SD Publication Series
Office of Sustainable Development
Bureau for Africa

Tips for Developing Life Skills Curricula for HIV Prevention Among African Youth: A Synthesis of Emerging Lessons

Media for Development International

Technical Paper No. 115
January 2002

Tips for Developing Life Skills Curricula for HIV Prevention Among African Youth

A Synthesis of Emerging Lessons

U.S. Agency for International Development
Bureau for Africa
Office of Sustainable Development
Basic Education Team

January 2002

Table of Contents

Introduction 11
Section I: Background 13
Young People and HIV/AIDS 13
Children and Life Skills 15
Adolescent Sexuality 15
Girls' Vulnerability 16
Barriers to Implementing Effective Life Skills 16
Availability of Youth-Friendly Reproductive Health Care 17
Importance of Community Involvement 18
Monitoring and Evaluation 18
Remaining Questions 18
Section II: Tips 21
Tips for Planners 21
Important Considerations for Planners 22
Tips for Curriculum Developers 23
Important Considerations for Curriculum Developers 24
Tips for Teacher Trainers 25
Tips for Head Teachers and School Administrators 27
Section III: Documents Reviewed 29
Annex A: Additional Resources 35

Acknowledgments

The contributions of many people were essential in finalizing this document. Special thanks go to Lindsay Stewart and everyone at the FOCUS on Young Adults Project, Ann McCauley of Horizons, and to all those professionals and community members working on life skills programs in sub-Saharan Africa. Thanks to education officers at USAID field missions for helpful suggestions and comments, particularly Kent Noel at USAID/Zambia who offered useful comments on life skills materials for young children. The author would also like to thank Kay Freeman, Brad Stickland, Megan Thomas, and Joe Kitts of the USAID Bureau for Africa; Shanti Conly of USAID Global Bureau; and Amaya Gillespie of UNICEF, for their guidance and assistance. John Engels of SAGE, and Christine Chumbler of ABIC contributed to production of this publication.

Joan Woods
Washington, DC
January 2002

Introduction

Skills-based health education for HIV prevention (referred to here as life skills) provides learners with the knowledge and skills they need to avoid HIV infection and maintain reproductive health. This document offers practical guidance for those planning, implementing, or strengthening life skills curricula for young people in sub-Saharan Africa.

There are many difficulties associated with implementing successful life skills programs, and there is a need for more rigorous evaluations of existing programs. Still, there are valuable emerging lessons from ministries of education (MOEs), UNICEF, nongovernmental organizations (NGOs), private voluntary organizations (PVOs), donor organizations, and others to guide implementation of such curricula. The Africa Bureau's Office of Sustainable Development of the U.S. Agency for International Development (USAID), in response to requests from its missions and partner MOEs and NGOs, compiled this document from a wide range of sources. In particular, the USAID-funded FOCUS on Young Adults project developed a consensus panel of individuals with expertise in adolescent sexuality and behavior change, which examined existing literature and their own field experience to develop a report, *Reproductive Health Programs for Young Adults: School-Based Programs* (Birdthistle and Vince-Whitman, 1997). The tips for planners, curriculum designers, school administrators, trainers, and teachers that appear at the end of this document are drawn largely from this FOCUS report and a review of the UNICEF life skills program in Zimbabwe (Chown et al., 1998). The tips were further informed by a review of published evaluations, program reports and descriptions, organizational publications, project proposals, and observations of implementers and evaluators.

Section I provides background on the issues of adolescent sexuality and vulnerability, and implementation of HIV prevention with young people. Section II offers practical tips for implementing life skills programs for young people, divided into Tips for Planners, Tips for Curriculum Designers, Tips for Teacher Trainers and Head Teachers, and Tips for Administrators. Section III is a bibliography of the documents reviewed for this publication. Finally, Annex A contains a list of example life skills curricula, and material and contact information.

SECTION I: Background

Young People and HIV/AIDS

People under the age of 20 make up 55 percent of the population in sub-Saharan Africa (U.S. Bureau of the Census, 2001). Childhood and adolescence are periods when norms, attitudes, values, and life patterns are established. They also encompass a time of risk, as sexual activity among young people outside of marriage increases. Worldwide, half of all new HIV infections each year occur in youth under age 25 (UNAIDS, 1999). Sub-Saharan Africa has been hardest hit by HIV/AIDS; the region accounts for 70 percent of new infections and 80 percent of AIDS-related deaths (Gachuhi, 1999). In eight African countries, over one third of 15 year-olds will eventually die from AIDS (UNAIDS, 1999).

