviour due to AIDS education	d	22.5	23.5	20.2	27.0
	ns	25.8	30.1	28.9	27.0
	a	51.7	46.4	50.9	46.0
AIDS topics are well taught	d	31.5	32.5	19.2	51.3
	ns	21.5	20.3	17.8	25.3
	a	47.0	47.2	63.0	24.4

5.4 Guidance and Counselling

Guidance and counselling is a relatively new introduction into the education system in Uganda and has focussed primarily on the appointment of senior women and senior men teachers (SWT and SMT respectively) in primary and secondary schools. The SWT is the more established role. She is appointed by the head-teacher and is responsible for providing guidance and counselling to female students and teachers. The SMT is supposed to play a similar role for males but observation and reports indicated that the SMT was much less likely to be appointed and even when appointed, less likely to be active.

The original cohort of SWTs received some training through the TDMS and was given some guidelines as to how they should carry out their duties. The project has not been fully integrated into administrative procedures yet; consequently subsequent appointees have received neither training nor any indication of their duties. The SWTs and SMTs were interviewed in every school visited. Only one SMT appeared to be fulfilling his role in any way. The SWTs felt somewhat overwhelmed by their roles. This was both because they had many students to talk to and also the complexity of the issues they had to deal with. There was an expectation within the school that they would 'handle' HIV/AIDS but without any guidelines most felt inadequate to the job. As a result, they tend to depend on invited organisations or speakers to deal with HIV/AIDS education. Another disadvantage of the system as currently practised is that most of the opportunities for guidance and counselling are currently directed at girls. Issues like prevention of pregnancy among schoolgirls and the curbing of sexual harassment within schools have a very high profile in Uganda and most of the SWTs' efforts are directed in this direction. Girls would be pulled out and talked to at regular intervals (once or twice a term). During the FGDs, this was a key complaint of boys interviewed: even with all the shortfalls of the current system, girls had an opportunity to receive some information and advice about sexual and reproductive matters; boys (particularly in secondary school) felt they had virtually none.

According to the comments made in the student focus group discussions, a major shortcoming was that guidance and counselling was almost always in large group settings in which two or three years would be put together as appropriate. In such a setting the guidance

and counselling session was usually a lecture and exhortation and not individualised in any way. Individual counselling was usually confined to situations in which a student had been identified as a troublemaker or appeared to be in trouble. The student questionnaires gave a more positive view. At both primary and secondary levels, more than 80% of the students reported that there was an individual at school with whom they could discuss problems. This individual is most likely to be a teacher, however, there is no indication as to whether this teacher is the SWT or SMT.

Table 7: Individual in School With Whom Problems are discussed, by Level

	Teacher	Other Student	Parent	Friend	Aunt	Sibling	Doctor	Various
Primary (178)	71.3	10.1	11.8	2.8	2.2	0.6	0.6	0.6
Secondary (126)	46.8	38.1	8.7	0.8	1.6	1.6	0.8	1.6

There was some lack of trust between teachers and students; students were afraid that teachers would betray their confidence and gossip with other teachers or inform parents about their problems. Others were concerned that letting their teachers know about their problems and concerns would lower them in their teachers' estimation.

The current system of guidance and counselling has several drawbacks. The first is that it is ad hoc. While all schools are attempting to appoint senior men and women teachers, not all have done so and even for those who have been appointed, not all are active. The second drawback is that the roles and responsibilities of senior women and men teachers are not yet well established. Further the content and strategies of the guidance and counselling are also individually determined. Therefore, while some SWT and SMTs reported discussing HIV/AIDS on a regular basis, others clearly never mentioned it and left it to visiting 'experts'. Boys were least likely to receive counselling because SMTs were often not active. Finally, opportunities for individual counselling were extremely limited.

5.5 Extra-curricular Activities

Thirteen percent of primary and 22% of secondary students reported that there was an HIV Club in their school, with HIV clubs more common in urban schools. A much higher proportion, approximately 65% in primary and 80% in secondary recalled that visitors had come to the school to talk about HIV. Location made a difference in this area also, with 83% of students in urban schools reporting receiving such visitors, compared to 59% of students in rural schools. These visitors were reportedly called in regularly by the school administration to talk about HIV. The nature of the counselling/interaction varied greatly. Student Partnership Worldwide had a resident programme in a handful of schools in Jinja, Mbale and Kampala in which one to three volunteer teachers from the UK and Uganda stayed in a school or a cluster of schools for an academic year and taught HIV/AIDS prevention. AIDS Information Centre visited schools and conducted voluntary HIV AIDS testing and counselling of both teachers and students. Condoms were supplied on request and after counselling. TASO, AMREF, Kitovu Mobile Farm School and other groups also visited schools and provided AIDS education and counselling when requested. Individual nurses and other medical personnel were also invited.

While valued, these visits seldom lasted more than a day and consequently both sides expressed dissatisfaction with this modality. Counsellors often felt that clients were left

hanging; students did not have the opportunity to discuss follow-up issues with knowledgeable advisors.

5.6 Student Attitudes and Behaviour

Students did not see HIV/AIDS as a major problem in the school, in other words they did not perceive that significant numbers of either fellow students or teachers were sick.

When asked about their own behaviour in focus groups, female students were mostly unsure about whether behaviour had changed, while boys were likely to indicate that behaviour had not changed. From the questionnaire, however, they did feel that the knowledge they had gained was helping to change behaviour. Both primary and secondary students, boys and girls were most likely to agree that students had changed their behaviour as a result of the HIV/AIDS information they had received. Boys and secondary students were somewhat less likely to agree, but even for them agreement was the most common option.

There was a difference of opinion among male and female teachers as to whether student behaviour was changing. Fifty-one percent of female primary teachers felt that students were changing their behaviour. On the other hand, close to 46% of male primary teachers were of the opinion that behaviour was not changing. At the secondary level, opinion was mixed with slightly higher proportions of both male and female teachers feeling that behaviour had not changed.

Table 8: Primary Teachers Statement Ratings (Questionnaire)—Sexual Harassment

	Disagree		Not Sure		Agree	
Statement	M	F	M	F	M	F
Sexual harassment by teachers is a big problem in this school	88	84.2	0	10.5	12	5.3
Sexual harassment among students is a big problem in this school	80	68.4	8	21.6	12	8.1
Sexual harassment by teachers at this school has got worse in recent years	66.7	81.6	20.8	13.2	12.5	5.2
Sexual harassment among students at this school has got worse in recent years	76	72.9	8	20.7	16	2.7
School management deals effectively with sexual harassment by teachers	20.8	24.3	8.3	24.3	70.9	51.4
School management deals effectively with sexual harassment by students	24	29.7	12	13.5	64	56.8

5.7 Sexual Harassment

On the whole there was a high level of awareness of what the term ‘sexual harassment’ meant and it was seldom necessary to explain this to either students or teachers. When requested, sexual harassment was defined as any unwelcome contact on breasts, buttocks or genitalia (private parts), ranging from touching to assault and rape, or verbal harassment that referred to sexual characteristics, either between students or between teachers and students. Questions on this issue centred around statements in the questionnaire and focus groups about how safe students felt in school and the occurrence, or not, of ‘love relationships’ either between students themselves or between students and teachers.

A majority of the girls in the focus groups (60%) indicated that they were anxious about their safety in school, while only a quarter of boys did so and for both genders the view of the other's safety was considerably more benign than for their own. The discussion within focus groups suggested that the threats to safety were multiple. In some schools, there was an

Table 9: Secondary Teachers- Questionnaire Statement Ratings

	Disagree		Not Sure		Agree	
Statement	M	F	M	F	M	F
Sexual harassment by teachers is a big problem in this school	89.1	89.3	10.9	10.7	0	0
Sexual harassment among students is a big problem in this school	70.9	78.6	18.2	10.7	10.9	10.7
Sexual harassment by teachers at this school has got worse in recent years	85.5	92.9	14.5	7.1	0	0
Sexual harassment among students at this school has got worse in recent years	76	79.3	14.8	20.7	9.2	0
School management deals effectively with sexual harassment by teachers	15.7	10.7	11.8	17.9	72.5	71.4
School management deals effectively with sexual harassment by students	10	10.7	4	7.1	76	82.2

Table 10: Statement Responses from Student Questionnaire

		Boys	Girls	Primary	Secondary
Student pregnancy is a big problem here	d	54.4	68.8	61.8	61.6
	ns	20.6	11.6	19.1	11.3
	a	25.0	19.6	19.1	21.7
Love relations between students common here	d	25.9	34.0	31.2	28.3
	ns	22.7	22.0	26.4	15.8
	a	51.4	44.0	42.4	55.9
Love relations between teachers and students common here	d	43.3	51.0	43.6	53.3
	ns	26.7	27.2	28.9	23.7
	a	30.0	21.8	27.5	23.0

Key: d—disagree, ns—not sure, a—agree.

indication that this danger came from teachers. Generally, however, it was more likely to come from members of the community or even non-teaching members of staff. For example, girls in one primary school described how they made sure they travelled home in groups and on public roads because they were anxious about abduction and sexual assault. In another school girls referred to the sense of threat they experienced from the verbal comments made to them by the security guards (*askaris*) or men in the community.

In mixed schools, it was common to receive some report of harassment from fellow students. Boys would hotly deny this or argue that it was mutual, that while they might try to look up

the skirts of girls, or in the extreme, demand sexual favours, this was encouraged by girls who "put their hands in the boys' pockets" or in other ways signalled that they welcomed their interest. Girls insisted that while there might be a few instances of girls asking boys for money or gifts, most of the harassment was unsolicited.

Regarding the question as to whether love relationships between students were common, half of the girls and 70% of the boys agreed; however, almost 40% of the girls disagreed. A majority of both girls and boys disagreed with statements that love relationships between teachers and students were common. In two or three of the schools, students specifically mentioned strict rules governing teacher behaviour that would make such an occurrence either impossible or very rare.

Table 11: Student Statements from Focus Groups		Boys (%)	Girls (%)
HIV/AIDS is a big problem in this school	d	12.0	60.0
	ns	63.0	30.0
	a	25.0	10.0
Topics on HIV/AIDS are not taught well in this school	d	12.0	10.0
	ns	25.0	10.0
	a	63.0	80.0
Students have not changed their sexual behaviour as a result of HIV/AIDS education	d	14.0	22.0
	ns	29.0	56.0
	a	57.0	22.0
Students do not feel free to talk to teachers about HIV/AIDS	d	37.0	20.0
	ns	0.0	10.0
	a	63.0	70.0
Students at this school do not get all the information and advice the need about HIV/AIDS	d	33.0	33.0
	ns	0.0	11.0
	a	67.0	56.0
Girls in this school are anxious about their safety	d	75.0	0.0
	ns	25.0	40.0
	a	0.0	60.0
Boys in this school are anxious about their safety	d	50.0	50.0
	ns	25.0	38.0
	a	25.0	12.0
Love relations between students and teachers are common in this school	d	57.0	56.0
	ns	0.0	22.0
	a	43.0	22.0
Love relations among students are common in this school	d	20.0	40.0
	ns	10.0	10.0
	a	70.0	50.0
Student pregnancy is a big problem in this school	d	62.5	70.0
	ns	25.0	20.0
	a	12.5	10.0

Teachers at both primary and secondary levels were adamant that sexual harassment was not a major problem. One teacher remarked, "*This would be against teaching ethics*." There was also a general consensus that the school administration dealt effectively with sexual harassment when it occurred (tables 11 and 12).

Table 12: Teacher Statements From Focus Groups		(%)
The school curriculum on sexual and reproductive health is not well designed	d ns a	7.7 0.0 92.3
Teachers are not properly trained to deliver the sexual and reproductive health curriculum	d ns a	21.4 0.0 78.6
Teachers are not confident teaching the sexual and reproductive health curriculum	d ns a	35.7 0.0 62.5
Parents do not want teachers to teach reproductive health and sexual health topics to their children	d ns a	38.4 30.8 30.8
HIV/AIDS is a big problem in this school	d ns a	46.7 33.3 20.0
Love relationships among students are common in this school	d ns a	50.0 0.0 50.0
Sexual harassment among students is a big problem in this school	d ns a	71.4 21.4 7.2
Sexual harassment among students at this school has got worse in recent years	d ns a	78.6 0.0 21.4
Students are changing their sexual behaviour in response to the sexual and reproductive health curriculum	d ns a	57.1 14.3 28.6

Key: d—disagree, ns—not sure, a—agree

6. IMPACT ON STUDENTS

The impact on students was assessed through a variety of methods. These included self-reports on the questionnaire with regard to absenteeism, repetition and school interruption, student and teacher focus groups. As information was also collected from the questionnaire on whether parents were still alive and whom they lived with, it was possible to correlate these background characteristics with the frequency of absenteeism, repetition and school interruption.

During the administration of the teacher questionnaires, head-teacher interviews and management interviews, particular attention was paid to three categories of students, that is, students who had been orphaned by AIDS, students who were responsible, in whole or in part, for the care of parents and guardians who were sick, and finally students who are HIV positive themselves. These are overlapping categories but served as foci for seeking information about the interventions that could be introduced to counter some of the negative effects of HIV/AIDS on students.

6.1 Characteristics of Study Schools

The primary schools were all mixed; three secondary schools were mixed and one was a girls' school. All the secondary schools had some boarding facilities with virtually all girls in the girls' school living on campus.

Each school was asked to complete a data sheet that requested data by grade and gender on enrolment, repetition, dropout, absenteeism and orphan numbers for 1995 to 1999. A completed sheet was received from every school except School 10, an urban secondary school. In addition examination results going back to 1990 were obtained for all study schools from the Uganda National Examinations Board. The tables and graphs are in Appendix 4.

Enrolment: All primary schools had an enrolment peak in 1996 or 1997, coinciding with the introduction of UPE; and there has been a gradual decline since then. The three secondary schools did not have a general pattern; the UPE bulge has not yet affected this level. School 2[15] had remained static, school 5 had experienced a gradual year on year increase and school 9 had a sudden jump in 1999.

Repetition: Repetition trends at both primary and secondary level were highly variable by school, appearing to reflect individual school practice rather than general policy.

Dropout: For most primary schools there had been a peak in dropout in 1995 and 1996 and a somewhat uneven decline since then. School 6 was an exception and dropout appeared to be on the increase. Secondary schools showed no consistent pattern with school 2 remaining stable, school 5 increasing and school 9 decreasing.

Absenteeism: Absenteeism is increasing for the three primary schools for which data is available, some quite steeply. This may be related to the number of orphans.

[15] Schools 1,3,4,6,7 and 8 are primary schools; Schools 2,5,9 and 10 are secondary.

School performance: School level data on performance on national examinations (at the end of primary and secondary school respectively) was obtained for each of the schools in the survey from 1989/1990 to 1999. The data is in appendix 4 with the graphs indicating the number of Division 1 passes and ordinary passes for each year.

There is no consistent pattern among secondary schools. Two schools have had a gradual increase in the number of passes between 1989 and 1999, and the other two had peaks at the beginning and end of the period with troughs in the early 1990s.

Among the primary schools the pattern is more consistent, with a peak in the early 1990s and late 1990s for four of the six schools. School 1 has had a high level of passes throughout the period and School 6 has had an upward trend from 1991.

6.2 Repetition, Absenteeism and School Interruption

Teachers and head-teachers repeatedly referred to absenteeism and drop out as a negative consequence of students losing parents or guardians, or of families being put under financial stress by sickness in the main breadwinner. To address this issue, data from the student questionnaire was used: information as to whether parents were alive, information on living arrangements, and information as to whether they had ever repeated a class, been absent this term, had to interrupt their schooling and their reasons for repetition, absence or repetition.

Just under two thirds (62.9%) of students reported that both parents were alive, 16.2% that only their mother was alive, 8.6% that only their father was alive and 10.2% that both parents were dead[16].

Table 13: Repetition, School Interruption and Absence by Parental Presence

	Primary				Secondary			
	Both Alive	Mother Alive	Father Alive	Both Dead	Both Alive	Mother Alive	Father Alive	Both Dead
Ever Repeated	34.9	41.7	22.7	30.8	26.3	21.4	25	28.6
Stopped Attending	13.5	13.9	23.8	26.9	16.2	17.9	25.0	42.9
Absent this Term	62.8	72.2	72.7	53.8	51.5	35.7	50	78.6

School interruption shows the clearest impact of whether a parent was alive or dead at both the primary and secondary level (see table 13). Only 13.5% of students at primary and 16.2% at secondary who had both parents alive have had to interrupt their schooling at all. When both parents are not alive this percentage goes up to 26.9% for primary and 42.9% for secondary students.

Parental absence or presence does not appear to have an effect on repetition. Certainly having both parents alive does not reduce the likelihood of repeating. An indication that this may be more a result of the student's own characteristics than their home situation.

Absenteeism is high for all groups. In primary school, there is a tendency for students who have lost both parents to be absent less than others. In secondary school, the orphans are absent more than others. In secondary school, the absenteeism may be related to being sent away for fees. During the focus group discussions students reported that some older siblings

[16] There was a 2.1% non-response on this question.

had to spend market days earning money and this might also contributed to higher rates of absenteeism among orphans.

Approximately 60% of the sample had been absent at least once during the current term. Personal sickness was the most common reason followed by being sent home from school. Primary students were more likely to be absent than secondary but no significant difference appeared by gender or location. Girls and primary students were more likely to report personal sickness than boys or secondary students. There was no support for the anecdotal claims that girls are being asked to remain home; only 15% of girls gave family sickness as a reason compared to almost 22% of boys and again boys were more likely to report being needed at home as the reason for absence. Deaths in the family were a more important reason for absence for primary students, rural students and girls compared to secondary, urban and boys.

Table 14: Absence and Reasons for Absence by Level, Gender and Location

	Prim	Sec	Boys	Girls	Urban	Rural
Absent this term	64.4	51.0	59.2	59.2	59.0	59.3
Was sick	47.0	32.5	32.1	50.4	46.3	38.9
Death in family	22.1	11.7	16.0	21.0	8.4	26.0
Teacher absence	6.7	1.3	4.7	5.0	2.1	6.9
Family sickness	22.1	11.7	21.7	15.1	5.3	28.2
Needed at Home	16.8	5.2	17.0	9.2	7.4	16.8
Sent Home by School	27.5	37.7	36.8	25.2	27.4	33.6
Other Reason	10.8	19.7	15.2	12.7	20.2	9.2

There were urban and rural differences in the reasons for absenteeism. Rural students were more likely than urban students to have missed school because of deaths (26% versus 8.4%) or sickness in the family (28.4% versus 5.3%). The difference could be caused by actual levels of mortality in the different environments or by the fact that the continuing tradition of burying the dead in their rural homes makes it more likely that a rural student would attend the funeral of a family member. An urban student is likely to travel only for very close family members.

With respect to secondary and primary; secondary students are more likely to be boarders and thus less likely to get released from school for reasons both of distance and administrative barriers. The small difference for girls may be a reflection of gender discrimination, with girls' schooling being viewed as more dispensable.

One clear indication is that the school itself contributes significantly to absence; children are being sent home for fees and materials and for discipline problems. Given the probable impact of absence on the opportunity to learn it would seem that school administrations should seriously consider a different approach to dealing with these issues.

Looking at the influence of parental presence on absenteeism (table 15), a number of different patterns emerge that call for further investigation. Deaths in the family and being needed at home was much more common for those with only their mother alive than any other category. Family sickness was more important for those with only their fathers alive. The reasons for these differences are not clear and deserve further investigation.

Table 15: Absenteeism by Presence of Parents				
	Both Alive	Mother Alive	Father Alive	Both Parents Dead
Absent this term	58.3	56.2	64.7	62.5
Was sick	41.3	45.7	47.6	32.0
Death in family	10.5	45.7	19.0	28.0
Teacher absence	4.9	8.6	4.8	0.0
Family sickness	14.0	11.4	52.4	28.0
Needed at Home	11.9	25.7	9.5	4.0
Sent Home by School	32.9	28.6	28.6	28.0
Other Reason	16.2	5.9	4.8	20.0

Table 16: Repetition, School Interruption and Absenteeism by Living Arrangement				
Whom Lived With	N	Repeated	Stopped Attending	Absent this Term
Both Parents	147	32	10.9	57.1
Mother Only	95	27.4	15.8	61.1
Father Only	25	28.3	16.0	72.0
Grandparents	57	33.3	21.1	50.9
Siblings	51	29.4	13.7	68.6

A large proportion of students, but not the majority lived with both of their parents, 37% at primary and 36% at secondary. A range of other living arrangements was reported. Rural students were more likely to live with grandparents than urban, 22.3% and 5% respectively.

6.3 Orphans

Context: There did not appear to be a generally recognised definition of an orphan among the respondent groups interviewed. The WHO defines an orphan as "an individual below 16 whose mother or both parents are deceased". The official definition in one of the districts visited was "an individual below 18 who has lost both parents". UWESO, the major national NGO that deals with orphans, defines one as 'a child under 18 who has lost one or both parents. Respondents (i.e. teachers, head-teachers, and NGOs providing services to orphans) used a number of other definitions. A cultural definition was reported to be "any child who has lost a father", while it appeared that for some the label 'orphan' was shorthand for a vulnerable or impoverished child, irrespective of whether parents were still alive.

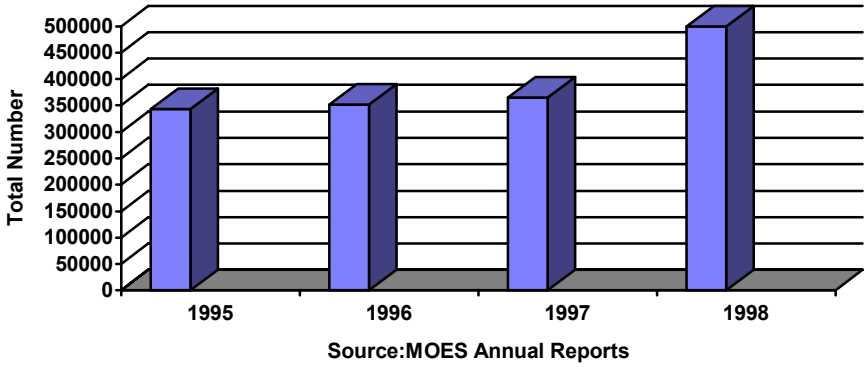
According to UWESO officials, the central strategy for dealing with orphans is to absorb them into families. The first option is to reunite them with other family members but failing that with families within their community. It was reported that while child-headed households did exist, these were temporary phenomena as communities disapproved of the continued existence of unsupervised groups of children—they were regarded as socially disruptive. There did not appear to be a generalised state policy on orphans, apart for provision for their schooling within the UPE programme and the limited scholarship programme for secondary students.

Population: The 1991 census indicated that 11.6% of children under 18 had lost at least one parent; the proportion varied geographically from 7.42 in Kasese District in the Western Region to 18.27% in Kumi District in Eastern Region. The two districts in which the study was conducted Masaka in Central and Jinja in Eastern had levels of 14.94% and 8.72% respectively.

At the official level, government estimates of orphans in Uganda were 1.5 million in 1997. This estimate was prepared by the Uganda AIDS Commission and based on AIDS case data. An orphan was identified as a child under 18 who had lost one or both parents. It is estimated that at least one million of these children lost their parents through HIV/AIDS. ***Children on the Brink***, a 1997 USAID-sponsored study with estimates of orphans for 23 countries made by the U.S. Census Bureau, has estimates that are considerably higher. Using a definition of children under 15 who have lost one or both parents, it was estimated that there would be 2.763 million orphans in the year 2000 (UNICEF/NY, 1998). Within the educational system, the number of registered orphans in primary school was close to 500,000 in 1998, or approximately 10% of all students.

The official roster of orphans is probably an under-estimate. Schools have been required to keep a list of war orphans for many years, as the government had clearly targeted programmes for them. With the introduction of UPE, war orphans are no longer a special target group. At secondary level there are modest government scholarships available for some orphans and the school keeps track of those admitted to this programme.

Fig 6: Number of Orphans in Primary Schools, 1995-98



Source:MOES Annual Reports

The government recognises that estimates of number of orphans are not very reliable and a community-based census has begun.

Findings: Approximately 35% of the study sample had lost one or both parents. This level is much higher than either of the estimates referred to above and as anecdotal evidence suggests that there is a higher than average probability for orphans to drop out of school, the true incidence could be even higher. Acknowledging that the study sites were chosen for historically high levels of sero-prevalence and that the sample is relatively small and this estimate is not nationally representative, these figures nevertheless provide added support to the need for a rigorous census of orphans.

Table 17: Number of Orphans and Percentage of Enrolment by Year, Study Schools, School Records						
Year	Enrolment		Number of Orphans		Orphan as Percentage of Enrolment	
	Primary	Secondary	Primary	Secondary	Primary	Secondary
1995	4357	1563	593	168	13.61	10.74
1996	5020	1528	789	256	15.71	16.75
1997	6403	1532	892	257	13.93	16.77
1998	6222	1581	797	231	12.81	14.61
1999	6414	1535	870	246	13.56	16.03

Data was gathered from orphans through the questionnaire (the questions on whether mother or father was alive allowed analysis of these sub-samples) and through focus group discussions. Students in general were asked to give their views, as were teachers and head-teachers.

In the five focus group discussions conducted with orphans (2 in schools, three with NGOs)[17], the major problem was identified as financial even though orphans are given preference for free school places under UPE. As they live either with elderly grandparents or guardians, they often lacked money for school dues (for example, contributions for food preparation); uniforms and scholastic materials and many also indicated that they were often hungry. Some reported being accused of having HIV/AIDS. This was particularly an issue for those whose parents were known or suspected to have died of HIV/AIDS.

The reported financial hardship meant that they had to earn money for things like exercise books, uniform, food contributions, etc. during the holidays, and sometimes during term time. At home, guardians were reported to demand substantial labour in return for food and shelter. In at least two focus groups, participants claimed that girls were advantaged in these circumstances because their labour contributions (housework, child-care, etc.) in the household tended to be more valued than those of boys.

Orphans' Comments

- Other children tease us and call us funny names
- We do not feel confident to play and share eats with others
- Orphans have inferior property, e.g. poor/torn mattresses, no suitcases, some use bark cloth at night to cover themselves although this is not allowed, so those who have, keep teasing us and at times refer to us as AIDS people (sic).
- Sometimes other children are suspicious of us and think we are thieves.

These reports of discrimination were not universal—at least one set of orphans reported considerable sympathy and support from fellow students and teachers. In the ordinary

[17] As indicated above, it was not always clear how a child was identified as an orphan by NGOs. During the focus group discussions, at least one of the children would indicate that they lived with their 'parents' or 'mother'. Unfortunately, the context was not conducive to exhaustive questioning about exact relationships. NGOs were not able to give us clear-cut criteria for their identification process.

student focus group sessions, the other students appeared to have a generally high awareness and sensitivity to the plight of orphans. They recognised their financial hardship and at times blamed teachers for not being understanding enough. For example, they pointed to the fact that orphans were punished for being late or for not doing homework. The teachers did not try to investigate the situation that students claimed was often due to the labour demands of guardians.