Despite the risks faced by young people, they are often viewed as the "window of hope" for stemming the tide of the epidemic. Young people aged 5 to 14 have very low HIV prevalence rates, even in very high prevalence communities. Rates are high for children under 5 due to mother-to-child transmission, and increase very rapidly after age 14, especially for girls (UNAIDS, 2000b).

In an attempt to prevent HIV infection among this vulnerable population and save the next generation of Africans, many ministries of education (MOEs) are introducing HIV prevention into formal curricula. MOEs are well-positioned to play a role in HIV/AIDS prevention, because the schools they manage help shape social norms, values, and behavior among a large proportion of young people (Siamwiza, 1999). This is especially at the early primary level.

While learners and communities need accurate information to effectively prevent HIV infection, that alone is not sufficient. Evidence shows that prevention information must be coupled with everyday skills to increase the likelihood that individuals will translate their knowledge into action. Life skills curricula are designed to do this by developing in young people abilities such as negotiation, assertiveness, and ability to cope with peer pressure; attitudes such as compassion, self-esteem, and tolerance; and knowledge about HIV transmission. These are best learned through "experiential" and "learner-centered" methodologies designed to help young people examine attitudes and practice skills (Gachuhi, 1999). Interactive teaching techniques allow discussion of social pressures relating to relationships and opportunities to practice negotiation, communication, and refusal skills (USAID, 2001).

These skills-based curricula aim to modify everyday behavior. When young people have acquired the necessary skills in a positive, safe environment, they may choose not to have sex or, for those who are sexually active, to use condoms consistently. The decision to modify sexual behavior is determined by many factors (EDC, 1997):

- Knowledge—Do young people have access to accurate information about sexuality and HIV/ AIDS? Correct and complete knowledge feeds into attitudes about vulnerability and can counteract the "invincibility" often felt by young people.

- Skills—Do young people have the ability to make healthy decisions and to negotiate in sexual situations? Similarly, do they have the self-esteem and confidence to voice their beliefs and resist peer pressure?
- Social environment—Are young people pressured or coerced by their peers and others to have sex? Is there social pressure on boys to have premarital sex? Do peers use condoms? Are parents and others discussing sexuality, HIV prevention, and condom usage?
- Physical environment—For those young people who choose to have sex, are condoms affordable and accessible from youth-friendly sources? Are schools safe for students?
- Cultural environment—When young people choose not to have sex or to use condoms, are they supported? What messages do they receive about sexuality and HIV prevention from the mass media? From community leaders?

Life skills curricula can examine attitudes and social norms such as discrimination and peer pressure. When implemented with community involvement and support, these programs can foster a positive social environment; when linked to a local health clinic or provider, they can address the access issues related to the physical environment. For the cultural environment to be conducive to safe sexual choices, coordinated interventions are needed that target parents, community leaders, teachers, and others with positive messages about HIV prevention.

Life skills programs are an important prevention measure. However, in isolation, they are not sufficient to protect young people from HIV infection; a broad array of interventions to improve knowledge, attitudes, skills, and the social, cultural, and physical environment are needed. Because so many factors determine the spread of HIV/AIDS in Africa, and because the effects of the pandemic extend throughout communities, responses must be cross-sectoral and aimed at all levels of society.

There are many barriers to overcome in introducing effective life skills curricula on a national level in sub-Saharan Africa. Those working with pre-adolescents may not understand the relevance of the topic and may not know how to address it. Teachers, parents, and other community leaders are often reluctant to discuss sexuality with young people. Teachers are not accustomed to interacting with students in the “participatory” methods these programs require. Gender inequities that leave young people, especially girls, vulnerable to HIV infection have not been confronted. If adolescents wish to use condoms and seek reproductive health care, services may not be accessible to them.

Despite these barriers, persons developing or strengthening life skills programs should not view youth simply as a collection of risk factors to be addressed, but also as a source of strength, energy, and creativity. Young people themselves have the best understanding of the pressures they face, and thus must play a vital role in stemming the tide of the epidemic.

Children and Life Skills

Many parents, educators, and planners are wary of discussing HIV/AIDS with pre-adolescents because of the link between HIV and sexuality. However, there are age-appropriate curricula available for standards 1 – 5. These deal with building basic skills such as self-esteem, problem solving, assertiveness, and negotiation that are useful to young learners in their everyday lives. Rather than dealing explicitly with sexuality, such curricula open up discussions about relationships between men and women, family roles, and stigmatization of those affected by HIV/AIDS. At slightly older ages (e.g. standard 6), curricula can begin to build group norms of abstinence, monogamy, and safe sex.

Adolescent Sexuality

Adolescents are not a homogenous group. They have different needs depending on many factors, including gender, age, cognitive developmental stage, sexual activity, school status, familial relationships, and cultural norms. However, research has shown consistent trends across regions of sub-Saharan Africa. Many factors have led to early sexual activity outside of marriage, including weakening of social controls, later age at marriage, changing sexual norms, and economic pressures. Social norms often condone or even force young people into sexual activity by encouraging early childbearing and male promiscuity, and failing to condemn sexual relationships between girls and older men (Hughes and McCauley, 1998). For example, a study in Lusaka, Zambia, revealed that the average age at first intercourse for girls and boys was 12 and 14 years, respectively. Some girls had become sexually active by age 8 (CARE, 1998). Of 300 girls surveyed in rural Malawi, the mean age at first intercourse was 13.6 years. More than half had sexual intercourse before first menarche (Weiss, 1996).

In the past, HIV and pregnancy prevention messages to youth have been developed on the assumption of individual autonomy and rational decision-making in which young people weigh the costs and benefits of protection (Swart-Kruger, 1997). However, young people clearly do not act simply as independent decision-makers, but within the context of social and cultural influences (Shepard, 2001). Therefore, life skills programs should give young people the skills they need to protect themselves from peer or adult coercion (Gachuhi, 1999). They should also reinforce group values against unsafe sexual behavior, both among peers and throughout the community.

Several studies have shown that parents in sub-Saharan Africa are often reluctant to talk about relationships and sexuality with their children out of embarrassment, lack of accurate information, or fear that they will appear to condone adolescent sexual activity. Consequently, youth often cite peers and the media as their primary sources of information about sexuality. Unfortunately, these sources are often filled with erroneous information and myths. Probably in recognition of this, many youth state that they wish they could get information about sexuality from a trusted adult (McCauley and Salter, 1995). With parents unable or unwilling to provide this information, teachers are an obvious alternative for in-school youth. However, teachers may suffer the same shortcomings as parents, and require training and support to fulfill this role effectively.

Girls' Vulnerability

Several studies have shown that girls age 15–24 in Africa are several times more likely to be infected with HIV than boys the same age. This is due to both biological and societal factors. The physiology of the developing cervix increases the susceptibility of young women to sexually transmitted diseases (STIs) including HIV (NAS, 1996). Another important factor in the discrepancy between young female and male prevalence is age-mixing between girls and older men who are more sexually experienced and therefore more likely to be infected (UNAIDS, 2000a).

Often implicit in reproductive health curricula for youth is the assumption that girls have consensual sex and are able to negotiate condom use. In reality, girls often have little control over their sexual activity. In Malawi, 55 percent of girls surveyed report that they are often forced to have sex, while in South Africa 30 percent of sexually active girls report that their first sexual intercourse was forced (Gachuhi, 1999). The South Africa Medical Research Council reported late in 2000 that one half of all schoolgirls in the district studied had been forced to have sex against their will—one-third of them by teachers (Coombe, 2001). Evidence suggests that in high prevalence areas, men seek younger and presumably HIV-negative girls (Gachuhi, 1999). Poverty also forces girls to exchange sex for economic favors, often with older men.

Life skills programs must therefore address gender equity. There must be clear acknowledgment that gender stereotypes and economic dependence on men often influence girls' sexual behavior. Properly designed and implemented life skills programs should contribute to a safe environment for young people, both in school and in the community. Life skills programs should strengthen young women's ability to think and act in ways to protect themselves. They should also address young men's issues by raising alternative views about male/female roles in society and addressing issues of gender and sexual identity through which they understand relationships with girls and women (Senderowitz, 2000).