Students were of the view that there was a high probability of dropout when a student becomes an orphan (table 18). They were also of the opinion that schools did little to assist children who were orphans (table 19).

Orphans expressed considerable anxiety and uncertainty about their future. For those in primary school, obtaining fees for attendance at secondary school was a major concern. A few girls were anxious about contracting HIV or becoming pregnant as they tried to earn money for school; a clear indication that some form of sex work was engaged in by young girls who had no other resources. Health care was also a concern for a minority, particularly those who were HIV positive.

A related issue was school performance. No historical data was collected on individual level performance, but some orphans reported that anxiety and the need to devote time to income generation had affected their performance in class. Teachers also reported that this occasionally happened but the view was that this depended on the ability of the students and their home circumstances. The very bright ones were reported to be able to maintain good marks in spite of absences and other difficulties.

Other orphans referred to an emotional vacuum, with girls in particular reporting missing their parents' love and care. Several orphans had experienced a series of disruptions in their home lives—on the death of the primary care giver they had moved to stay with a grand-parent and on the death of that relative may have had to move to yet another.

Another problem cited by orphans was bullying. However, it is unclear whether or not this is a general problem.

Table 18: Statement Responses from Student Questionnaire–Orphans

		Boys	Girls	Primary	Secondary
Students whose parents die often have to drop out of school	d	21.3	34.5	28.3	28.7
	ns	26.9	17.5	27.4	14.7
	a	51.8	48.0	44.3	56.6

Key: d—disagree; ns—not sure; a--agree

Table 19: Student Statements from Focus Groups—Orphans

		Boys (%)	Girls (%)
Students who have lost close relatives often drop out of school	d	12.5	0.0
	ns	12.5	10.0
	a	75.0	90.0
Students who are orphans do not receive any help from this school	d	37.5	56.0
	ns	0.0	0.0
	a	62.5	44.0

Key: d—disagree; ns—not sure; a--agree

When asked to indicate how their school had been affected by HIV/AIDS, many teachers pointed to the increasing numbers of orphans and their often-sorry plight. They claimed that drop out, absenteeism and poor performance often resulted when students became orphans[18]. Teachers characterised orphans as badly dressed, lacking parental love and possibly physically abused. One common perception was that they were often sleep deprived because of long hours of household labour; dozing in class was said to be typical behaviour.

Most teachers felt that the number of orphans would increase, driven by the continuing AIDS death toll among parents. This concern for their welfare was generalised. It was recognised that they often faced hardship before and after death of their parents. Some teachers were of the opinion that educational efficiency would be affected in at least two ways: Dropout would increase because orphans generally have more difficulty than others in obtaining school fees. Those who do manage to raise fees might have difficulty with getting additional funds for scholastic materials and thus not perform well.

Among some teachers, there was a reluctance to become too aware of the problems of orphans: "*I cannot do anything about it, so I would rather not raise expectations by asking questions.*"

There were limited remedies for the problems. In some schools, orphans who were known to be having financial difficulty were either given fee waivers or allowed to pay in instalments. In secondary schools there were a limited number of 'school dependants'. These were orphans who were known to be outstanding students and given places either free or in exchange for their labour during holidays and over the weekends. The amount of labour demanded varied from school to school. Commonly these orphans had either been enrolled in the school prior to the death of their parents or were the children of deceased staff members.

Head-teachers identified orphans as the single most troubling effect of the AIDS epidemic; they saw them as experiencing much hardship and also suffering from long-term psychological stress.

6.4 HIV Positive Students

According to medical statistics, 90% of children who are born HIV positive die before their fifth birthday[19] even though anecdotal reports were that they survived much longer. One respondent indicated that the prevailing assumption was that any child suspected of being born HIV positive was assumed to be negative if they had survived into their mid-teens. However, a real possibility exists that children who die of AIDS after their tenth birthday could have contracted the virus after birth, either accidentally or because of risky sexual behaviour/sexual abuse during childhood.

[18] The National Household Survey (1994-5) indicated that 'inability to meet educational costs' was the most reason for school dropout in the 10-19 age range, accounting for at least two thirds of dropout, depending on age and gender.

[19] The mean age of an HIV positive child in Uganda is 2.3 years (STD/AIDS Control Programme, 2000).

Table 20: Statement Ratings from Student Questionnaire—HIV Affected Students					
		Boys	Girls	Primary	Secondary
Students of HIV infected families are treated unkindly by other students	d ns a	43.2 32.4 24.4	51.8 26.6 21.6	38.0 36.7 25.3	62.8 17.6 19.6
Students of HIV infected families are treated unkindly by teachers	d ns a	57.3 24.7 18.0	59.3 27.6 13.1	51.0 30.3 18.7	69.6 20.3 10.1
Students who have to look after sick relatives often drop out of school	d ns a	29.7 29.7 40.6	37.8 21.1 41.1	30.0 28.1 41.9	39.4 21.9 38.7

There were few students identified as being HIV positive by the teachers. At the primary level only four of the teachers interviewed (10.8%) indicated they knew of an HIV positive student and there were no more than two in any one school (in one case, siblings). At the secondary level, 25% (11 teachers) reported knowing of such students but the number was also low[20]. The AIC routinely does voluntary HIV testing when it goes to visit secondary schools and a counsellor reported that typically 1% of those tested were positive. Teachers described them as sickly, frequently absent and as they were usually orphans also exhibiting signs of lack of parental care.

Table 21: Student Statements from Focus Groups—Students Affected by HIV			
		Boys (%)	Girls (%)
Students whose families have been affected by HIV/Aids are treated unkindly by teachers	d ns a	78.0 22.0 0.0	67.0 11.0 22.0
Students whose families have been affected by HIV/AIDS are treated unkindly by other students	d ns a	63.0 25.0 12.0	44.0 12.0 44.0
Students who have to look after sick relatives often drop out of school	d ns a	12.0 38.0 50.0	10.0 40.0 50.0

From the tables above, only a minority of students felt that children who are affected by HIV/AIDS were treated unkindly either by teachers or by their fellow students. The message about not discriminating against those affected by HIV appears to have been generally accepted.

6.5 Students Looking After Sick Family Members

Students looking after sick family members is a small group but one that combines the difficulties of the previous two groupings. Children with sick parents suffer financial hardship, as the household breadwinner is either unable to work regularly or has medical expenses to meet. In addition, the students have to watch the deterioration and suffering of

[20] These reports should be interpreted with caution as those teachers willing to identify children as HIV positive often used circumstantial evidence, most commonly that their parents had died of AIDS-related causes and that the children appeared to be in ill health.

loved ones. Teachers reported that even in boarding schools such students were often distracted and depressed when their parents were sick, even when they were not directly involved in the care of the sick individual. One class teacher in a boarding school reported having stopped one of her charges from going home at weekends to visit her sick father because the student was always upset and distressed when she came back to school.

The memories are vivid and powerful: some of the orphans who had nursed their parents reported being reminded of their parents' suffering whenever they saw a sick person.

As can be seen from tables 20 and 21, their fellow students see such students as almost as likely to drop out as orphans.

6.6 Addressing the Problems

Counselling: On an individual basis, teachers reported 'comforting' or 'counselling' those students who appeared particularly distressed or distracted. Sometimes the student in question was referred to the senior woman teacher for follow-up.

However, there was no systematic method of identifying children in need and the opportunities and resources for providing emotional and psychological support were very limited.

Financial Assistance: Head-teachers would on their own discretion forgive debts to the school. This was clearly a limited option and was often reserved for children seen as deserving of special consideration, children of teachers, or those from families with a long connection to the school or who were exceptionally bright.

There are government scholarships available but these are limited in number and size.

NGO Support: In some schools NGOs were working with the school administration to provide assistance for needy students. This assistance usually took the form of material support although there were some NGOs who followed the sponsorship model and had a more extensive connection with particular children. There was reported to be some reduction in NGO support in the recent past since the introduction of UPE. The schools sometimes complained also that there appeared to be duplication in the services provided by NGOs and that there was no regulation or supervision[21]. This also meant that the distribution of NGO activity appeared uneven, with some schools having many more contacts with NGOs than others.

It was clear from the interviews with NGOs that the programmes of many were in a state of flux. At least two organisations, UWESO and World Vision, were moving or had recently moved from a strategy of directly funding individual orphans to a strategy of family-based income generation. Others like Redd Barna and Kitovu Mobile had completely withdrawn from schooling support. For both UWESO and World Vision, the shift in strategies was regarded as a more sustainable, equitable option. For example, one UWESO district manager reported that under the previous model of direct provision of school fees they had been able to support 200 orphans; however the new revolving loan scheme benefited households

[21] The government of Uganda has traditionally practiced a laissez *faire* policy with respect to NGOs. At the district level, the education officer was often represented on executive committees or was kept regularly informed of activities but there did not appear to be any attempt to control or regulate their activities.

containing 7500 orphans—all of whom were reportedly enrolled in school. Obviously, however, the school's perception would be that there had been a significant reduction in available resources, as funds were no longer being targeted directly through, or to, them.

Private boarding primary schools appear to be on the increase and anecdotal reports suggested that they were being used as dumping grounds and that the students were more likely to be orphans or the children of sick parents. However, the MOES did not appear to bring together the information on the number of licenses issued, enrolment, number of teachers employed etc. in these schools, as they are not reflected in the comprehensive educational statistics abstracts. Further, if many students in such institutions are orphans, the possibility for abuse (physical, mental, sexual) does exist as such students would be less likely to be visited or to have a close adult willing to take up the cudgels on their behalf. Undoubtedly, such boarding schools (and orphanages) provide an extremely vital service to children in need as they can provide a source of physical and emotional stability and safety that may be lacking at home; but the authorities should ensure that caregivers continue to provide an appropriate level of care and support.

7. IMPACT ON TEACHING STAFF

7.1 Introduction

The teacher is an important part of any education system; for one like Uganda's that is trying to reach universal primary enrolment, the role of the committed teacher is vital. Hence their preparation, conditions of work, levels of remuneration and general morale are of great significance. Within the context of HIV/AIDS, teachers have two major roles—helping to protect the young by giving them the required knowledge and skills for safe and abstinent living as well as protecting themselves from becoming infected. Those who are infected also need access to treatment and advice on positive living.

UPE created a huge demand for primary teachers; the number of teachers increased by 14,000 between 1996 and 1997. The following year saw another increase of 9000. The increases in both student and teacher numbers are projected to continue until 2003 after which student numbers are projected to fall as the UPE bulge passes through to secondary school. A net enrolment ratio of 100% is projected for the year 2003.

The drive to UPE is causing major upheavals in the education sector and is clearly the dominant issue with which managers, i.e. head-teachers, district officials and MOE officers, have to deal.

Age Profile: As table 22 indicates, the teaching force is quite young, with 40% of the male teachers being below 30 years of age at both primary and secondary level. Female teachers are younger, with over 60% of the primary and over 50% of the secondary teachers being below 30. The age profile of the teachers in the study sample is similar but slightly younger than the national sample at the secondary level.

Table 22: Age Profile of Teachers in Study and 1998 National Sample

	N	20-30[22]	31-40	41-49	50-60
PRIMARY					
Study Male	23 (38.3%)	39	30.4	26.1	4.3
National Male	62291 (63.9%)	42.7	35.3	16.9	5.0
Study Female	37 (61.7%)	59.5	32.4	8.1	--
National Female	35074 (36.0%)	61.5	27.5	8.7	2.3
SECONDARY					
Study Male	55 (65.5%)	42	47	5.5	5.5
National Male	12980 (80.8%)	38.6	44.2	13.5	3.8
Study Female	29 (34.5%)	65.5	31.0	--	3.4
National Female	3079 (19.2%)	52.6	35.7	9.6	2.0

The study sample is more female; the proportion of female teachers at both primary and secondary is almost double that in the nation. This is probably a result of the sampled districts being relatively more developed and the schools selected being relatively close to urban centres in those districts. No school was more than 1.5 hours away from the town by vehicle.

[22] The age groupings for the national sample differ slightly: 29 and under, 30-39, 40-49 and over 50.

Age is an important indicator of probability to be HIV positive. In Uganda, the population aged over 30 has not experienced as great a reduction in HIV prevalence over time as the younger age groups. Those aged 15-29 had a lower prevalence to start with and experienced a sharper drop. For example, among first time testers at the AIDS Information Centre, there has been a ten-percentage point drop from a level of 20% to 10% in the 20-29 year age groups (see Figure 4). A substantial proportion of the national teaching force, male and female, secondary and primary is in the over-30 age group.

Qualifications: Official policy is that all teachers should be trained, that is should undergo some form of formal teacher preparation. The proportion of untrained teachers at primary level was 12% in 1998. The proportion at secondary level was 15% in the same year.

Table 23: Academic Qualifications, Teachers in Study Sample						
	N	O level or less	A Level	Diploma	University	MA
SECONDARY						
Male	52	7.7	15.4	28.8	40.4	7.7
Female	29	6.9	17.2	27.6	48.3	--
PRIMARY						
Male	22	77.3	13.6	4.5	4.5	--
Female	36	88.9	2.8	13.6	--	--

Experience: The teachers in the study sample were relatively more experienced than average, except for female secondary teachers. Male primary teachers in the study were most heavily clustered in the 5-9 and 10-14 years categories and female teachers in the study were observed in higher proportions in the 2-4 and 5-9 years category.

Table 24: Years of Experience, Teachers in Study Sample and 1998 National Sample						
	1 or less[23]	2-4	5-9	10-14	15-19	20+
PRIMARY						
Study Male	8	12.0	32.0	24.0	8.0	16.0
National Male	6.7	30.6	28.2	16.2	7.8	10.5
Study Female	13.5	27.0	18.9	16.2	10.8	18.9
National Female	7.8	34.8	28.3	14.2	6.4	8.5
SECONDARY						
Study Male	10.9	18.2	41.8	20.0	3.6	5.5
National Male	7.4	33.5	33.5	13.8	5.3	6.5
Study Female	7.4	33.3	44.4	7.4	7.4	--
National Female	9.3	36.3	29.9	13.9	6	5.3

On the national level, 37% of male primary teachers had less than five years experience while only 20% of the equivalent study sample did. The differences were not as sharp for female

[23] For national sample the categories are less than one year; 1-4, 5-9, 10-14, 15-19 and over 20.

primary teachers; but there were more likely to be more experienced female teachers, i.e. over 10 years of experience, in the study schools than in the national sample as a whole.

At secondary level, male study teachers were more experienced than female, with over 70% having more than five years experience, compared to 60% for women teachers. There was a higher proportion of inexperienced male teachers in the national sample. The differences in experience between the study and national samples were small for the female teachers at the secondary level.

7.2 Impact of HIV/AIDS

Head teachers, who had been at their schools for an average of just over four years, reported that the situation with respect to teachers was much better than it used to be. Teacher deaths were reported in most schools, although this was over a long period, going back to 1991.

Head-teachers reported that teachers were burdened by the costs and demands imposed by sick relatives and by attendance at funerals.

Several head-teachers claimed to be unaware of any policy on AIDS by the MOES. However several suggested that a specific policy statement to deal with issues of sensitisation regarding students, staff and parents was urgently required. Some head-teachers pointed to the collaboration with the Ministry of Health in bringing visitors to schools, as evidence of an MOES policy of promoting HIV/AIDS awareness.

Attrition and Mortality[24]

According to the Ministry of Education, in 1998, 16.5% of primary teachers, trained and untrained left their schools. More untrained (24.34%) than trained teachers (13.9%)[25] left. This percentage includes transfers, promotions and teachers who left to pursue further training. The discussion below will focus on a more restricted definition that includes teachers who are truly lost to the teaching force, i.e. those who retired, resigned, left without notice or died.

With the more restricted definition, attrition between 1995 and 1998 ranged between 3.9 and 5.4%. The highest contribution of mortality from all causes to teacher attrition was in 1997 when it constituted 25% among primary teachers and 31% among secondary teachers. A recent WHO publication estimates that 21% of adult mortality in Africa is caused by AIDS. Using this figure, table 25 contains estimates of how many teacher deaths were caused by AIDS in 1995 to 1998. According to this calculation no more than 2% to 5% of teacher attrition among primary and 1% to 6% among secondary teachers is due to AIDS between 1995 and 1998.

Further, if one compares the estimates of teacher mortality due to AIDS to estimates for the general population (table 25), teacher mortality is considerably lower than that among the

[24] The analysis of mortality uses aggregate statistics for primary and secondary levels. Data is disaggregated by training status for three years and by gender in one year. However, there was no significant difference in death rates between trained and untrained or males and females.

[25] A large proportion (up to 30%) of the attrition was due to 'transfers'; and a full definition of this term was not provided in the annual reports.

general population[26]. Estimated teacher mortality from HIV/AIDS at both the primary and secondary levels is approximately half that of the general population.

Table 25: Mortality Among All Teachers in Uganda				
	1995	1996	1997	1998
PRIMARY				
Total Deaths	646	792	987	948
Total in Post	74401	81564	88751	100946
Attrition rate	*6.9*	*5.3*	*4.3*	*5.3*
Total Mortality rate	*0.87%*	*0.97%*	*1.11%*	*0.94%*
Total Mortality as % of all attrition[27]	13	17.9	25.45	17.66
AIDS deaths as % of total attrition	2.65	3.82	5.34	3.71
Estimated AIDS deaths among teachers (21% of total mortality)[28]	136	166	207	199
AIDS deaths at 2003 rate for general population	320	320	382	434
SECONDARY				
Total Deaths	166	158	137	160
Total in post	12918	13997	13470	16206
Attrition rate	*4.2*	*3.6*	*3.2*	*4.1*
Mortality rate	*1.28%*	*1.13%*	*1.02%*	*0.99%*
Mortality as a % of all attrition	30	31.2	31.9	23.95
AIDS deaths as % of attrition	3.71	6.54	1.34	5.03
Estimated AIDS deaths (teachers)	35	33	29	34
AIDS deaths at 2003 rate	56	60	53	70

The level of mortality is similar in primary and secondary schools, but the pattern appears to differ. While secondary mortality has been falling over the last four years for which data was available, the mortality among primary teachers rose for three years before falling in 1998. The absolute levels are so small, however, that it is doubtful whether the movements are statistically significant.

The public perception of the level of teacher mortality may be different. Although the survey respondents were consistent in describing teacher deaths as an issue of the past, some of the participants in the preliminary dissemination workshop disputed this. Further investigation is warranted, as official statistics, which depend on reports from schools and districts, may not provide a complete picture.

Some information was gathered on teacher deaths in the survey schools. The reliability of this information is questionable because the information from the separate interviews with the head-teacher and senior management was not always consistent. The following

[26] The estimates for the adult population are drawn from Goliber (2000). He indicates that the epidemic is Uganda is expected to stabilise in 2003 with mortality rates of 4.3 per 1000 for the 15-49 year-old age group.
[27] Teacher Attrition includes leaving the service through resignation, leaving without notice, death or retirement. Transfers, secondment or leaving for training is not regarded as attrition.
[28] This is based on a WHO estimate that HIV/AIDS accounted for 20.6% of the mortality in Sub-Saharan Africa in 1999.

information combines data from both sets of interviews. School 1 had two deaths since 1991, and School 2 had three since 1997. School 3 reported six deaths in the past three years. Schools 5, 6 and 7 reported one teacher death in the past year and School 8 had one death in 1991.

Morbidity and Absenteeism

Head-teachers from three of the ten schools indicated that four teachers were currently sick or infected with HIV. A fourth head-teacher reported that there were 'some' teachers who were 'weak'. Two teachers who were interviewed reported to a team member that they were HIV positive but were still healthy. Neither was mentioned by their head-teacher.

Sick teachers had a variety of problems that impacted on the school. An obvious one was absenteeism, but head-teachers also reported that sick teachers also suffered from low morale and financial pressures. Although no head-teacher indicated that sickness among teachers was currently a major issue, they did report that in the past when a number of teachers would be sick, there would be problems when teachers would not take sick leave even when they could not function at school and another teacher would have to assist them in their duties. According to the head-teachers, other teachers did this willingly.

The schools (head-teachers and individual teachers) generally reported treating such situations with sympathy and providing moral and financial support both to a teacher who was sick and, to whatever extent possible, to the family if the teacher died. The family support was generally in kind, like granting fee waivers to allow the children to attend school.

The self-reports of absenteeism were relatively low. At the secondary level, 90% had been absent for five days or less and approximately 35% reported not being absent at all. At primary the reported absences were even lower with approximately 45% not having been absent at all. Head-teachers concurred that absenteeism among teachers was not a major problem. Two schools reported having teachers with persistent illness that caused them to be absent, but both were secondary schools and other teachers taught the sick teachers' classes.

When teachers were asked about their own absences this term during the interview, the absences were seen as being caused more by funerals and family responsibilities than because teachers were themselves sick. This was true for both primary and secondary teachers; among secondary teachers, school related reasons (attending competitions, etc) were the most common reason.

Table 26: Number of Days Absent This Term, Study Sample Self-Report

	N	0	1	2	3	4	5	6	**7**	**8+**
Secondary Male	42	33.3	14.3	16.7	7.1	14.3	4.8	4.8		4.8
Secondary Female	26	42.3	11.5	23.1	11.5	3.8	-	-	3.8	7.8
Primary Male	25	50	20.8	20.8	8.3	-	-	-	-	-
Primary Female	37	41.7	13.9	19.4	13.9	2.8	2.8	2.8	2.8	-

Table 27: Absenteeism This Term, School Records				
	School 1	School 4	School 5	School 6
% Of Teachers Absent[29]	8.8	21.5	34.3	14.1
Number of Teachers	23	18	16	14
Number of Days	48	36	37	39

The school records of attendance during the present term (daily sign-in books) were obtained for four schools (table 27). School 5 is a secondary school. Generally this level of absenteeism was regarded as non-problematical by school management. Secondary head-teachers also felt that teachers were not expected to be in school if they did not have classes or other school responsibilities; that may explain the higher level of absenteeism in School 5 compared to the other schools.

Table 28: Reasons for Absence, % of Teachers Indicating Reason				
Reasons for Absence	Primary Male	Primary Female	Secondary Male	Secondary Female
Personal Sickness	16.0	15.8	10.7	17.2
Funeral	8.0	13.2	10.7	17.2
Family Sickness	--	5.3	7.1	10.3
School-related	20.0	15.8	23.2	24.1
Other	4.0	2.6	14.3	6.9

There is a parallel here between reasons for absence for teachers (table 28) and students (table 14). 'School-related' is the most common reason for absence for teachers, as it was for some students. In table 14, 'sent home from school' was the most common reason for boys and secondary students. For teachers, 'school-related' reasons include attendance at sports and drama festivals, attending official meetings at the District Education Office, MOE, and so on.

Personal sickness is the second most common reason followed closely by attendance at funerals. Family sickness is the next most common reason for all categories except for male secondary teachers, who indicated 'other'.

However, when asked to characterise the situation for all teachers in the school, sickness was usually named first followed by funerals and family illness.

Table 29: Primary Teachers Statement Ratings—Absenteeism						
	Disagree		Not Sure		Agree	
Statement	M	F	M	F	M	F
Teachers absenteeism is a big problem in this school	92	81.1	0	5.4	8	13.5
Teachers absenteeism has increased significantly as a result of HIV/AIDS	92.6	78.9	3.1	13.2	4.3	7.9

[29] (1 – (Number of teacher-days absent/maximum number of teacher-days)) x 100

Table 30: Secondary Teachers Statement Ratings—Absenteeism						
	Disagree		Not Sure		Agree	
Statement	M	F	M	F	M	F
Teachers' absenteeism is a big problem in this school	79.2	79.3	11.3	3.4	9.5	17.3
Teachers' absenteeism has increased significantly as a result of HIV/AIDS	70.9	82.8	21.8	10.3	7.3	6.9

Teaching Cover: Head-teachers claimed that other teachers took over the classes of teachers who were absent. Approximately, 90% of teachers who responded to the questionnaires agreed. The strategies for providing cover varied. At primary school, the most common strategy (35%) was for classes to be combined and the co-teacher (a teacher of another stream of the same class) to take over the two classes. With average class sizes of over 30, this strategy leads to very large instructional units of over 60 students and as many as 90. Inevitably, one would expect that the quality of instruction in such combined classes would be compromised because of the sheer number of students. The advantage would be that the co-teacher would be relatively familiar with the students' progress and disruption would be minimal.

Table 31: Type of Teacher Cover Provided, Primary	
Type of Teaching Cover	n
Classes merged and co-teacher carried on instruction	15
Another teacher taught lesson prepared by absent teacher	12
Classes swapped with other teachers	2
No actual teaching done	2
Roving teacher took over class	1
No description provided	7
No teaching cover provided	5
N[30]	43

Table 32: Type of Teaching Cover Provided, Secondary	
Teaching Cover	n
Assignments pre-planned	14
Other teachers provide assistance	8
No cover provided (no other teachers for subject)	2
Students have personal study time	2
Lessons swapped	2
Absent only on days when no classes to teach	1
No cover provided	1
No explanation provided	3

[30] Responses add up to more than 43 (or 33 for secondary), as some teachers gave more than one response.

N	35

Class size can also be a problem in secondary schools and there is an additional factor of subject specialization. For core subjects that had several teachers, covering for an absent teacher was usually relatively simple. Teaching cover for some optional subjects, e.g. accounting, usually was more difficult to manage if the single teacher was absent. Like primary school, leaving work for students or having other teachers cover classes were the most common options.

Almost all the options given are more suited to brief, foreseen absences than long unpredictable ones as would be occasioned by a teacher with AIDS. The use of a roving teacher in the primary school would provide help in such a case but it is clear that only a minority of schools, primarily urban, have the luxury of such a staff member.

Official Policy on Sick Leave: According to public service regulations, a teacher is entitled to up to 90 days of sick leave within any period of twelve months. "This period can be extended to 180 days on full pay in any period of twelve months if the Director of Medical Services, or any Government Senior Medical Officer designated by him or her, is satisfied that the officer will be fit to resume duty within a reasonable time." If there is doubt that the officer can recover within the specified time, the Director of Medical Services or a Medical Board can express a final opinion, and an officer who is not expected to recover will be terminated on the grounds of ill health.

The general understanding from head-teachers appeared to be that any teacher who suffers from any long-term illness can go on sick leave for one month/45 days at full pay, then half pay for a month/45 days and is then struck off the pay roll. The observance of this policy may be one reason why there are relatively few reports of teacher deaths. The characteristics of AIDS would mean that an affected teacher would probably die when no longer on the payroll. Also such a system encourages a teacher not to take long periods of sick leave and thus continue receiving full pay for as long as possible.