The creation of safe schools will require confronting the issue of sexual relations between teachers and students. Most education ministries have explicit regulations barring such relations; however, they are rarely enforced. Action at the central policy level as well as the school and community level will be required to ensure that everyone is aware that such relations are dangerous for students and will not be tolerated. The creation of safe environments for youth will likely have the additional benefit of allowing many girls to complete their education when they might otherwise have withdrawn or been withdrawn by their families due to harassment and/or assault (Schenker, 2000).

Barriers to Implementing Effective Life Skills

Even as education ministries formally integrate HIV prevention into curricula, teachers and parents are often wary, frequently believing that providing young people with sexuality education will increase sexual activity. Many studies have demonstrated that this is not the case. In fact, sexuality education, when combined with improved negotiation and communication skills, often leads to delayed sexual initiation, fewer partners, and increased use of condoms and/

or other contraception (UNAIDS, 1997). In order to alleviate the fears of parents and other community members, there is an increasing awareness that communities must have a voice in the development and implementation of HIV prevention activities (Senderowitz, 2000).

In addition to a lack of comfort with the topic of adolescent sexuality, many teachers and students express frustration with an already overcrowded curriculum (Siamwiza). Many teachers also lack the confidence and training to use participatory methodologies, continuing to lecture rather than allow students to discuss and practice skills-building (Gachuhi, 1999). Teacher (and peer educator) development programs need to focus on increasing trainees' comfort level. Teachers will only be effective change agents if they have dealt with their own views of adolescent sexuality and attitudes towards those infected by HIV. Training must also address trainees' own vulnerability to HIV/AIDS and acknowledge how HIV/AIDS has affected them (Weiss, Whelan, and Gupta, 1996).

Availability of Youth-Friendly Reproductive Health Care

STIs increase HIV susceptibility and infectiousness (UNAIDS, 2000a; Jha et al., 2001). A study in Mwanza, Tanzania, demonstrated that improved STI treatment reduced HIV prevalence by about 40 percent (Grosskurth et al, 1995). Several studies have shown that STIs are prevalent among adolescents in sub-Saharan Africa and that detection and treatment of infections is rare (Zabin and Kiragu, 1998). Youth generally avoid public health facilities because of perceived hostile attitudes of providers toward adolescent sexuality and lack of confidentiality (Senderowitz, 2000). Consequently, rather than seeking preventive care, young people may have no contact with clinic personnel until they develop a symptomatic STI or become pregnant (Hughes and McCauley, 1998).

Youth-friendly reproductive health care refers to services provided by specially trained providers within a context of a supportive policy and physical environment. This means that providers are selected to work with youth based on their positive attitudes toward young people, and are trained on the particular reproductive health needs of young people. The policy environment is one in which health care personnel understand that young people have the right to access to nonjudgmental care, including STI and HIV counseling, STI treatment, and their choice of contraceptive method. The physical environment is one that assures young people privacy and confidentiality.

Most school-based behavior change programs are isolated, without links to clinics, health care workers, or drop-in counseling (Siamwiza, 1999). While the development of youth-friendly health care at the clinic level clearly falls outside of the education sector, education ministries should encourage ministries of health (MOHs) to provide such services. In addition, school-clinic links should be encouraged at the local level. Such links may include regular classroom presentations and discussions by health care providers on issues including reproductive health and HIV prevention.

Importance of Community Involvement

Early and continuous involvement of parents, officials, elders, and other community leaders in planning and implementation of programs is important. Adults who are engaged in assessing the needs and behavior of youth in their area and are kept informed of interventions are more likely to support such programs (Hughes and McCauley, 1998).

Community members can also be important in adapting life skills programs to make them relevant to the local situation. Community participation garners broad-based support and reinforces school efforts. Representatives from respected local community groups can provide letters of endorsement and act as advocates for the program. For example, The Friends of Youth project in Kenya utilizes respected parents in communities, training them on adolescent reproductive health issues and advocacy to educate and encourage dialogue between youth and parents (Erulkar, 1998).

Communities can play an important role when they are linked to life skills programs through community mobilization/sensitization activities. This can involve an NGO, school management committee, or parent/teacher association acting as a bridge between the school and the community, and opening a space for dialogue about the purpose, content, and appropriate implementation of life skills.

Monitoring and Evaluation

Both process and impact evaluation are needed. If a program fails to achieve expected results, either in terms of behavior change or health outcomes, process evaluation allows for targeted adjustment of strategies. When a program does achieve expected results, good data on process indicators allows for analysis of the essential factors in success. This information is very important for scaling up or replicating the program (Shepard, 2001).

There is a need for solid baseline data for impact indicators, and planners need to allow time for change. Ideally, a program will measure reported behavior change, increases in condom sales/distribution, increase in health seeking for STI screening and testing, and utilization of referral services. After allowing for sufficient time and possibly in conjunction with the MOH, data should be collected on expected health outcomes such as lower rates of STIs, unintended pregnancy, and HIV/AIDS.

Remaining Questions

1. Should life skills be tested?

On one hand, teachers and learners may not take the subject seriously if there is not an exam on it. Moreover, it may not be integrated into already full curricula, especially those that emphasize preparing students for exams. On the other hand, testing may lead to teachers and students stressing informational content rather than acquisition of skills, because teachers often do not have the training to effectively test mastery of skills components.

2. Should life skills be taught to segregated students by same-sex teachers? Or perhaps just sections of the life skills course?

Teachers should be trained to make these decisions, and the decision should be made at the local level. Some components of life skills, such as frank discussions about students' questions about sexuality, work well in separated classes. However, one overall goal of life skills, that boys and girls learn to communicate with each other better, requires integrated gender discussions and work.

SECTION II: Tips

Tips for Planners

Promote a large vision and big ideas

- Successful programs articulate a vision of significant change to be brought about, give schools and communities the sense of being part of an important national or international movement, and have the visible and vocal support of respected leaders.

Use data-driven planning and decision-making

- An understanding of when and why young people choose not to have sex or to have safe or unprotected sex is vital to the design and implementation of relevant curricula. Such data may also be used to promote the need for life skills programs.

Introduce life skills curricula early in primary school

- Curricula for young primary school learners can focus on relationships and basic skills such as negotiation and self-esteem.
- HIV prevention is more effective among youth who are not yet sexually active. It is easier to encourage the formation of healthy reproductive health attitudes and practices before the initiation of sexual activity than it is to change well-established unhealthy habits.
- Primary schools have the opportunity to reach the many African children who do not continue on to secondary school.

Develop policies that encourage community participation in implementation

- For curricula to be successfully implemented, communities must be consulted, informed, and supportive. Head teachers and district level managers should be mandated to discuss curricula with relevant community members.

Involve young people in planning

- Young people are more likely to "buy into" a program if they are involved in design and planning.
- Involvement of young people ensures that the program will be socially and culturally appropriate.

Teach life skills in an environment with a range of HIV prevention interventions

- Life skills curricula are more effective when reinforced by consistent messages from media, peer educators and counselors, health care providers, and the community.

Include a peer education component

- Well-trained and supported peer educators can supplement classroom work and allow young people to ask questions one-on-one.
- Young people listen to their peers and use the same language.

- Young people who talk to peer educators spread information to families, partners, and friends. Peer educators demonstrate positive behavior change.

Work closely at all stages with the ministry of health

- HIV prevention programs and messages should be coordinated to be consistent and complementary.
- Programs are more effective when there is access—perhaps through school-clinic links—to youth-friendly health services, including counseling, STI screening and treatment, and readily available condoms.

Work closely with all relevant NGOs

- HIV prevention programs and messages should be coordinated, consistent, and complementary. Links can be formal or nonformal.

Include sensitivity training for national- and district-level education ministry personnel

- Education ministry personnel should receive information about the necessity of life skills education for the prevention of HIV among young people. This training will allow them to answer questions, allay concerns, and build support for the program. Personnel should receive regular updates on the status of the life skills program implementation at the national and local levels.

Important Considerations for Planners

Each planner must decide which method or combination of methods is appropriate based on local and national context.

Implementation as a separate course or as a key component of a conducive subject such as health or civic education appears to be the most successful method of teaching life skills (Gachuhi, 1999). This allows for time to adequately address all aspects of life skills and decreases dilution of content that can take place when life skills are infused in the general curriculum.