However, head-teachers appeared to interpret these regulations quite loosely. There was a general reluctance to rush to strike teachers off the payroll. Teachers were maintained on the payroll while they were alive and in some cases, bureaucratic delays meant that salaries would continue for up to three months after the death and these funds were reportedly passed on to surviving family members as a way of easing the transition.

There is no insurance scheme to which teachers can subscribe; districts do not routinely pay funeral expenses and teachers must rely on their own and family resources to meet both sickness and funeral expenses.

Discrimination

Discrimination against sick teachers was reported not to be a major problem, but it did exist to some extent according to some respondents. It was claimed that the reduction of the teaching force in some schools that occurred in 1997 was an opportunity for head-teachers to release teachers who were believed to be 'sick'[31]. One or two teachers reported situations in

[31] The introduction of UPE was accompanied by a number of regulations, including ceilings on government-employed teachers at each school. Surplus teachers were therefore let go at this time.

which sick teachers had been 'tortured' on the job, by not having their responsibilities reduced.

Table 33: Primary Teachers Statement Ratings—Discrimination						
	Disagree		Not Sure		Agree	
Statement	M	F	M	F	M	F
Teachers who are HIV positive are discriminated against by the Ministry of Education	84	61.1	16	19.4	0	19.5
Teachers who are HIV positive are discriminated against by school management	76	75	12	25	12	8.3
Teachers who are HIV positive are discriminated against by other teachers	79.2	86.8	8.3	10.5	12.5	2.6
School management has taken firm action to counter discrimination against teachers and students who have AIDS	64	64.8	24	27	12	8.2

Table 34: Secondary Teachers Statement Ratings—Discrimination						
	Disagree		Not Sure		Agree	
Statement	M	F	M	F	M	F
Teachers who are HIV positive are discriminated against by the Ministry of Education	49.1	65.5	38.2	10.7	12.7	3.4
Teachers who are HIV positive are discriminated against by school management	60.7	62	28.6	24.1	9.1	13.7
Teachers who are HIV positive are discriminated against by other teachers	78.2	79.3	16.4	10.3	5.5	10.3
School management has taken firm action to counter discrimination against teachers and students who have AIDS	34	55.5	52.8	33.3	13.2	11.1

Despite the reported absence of discrimination, a certain degree of anxiety was apparent both during the FGDs and also during the individual interviews. There were three main aspects to this anxiety. The first was based on lack of information about the disease; particularly puzzlement or misunderstanding of some of the recent 'discoveries' about the disease and this could be linked to a certain degree of personal anxiety.

They were also concerned about the impact of the epidemic on their students and working environment. Teachers were worried that the increasing number of orphans in their classes would mean more difficult teaching conditions, lower levels of performance and more troubled students.

The third area of concern was the impact on their families; the financial cost and time that they had to devote to health care and funerals among their extended families. The questions below that were asked after the FGDs or interviews reflect these anxieties:

Primary

- Why are some couples discordant (i.e. partners have different HIV statuses)?
- Why do some HIV positive individuals live so long?
- What did the headline (in the newspaper the previous week) about micro-biocides for women mean?
- Why can't the government provide free AIDS drugs for all teachers?
- Why are HIV tests expensive?
- Where can HIV tests be obtained?
- Can (research team) provide assistance to people with AIDS?
- Can (research team) give a talk to teachers and students?
- What can one do with an HIV positive student? Who should he/she be referred to?
- Why are we being encouraged to use condoms, when they cause immorality among children?

Secondary

- How can one have (develop) the confidence to take a test?
- How will this research assist some one with AIDS?
- How will we be helped by this research?
- What does one do about a student who one suspects is HIV positive and having unprotected sex? What do you say to his partners when they realise what may have happened?
- Can you force a student to have an HIV test?
- What assistance can be provided for impoverished students (non-orphans) who are bright?

Teacher Morale

There appeared to be differences of opinion as to whether or not morale was good. There are several major influences on morale: work load, pay and general conditions of work. The influx of students due to UPE has increased teachers' workload in primary schools. Pay is moderate, approximately USH70,000 a month. There have been some improvements in pay with the rationalisation of the teaching force that came with UPE. However, there were some complaints of payments (salaries and UPE grant) being late, although some respondents claimed this was due to late accounting by rural schools.

In secondary boarding schools and urban primary schools, active management committees are able to raise enough money to provide non-trivial top-up and duty allowances[32] as well as other benefits like housing and meals. These considerably improve the incomes of teachers who have access to them. Several schools also provide free schooling for one child. Teachers in such schools were relatively happy with their conditions. Some schools also reported assisting with medical expenses whenever funds were available.

Teachers in rural primary schools are worse off. The communities they work in are poor, the schools are poor, and therefore parents cannot afford a high level of supplementary payments. The conditions of schools and facilities are also generally inferior. Teachers were more

[32] For example USH150, 000 ($83) as a top-up, USH10, 000 ($5.60) for being in charge of an extra-curricular activity and USH20, 000 ($11.20) for additional responsibilities.

interested in working in urban schools and head-teachers in these schools had a pool of qualified talent to choose from whenever they wished to recruit additional staff.

The conditions within the community can also be difficult; transportation and medical services were two problems highlighted. Teachers for example who needed health care found it difficult and expensive to access it as clinics and medical facilities available to them did not cater for AIDS cases. Testing, advice on positive living and medications all had to be obtained from the nearest towns of Jinja and Masaka.

Some teachers also see the banning of corporal punishment as negative as it is seen as undermining their authority with students.

There was no consensus on whether or not the administration was supportive, approximately half indicated that they could discuss problems or get advice from the head-teacher or deputy head teacher (tables 35 and 36) but the discussion indicated that this was mostly about financial matters and only a minority were interested in involving the administration in discussion of personal matters.

Table 35: Primary Teachers Statement Ratings–Teacher Morale

	Disagree		Not Sure		Agree	
Statement	M	F	M	F	M	F
Teacher morale at this school is high	24	32.4	20	8.1	56	59.5
The MOES is effectively tackling the impact of HIV/AIDS on teachers' morale	45.8	38.9	8.3	25	45.9	36.1
Teachers can discuss their personal problems with school management	45.8	50	16.7	0	37.5	50
Teachers who are HIV positive are properly supported	66.7	65.8	20.8	21.1	12.5	13.1

Table 36: Secondary Teachers Statement Ratings—Teacher Morale

	Disagree		Not Sure		Agree	
Statement	M	F	M	F	M	F
Teachers morale at this school is high	16.4	35.7	24.5	3.6	60	60.7
The Ministry of Education is effectively tackling the impact of HIV/AIDS on teachers' morale	59.2	55.5	24.1	25.9	16.7	18.5
Teachers who are HIV positive are properly supported	41.9	51.7	45.5	27.6	12.6	20.7
Teachers can discuss their personal problems with school management	26	37.9	1.9	10.3	72.1	51.8

Behaviour Change

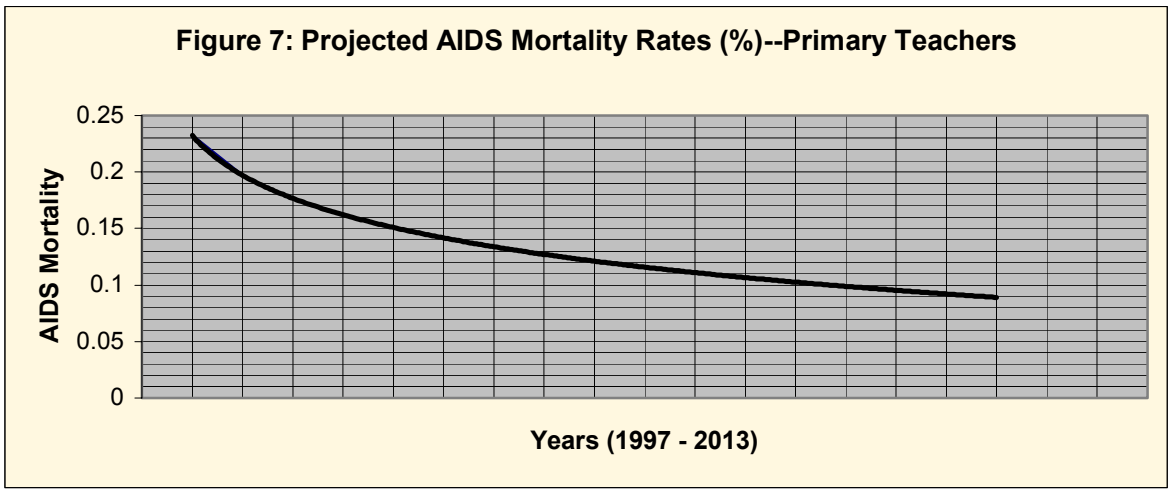
When asked what had been done to mitigate the impact of HIV/AIDS, some secondary teachers reported on the questionnaires that most people had changed their sexual behaviour—sticking to one sexual partner, using condoms and abstaining from sex before marriage. The same messages, particularly about abstaining from sex, were also being given

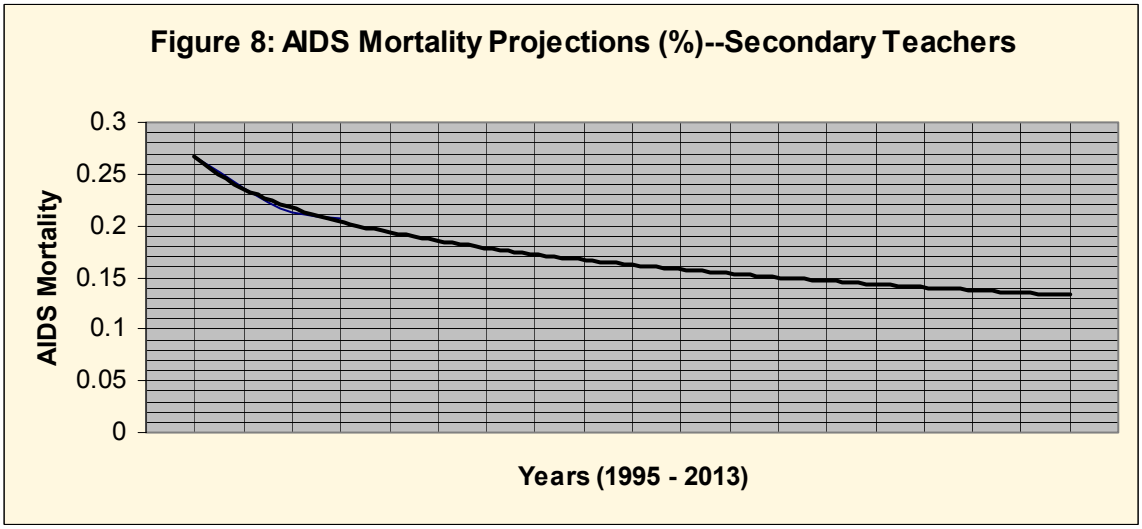
to students. Voluntary testing was also reported to have become much more common and thus contributed to the decline in prevalence.

On the negative side, some head teachers suggested that single teachers in particular tended to be promiscuous. One school reported that other teachers helped in fund-raising efforts so that single teachers could marry.

7.3 Projections

An integral part of the analysis of impact on teachers was an assessment of the long term direction of teacher numbers and requirements based on the use of a model that predicts teacher numbers based on, *inter alia*, a range of projections of student numbers and teacher attrition (AIDS-related and otherwise).





Figures 7 and 8 illustrate the probable trend of the epidemic among stages. The trend was extrapolated from data on total mortality among teachers and an assumption that a certain proportion of these deaths were AIDS-related (21%). No scenario is developed within the model about the use of anti-retrovirals because current levels of cost are so high compared to general income levels that the cost of the drugs would have to fall to 100th of current levels before they became a feasible treatment option for primary school teachers. The assumption is therefore made that anti-retrovirals will not be part of the battle against AIDS for the foreseeable future.

The data points for secondary teachers showed a smoothly decreasing mortality pattern from 1995; for primary teachers the mortality rose for the first three years (1995 to 1997) and started falling in 1998. A logarithmic projection to 2013 for secondary teachers produced a pattern as shown in Figure 8, with mortality from AIDS approaching stability, decreasing by a smaller amount every year. For primary teachers only the last two data points (1997 and 1998) were used. The use of the earlier data points led to projection of exponential growth in AIDS mortality over the relevant time period. Nothing currently known about the history and probably future pattern of HIV/AIDS prevalence and mortality makes this a believable scenario.

The two points to be observed are first that the absolute level of AIDS-related mortality is low, starting at 2.3 and 2.7 teachers per thousand (for primary and secondary respectively) at the start of the period and falling to approximately one teacher per thousand by 2013. The second point that derives from the first is the contribution of AIDS-related mortality to overall teacher attrition is small and will become even less significant.

Tables 37 and 38 illustrate the probable primary teacher and student enrolment numbers from 1998 to 2013 (see appendix 3 for details about assumptions and calculations). The size of the student enrolment is expected to keep growing until 2003 when the main UPE bulge will pass through to S1. Student numbers then fall slightly until 2006 after which they start rising again.

Table 39 shows similar projections for the secondary student and teacher populations. The UPE bulge enters secondary school in 2004 and the model assumed 100% of the age group would be entering secondary school by the year 2013.

The number of teachers required in the system is determined by the total number of students and the expected pupil-teacher ratio. The MOE has a target of reaching a PTR of 40 in primary schools by 2003. Under the assumption of a decreasing PTR, the total teacher deficit is expected to rise from approximately 9000 in 1999 to 17000 in 2003. In 2004 and 2005 there will be a surplus of teachers and the deficit will emerge again in 2006 but will not reach the levels of 2003 by 2013. If the PTR remains at 1998 levels, the teacher deficit will not be greater than 5000 between 1999 and 2013. In 2003 to 2006 there will be a surplus of teachers.

At the secondary level, there will be a surplus of teachers up to 2003. From 2004 there will be a deficit (reaching a maximum of 14,000 in 2009) despite the increasing PTR.

The MOE estimates that for the foreseeable future there will be 7000 new entrants to the primary teaching force every year. The equivalent number of new secondary teachers is 4500.

Indeed from the above, concern about the impact of HIV/AIDS on the teaching profession should focus less on how it has reduced teacher numbers and more on its effect on other aspects of the teaching force, for example, morale, sickness and death costs.

Table 37: Primary Student and Teacher Projections																
YEAR	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Projected Primary Enrolment	5806385	6087179	6441872	6684888	6819718	6850095	6653689	6483969	6469661	6556637	6785688	6971314	7205621	7518971	7807679	8041935
Target PTR (MOE)	57.5	54.8	51.1	47.4	43.7	40	40	40	40	40	40	40	40	40	40	40
Total Teachers Required	100981	111080	126064	141031	156058	171252	166342	162099	161742	163916	169642	174283	180141	187974	195192	201048
Teacher Deficit		8984	14643	15400	16239	17194	-3181	-2745	1112	3747	7594	6745	8261	10637	10392	9325

Assumptions: Smooth decline in PTR ratio to target of 40 in 2003; New entrants to teaching force of 7000 per year
Attrition rate (including death) 5.12% per year

Table 38: Primary Student and Teacher Projections																
YEAR	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Projected Primary Enrolment (model generated)	5806385	6087179	6441872	6684888	6819718	6850095	6653689	6483969	6469661	6556637	6785688	6971314	7205621	7518971	7807679	8041935
Target PTR (MOE)	57.5	57.5	57.5	57.5	57.5	57.5	57.5	57.5	57.5	57.5	57.5	57.5	57.5	57.5	57.5	57.5
Total Teachers Required	100981	105864	112033	116259	118604	119132	115716	112765	112516	114029	118012	121240	12532	130765	135786	139860
Teacher Deficit		3492	5087	3353	1586	-211	-4344	-4040	-1357	476	3153	2562	3616	5269	5099	4357

Assumptions: Constant PTR at 1998 level, New entrants to teaching force of 7000 per year
Attrition rate (including death) 5.12% per year

Table 39: Secondary Student and Teacher Projections																
YEAR	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Projected Student Enrolment	265676	246897	211216	214443	264560	387440	604926	958799	1344155	1783992	2253294	2697897	3084908	3329521	3602166	3915550
Projected P.T.R. (MOE)	16	22	26.5	28	29	30	32	34	36	38	40	42	44	46	48	50
Total Teachers Required	16206	11223	7970	7659	9123	12915	18904	28200	37338	46947	56332	64235	70111	72381	75045	78311
Teacher Deficit		-9121	-7496	-4566	-2743	-295	2094	5696	5828	6604	6677	14444	12601	66	543	1246

Assumptions: Increasing PTR ratio; new entrants to teaching force at 4500 per year; Teacher attrition from 1999 to 2013 at 3.034%.

8. Government of Uganda Response

The second half of this report presents key areas in which action should be taken to address the issues identified in the first half. These recommendations and commentary try to take account of the following key features of the Uganda context, namely:

- The substantial progress that has already been made with respect to reducing HIV/AIDS prevalence and changing sexual behaviour among the young, despite a hitherto muted response within the education sector
- The highly decentralized nature of school management and governance
- The Education Strategic Investment Plan, 1998-2003 which governs the whole sector
- The Medium Term Budget Framework

Further, the government of Uganda has begun or is beginning a rejuvenated anti-AIDS programme to guard against the threat of complacency. There are two linked initiatives that govern all the sectors and two initiatives from the Ministry of Education and Sports that are relevant to HIV/AIDS. These are:

- Uganda AIDS Commission's Strategic Framework;
- World Bank's HIV/AIDS Control Project in support of the UAC's Strategic Framework.
- Ministry of Education's Strategic Plan for HIV/AIDS,
- The ongoing Primary Teacher Development and Management Plan, 2001-2003

Discussion of the above initiatives highlights the three areas of prevention, mitigation of impact on students and mitigation of impact on teachers.

8.1 Planned Government Initiatives

The Uganda AIDS Commission is coordinating the national fight against AIDS. They have developed a National Strategic Framework (2000/1 – 2005/6) in collaboration with all major stakeholders. The framework's goals are to:

- Reduce HIV prevalence by 25% by the year 2005/6
- Mitigate the health and socio-economic effects of HIV/AIDS at individual, household and community levels, and
- Strengthen the national capacity to respond to the epidemic.

Ministry's Role within the Framework: Under this framework, the MOES has been identified as lead agency in a number of activities. The Ministry is taking the lead for goal 1, objective 1—"Promoting behaviour change (abstinence, faithfulness and safer sex) among sexually active populations, particularly young people ages 15-24 ". They are being asked to:

Promote AIDS education and counselling in schools, colleges and institutions of higher learning.

The activities identified under this strategy include:

Conduct advocacy seminars for AIDS education and counselling in schools, colleges and institutions of higher learning

Produce and distribute AIDS education materials to schools

Train trainers for teachers in AIDS education and counselling

Equip one lecturer/head-teacher per school with techniques and skills of providing AIDS information to students/children

Under objective 4, "Reducing the vulnerability of individuals and communities to HIV/AIDS with a focus on children, youth and women", the Ministry is being asked to:

> **Develop and distribute materials and messages geared towards life skills and psychosocial development at all levels**

Under goal II, objective 1, "Promoting AIDS care, social support and protection of rights of PHAs and affected individuals and families", the MOES is responsible for:

> **Developing standard training curricula on palliative care**
> **Integrating palliative care issues into the pre-service training curriculum for health workers and teachers**

These roles are educational—developing syllabi, conducting training courses and also providing HIV/AIDS education to students. The focus for the educational system is being seen as almost entirely preventative. The MOES is not being asked to take direct responsibility for mitigation, either for the impacts on children or for the impacts on teachers.

Under the UAC framework, each line Ministry is being asked to prepare a plan of action that will contribute to the achievement of the above goals and to report regularly on its implementation to the Uganda AIDS Commission. The Ministry has recently formed a Task Force whose responsibility will be the elaboration and implementation of this strategic plan. This plan is still preliminary but the current objectives are:

- To promote the development and implementation of policy guidelines and legal provisions relevant to the HIV/AIDS epidemic in the education and sports sector.
- To intensify advocacy and mobilization for HIV/AIDS education institutions and sports organisations
- To incorporate HIV/AIDS and other reproductive health issues into the curriculum for all education institutions
- To promote specialized skills-based teacher training in HIV/AIDS/STIs and reproductive health education
- To promote AIDS education, counselling and health care services at all levels of education
- To promote the welfare of AIDS orphans and staff living with HIV/AIDS in education and sports institutions/organisations including Ministry staff
- To promote partnerships and networking with NGOs/CBOs, private sector and other stakeholders in AIDS education, counselling/testing and health care in the Ministry, including education and sports institutions
- To strengthen information documentation and research relevant to the HIV/AIDS epidemic in the education and sports sector.
- To promote joint planning, coordination, monitoring and evaluation of HIV/AIDS activities in the education and sports sector.

Identified strategies for meeting these objectives include:

- Initiating and disseminating policy guidelines;
- Advocacy for children's rights and AIDS education;
- Incorporation of STI/AIDS issues into the curriculum;
- Skills-based training for teachers;
- Initiating a welfare scheme for AIDS orphans and staff living with HIV/AIDS;
- Fostering partnerships with other stakeholders;
- Strengthening capacity for planning, co-ordination, monitoring and evaluation of AIDS activities in the education and sports sector.

Under this framework, a study such as this will contribute to each of the goals by improving knowledge and working to inculcate the skills necessary for behaviour change.

World Bank Project: The World Bank is providing financing for the National Strategic Framework ($75 million credit) over a five-year period. The project consists of three components, at the national, district and community level. At the national level, funds are being directly channelled to Ministries for the control and mitigation of HIV//AIDS based on plans of action they develop. The Ministry of Education is to benefit from these funds. Separate funds are to be provided for:

- The training of teachers on HIV/AIDS control and mitigation under the District Initiatives component, for which 43% of the funds are being provided,
- Cash transfers to poor orphans and AIDS stricken impoverished households to keep orphans at school and reduce child labour under the Community-led HIV/AIDS Initiatives for which 18% of the funds have been set aside.

The agreement calls, *inter alia,* for the implementation of a new HIV/AIDS education curriculum in 60% of primary and secondary schools by 2006 and for 30% of orphaned children to be attending school regularly by the end of the project period. The MOES is being asked to:

- Review the primary and secondary education curriculum and introduce the following topics (a) reproductive health, (b) the prevention of HIV/AIDS and of sexually transmitted infections, and (c) risks posed by alcohol abuse, female mutilation (sic), defilement and early marriage,
- Develop and distribute the relevant training materials and train teacher trainers on the prevention of HIV/AIDS and sexually transmitted infections, at the national and district levels
- Promote youth HIV prevention programmes including condom distribution in collaboration with the AIDS Commission and Ministry of Health
- Expand HIV/AIDS and sexually transmitted infections related counselling and testing to schools, colleges and institutions of higher education, using peers and parents as key resources
- Promote school-, student association-, and sport club-led HIV/AIDS initiatives as well as of community-led initiatives for the education and welfare of orphans (i.e. “school check” scheme),
- Monitor and evaluate the impact of HIV/AIDS prevention activities in the education sector, in collaboration with the Uganda AIDS Commission.

There are also specific activities planned for eight other ministries including Health; Gender, Labour and Social Development; Agriculture; and Works, Housing and Communications.

8.2 Comment on Initiatives

The development of the strategic framework that explicitly includes the MOES and the provision of financing from the World Bank and other donors augurs well for the development of an environment in which AIDS prevention will be better coordinated and the role of formal education will be enhanced.

Extensive capacity building of teachers is planned generally under the National Strategic Framework and also under MOES HIV/AIDS plan. One of the specific output indicators of

the World Bank funding is the introduction and implementation of a new HIV/AIDS curriculum.

However, some of the needs identified in this study with respect to prevention are not being addressed. The following need to be either included or made more explicit:

The **curriculum review needs to take a broader perspective**, just adding topics will not be sufficient and there needs to be an elaboration of issues of empowerment, values clarification that should be included in the curriculum. It is unclear what type of teacher training for HIV/AIDS education is envisaged and a component on this topic should be part of pre-service education.

Incorporating HIV/AIDS into the curriculum is only part of the problem—**what will the links be to examinations, to teacher assessment, school inspection, and system management?** Unless these aspects are made explicit and incorporated into standing guidelines the HIV/AIDS component of the curriculum will not be sustainable.

There are no school-based interventions planned in the UAC framework directed at the care of orphans or the mitigation of the impact of the epidemic on both children and teachers. There is an assumption that a very small percentage of orphans are enrolled in school. Despite the absence of reliable estimates of the schooling status of orphans (nationally and by district), there is some evidence that this assumption may be misleading. Evidence from this study indicates that a substantial proportion of children currently in school are orphaned.

The MOES strategic plan depends very heavily on the oversight of a single individual, the focal officer for HIV/AIDS, who already has a substantive high level posting within the MOES as a Commissioner. With the best will in the world, it seems unlikely that this single individual will be able to effectively fulfil the management roles with respect to HIV/AIDS, no matter how committed and enthusiastic**. At a minimum the appointment of a commissioner for HIV/AIDS with sufficient support to provide technical advice and expertise at both the national and district level would seem necessary** if the activities planned are to be implemented.

The management at the district level will probably also need bolstering. The work of the teachers who are to be specially trained as **HIV/AIDS educators will need extensive support** in the first few years until they become an accepted part of the education system. The Inspectorate at district level will need special training to help them provide this support.

Apart from the funding from the strategic framework, **the MOES does not appear to have budgeted any resources specifically for HIV/AIDS prevention**, judging from the Medium Term Budget Framework, yet extra resources will clearly be needed.

9. HIV PREVENTION

9.1 Introduction

There are four strategies that can be used to improve the capacity of the education system to contribute to a decline in HIV/AIDS prevalence. These strategies are:

- Enhancing the HIV/AIDS content in the curriculum
- Improving the ability and skills of teachers to transmit this curriculum
- Developing and enhancing guidance and counselling services
- Creating an environment within schools that is hostile to sexual harassment, early sexual activity, etc.

Together these strategies can improve the knowledge and life skills of students and enhance their ability to avoid the behaviours that can lead to HIV infection.

9.2 Enhancing HIV/AIDS Content[33]

All schools visited took pains to provide some supplementary HIV/AIDS education to their students whether this was through counselling sessions or through sponsored visits from NGOs. However, the MOES can take a more direct and pro-active role towards the prevention of HIV/AIDS infections by both starting at a younger age and also expanding the topics covered. By starting at a younger age there will be some guarantee that children will be equipped with both the knowledge and the strategies for negotiating sexual relationships and options for relating to the opposite sex that do not involve sexual intercourse. When the knowledge is provided early, children have time to integrate this knowledge into their overall worldview and develop a coherent ethos *before* they are called on to make use of the knowledge. Waiting until puberty to provide children with the tools they need, ignores the fact that the timing of this occurrence is highly variable and also that is accompanied by powerful hormonal changes that will confuse and confound children if they are not prepared for them. Advocacy of temperance, control and abstinence are not likely to be successful if introduced so late.