Infusion, however, utilizes structures that are already in place and may be more politically acceptable than a stand-alone course. Still, there is no evidence that infusion works in practice, as it may dilute content and discourage innovative, participatory teaching methods.

Outside educators who are known and trusted by the community and students can provide life skills instruction, coordinated with in-school staff and programs. This may alleviate concerns about confidentiality and allow students to talk more openly about sexual behavior. Additionally, outside educators may have skills in innovative educational techniques that school staff lack. However, use of outside educators may be unsustainable. Moreover, there may be insufficient classroom time to yield changes in behavior, or questions may arise after the educator has left the school.

Tips for Curriculum Developers

Choose an existing curriculum and materials, and modify them to meet local/national requirements

- There are already many life skills curricula and materials; thus, there is no need to create a new one entirely from scratch. (A sampling of life skills curricula and materials is listed in Annex A.)

Allow flexibility at the local and classroom level

- Built-in flexibility allows programs to respond to community concerns and questions as well as to students' questions.
- Time should be built in for students to ask questions anonymously and for follow-up discussion. This allows students to determine, to some extent, the content and direction of the course and makes it more relevant to them.

Involve young people in curriculum and materials design/selection/or adaptation

- Young people are more likely to "buy into" a program if they are involved in its development. Young people can help design important parts of the curriculum such as skits and discussion and debate topics. This helps ensure the relevance of the programs to young people.

Involve teachers in curriculum and materials design, selection, and adaptation

- "Buy-in" of teachers is crucial to program acceptance and implementation in the classroom. When curriculum development takes place only at the ministry level, teachers often feel that it is being imposed and fail to teach it.
- Teachers can offer valuable practical insight given their direct involvement with young people in the classroom.

Include other youth concerns in curricula, such as pregnancy and STI prevention

- Young people are often more concerned with the more immediate risk of pregnancy than with the risk of HIV, which will likely be dormant for several years. This is especially true in communities with low prevalence of HIV/AIDS.

Important Considerations for Curriculum Developers

Effective life skills curricula deliver and consistently reinforce clear messages about abstaining from sexual activity and using condoms or other forms of protection. This appears to be one of the most important characteristics that distinguishes effective from ineffective programs (Kirby, 2001a).

Programs should provide models of and practice in communication, negotiation, and refusal skills. Programs should last long enough to allow participants to complete important activities, at least 14 hours, and involve intense small-group exercises.

Programs should provide basic, accurate information about the risks of unprotected intercourse and methods to avoid it.

Programs should employ a variety of interactive teaching methods and include activities that address social pressures (including media) related to sex (Kirby, 1997).

In Africa, emphasis should be placed on personalizing the risk of HIV/AIDS (Kirby, 2001b).

Tips for Teacher Trainers

Train teachers in a variety of participatory methodologies

- For life skills programs to effectively impart skills, teachers must move beyond lecturing and rote learning styles and use a variety of interactive methodologies, including role playing, discussion, and debate.
- Trainees should be allowed enough time and support to master these methodologies through practice in the classroom.

Train a team from each school

- Training should go beyond those who will teach life skills in the classroom to include other interested staff. Trained teams are more likely to have shared values and skills, and can critique and support the change effort.
- Trainees who do not teach life skills in the classroom can reinforce and support classroom-based work.
- Teams may consist of interested teachers, school staff, youth educators, administrators, local health-care workers, and counselors.

Provide ongoing training and support

- The adaptation of participatory teaching methods by teachers will require ongoing encouragement and reinforcement. Such support may include peer coaching, working with a mentor teacher, peer support groups, and/or in-service training.
- Creativity may be needed to provide adequate in-service training under constrained budgets. Ministries should consider innovative ways of reaching teachers, such as radio programs.

Train teachers directly through pre- and in-service programs

- Well-trained teachers are essential for the acceptance and successful implementation of life skills, but even well-trained teachers will require ongoing training in both content and participatory teaching methods.
- The "cascade" model of training has weaknesses, with training being diluted at the district and head teacher level and rarely reaching classroom teachers. If this model is chosen, support teams may boost results.
- Teacher training should utilize personnel from the health sector, NGOs, or others.

Trainees must address their own attitudes and vulnerability

- In order to effectively facilitate life skills, teachers must learn to confront their own fears about HIV as well as their negative attitudes toward those with HIV and towards adolescent sexuality. They must acknowledge the ways in which HIV personally affects them.

Tips for Head Teachers and School Administrators

Establish links with influential stakeholders early on

- Interaction with youth, parents, teachers, religious leaders, local politicians, and other influential people in the community is very important at all stages.
- It is especially important to inform parents regularly about what the life skills courses will cover and to reassure them so they will not be embarrassed or uncomfortable and will be able to answer children's questions at home.

Select teachers with an interest in adolescent reproductive health, a healthy rapport with students, and the ability to be nonjudgmental

- Life skills is often taught by teachers of a particular subject, often biology or family life education. However, these may not be the most effective people to convey reproductive health messages. Some teachers may be uninterested in or embarrassed by the topic. Others may not have the trust of young people or parents.

While a limited number of teachers should be chosen to implement life skills in the classroom, a team-training approach is recommended

- Trained teams have shared values and skills and can critique and support the change effort.
- Trainees who do not teach life skills in the classroom can reinforce and support classroom-based work.
- Teams may consist of interested teachers and school staff, youth educators, administrators, local health-care workers, and counselors.
- School administrators can support and coordinate the work of these teams.

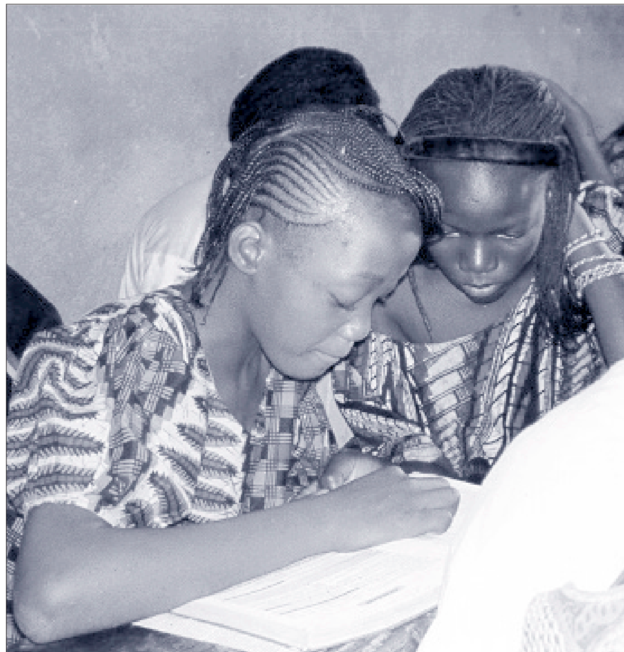
Encourage community participation

- In a well-designed life skills program, community participation is mandated by the education ministry. This encourages communities to share knowledge and participate in the dialogue, as well as builds local support for the program. This interaction allows the community to be involved in curriculum modifications, thus making the course more relevant to the local culture and increasing the likelihood that it will be taught. Public events may be organized by teachers and students. The events may be relevant to life skills, such as poetry or essay contests, concerts, plays, and other entertainment. Trained students can act as peer leaders in churches, mosques, or other community organizations. Students can design murals, posters, bulletin boards, and pamphlets and, with their teachers, make them accessible to the community.

- Parents should be encouraged to participate in designated life skills classroom discussions.

Encourage extracurricular HIV prevention activities

- These can include anti-AIDS clubs, peer education teams, outreach to out-of-school youth with HIV prevention messages, and care for those suffering from AIDS within the community.



Section III: Documents Reviewed

Academy for Educational Development. 2000. “Behavior Change Interventions.” Prepared for The Change Project, AED. Washington, DC.

Academy for Educational Development. 1997. “What the Experts Have to Say…About Implementing Teen Reproductive Health Activities: U.S. Experts Comment on Promising Approaches to Reducing Sexual Risk-Taking.” Prepared for The Change Project, Jamaica Adolescent Reproductive Health Project, AED. Washington, DC.

Agha, S. 2000. “An Evaluation of Adolescent Sexual Health Programs in Cameroon, Botswana, South Africa, and Guinea.” Population Services International Research Division Working Paper No. 29. Washington, DC.