Within the primary curriculum such issues as permissible physical contact, developing self-esteem and an ethos that places a premium on chastity, faithfulness and respect for others, particularly the other gender, must be introduced as soon as possible.

At the secondary level, cognisance must be taken of the fact that students are probably wrestling with the personal decision-making about sexual activity and may need more detailed information and opportunities for discussion about their bodies, their hormonal levels and HIV/AIDS than was necessary in primary school. Despite the fact that the syllabuses are only designed for the examinations and thus may only reflect part of the secondary curriculum, the total absence of HIV/AIDS issues is unfortunate. Apart from the present concern with preventing transmission through greater information, HIV/AIDS touches many aspects of life in Uganda today and it would seem appropriate to give students the opportunity to review and research such aspects as the impact of HIV/AIDS on population growth, life expectancy and rural development. The inclusion of discussion of a disease that has been eradicated, namely smallpox, and the omission of conditions like HIV/AIDS or lung cancer that pose serious contemporary threats is puzzling. Another gap that should be filled is the role played by cultural practices in the transmission of HIV/AIDS.

[33] Specific recommendations from teachers and students are included in appendix 6.

Cultural practices vary and place different emphases on chastity. However, a simple ban on promiscuous practices or those liable to spread HIV is not sufficient. Students need the opportunity to understand the significance and meaning of different cultural practices and develop, in concert with their age-mates and parents, safer options that would fulfil the same role as the previous practices.

The curriculum can address this by explicitly including certain information. Specifically, human reproductive health, the prevention of HIV/AIDS and sexually transmitted infections, the risks posed by early marriage, risks of defilement and the female genital mutilation (FGM) should be explicitly included in the Biology and Christian Religious Education (CRE).

HIV/AIDS education and counselling and care can be incorporated into the CRE syllabus of - particularly in the sub-theme 3 "Leisure in a Changing Society", Major theme IV: Man and Woman, sub-theme 1: Family Life, sub-theme 2: Sex Differences and the person. Students could be taught about gender roles, changing roles as they enter adulthood, the dangers and risks they face, especially with the current HIV/AIDS scourge. Sub-theme 3 on Courtship and Marriage could include issues of Voluntary Testing and Counselling among couples. Further, if Uganda comes to the conclusion that condom distribution in schools has a role to play in the fight against AIDS, the ethical and moral, and even practical, dimensions of condom use should be part of CRE and Islamic Religious Education[34].

Life skills must be a part of the curriculum, for example girls and boys need to learn how to be assertive and how to say no to sex.

In Biology, there are many opportunities for natural and appropriate inclusion of HIV/AIDS issues. For example, the discussion of the functions of a Healthy Body could highlight how HIV/AIDS weakens the body immune system. The discussion of the germ theory of disease could be enriched with a discussion of viruses and their emerging role in increasing mortality. The epidemiology of viruses like HIV and Ebola whose profile in sub-Saharan Africa is growing could be reviewed. The relationship between AIDS and TB should be discussed as well as the management of TB treatment and safeguards against transmission of TB infection.

Under the Population Change theme, the contribution of HIV/AIDS to slowing population growth through increases in overall adult mortality, particularly in the 15-19 age group, increases in infant mortality, reductions in birth rate and reductions in life expectancy would help students relate the virus to their own situation and begin to comprehend the far reaching consequences of the epidemic and the relationship between their own individual behaviour and the growth or decline of the epidemic.

Given the long-term nature of curriculum change and the fact that the revised curriculum has just been introduced (and the planned further revisions); the MOES needs to maintain current pattern of encouraging HIV/AIDS education through extra-curricular activity. The use of HIV/AIDS clubs, visits from NGOs and the circulation of such newsletters like *Straight Talk* and *Young Talk* should continue and be intensified. All schools should be encouraged to have AIDS clubs and also incorporate relevant anti-HIV/AIDS messages in other clubs. For

[34] Including such issues in an elective subject is problematic as a substantial minority may go through secondary without exposure to these ideas.

example drama clubs could develop plays or skits that address specific issues in their community with respect to promoting abstinence among young people. Sports clubs that travel to other schools for athletic events should discuss sexual abstinence and alternative non-sexual ways of relating to members of the opposite sex so athletic events are not seen as opportunities for promiscuity.

9.3 Capacity Building for Teachers

Building the capacity of teachers to be counsellors and change agents in the area of sexual and reproductive health is a major undertaking. Encouraging children to recognise and exercise the right to self-protection involves engaging them in an on-going process of formulating a value system and pattern of behaviour that can last them for life. As a partner and guide in this process the teacher must reach beyond a conventional role of instruction and fact giving and become a personal change agent. Present methods of teacher training do not prepare teachers adequately for this role. For the foreseeable future therefore the MOES will need to rely on in-service training to fill this gap.

Teachers will need more knowledge and skills. Apart from a thorough grounding in the basic facts of HIV/AIDS transmission; treatment, and avoidance, they will also need to have a comprehensive understanding of the social, economic and psychological effects of HIV infection and full blown AIDS in order to answer the questions of their students and discuss the issues in a way that will empower their students.

Apart from basic knowledge, teachers need the skills to modify the content to fit the age and maturity and situation of the student to whom it is being transmitted. The question, "How can I avoid catching HIV/AIDS" has very difficult implications for a 10 year old helping to look after an HIV positive parent, a six year old who has heard a radio programme about the disease and the 18 year old who may be sexually active. However, all of these can be given the information in ways that will meet their needs.

According to the different strategic plans, the government appears to be considering training teachers as specialist HIV/AIDS educators. This is probably the best approach both for financial reasons and also because special skills and capabilities are called for and not all teachers will be able or willing to take on such a role.

9.4 Enhancing Guidance and Counselling

Enhancing guidance and counselling requires at a minimum the following:

- Clear well-documented guidelines as to the content and procedures of counselling
- Training of teachers in the implementation of these guidelines, including sufficient information to refer on children with problems that cannot be addressed within the school environment.
- Training of teachers in counselling, with special attention to the needs of orphans, grieving children and children infected with HIV.
- Sufficient time in the school day for students who need it to seek and be provided with counselling.

In the long term, an effective guidance and counselling programme will also require a teacher preparation programme that provides for the development of specialist counselling teachers and scope for periodic refresher courses.

Support services (health, social welfare, etc.) also need to be developed to provide accessible backup services for the counsellors and specialist HIV/AIDS educators.

9.5 Sexual Harassment

The setting of clear boundaries in certain schools has gone a long way towards reducing the occurrence of sexual harassment. The illustrations below suggest that both the public campaign to reduce sexual harassment and the individual action of head teachers can and do make a difference to both reality and perception.

Countering Sexual Harassment

There were two schools (one primary and one secondary) where both teachers and students reported that there was no or very little sexual harassment between teachers and students. In both cases this was attributed to the uncompromising position on the part of the school administration. In one case the head-teacher had taken the lead in ensuring the prosecution and subsequent jailing of a teacher who had impregnated a 14-year- old house girl employed in the home of a student.

Sexual harassment occurred in the study schools, but did not appear to be a major problem. However, it should be noted that the visits to the schools were short and this could have limited the ability to collect data on sexual harassment. Secondly, the study schools had a substantially higher proportion of female teachers than the national average. The presence of large numbers of female teachers could have had a mitigating influence.

From the discussion in the interviews and focus groups, it became clear that sexual harassment was a community wide problem. While there is, particularly in primary schools, an awareness of the problem, as it exists between teachers and students and among students, the attitude of the wider community still needs to be addressed. Students saw individuals outside the education system as a significant source of danger and teachers claimed that parents shut their eyes to inappropriate sexual behaviour in the belief that either they or their children could benefit from it. Clearly, there is a need for an intensified community campaign against sexual harassment.

10. MITIGATION OF IMPACT ON STUDENTS

10.1 Primary Education

Due to the impact of UPE, the primary enrolments are expected to continue rising until the year 2003 when they will fall until 2006 and then begin rising again through 2010. No significant differences were found between the projections of enrolments being used by the MOES (MOES, 2000) and the projections produced as part of this study (tables 37-39).

The number of orphans in schools has been increasing steadily since 1994 and is expected to continue increasing. The absolute number of orphans in school is difficult to assess, with current estimates running from 10% (MOES figures) to 35% (this study).

While this study cannot shed definitive light on this issue given its small size and geographic limitation, there is not much evidence that substantial proportions of orphans are staying out of school. First, the proportion of students reporting that they were either single or double orphans was so high (35%) that the implication must be that a significant proportion of orphans are in fact enrolled. Second, the proportion of children claiming to be orphans varied little by level of school, even though primary school is heavily subsidised through the UPE programme and secondary school is not. If cost were a major barrier, it would be expected that only a small proportion of secondary students would be orphans. Therefore it appears that despite their difficulties, orphans are managing to attend school. Third, a recent evaluation[35] of the UWESO programme in Masaka reported that the 7500 orphans covered by the programme were all in school. Despite this, there is little provision for school-based support for orphans, including the strengthening of guidance and counselling services (as separate from HIV/AIDS education) within the government initiatives.

However, respondents (head-teachers, teachers and students) all indicated a need for financial and emotional support of orphans and other students affected by HIV/AIDS. There are least three possible sources of this support: government (district or central), NGOs and individual schools.

The government can enhance the training already planned for teachers and educational staff to include issues of orphan support:

- ✓ Explicit development of guidance and counselling guidelines covering such issues as confidentiality, ethical standards, appropriate referrals, roles and responsibilities of guidance and counselling staff, head-teachers, school management and district education officers.
- ✓ Government can review the options for providing supplemental material support for orphans and other vulnerable children, in an inclusive and non-stigmatising way.
- ✓ Districts can coordinate the work of NGOs to ensure that service provision is more even.
- ✓ Districts can assist the line Ministries to provide a coordinated response to the needs of orphans and other needy children, even if this is only to make assessments and identify those most in need of assistance.

NGOs can:

- ✓ Reach out more consistently and extensively to schools and educational institutions with HIV/AIDS prevention

[35] Personal communication, UWESO Manager

Schools can:

- ✓ Proactively reach out to communities through PTAs and school management committees to identify children in need of material and emotional support
- ✓ Develop systematic strategies for providing assistance to needy children enrolled in schools (see box below)

Bringing Orphans Back

In one urban primary school, the head teacher had 'recruited' 150 orphans, children who had dropped out from that school when guardians had been unable to pay fees or who were known to be out of school by students currently in the school. The orphans were being exempted from school fees and had been given uniforms, pens, pencils, exercise books and textbooks.

11. TEACHING STAFF--MITIGATION

The Ministry of Education does not have an explicit policy about HIV/AIDS among staff and they are governed by the general regulations for public service employees. Consequently, the special circumstances of teachers—their regular and intensive interaction with children and young people, the long-term impact of their absence from duty—have not been recognised and no accommodation has been made. Similarly, the current curriculum pays scant attention to HIV/AIDS.

As with the prevention of HIV/AIDS infection, the government of Uganda has an ongoing programme within which many of the changes necessary could be accommodated. A new three-year primary teacher development and management plan (TDMP) is to come into force in 2000/1 (MOES, 2000) and has, *inter alia,* the following objectives:

- ✓ Improve the training and qualifications of the Primary Teacher Education students
- ✓ Improve the process of recruitment into the service
- ✓ Improve teacher deployment to ensure equitable distribution of teachers throughout the school system
- ✓ Improve the provision of incentives to teachers
- ✓ Improve teacher supervision, accountability
- ✓ Improve the administration of sanctions
- ✓ Improve the organisation and implementation of the TDMP

In the discussion of the strategies and actions to be used to reach these objectives, HIV/AIDS is explicitly mentioned only for objective 3 (teacher deployment) with reference to its impact on teacher supply and the need for good personnel management at the school level and the need for occasional utilisation of counselling service of AIDS victims in the teaching force.

Attention to HIV/AIDS issues for teachers both as educators and employees could be broadened considerably. Fortunately the plan provides significant scope for the broadening of strategies that have already been identified to include HIV/AIDS issues. At a minimum the TDM work plan could encompass HIV/AIDS at the following points:

- Objective 1 (training and qualifications).
  - Improvement of the pedagogical skills could include more skills in teaching sexual and reproductive health topics
  - The content of the pre-service training could pay more attention to sexual and reproductive health topics, life skills development and guidance and counselling.
  - More attention to and credit for developing skills in guidance and counselling should be given.
- Objective 2 (recruitment)
  - Develop a uniform procedure for the selection of teachers; this will make the process of recruitment more efficient and reduce the gap between the loss of a teacher and the hiring of a new one
  - Recognise more child-friendly and flexible teaching styles when selecting teachers

- Objective 3 (deployment)

  - Review teachers' conditions of service
  - Train teachers and head-teachers in guidance and counselling, including ethical standards and linkages with district level support services, like probation and welfare officers, NGOs, Ministry of Health and police.
- Objective 4 (provisions of incentives to teachers)
  - Joint teachers' councils in each district to discuss teachers' welfare could include sickness and death benefits for teachers and health insurance possibilities
- Objective 5 (teacher supervision and accountability)
  - Strengthen the enforcement of norms and standards that govern work conduct and performance of teachers and head-teachers, to reinforce the stand against sexual harassment
  - Strengthen and expand supervisory services accordingly to enhance their ability to supervise HIV/AIDS education and guidance and counselling
  - Special pre-service training programme for newly appointed supervisors to raise awareness of HIV/AIDS issues
  - Encourage supervisors to regularly read education literature, and keep themselves up to date with issues of HIV/AIDS education and prevention
  - Encourage supervisors and tutors to carry out action research in such areas as HIV/AIDS education, the impact of parent loss on orphans, strategies used by indigent children to cover the costs of schooling, etc.

Similar initiatives could be put in place to cover secondary teachers also.

Teacher Attrition

HIV/AIDS contributes little to teacher loss. In the past few years attrition due to death has been about 1% of the teaching force, while overall attrition (based on recorded levels over the past few years), was between 4.3% and 6.9% for primary and 3.2% and 4.2% for secondary. The driving force for teacher requirements is the increase in enrolments caused by the drive for UPE.

The combined output of all primary teacher-training institutions is close to 7000 per year despite a high failure rate of between 40% and 50%. Under any scenario[36] envisaged by the Ministry of Education and Sports the number of newly qualified teachers is surplus to requirements in almost every year between 2000 and 2015. The MOES scenarios also include the assumption that the staff ceiling (dictated by the pupil/teacher ratio) is maintained. However, according to the 1999 headcount, the actual number of teachers on the payroll was 79,627 (approximately 27,000 below the staff ceiling). There were an additional 25,414 teachers in schools, either in private schools or hired by PTAs.

Under the more realistic assumption of 5% attrition adopted in the modelling used for this study, the system is likely to be short of teachers until the year 2003 when the number of students is expected to drop. Between 2000 and 2003 the annual growth in teacher requirement is expected to exceed new entrants to the profession (see tables 37 and 38). However, if the MOES can address the causes of attrition and/or improve the pass rates from teacher-training institutions, this shortage can be ameliorated

AIDS in the Workplace

[36] The major variable was the pupil/teacher ratio, which ranged from 70:1 for P1 & 2, and 55:1 for P.3 – 7 to 40:1 for P.1-7.

As a major employer the government owes its employees a modicum of care for their welfare. This must include providing education, access to condoms and reasonable access to medical facilities for those who are sick. The government also needs to ensure that other general conditions are not such as would increase teachers' susceptibility to HIV/AIDS—that is more stressful, more isolated from medical care (including access to condoms) and less informed about HIV/AIDS transmission than other workers with comparable education and training.

Teachers voiced concerns about having to live and work apart from their spouses and also about needing more education on every aspect of HIV/AIDS like avoiding infection, care of sick, living positively, testing, etc.

Testing and Counselling

Teachers in rural areas are particularly cut off from access to testing and counselling services and this is a direct result of the still poorly developed network of clinics and hospitals that can offer these services. This aspect of the Ministry of Health's work is a major component of the national strategic framework and will, if implemented, directly benefit not only teachers but also the public in general.

In the meantime, the District Education Offices can help address this gap by sponsoring or organising more extensive coverage by NGOs who can supply these services to teachers.

Under the current Teacher Development and Management Plan, HIV/AIDS testing and counselling issues can be included in the following activities:

- ✓ Include HIV/AIDS education and guidance and counselling in inspection guidelines
- ✓ Address HIV/AIDS education and guidance and counselling in pre-service preparation of supervisors
- ✓ Include HIV/AIDS updates in the bulletins issued by supervisors

Sickness and Medical Support

In the absence of a national health insurance or social support scheme, the cost of illness and death was a key concern of teachers and some of their recommendations for addressing the gap were as follows:

- ➢ NGOs like TASO and AIC should help teachers with drugs, food guidance and counselling to prolong their lives
- ➢ Price of anti-retrovirals should be reduced and/or HIV/AIDS infected teachers to be aided in the procurement of anti-viral drugs
- ➢ Tax break for those who declare their HIV status
- ➢ Sick teachers should be supported by the government and continue to be on full pay as they receive counselling services

For those who have reached a certain age or have a certain number of years of service, early retirement is an option as they are entitled to a pension. Unfortunately, this option is utilised by relatively few, both because of the age profile of the teaching force and because there is a psychological reluctance to accept the termination of one's working career (anecdotal).

Professional misconduct

Ugandan legal code is very firm about defilement (sexual intercourse with someone below the age of consent) and teachers and head-teachers were also generally firm about these strict penalties being maintained and implemented.

12. CONCLUSION AND RECOMMENDATIONS

12.1 Prevention

Although the school system has very little formal HIV/AIDS instruction, the combination of extra-curricular events and programmes and the system of public health education in Uganda have resulted in a good level of knowledge about HIV/AIDS among students.

The lack of explicit inclusion of HIV/AIDS instruction does mean that the quality and breadth of information and skills that students do get is overly dependent on the interest and energy of head teachers and SWTs/SMTs. Further there is a dependence on the information obtained through public health campaigns and this information primarily targets adults.

The recommendations for this area include:

- Enhancing HIV/AIDS education content in the curriculum
- Improving skills of teachers to impart this content
- Promoting peer education strategies through school level extra-curricular activities (AIDS clubs, drama groups, etc.)
- Rationalising, as far as is possible, the work done in schools by NGOs
- Developing and disseminating a policy on a range of issues, include condom distribution among school children and teachers,
- Identifying and disseminating information about NGOs working in the area of HIV/AIDS education to districts and schools.

12.2 Impact on Students

There is very little policy to ameliorate the impact on students. Although the central government has a scholarship programme for orphans, it does not cover all of them, it contributes only a minimal amount to 'school fees' and was put in place to cover war orphans. Therefore the issues of discrimination and loss of mothers were not really considered when the programme was put in place.

Students suffering financial hardship due either to death or disability of parents receive some help—from the school, relatives and well-wishers and sometimes NGOs, but the ad hoc nature of the assistance leaves them subject to anxiety and stress because the source and nature of the assistance cannot be predicted.

The recommendations in this area include:

- Adding more information on orphans to the educational management data base
- Tracking and supervising residential institutions that have children under 18
- Developing guidance and counselling guidelines in general
- Disseminating guidelines for SWTs and SMTs to all schools and district offices
- Clarifying ethical standards and practical conditions for guidance and counselling

12.3 Teachers and Other Staff

With the decline in prevalence, issues of teacher loss due to AIDS deaths are a relatively small proportion of overall teacher attrition but there are teachers who are HIV positive and they need support to live positively as well as assistance with health care. Discrimination from administration and fellow teachers is reported to be relatively insignificant.

As educators, their preparation for teaching sexual and reproductive health topics has been poor, and the scope within the formal curriculum is limited.

Recommendations in this area include:

- Reviewing the HIV/AIDS content of the pre-service training curriculum
- Enhancing the ability of supervisors and managers to oversee HIV/AIDS education
- Systematising and enhancing HIV/AIDS education directed at teachers and educational staff
- Incorporating HIV/AIDS issues into the training being planned for primary teachers under the TDMP
- Reviewing the structure for management of HIV/AIDS issues within the Ministry
- Investigating and reviewing options for health insurance for teachers and other mid-level government workers
- Incorporating information about teacher absenteeism, sick leave into the EMIS and disaggregate death statistics by gender and age.

12.4 Research and Monitoring

One of the clearest lessons from this study is that more detailed information is needed about all facets of the way in which the epidemic is touching educational institutions. There are two kinds of information needed; one is in the form of ongoing monitoring of such phenomena as the number of orphans enrolled, their needs and the needs of other vulnerable children who might or might not be affected by HIV/AIDS.

This information can be obtained through enhancing data gathering processes that are already part of the education system or are planned as new initiatives. For example, the existing educational abstracts already contain information on numbers of orphans. Efforts to ensure that the criteria for inclusion in this list be clarified to head-teachers and the significance of the numbers be impressed on school and district MOES staff would go a long way to raise awareness of the necessity for meeting some of the basic needs of orphans and other vulnerable children through the schools.

The second area is in the documentation of impact. A combination of recurrent and intermittent processes can be used to monitor both general impact and the experience of targeted populations. For example, the longitudinal study in 25 primary schools from each of the four regions in Uganda[37] is intended to monitor change in teaching/learning processes in schools as a result of policy changes at the central and district levels and provide feedback to policymaking. The implementation of this study is supposed to take at least three years and represents an excellent opportunity for the integration of HIV/AIDS issues into the research design. The longitudinal impact of losing parents on such factors as performance, attendance, and behavioural problems could be tracked for representative cohorts of children.

Similarly, the impact of teacher sickness and mortality, if any, could be systematically studied and comparisons made of the effectiveness of different strategies of coping with teacher absence, i.e. leaving work versus combining classes versus assigned work, and how it varies with the level and other characteristics of the students.

[37] Loose Minute of 24 February, 2000 from the Commissioner, Education Planning to Director, PIU

One area in which data was lacking was the role of private boarding primary schools. Anecdotal evidence suggested that there has been a big increase in the numbers of such schools precisely because the guardians of children who have lost parents are more willing to take on the additional responsibility if these children can be left in boarding schools for most of the year. The records of the licensing of such institutions need to be kept in such a way that the numbers of children attending them and the proportion that are orphans can be a matter of public record. Provisions should also be made for regular monitoring.

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Rape and Defilement: What you need to know and to do.

Common Reproductive health Questions Asked by Adolescents.

HIV Infection AIDS: Information for Adolescent Girls and Boys.

Living Effectively and competently with Yourself & Other People: Some of the Life skills needed by Adolescents

Making Choices About Sex, Without Bending to Peer Pressure

Growing Up: Information for Adolescent Girls and boys.

Basic Knowledge on Common STIs

Sugar Daddy Syndrome: Short Term Happiness, long-term troubles.

Be Careful

What if Your girl has a Baby.
National AIDS Documentation and Information Centre (Brochure)

World Vision: Caring for Children (Brochure)

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APPENDIX 1: FOCUS GROUP STATEMENTS

STUDENT STATEMENTS

1. Students whose families have been affected by HIV/AIDS are treated unkindly by teachers
2. HIV/AIDS is a big problem in this school
3. Topics on HIV/AIDS are not taught well in this school
4. Students have not changed their sexual behaviour as a result of HIV/AIDS education
5. Teachers in this school are not hard-working
6. Students do not feel free to talk to teachers about HIV/AIDS
7. Students at this school do not get all the information and advice they need about HIV/AIDS
8. Students whose families have been affected by HIV/AIDS are treated unkindly by other students
9. Students who have to look after sick relatives often drop out of school
10. Students who have lost close relatives often drop out of school
11. Students who are orphans do not receive any help from this school
12. Our teachers are often absent from school
13. Fighting and bullying are common in this school
14. Girls in this school are fearful and anxious about their safety
15. Boys in this school are fearful and anxious about their safety
16. Love relationships between students and teachers are common in this school
17. Love relationships among students are common in this school
18. Student pregnancy is a big problem in this school

TEACHER STATEMENTS

1. The school curriculum on sexual and reproductive health is not well designed
2. Teachers are not properly trained to deliver the sexual and reproductive health curriculum
3. Teachers are not confident teaching the sexual and reproductive health curriculum
4. Teachers cannot discuss their personal problems with school management
5. Parents do not want teachers to teach reproductive and sexual health topics to their children
6. Student absenteeism is a serious problem in my class
7. Students whose family members are HIV positive are discriminated against by other students
8. HIV/AIDS is a big problem in this school
9. Love relationships among students are common in this school
10. Pupils at their school who have lost one or more parents have more problems than others
11. The number of orphans at this school is going to grow in the next three years
12. The number of teachers with persistent illness will grow over the next three years
13. The Ministry of Education does not have an effective policy to deal with students whose lives are affected by HIV/AIDS
14. Sexual harassment among students is a big problem in this school.
15. Sexual harassment among students at this school has got worse in recent years
16. Students are changing their sexual behaviour in response to the sexual and reproductive health curriculum

APPENDIX 2: STAKEHOLDERS INTERVIEWED

Government of Uganda

Ministry of Education and Sports
Sam B. Onek, Director (Acting)
Yusuf Nsubuga, Commissioner of Secondary Education
Florence Malinga, Commissioner, Planning
Albert Byamugisha, Assistant Commissioner, Planning
Cephas Z. Lutwana-Kizza, Science Specialist, National Curriculum Development Centre
Joshua Ongom, O-Level Biology Curriculum Co-ordinator, National Curriculum Development Centre
Edward Walugembe, Principal Statistician
S. M. Lule, Senior Office Supervisor, Educational Planning Department
Mr. Ssemakule, Principal Personnel Officer
Christopher Acar, Principal Education Officer
Zikanga Kiyundo, Assistant Commissioner, Secondary Teacher Education

Lilian Acen, Assistant District Education Officer, Jinja District
George Byansi, Education Liaison Officer, Jinja District
F.X. Ssekaddu, District Education Officer, Masaka District.
Anthony Musedde (SEO) Statistics, Masaka District
Muwonge Kewaza, District Education Officer, Kampala City Council

Ministry of Gender, Labour and Social Development
The Honourable Janat Mukwaya
Sanyu Jane Mpagi, Director, Gender and Community Development
Edward Mugyimba, ACP Focal Point Officer
Mr. Bageta-Waiswa, Welfare Officer, Jinja Municipality

Ministry of Health
Elizabeth Madraa, Director, AIDS Control Programme
Godwill Asiimwe-Okiror, Epidemiology/Surveillance Unit, STD/AIDS Control Programme
Joshua Musinguzi, Epidemiology/Surveillance Unit, STD/AIDS Control Programme
Charles Muhumuza, Senior Health Educationist
Jonathan Gaifuba, ACHS, HP&E
Vastha Kibirige, IEC, STD/ACP

Uganda Bureau of Statistics
Z.E.A. Kaija, Director, Population & Social Statistics
Helen Nviiri
Andrew Mukulu

International Agencies

Paud Murphy, World Bank
Harriet Nannyonjo, Operations Officer, World Bank

HIV/AIDS AND EDUCATION IN UGANDA: WINDOW OF OPPORTUNITY?
Michael Ward, Education Advisor, Department for International Development, Kampala
Roz Cooper, Health and Population Field Manager, Department for International Development, Kampala
James Thornberry, Field Manager, Department for International Development, Kampala

Neil McKee, UNICEF
Tim Rwabuhemba, UNICEF
Sibeso M. Luswata, UNICEF
Charles Nabongo, UNICEF

Fabian Byomuhangi, Assistant Representative, United Nations Population Fund
Jasper Egevang, Programme Officer, United Nations Population Fund
Akiko Ita, Programme Officer, United Nations Population Fund

Non-Governmental Agencies

Uganda AIDS Commission
David N. K. Apuuli, Director General
John Rwomushana, Senior Programme Coordinator
Kindijomunda Rosemary Mwesigwa, Head, National AIDS Documentation and Information Centre

Godfrey Ssewankambo, Deputy Director, Uganda Women's Effort to Save Orphans
Thomson Odoki, UWESO Branch Manager, Masaka
Naomi Afunadula, Chairperson, UWESO, Jinja

Samuel Muiri Wangalwa, Branch Manager, AIDS Information Centre
Josephine K. Kalule, Research Evaluation & Data Manager, AIDS Information Centre
Drake Katongole, Counsellor/Trainer, Box 2159, Jinja AIDS Information Centre

Rebecca Nvule Musoke, Assistant Advocacy & Mobilisation Officer, TASO
Edward Misigwa, TASO Counsellor, Jinja
Agnes, TASO Counsellor, Jinja

Kibi Paddy, Director, Masaka Theatre Artists

Teo Walusimbi, Programme officer, REDD BARNA, Masaka.

Cathy Watson, Director, STRAIGHT TALK Foundation

Moses Dombo, Director, Communication and Advocacy, World Vision
George Sebaggali, World Vision Field Office, Masaka-Kaswa

John Okello, Counsellor, Tulina Omubeezi Child Development Centre, Masaka
Enoch Tindiwegi, Counsellor, Tulina Omubeezi Child Development Centre, Masaka

Stembile Matatu, Training and Clinical Services Advisor/Deputy COP, Delivery of Improved Services for Health Project (DISH)
Charles Katende, Research and Evaluation Advisor, DISH

HIV/AIDS AND EDUCATION IN UGANDA: WINDOW OF OPPORTUNITY?

Melanie Smith, Assistant Programme Coordinator, Student Partnership Worldwide, Jinja
Christopher Mugumya, Assistant Programme Coordinator, Student Partnership Worldwide, Jinja

Mr Kisoro, Programme Manager, Youth With a Mission, Masaka

Kitovu Mobile AIDS Care and Orphans Programme (MACOP)

Benson F. Kwikiriza Salongo, Deputy Director, Nile Vocational Institute, Jinja

Dr.Ndyanabangi, National Expert ,PEARL

Researchers

Thomas Goliber, Futures Group
Dr. E. Kirumira, Sociology Department, Makerere University

APPENDIX 3: MODELLING STRATEGY AND PROCEDURES

1. INTRODUCTION

Data used in the model was derived from many sources. In some cases data was missing or was not straightforward or even absent and so calculations from and comparisons with existing data was necessary. The specific data required for each part of the simulation model and the sources of data introduced into the model are detailed below.

The most recent enrolment data available from the Ministry of Education was from 1998. Although a teacher headcount was conducted in 1999, the information it contains is not as rich as that of the 1998 Educational Statistical Abstract. The 2000 Educational Statistical Abstract was still being analysed when this report was being written and so the more recent data could not be used.

Inconsistencies exist in the Abstracts. There was no uniform definition or explanation of the terms used. In several instances the totals provided in one table did not consistently correlate in other sections.

Although the MOE has done projections for both primary and secondary students their projections are not so consistent with the ones indicated. Efforts to obtain documentation of the method used by the MOE statisticians were unsuccessful.

2. DATA SOURCES

2.1 Enrolment Data

Enrolment data were easy and straightforward to obtain from the Educational Statistical Abstracts, which are published annually by the Planning Department. The data contained in these publications is collected during a National Education Census that until 1999 was being conducted between September and November. Instruments are designed by the statistical unit and are sent to each school via regional and sub-regional educational offices to be completed. The data obtained from the school questionnaires is then compiled and analysed at the Ministry headquarters and then data for the whole country is published in the Statistical Abstracts.

The Statistical Abstracts contain data on pupils enrolled, repeaters and dropout by grade, gender and region, number of teachers by age, qualification, longevity of service, teacher attrition by reason, status of school facilities such as buildings, furniture availability of textbooks, water and power supplies. This information is provided for primary, secondary and tertiary levels.

2.2 Enrolment Projections

2.2.1 Population Data[38]

Population projections for 6 year olds were obtained from the Bureau of Statistics. The data is gender aggregated. Although various population scenarios exist, the medium variant

[38] Source: Uganda Bureau of Statistics.

Scenario A values were used as these closely parallel the current population trends. The assumptions behind these projections are that:

a) The prevalence of HIV is to rise from 9% in 1991 to 12%in 1996 and stay so until 2001.It then declines linearly to 8% by 2006 and to 4% by 2011 where it continues at that level in 2016
b) The total fertility rates in Uganda are anticipated to change as follows: 1991 – 9%, 1991 to 1996-7.1%, 1996 to 2001 - 7%, 2001to 2006 - 6.6%, 2006 to 2011 - 6.3%, 2011 to 2016 - 5.8%

The assumptions about prevalence are over-estimates. The actual data suggests that prevalence has been declining since 1992/3 and is now expected to reach stability in 2003.

2.2. Primary and Secondary Enrolments[39]

For accuracy all rates used in the model were computed by the formulas described below. In some cases the resulting level of dropout generated in the model differs significantly from government statistics. This is because the statistics included in the educational abstracts are taken directly and summed from the school returns.

2.2.3 Admission rates

Admission rates for primary were calculated using new entrants in the first grade of primary and the population of children at the official admission age in primary one (6 years). New entrants were in turn calculated by subtracting repeaters in primary 1 from the total enrolments.

Secondary admission rates were calculated by using primary enrolments for the last grade of primary in the year before and new entrants in the first year of secondary.

2.2.4 Promotion rates and Repetition rates

Primary and Secondary promotion and repetition rates for each class were computed as follows:

$$\text{Promotion rate in grade x} = \frac{E_{(x+1),\,t} - R_{(x+1)\,t}}{E_{(x),\,t-1}} = \frac{N_{(x+1)\,t}}{E_{(x),\,t-1}}$$

Where: x = grade involved

E (x +1) =total enrolment in the next immediate grade

t = the involved year

R (x +1)t = total number of repeaters in the next immediate grade in the year t

N (x+1)t = New enrolment in the next immediate grade in the year t

E (x), t-1 = Total enrolment in grade x the previous year.

$$\text{Repetition rate in grade x} = \frac{R_{(x)\,t}}{}$$

[39] Sources: 1997 and 1998 Educational Statistical Abstracts, Ministry of Education and Sports, Educational Planning Department.

$$E(x),\ t\text{-}1$$

Where: $R(x)\ t$ = repeaters in grade x in the year t
E (x), t-1 = Total enrolment in grade x the previous year

Similarly the drop out rate would be computed as follows:

$$= E(x),\ t\text{-}1 - \frac{N(x+1)\ t + R(x)\ t)}{E(x),\ t\text{-}1}$$

However, no calculations are made or entered for dropouts because the model does these calculations automatically from the repetition and promotion rates entered.

2.2.5 Annual teacher attrition[40]

The total attrition was obtained by summing up all the teachers who left their schools for the following reasons—death, retirement, resignation and departure without reason. The teachers who were recorded as promoted, transferred and going for further training were not included as part of the definition for this model. There is the strong possibility that most if not all of these teachers went to other schools or were returning to teaching within a relatively short period (1 to 2 years) and therefore cannot be considered lost to the profession

Attrition rate = number of teachers who left the profession in a given year
Total number of teachers that year.

From the tables it was preferred to keep the attrition rate for teachers in primary at a constant value of 5.12% from 1999 to 2013 and let the variable be the HIV/AIDS associated deaths. The attrition rate for the secondary teachers was assumed constant at 3.034%

2.2.6 HIV Associated Deaths

The WHO/UNAIDS (2000) publication estimates that 21% of adult mortality in 1999 in Sub-Saharan African was due to AIDS-related causes. Thus teacher AIDS-associated deaths were then taken to constitute 21% of the deaths that occurred during the given year as reflected in the statistical abstracts. However, a more accurate figure of deaths could have been obtained form the payroll as this includes more detailed explanations as to why one has been struck off the payroll and so more civil servant deaths are likely to be captured from the payroll. However, this process promised to be so long and cumbersome that the alternative was opted for.

Teacher mortality rates from 1995-1998 were plotted on a graph. Mortality peaked in 1995 for secondary and 1997 primary teachers[41]. Projections of assumed HIV related deaths were then obtained by generating a trend line using the available data points (i.e. 1995 to 1998 for secondary and 1997 and 1998 for primary. The assumption was made that AIDS related

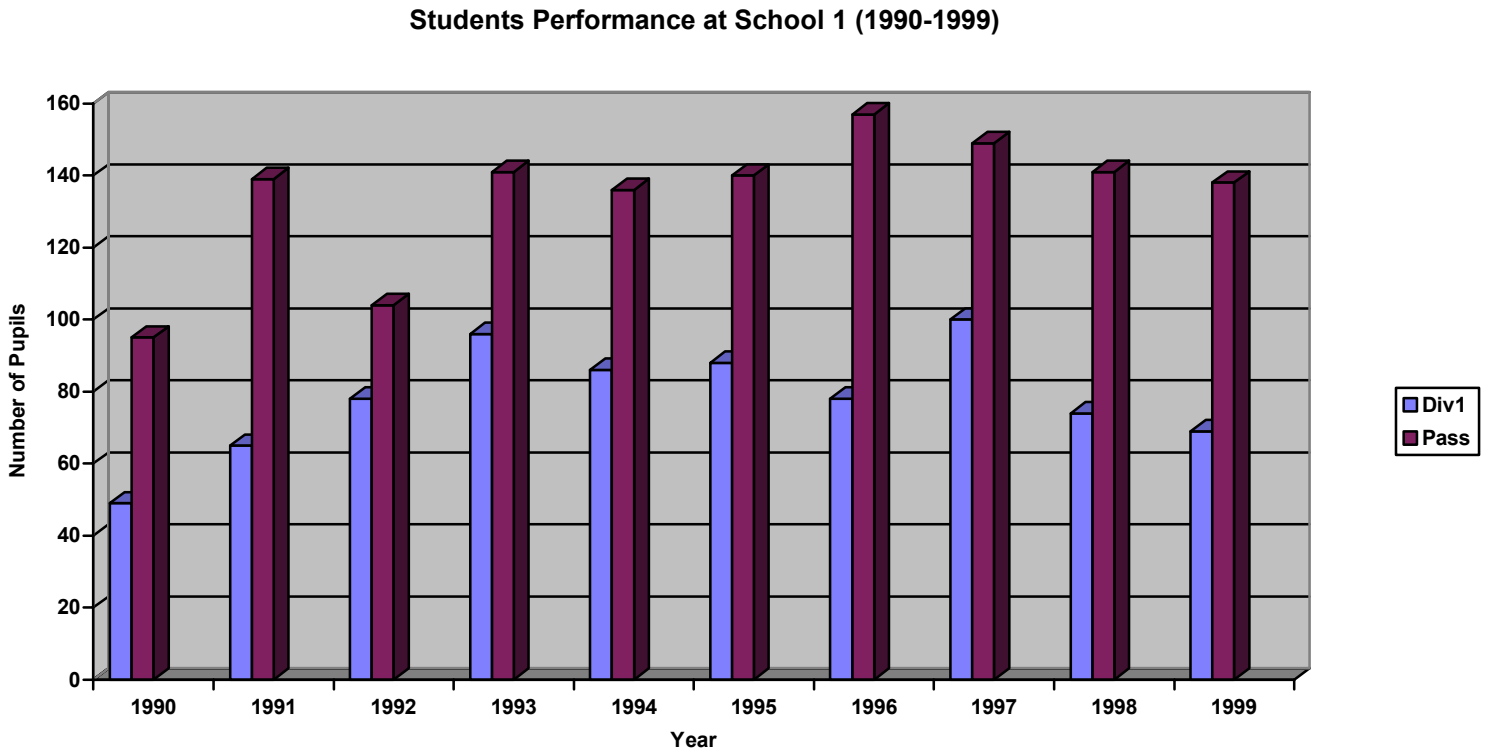
[40] Source: 1995, 1996, 1997, 1998 Educational Statistical Abstracts.

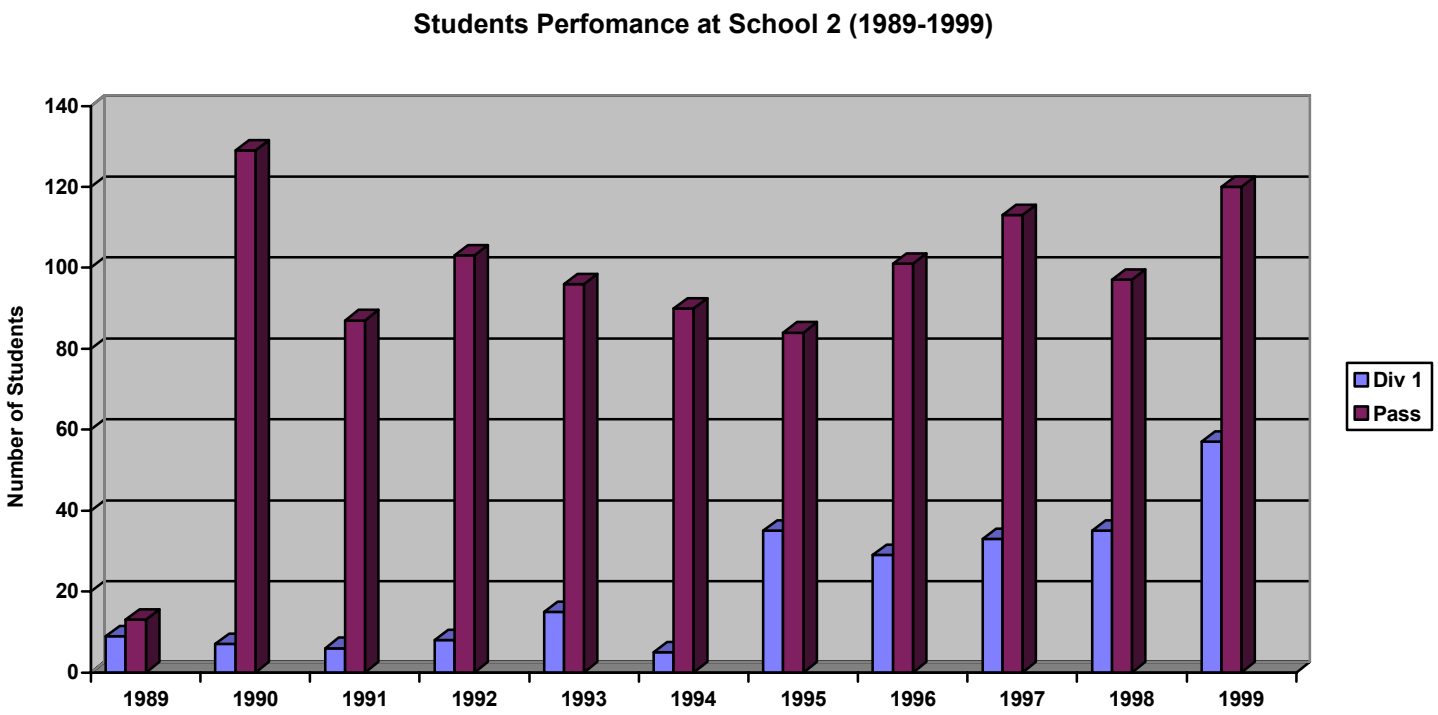
[41] The Abstract did not gender disaggregate deaths until 1998; therefore the analysis was done for the teaching force as a whole.

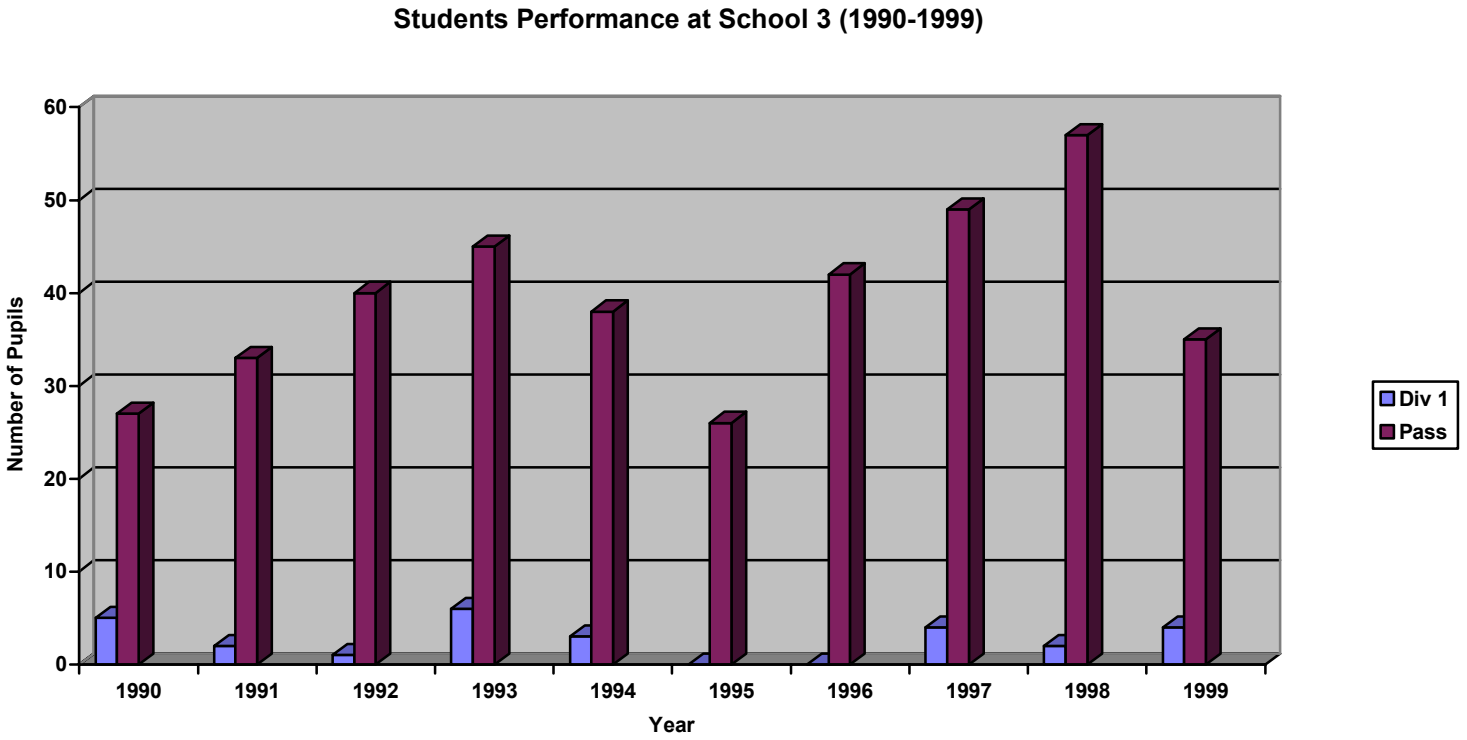
death rates were approaching a steady state and the graphical form that best mimicked this assumption was the logarithmic form.

A summary of the information gathered was tabulated and compared with similar projections made by the MOE. Although there is quite a disparity in the values obtained especially with the projected primary and secondary enrolments and thus the teacher requirements it is overwhelmingly clear that HIV/AIDS deaths among teachers have not significantly impacted on the MOE with respect to teacher needs. In fact HIV/AIDS associated deaths account for between 2.65% to 5.34% of the total teacher attrition at primary level. At secondary level the corresponding levels are 1.34% to 6.54%.

APPENDIX 4: EDUCATIONAL DATA FROM STUDY SCHOOLS


Students Performance at School 1 (1990-1999)
Number of Pupils
160
140
120
100
80
60
40
20
0
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
Year
Div1
Pass


Students Perfomance at School 2 (1989-1999)
Number of Students
140
120
100
80
60
40
20
0
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
Div 1
Pass


Students Performance at School 3 (1990-1999)
Number of Pupils
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40
30
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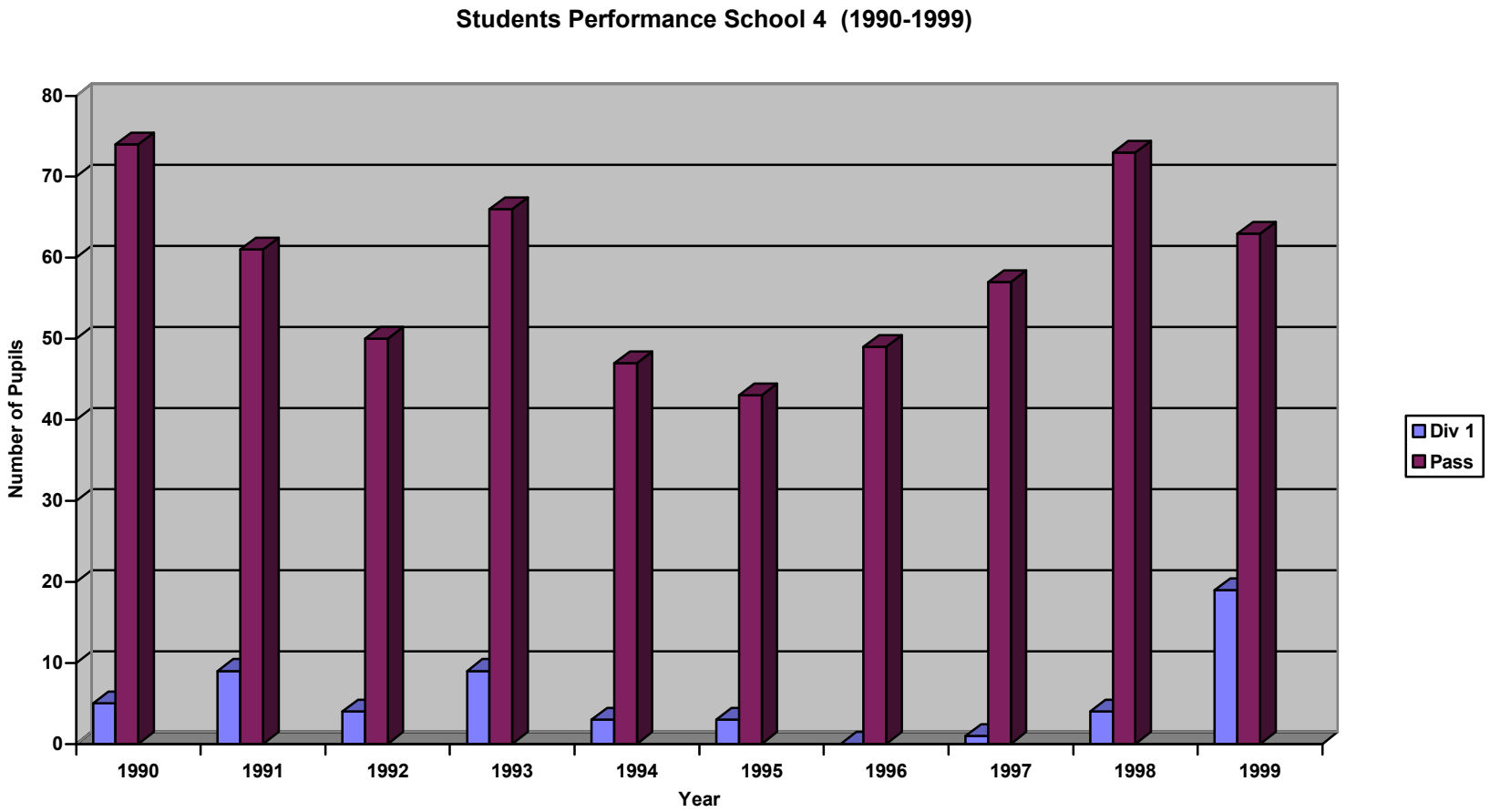
10
0
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
Year
Div 1
Pass


Students Performance School 4 (1990-1999)
Number of Pupils
80
70
60
50
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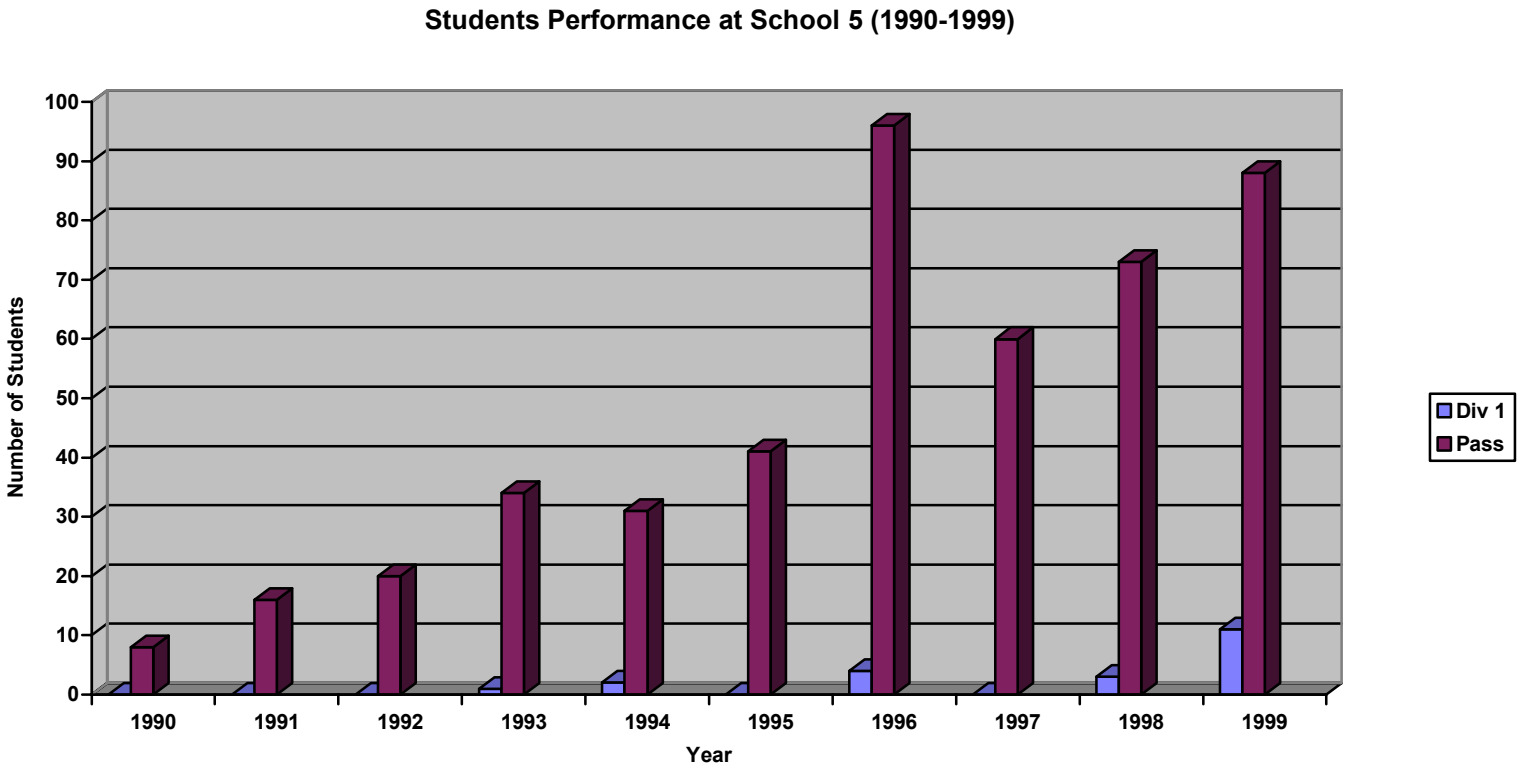
30
20
10
0
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
Year
Div 1
Pass


Students Performance at School 5 (1990-1999)
Number of Students
100
90
80
70
60
50
40
30
20
10
0
1990
1991
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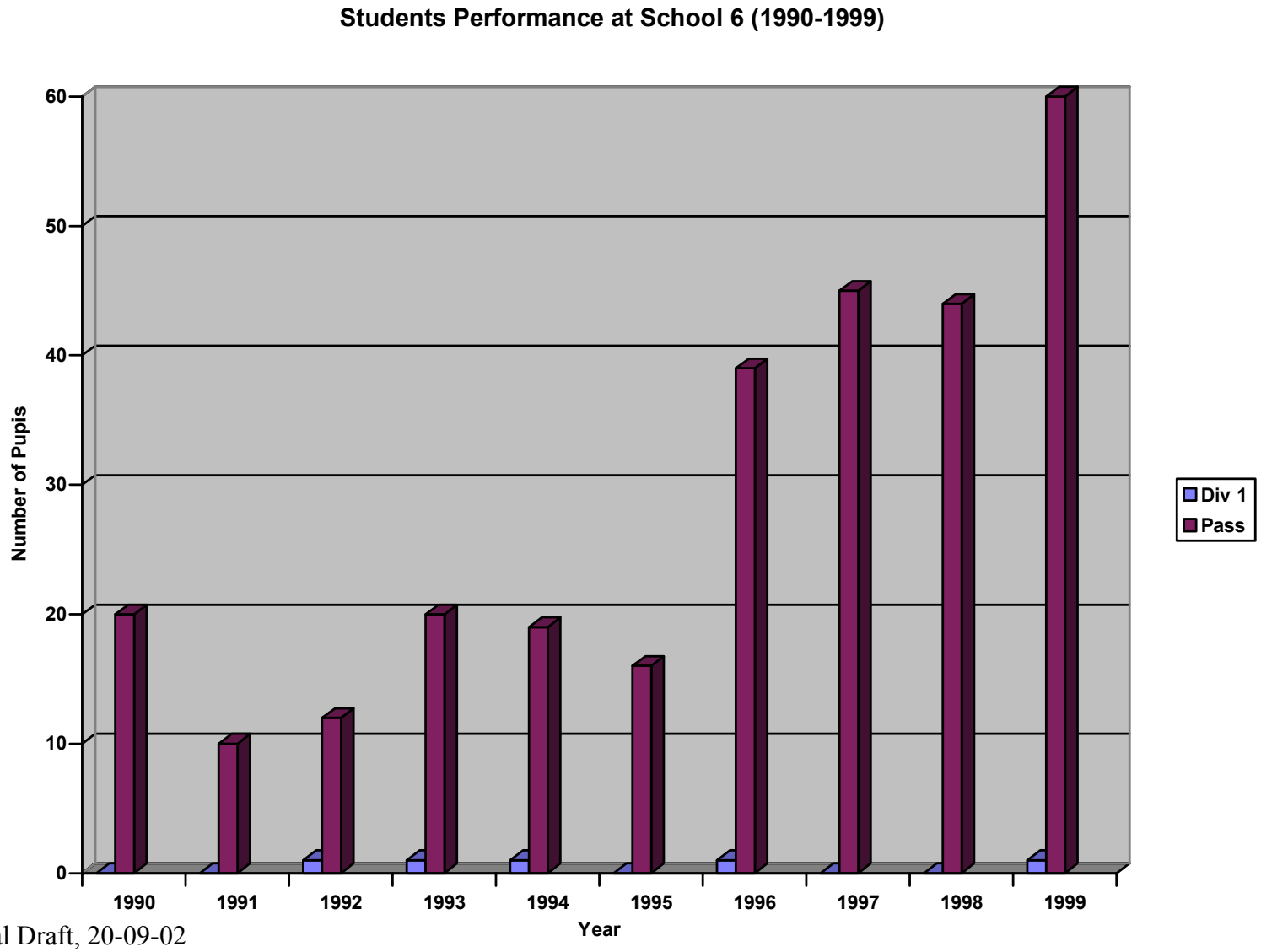
1993
1994
1995
1996
1997
1998
1999
Year
Div 1
Pass


Students Performance at School 6 (1990-1999)
Number of Pupis
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50
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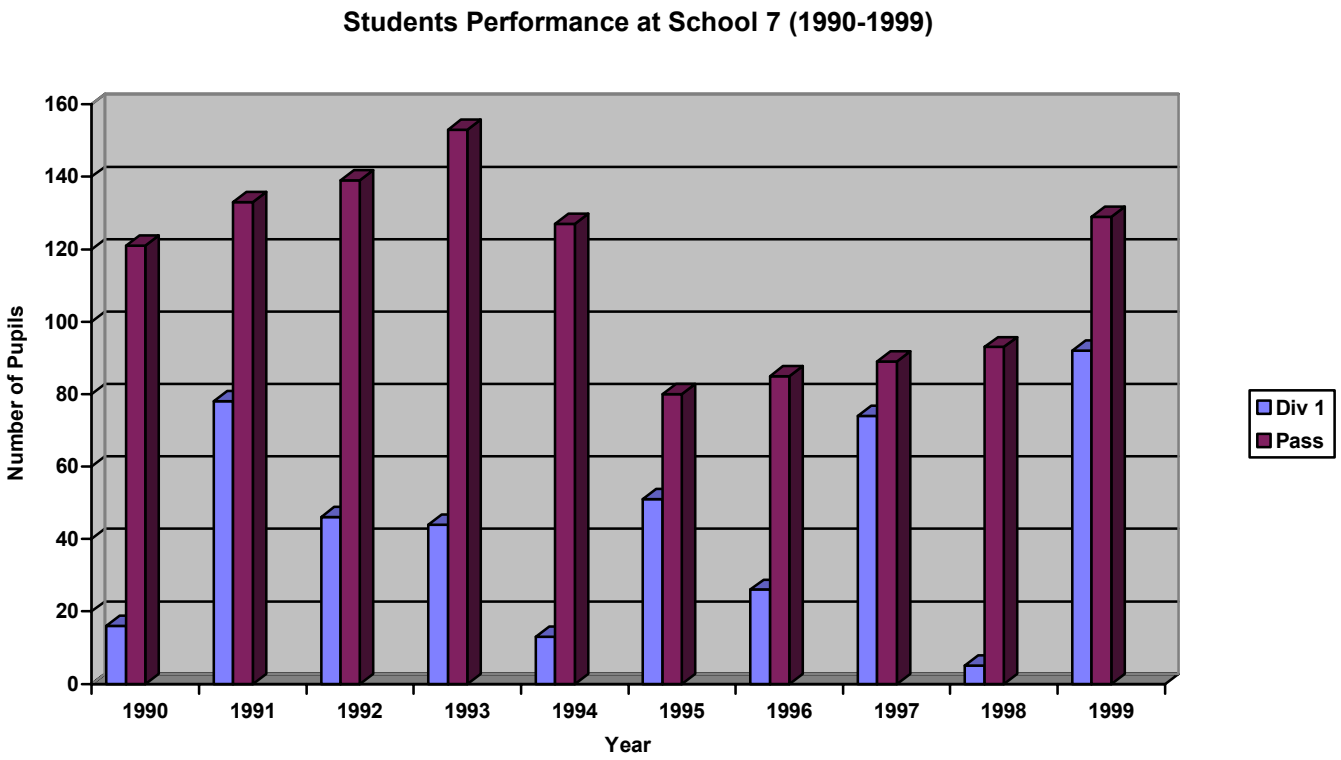
30
20
10
0
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
Year
Div 1
Pass


Students Performance at School 7 (1990-1999)
Number of Pupils
160
140
120
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40
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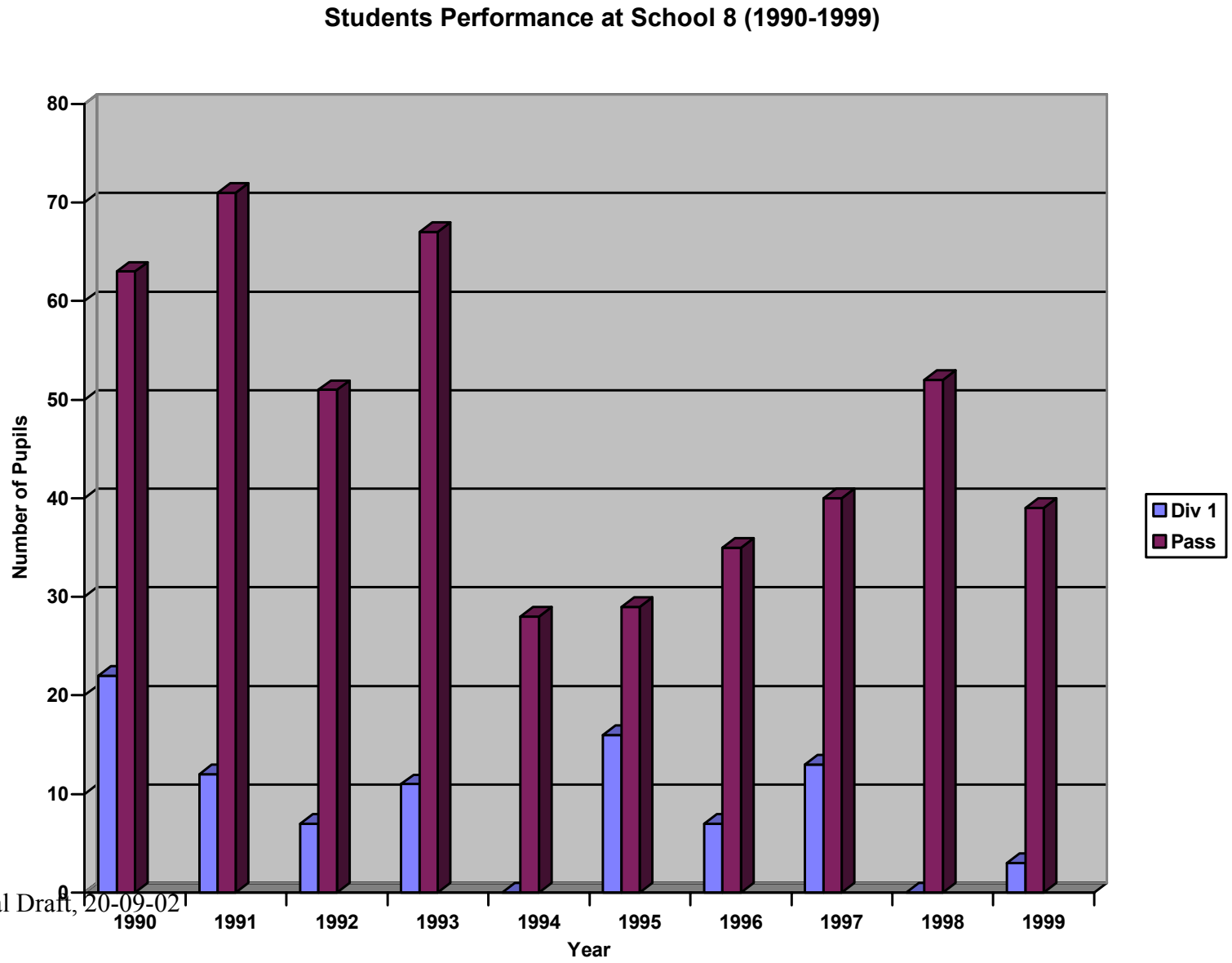
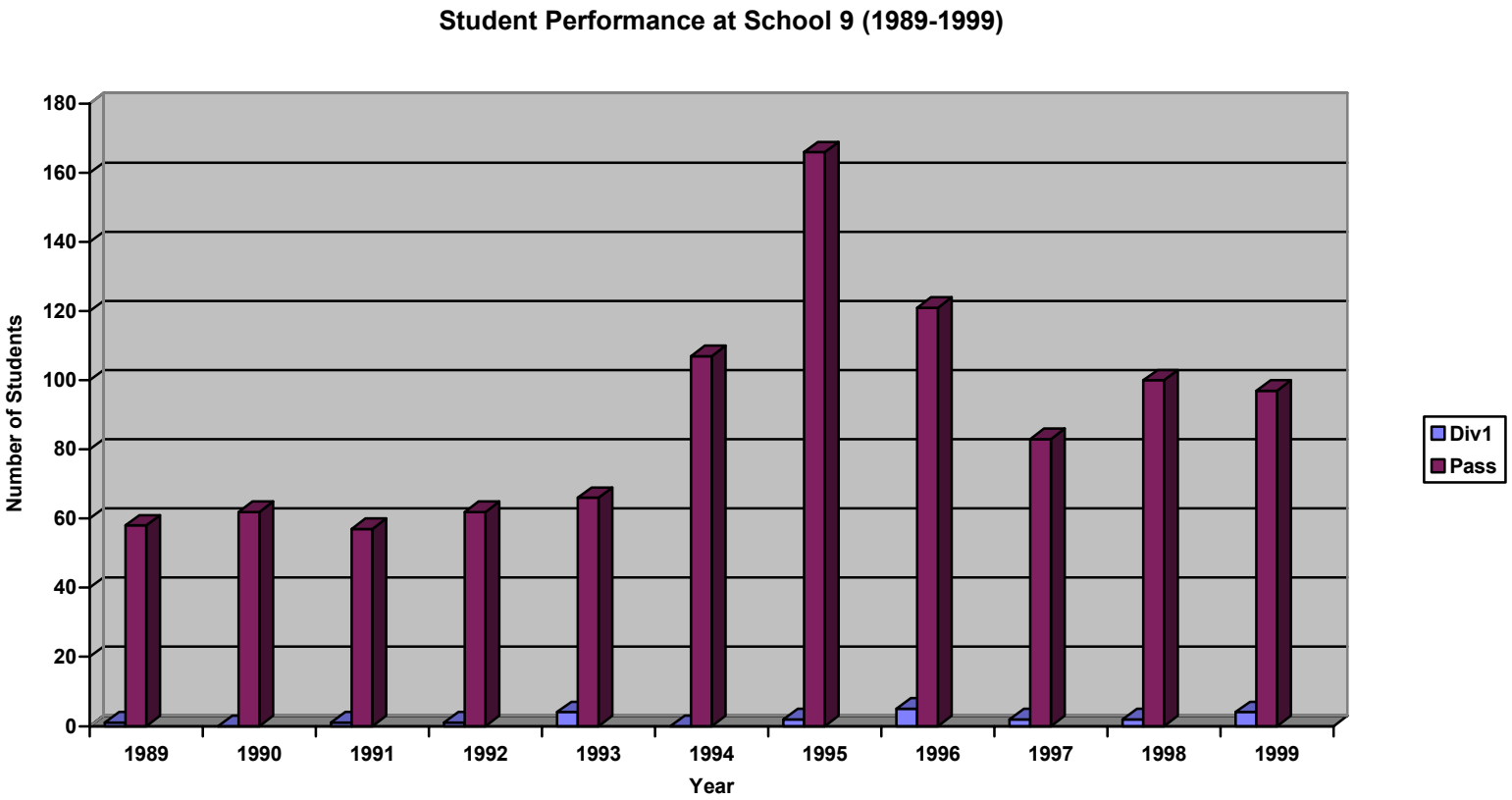
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
Year
Div 1
Pass


Students Performance at School 8 (1990-1999)
Number of Pupils
80
70
60
50
40
30
20
10
0
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
Year
Div 1
Pass


Student Performance at School 9 (1989-1999)
Number of Students
180
160
140
120
100
80
60
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20
0
1989
1990
1991
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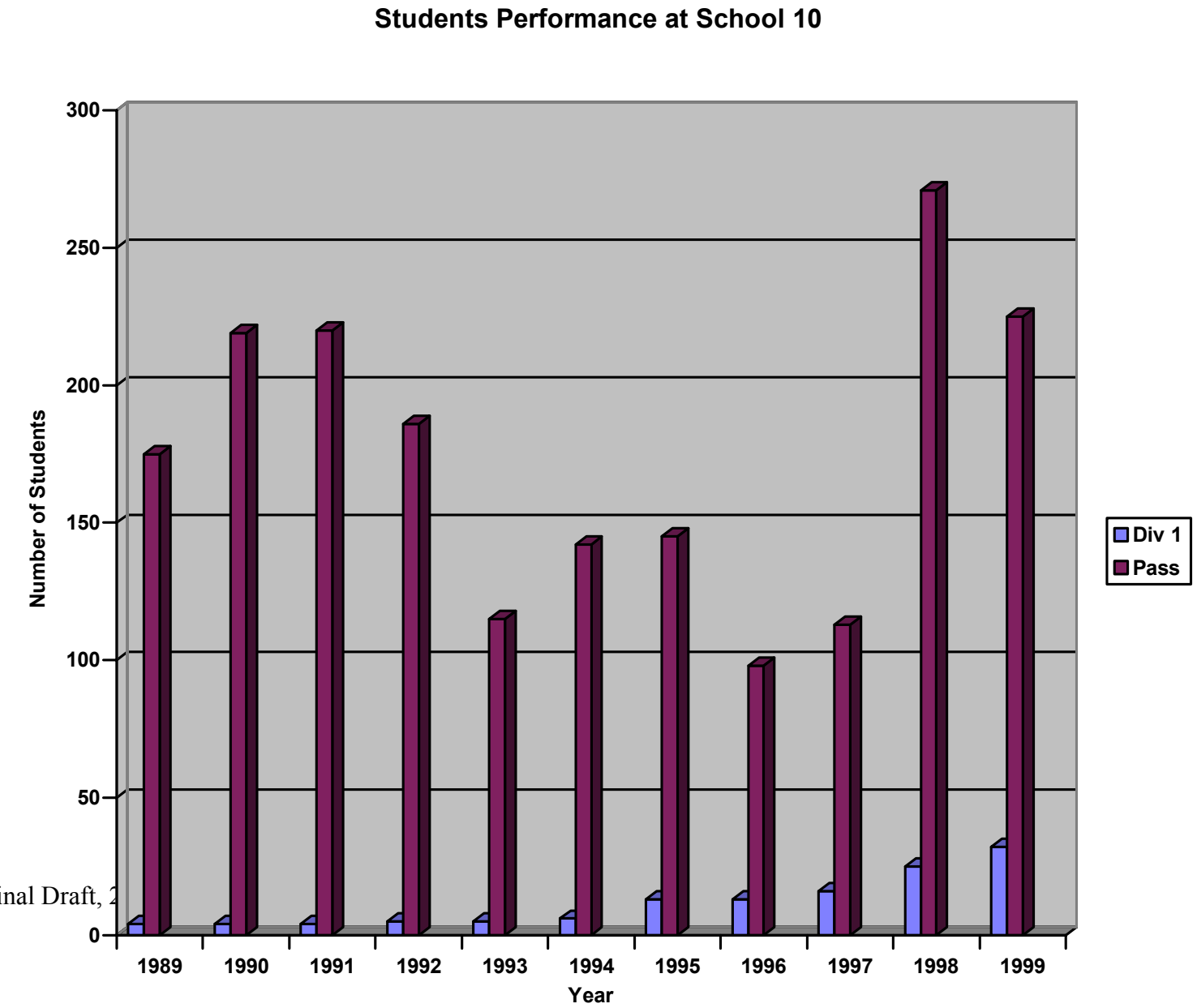
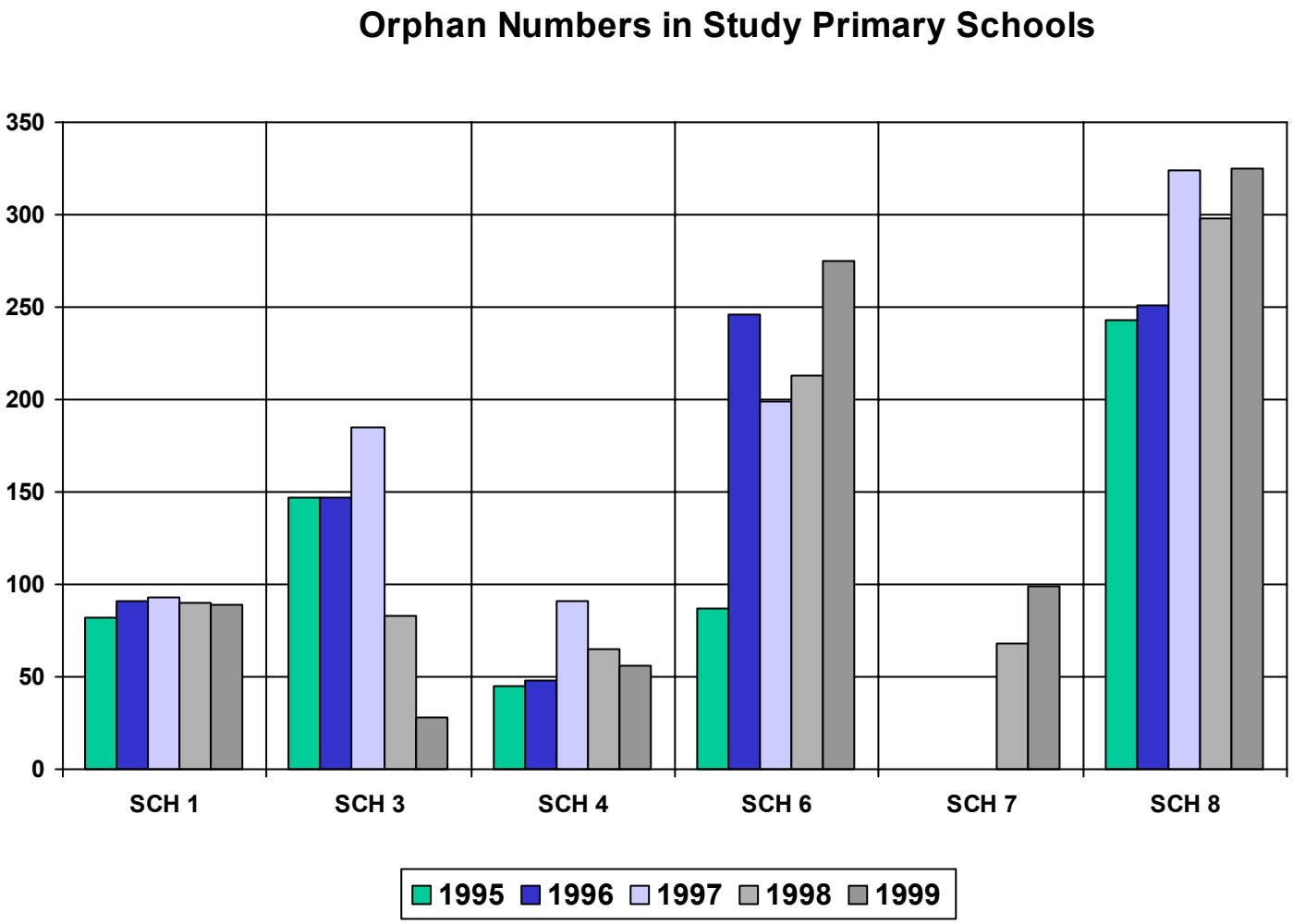
1994
1995
1996
1997
1998
1999
Year
Div1
Pass


Students Performance at School 10
Number of Students
300
250
200
150
100
50
0
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
Year
Div 1
Pass


Orphan Numbers in Study Primary Schools
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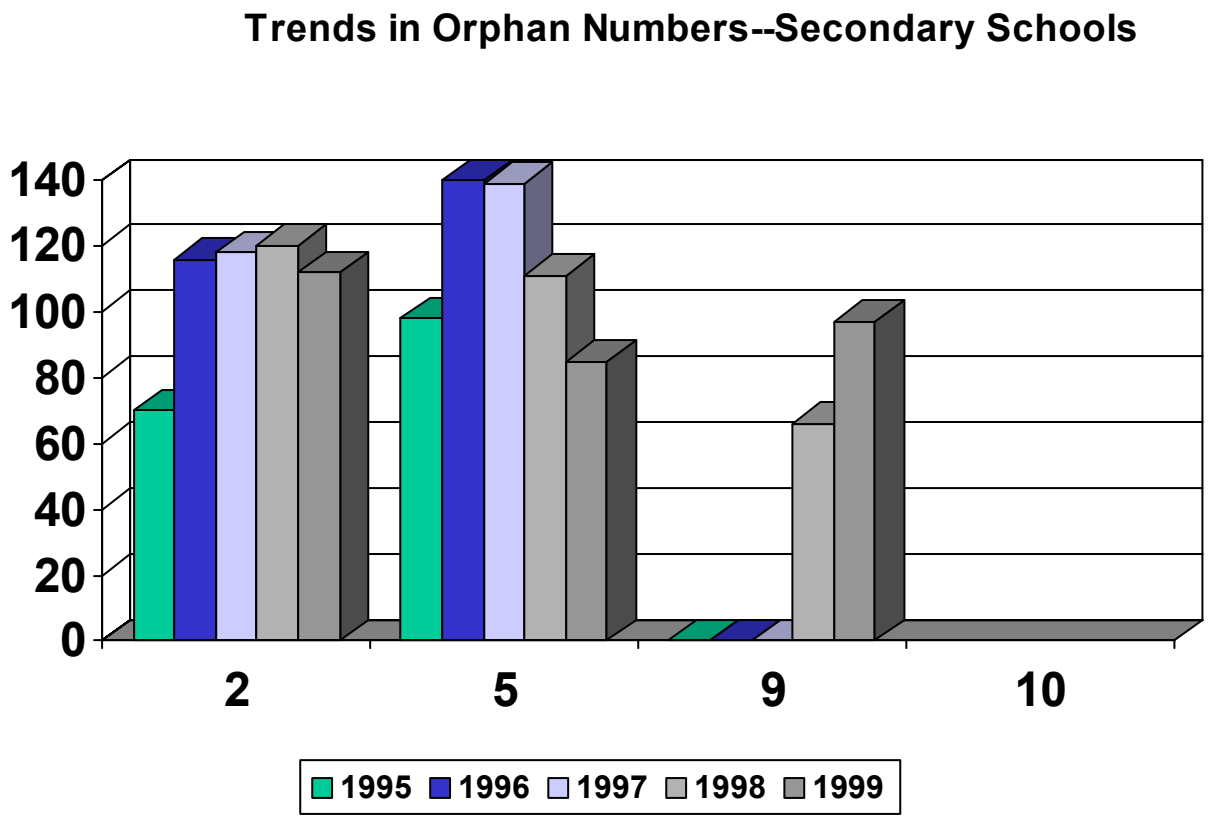
300
250
200
150
100
50
0
SCH 1
SCH 3
SCH 4
SCH 6
SCH 7
SCH 8
1995
1996
1997
1998
1999


Trends in Orphan Numbers--Secondary Schools
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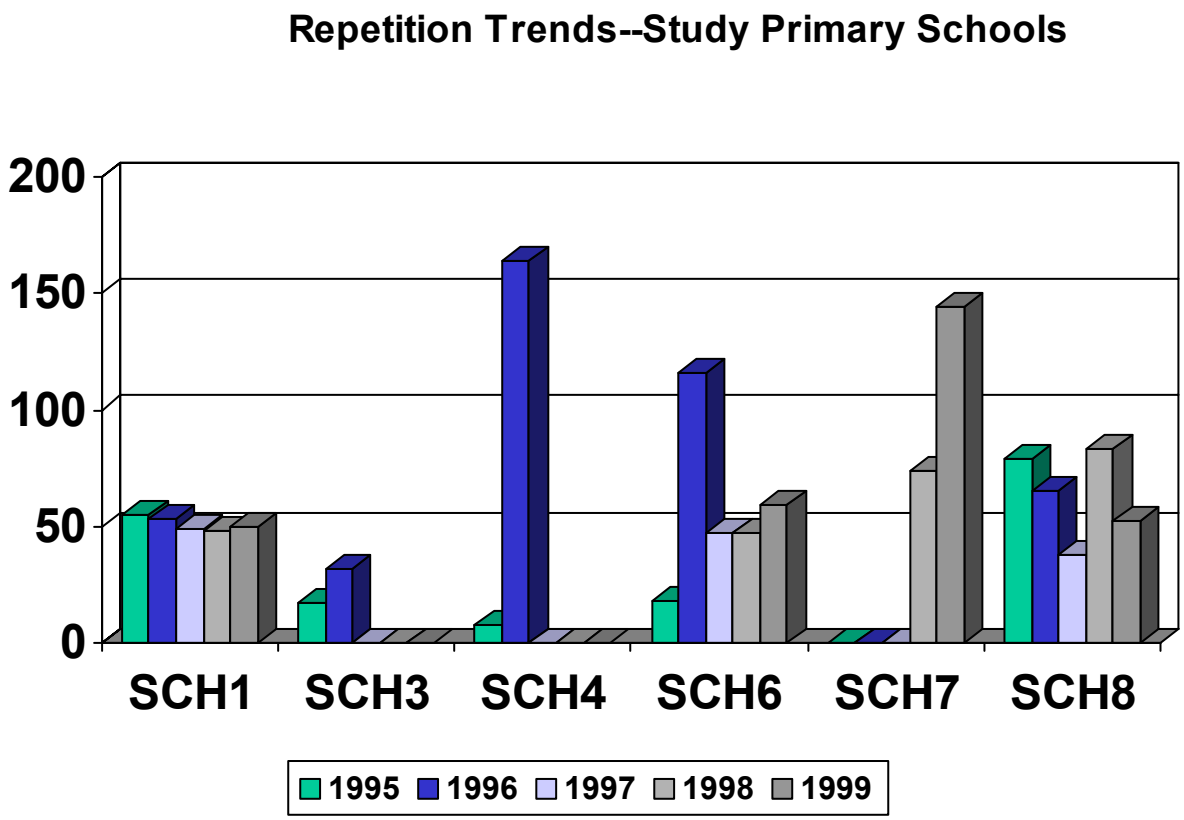
120
100
80
60
40
20
0
2
5
9
10
1995
1996
1997
1998
1999


Repetition Trends--Study Primary Schools
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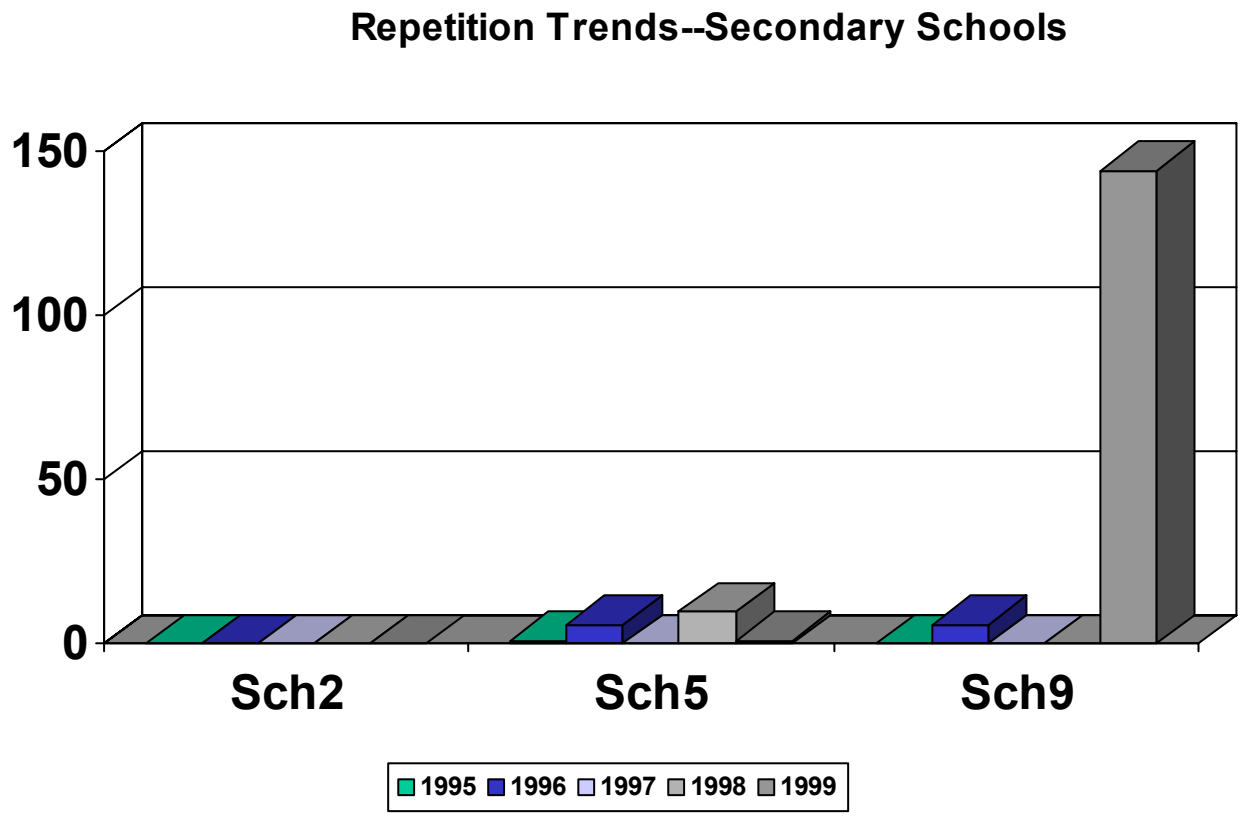
150
100
50
0
SCH1
SCH3
SCH4
SCH6
SCH7
SCH8
1995
1996
1997
1998
1999


Repetition Trends--Secondary Schools
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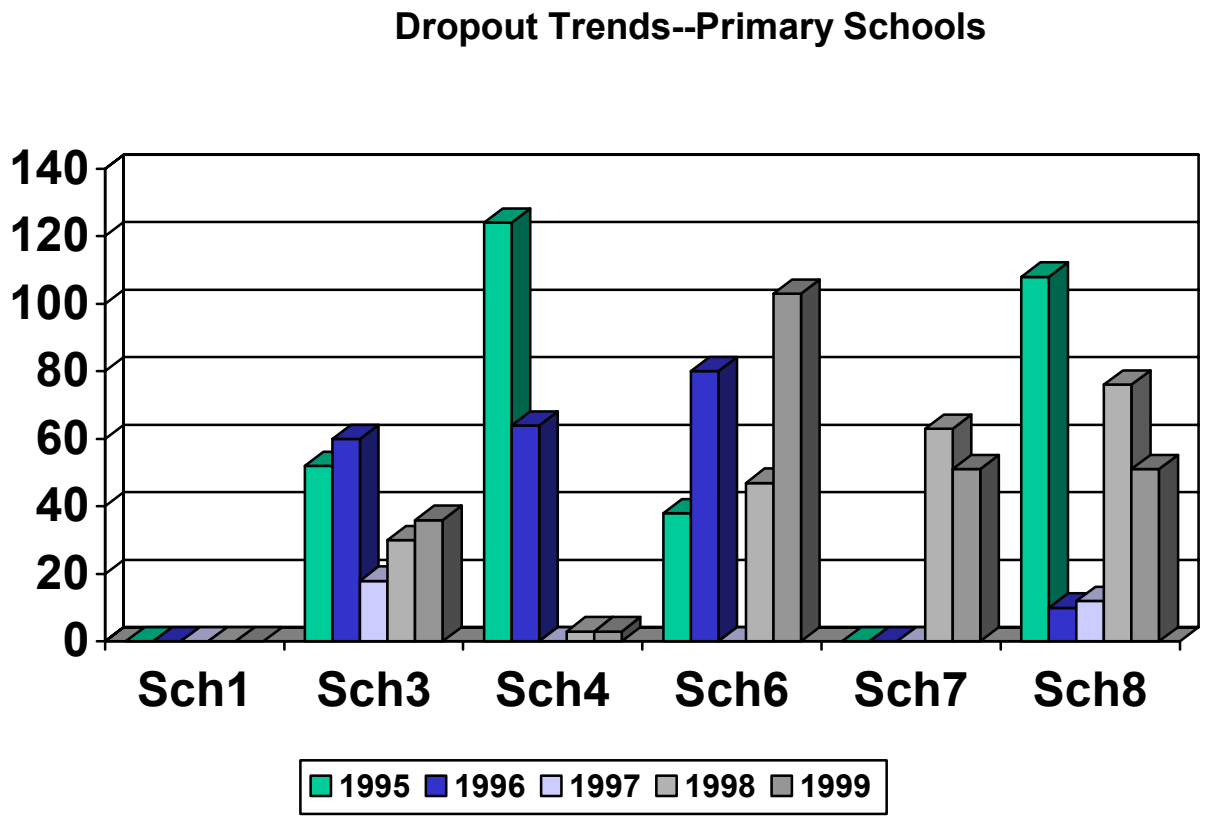
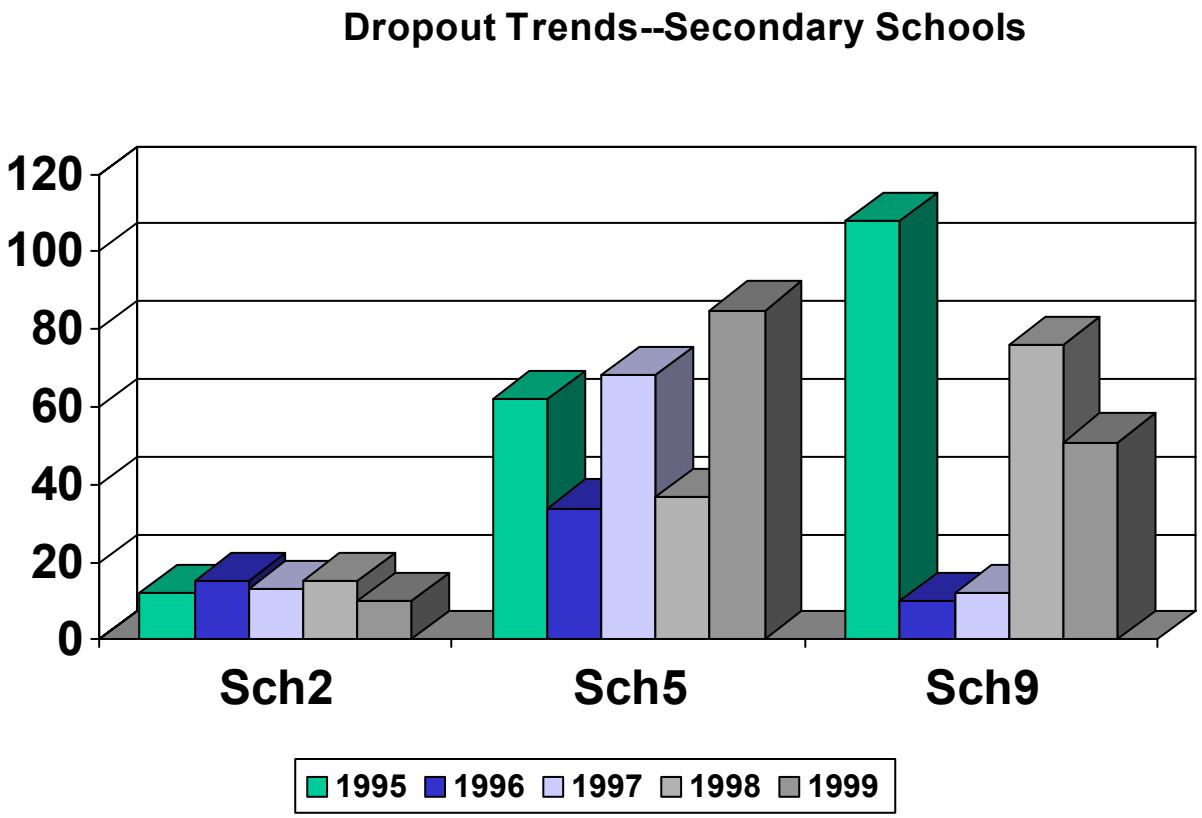
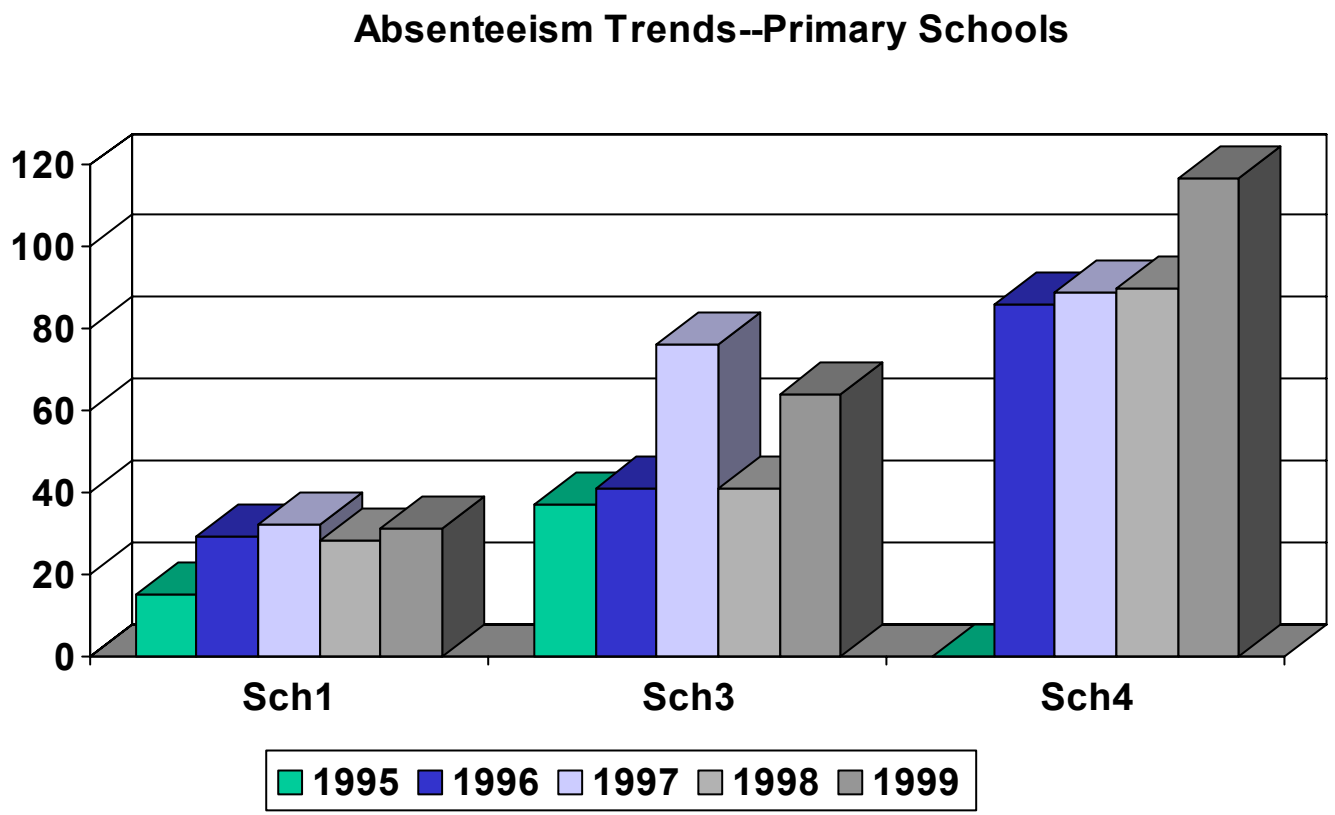
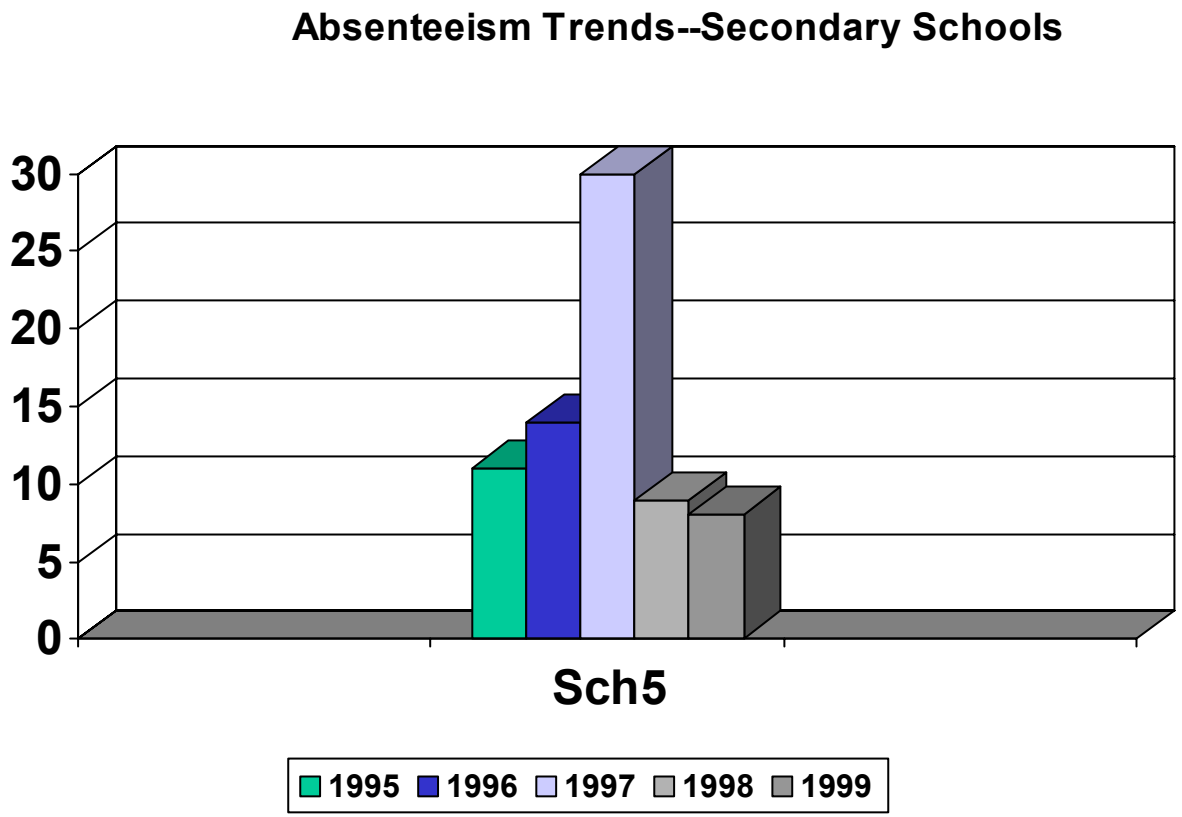
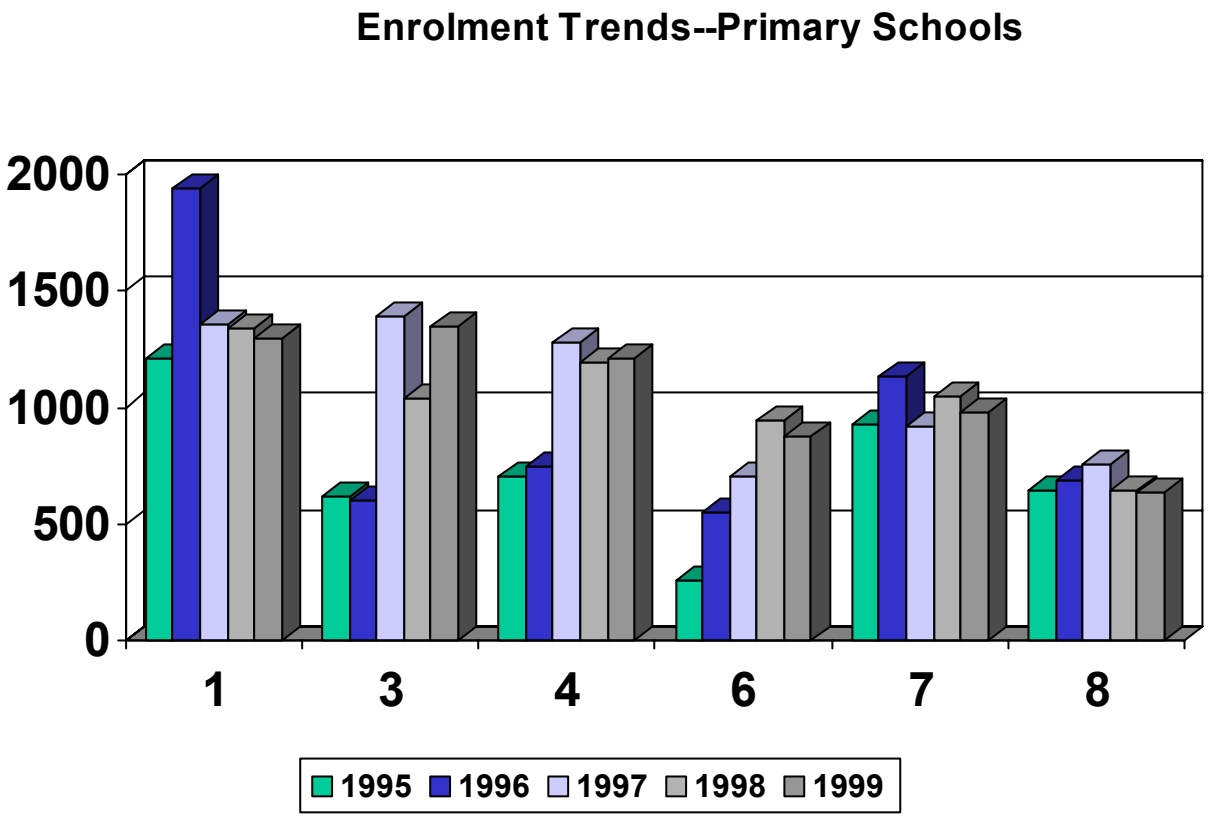
100
50
0
Sch2
Sch5
Sch9
1995
1996
1997
1998
1999

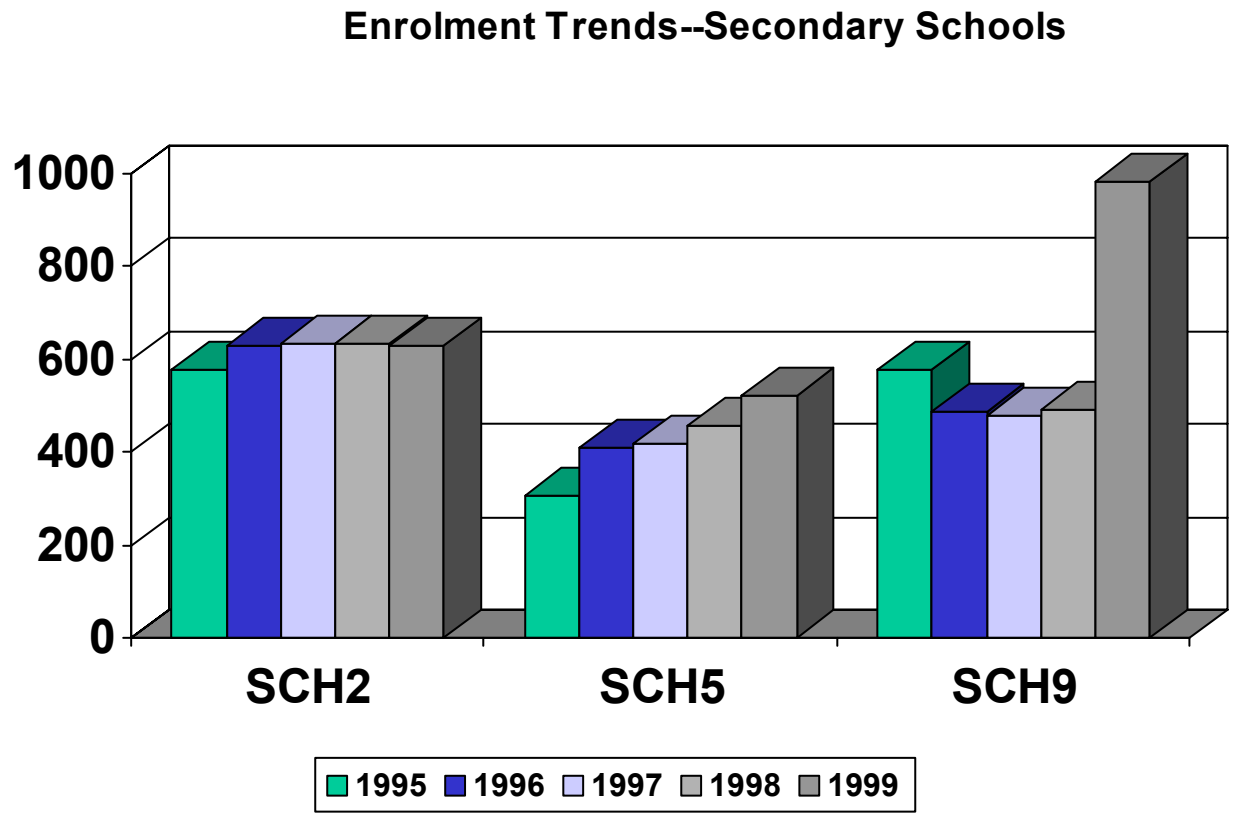

Dropout Trends--Primary Schools
140
120
100
80
60
40
20
0
Sch1
Sch3
Sch4
Sch6
Sch7
Sch8
1995
1996
1997
1998
1999


Dropout Trends--Secondary Schools
120
100
80
60
40
20
0
Sch2
Sch5
Sch9
1995
1996
1997
1998
1999

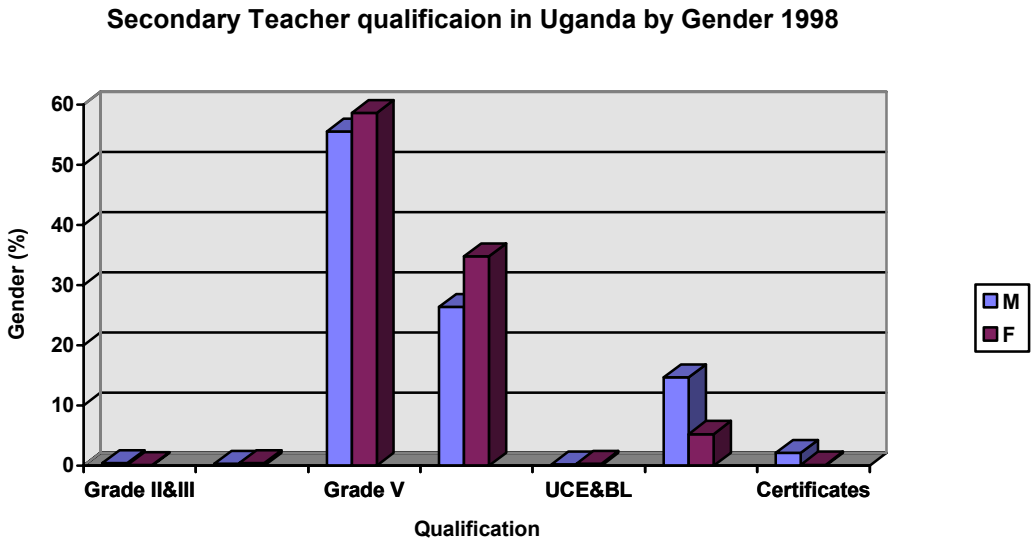

Absenteeism Trends--Primary Schools
120
100
80
60
40
20
0
Sch1
Sch3
Sch4
1995
1996
1997
1998
1999

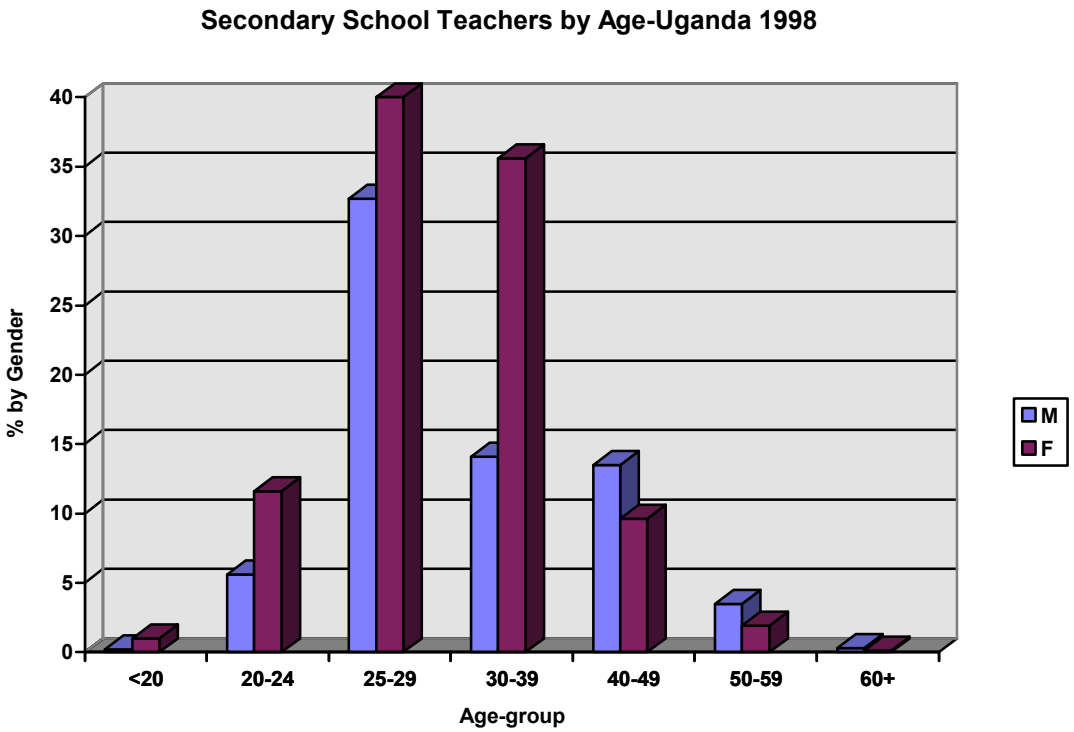

Absenteeism Trends--Secondary Schools
30
25
20
15
10
5
0
Sch5
1995
1996
1997
1998
1999

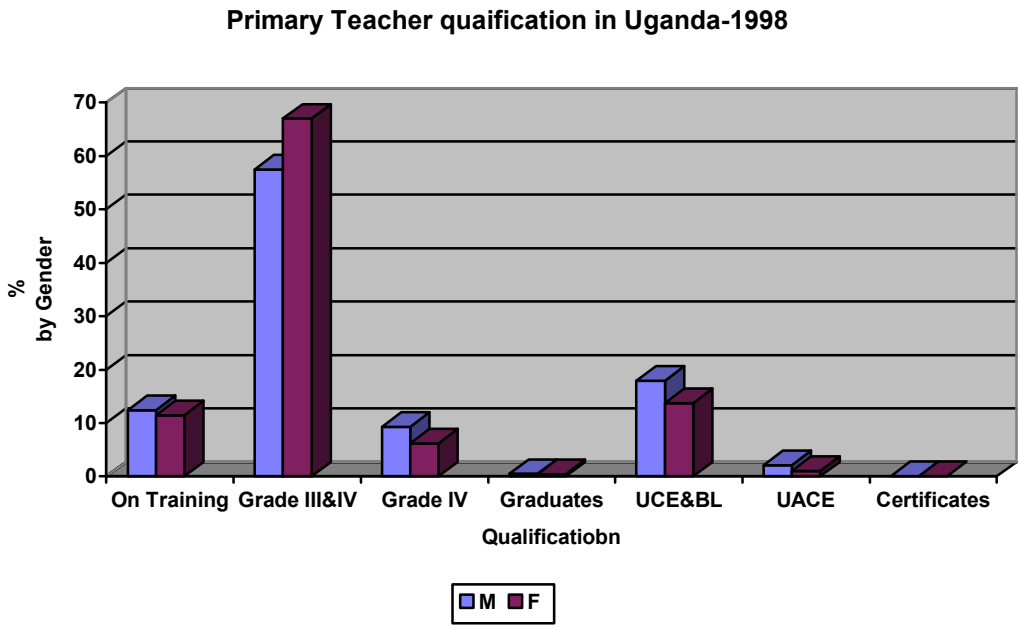

Enrolment Trends--Primary Schools
2000
1500
1000
500
0
1
3
4
6
7
8
1995
1996
1997
1998
1999

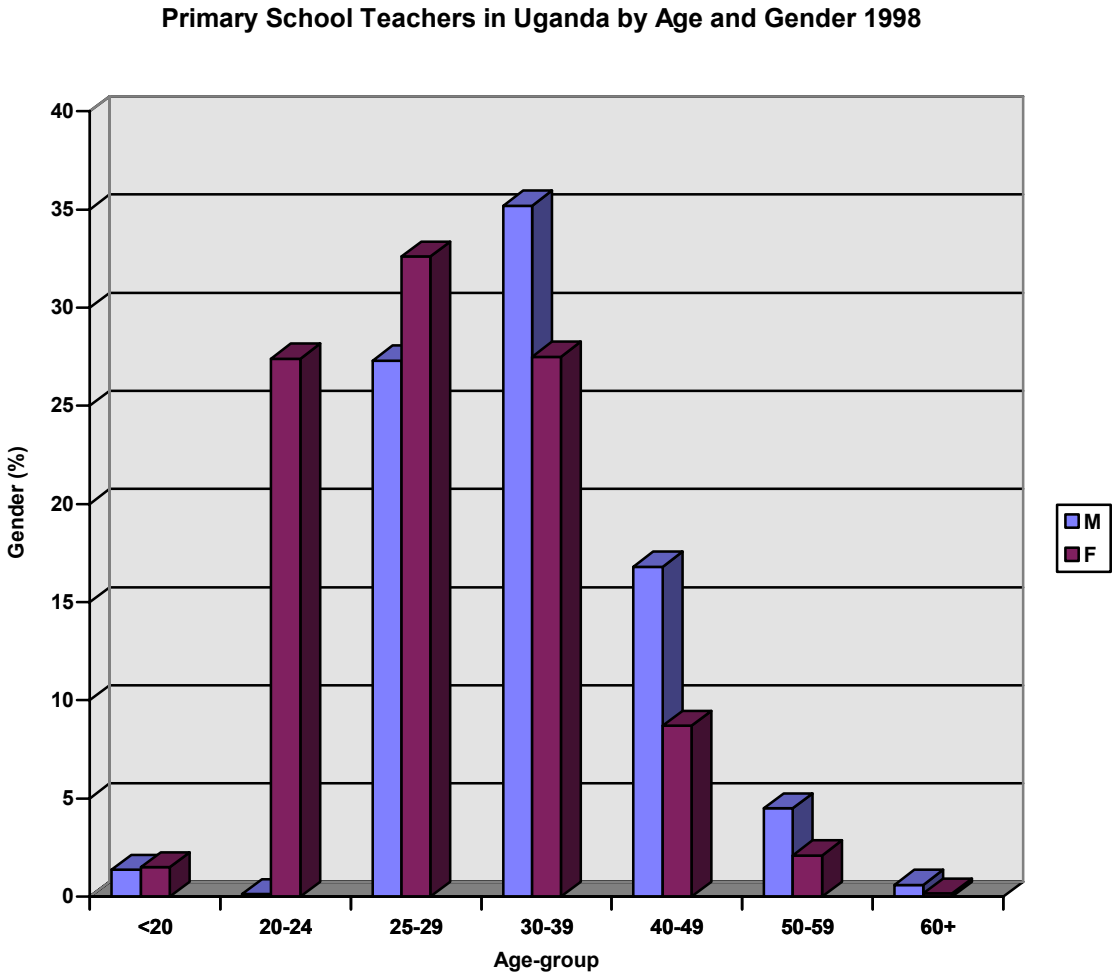

Enrolment Trends--Secondary Schools
1000
800
600
400
200
0
SCH2
SCH5
SCH9
1995
1996
1997
1998
1999

APPENDIX 5: EDUCATIONAL STATISTICS, UGANDA




Secondary School Teachers by Age-Uganda 1998
% by Gender
40
35
30
25
20
15
10
5
0
<20
20-24
25-29
30-39
40-49
50-59
60+
Age-group
M
F


Primary Teacher quaification in Uganda-1998
70
60
50
40
30
20
10
0
% by Gender
On Training
Grade III&IV
Grade IV
Graduates
UCE&BL
UACE
Certificates
Qualificatiobn
M
F


Primary School Teachers in Uganda by Age and Gender 1998
Gender (%)
40
35
30
25
20
15
10
5
0
<20
20-24
25-29
30-39
40-49
50-59
60+
Age-group
M
F

TOTAL ENROLMENT--PRIMARY

	1995			1996			1997			1998		
CLASS	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**
P1	355,423	317,139	672,562	415,668	381,540	797,208	1,102,346	1,057,504	2,159,850	848,973	806,153	1,655,126
P2	242,832	209,952	452,784	290,131	260,018	550,149	435,147	385,398	820,545	671,945	640,648	1,312,593
P3	232,761	199,726	432,487	266,181	234,512	500,693	391,659	334,127	725,786	455,744	407,404	863,148
P4	198,196	165,778	363,974	224,894	195,073	419,967	308,802	256,436	565,238	376,226	327,937	704,163
P5	166,604	132,919	299,523	184,576	153,760	338,336	251,141	198,140	449,281	293,697	251,454	545,151
P6	134,637	101,446	236,083	149,981	117,017	266,998	195,093	144,955	340,048	239,590	188,974	428,564
P7	108,533	70,463	178,996	116,311	78,964	195,275	148,284	94,532	242,816	175,547	122,093	297,640
TOTAL	**1,438,986**	**1,197,423**	**2,636,409**	**1,647,742**	**1,420,884**	**3,068,626**	**2,832,472**	**2,471,092**	**5,303,564**	**3,061,722**	**2,744,663**	**5,806,385**

ORPHANS

	1995			1996			1997			1998		
CLASS	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**
P1	42,191	36,022	78,213	43,454	36,925	80,379	60,847	53,308	114,155	62,571	56,783	119,354
P2	31,441	26,738	58,179	33,086	28,747	61,833	32,936	29,196	62,132	51,981	48,478	100,459
P3	31,370	26,046	57,416	31,965	26,998	58,963	29,877	25,484	55,361	42,016	37,213	79,229
P4	26,794	22,494	49,288	27,780	23,143	50,923	24,598	20,744	45,342	36,078	31,480	67,558
P5	23,722	18,245	41,967	23,175	18,506	41,681	20,482	16,829	37,311	30,236	25,848	56,084
P6	19,442	13,825	33,267	18,831	14,442	33,273	16,528	13,090	29,618	24,102	20,416	44,518
P7	15,234	9,634	24,868	15,017	9,863	24,880	12,171	8,761	20,932	18,319	14,185	32,504
TOTAL	**190,194**	**153,004**	**343,198**	**193,308**	**158,624**	**351,932**	**197,439**	**167,412**	**364,851**	**265,303**	**234,403**	**499,706**

REPEATERS

	1995			1996			1997			1998		
CLASS	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**
P1	75,612	63,226	138,838	70,303	62,179	132,482	94,495	85,528	180,023	79,323	72,819	152,142
P2	43,451	37,254	80,705	42,451	37,582	80,033	45,561	41,105	86,666	64,393	30,496	94,889
P3	42,748	35,457	78,205	39,134	34,349	73,483	40,222	35,591	75,813	25,742	23,103	48,845
P4	33,917	28,679	62,596	31,409	28,163	59,572	31,408	27,027	58,435	19,329	17,370	36,699
P5	26,236	22,147	48,383	24,628	22,341	46,969	25,091	21,423	46,514	16,091	13,554	29,645
P6	21,829	17,200	39,029	20,238	17,258	37,496	20,150	16,067	36,217	13,465	10,506	23,971
P7	16,957	8,334	25,291	15,425	8,601	24,026	14,749	7,372	22,121	11,518	5,727	17,245
TOTAL	**260,750**	**212,297**	**473,047**	**243,588**	**210,473**	**454,061**	**271,676**	**234,113**	**505,789**	**229,861**	**173,575**	**403,436**

DROP-OUTS

	1995			1996			1997			1998		
CLASS	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**
P1	50,556	42,553	93,109	-	-	-	50,845	46,266	97,111	49,192	45,160	94,352
P2	26,686	23,633	50,319	-	-	-	18,966	17,397	36,363	31,410	29,442	60,852
P3	23,506	19,502	43,008	-	-	-	16,275	13,869	30,144	22,300	19,819	42,119
P4	18,977	16,094	35,071	-	-	-	13,279	11,538	24,817	18,946	16,745	35,691
P5	15,487	13,230	28,717	-	-	-	11,834	9,810	21,644	16,259	14,690	30,949
P6	12,657	10,537	23,194	-	-	-	9,774	8,472	18,246	14,064	13,210	27,274
P7	8,938	6,621	15,559	-	-	-	7,959	5,725	13,684	11,928	10,788	22,716
TOTAL	**156,807**	**132,170**	**288,977**	**-**	**-**	**-**	**128,932**	**113,077**	**242,009**	**164,099**	**149,854**	**313,953**

TEACHERS QUALIFICATION

	1995			1996			1997			1998		
	M	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**
ON TRAINING	2,336	1,640	3,976	2,916	2,086	5,002	5,013	2,089	7,102	8,198	3,823	12,021
GRADE III & IV	28,530	16,711	45,241	30,376	18,200	48,576	32,219	18,394	50,613	37,950	22,324	60,274
GRADE V	3,109	1,053	4,162	4,415	1,369	5,784	4,822	1,479	6,301	6,136	2,064	8,200
GRADUATES	97	42	139	289	96	385	396	162	558	319	139	458
UCE&ELOW	6,671	2,071	8,742	14,039	5,283	19,322	17,080	6,678	23,758	11,870	4,586	16,456
UACE	8,012	2,129	10,141	1,882	418	2,300	2,247	454	2,701	1,417	336	1,753
CERTIFICATES	-	-	-	93	102	195	138	76	214	61	14	75
TOTAL	**48,755**	**23,646**	**72,401**	**54,010**	**27,554**	**81,564**	**61,915**	**29,332**	**91,247**	**65,951**	**33,286**	**99,237**

TEACHERS BY AGE

	1995	1996	1997	1998

AGE GROUP	M	F	T	M	F	T	M	F	T	M	F	T
BELOW 20	75	128	203	186	247	433	220	352	572	859	529	1,388
20 - 24	3,595	5,836	9,431	4,240	4,733	8,973	5,655	5,833	11,488	8,700	9,611	18,311
25 - 29	15,985	8,277	24,262	14,199	8,845	23,044	17,468	10,289	27,757	17,019	11,428	28,447
30 - 39	20,687	7,043	27,730	20,051	7,954	28,005	22,584	8,943	31,527	21,977	9,661	31,638
40 - 49	8,348	1,868	10,216	8,311	2,316	10,627	9,565	2,676	12,241	10,520	3,052	13,572
50 - 59	1,882	443	2,325	2,357	614	2,971	3,216	815	4,031	2,838	738	3,576
OVER 60	179	55	234	241	56	297	625	118	743	378	55	433
TOTAL	**50,751**	**23,650**	**74,401**	**49,585**	**24,765**	**74,350**	**59,333**	**29,026**	**88,359**	**62,291**	**35,074**	**97,365**

TOTAL ENROLMENT-- SECONDARY

	1995			1996			1997			1998		
CLASS	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**
S1	40,881	27,606	68,487	41,737	30,086	71,823	41,439	30,048	71,487	42,464	29,160	71,624
S2	36,487	24,621	61,108	36,626	26,238	62,864	36,983	26,076	63,059	33,771	24,194	57,965
S3	32,472	20,588	53,060	31,224	21,466	52,690	31,773	21,755	53,528	29,908	20,095	50,003
S4	29,350	17,354	46,704	25,873	15,998	41,871	24,887	16,328	41,215	25,032	16,354	41,386
S5	9,163	4,285	13,448	9,759	5,128	14,887	9,432	4,836	14,268	11,235	6,753	17,988
S6	9,700	3,752	13,452	8,807	3,789	12,596	7,799	3,979	11,778	10,462	4,743	15,205
TOTAL	**158,053**	**98,206**	**256,259**	**154,026**	**102,705**	**256,731**	**152,313**	**103,022**	**255,335**	**152,872**	**101,299**	**254,171**

ORPHANS

	1995			1996			1997			1998		
CLASS	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**
S1	3,668	2,211	5,879	3,047	2,076	5,123	2,694	1,968	4,662	3,580	2,405	5,985
S2	3,225	1,999	5,224	2,598	1,948	4,546	2,270	1,710	3,980	2,725	2,038	4,763
S3	2,892	1,586	4,478	2,210	1,510	3,720	2,009	1,354	3,363	2,224	1,600	3,824
S4	2,659	1,373	4,032	1,881	1,159	3,040	1,617	1,151	2,768	1,728	1,217	2,945
S5	518	147	665	383	193	576	327	213	540	1,028	325	1,353
S6	502	204	706	321	190	511	362	212	574	442	277	719
	13,464	**7,520**	**20,984**	**10,440**	**7,076**	**17,516**	**9,279**	**6,608**	**15,887**	**11,727**	**7,862**	**19,589**

REPEATERS

	1995			1996			1997			1998		
CLASS	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**
S1	492	380	872	485	322	807	258	205	463	299	555	854
S2	744	570	1,314	626	538	1,164	216	194	410	430	547	977
S3	829	589	1,418	674	513	1,187	166	149	315	480	536	1,016
S4	1,000	453	1,453	632	359	991	157	102	259	467	316	783
S5	151	54	205	175	70	245	47	19	66	148	102	250
S6	461	133	594	335	110	445	33	18	51	206	1,137	1,343
	3,677	**2,179**	**5,856**	**2,927**	**1,912**	**4,839**	**877**	**687**	**1,564**	**2,030**	**3,193**	**5,223**

DROP-OUTS

	1995			1996			1997			1998		
CLASS	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**
S1	2,152	1,686	3,838	-	-	-	2,131	1,663	3,794	-	-	5,433
S2	2,873	2,192	5,065	-	-	-	2,155	1,833	3,988	-	-	6,054
S3	2,152	1,892	4,044	-	-	-	1,782	1,517	3,299	-	-	5,020
S4	1,622	1,322	2,944	-	-	-	1,052	740	1,792	-	-	2,371
S5	267	130	397	-	-	-	302	178	480	-	-	678
S6	364	181	545	-	-	-	202	203	405	-	-	782
	9,430	**7,403**	**16,833**	**-**	**-**	**-**	**7,624**	**6,134**	**13,758**	**-**	**-**	**20,338**

TEACHRS QUALIFICATION

	1995			1996			1997			1998		
	M	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**
GRADE II& III	67	14	81	69	5	74	59	17	76	64	4	68
GRADE IV	5,877	1,606	7,483	44	9	53	68	10	78	57	17	74
GRADE V	2,563	791	3,354	6,772	1,784	8,556	5,964	1,603	7,567	7,249	1,839	9,088
GRADUATES	2,563	791	3,354	3,230	951	4,181	2,773	960	3,733	3,444	1,092	4,536
CE & BELOW	36	16	52	63	9	72	114	17	131	45	11	56
UACE	1,527	97	1,624	2,135	159	2,294	1,349	113	1,462	1,926	167	2,093
CERTIFITES	351	24	375	514	59	573	393	26	419	284	7	291
	12,984	**3,339**	**16,323**	**12,827**	**2,976**	**15,803**	**10,720**	**2,746**	**13,466**	**13,069**	**3,137**	**16,206**

TEACHRS BY AGE

	1995			1996			1997			1998		
AGE GROUP	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**
BELOW 20	-	-	-	9	4	13	5	12	17	26	32	58
20 - 24	-	-	-	579	260	839	417	211	628	730	357	1,087
25 - 29	-	-	-	3,673	1,030	4,703	3,002	1,001	4,003	4,252	1,232	5,484
30 - 39	-	-	-	5,259	886	6,145	4,460	938	5,398	5,731	1,098	6,829
40 - 49	-	-	-	1,577	246	1,823	1,434	248	1,682	1,753	297	2,050
50 - 59	-	-	-	376	51	427	416	55	471	451	59	510
60 & ABOVE	-	-	-	44	3	47	55	1	56	37	4	41
	-	**-**	**-**	**11,517**	**2,480**	**13,997**	**9,789**	**2,466**	**12,255**	**12,980**	**3,079**	**16,059**

Appendix 6: Respondent Recommendations

Enhancing HIV/AIDS Content

Teacher Recommendations

- School curriculum should be designed to include HIV/AIDS education so learners are equipped with the necessary knowledge
- The amount of time devoted to sex education should be increased in both secondary and primary schools
- Students should be encouraged to be patient and wait until they can make mature decisions about their partners
- More intensive of distribution of materials such as "Straight Talk"

Student Recommendations

- Students wanted Young Talk to be sent to schools.
- The students felt that the teachers were not giving them proper information on HIV/AIDS.
- School administration to call health personnel more frequently to give talks on HIV/AIDS.
- HIV/AIDS books to be sent to schools to learn more information on AIDS from such books.
- Plays and drama on AIDS be introduced in schools.
- AIDS lessons should be introduced in schools so that they can learn much about HIV/AIDS modes of transmission and prevention.
- HIV/AIDS clubs should be introduced in schools so that they can discuss freely about HIV/AIDS and address HIV/AIDS issues by creating awareness among the students.
- The students asked for more open talks on HIV/AIDS issues with their teachers.

Capacity Building for Teachers

Teacher Recommendations

- Teachers should be properly trained to deliver reproductive health topics
- Teachers should receive refresher courses on HIV/AIDS
- Teachers should receive training in counselling
- Teachers to be trained more about HIV/AIDS in order to deliver the rightful messages to students

Student Recommendations

- The students recommended that Voluntary Counselling and Testing for HIV/AIDS be introduced in schools so that they know their HIV status.
- Students to refrain from sex before marriage.
- They also recommended that a compulsory HIV test be undertaken before young couple start living together.

Guidance and Counselling

Teacher Recommendations

- AIDS counsellors should visit schools and give talks to students
- Schools be provided with a condom section where condoms can be provided every month by anti-AIDS organisations for use by the teachers and students
- Strengthen HIV/AIDS counselling services

- Peer educators to be put in place to educate people on HIV/AIDS
- Adolescent and HIV counselling be encouraged
- Preaching against promiscuity and unsafe sex to both the students and teachers in assembly

Sexual Harassment

Student Recommendations

- Disciplinary measures should be taken against the boys and teachers who harass and defile girls.
- The students asked for the government to intensify security at schools as some of them have been abducted and defile when they leave school late for home.
- Female students called for severe punishment (disciplinary action) on boys who write them love letters, touch them and beat them up if they refuse their requests.