Akoulouze, R., G. Rugalema, and V. Khanye. 2001. “Taking Stock of Promising Approaches in HIV/AIDS and Education in Sub-Saharan Africa: What Works, Why and How? A Synthesis of Country Case Studies.” Presented at the ADEA Biennial Meeting, October 7 – 11, 2001. Arusha, Tanzania.

Antones, M. C. et al. 1997. “Evaluating an AIDS Sexual Risk Reduction Program for Young Adults in Public Night Schools in Sao Paulo, Brazil.” AIDS 11: (suppl 1): S121-S127.

Baunni, E. and B. Jarabi. 2000. “Family Planning and Sexual Behavior in the Era of HIV/AIDS: The Case of Nakuru District, Kenya.” Studies in Family Planning 31: 1.

Birdthistle, I. and C. Vince-Whitman. 1997. “Reproductive Health Programs for Young Adults: School-Based Programs.” Prepared for FOCUS on Young Adults, Pathfinder International. Education Development .enter, Newton, MA.

Blanc, A. and A. Way. 1998. “Sexual Behavior and Contraceptive Knowledge and Use among Adolescents in Developing Countries.” Studies in Family Planning 29: 2.

Blum, R. 2000. “Healthy Youth Development as a Strategy to Improve Youth Health.” Presentation at USAID. Washington, DC.

Brown, A. et al. 2000. “Sexual Relations among Youth in Developing Countries: Evidence from WHO Case Studies.” Draft. UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development, and Research Training in Human Reproduction. Geneva, Switzerland.

CARE International. 1998. “’Don’t Trust Your Girlfriend or You’re Gonna Die Like a Chicken’: A Participatory Assessment of Adolescent Sexual Reproductive Health in a High Risk Environment.” Lusaka, Zambia.

Chown, P. et al. 1998. “Report of an Independent Evaluation of Three Projects in the UNICEF-Zimbabwe Programme on AIDS Prevention: In-School Youth AIDS Prevention, Out-of-School Youth AIDS Prevention, and Community Based Orphan Care.” Prepared for UNICEF. Harare, Zimbabwe.

Background

Tips for Planners

Tips for Curriculum Developers

Tips for Teacher Trainers

Tips for Head Teachers/ Administrators

Resources

Coombe, C. 2001. "Trauma Among South Africa's Learners: The Culture of Sexual Violence and Fear and the Culture of Deprivation." *Lifeskills within the Caring Professions: A Career Counseling Perspective for the Bio-Technical Age.* Van Schaik Publishers. Cape Town, South Africa.

Dowsett, G. and P. Aggleton. 1997a. "Community Responses to AIDS." UNAIDS Best Practice Collection. Geneva, Switzerland.

Dowsett, G. and P. Aggleton. 1997b. "Young People and Risk-Taking in Sexual Relations." UNAIDS Best Practice Collection. Geneva, Switzerland.

Education Development Center (EDC). 1997. "Promoting Reproductive Health for Young Adults through Social Marketing and Mass Media: A Review of Trends and Practices." Prepared for FOCUS on Young Adults, Pathfinder International. EDC. Newton, MA.

Education International. 1995. "Recommendations of the Conference on School Health and HIV/AIDS Prevention." Harare, Zimbabwe.

Eggleston, E. et al. 2000. "Evaluating of a Sexuality Education Program for Young Adolescents in Jamaica." Pan American Journal of Public Health 7(2): 102-111.

Erulkar, A. et al. 1998. "Adolescent Experiences and Lifestyles in Central Province Kenya." Population Council. New York, NY.

Gachuhi, D. 1999. "The Impact of HIV/AIDS on Education Systems in the Eastern & Southern Africa Region and the Response of Education Systems to HIV/AIDS: Life Skills Programmes." Prepared for UNICEF presentation at the All Sub-Saharan Africa Conference on EFA. Johannesburg, South Africa.

Garenne, M., S. Tollman, and K. Kahn. 2000. "Premarital Fertility in Rural South Africa: A Challenge to Existing Population Policy." Studies in Family Planning 31: 1.

Grosskurth, H. et al. 1995. "Impact of Improved Treatment of Sexually Transmitted Diseases on HIV Infection in Rural Tanzania: Randomised Controlled Trial." The Lancet Vol. 346.

Grunseit, A. 1997. "Impact of HIV and Sexual Health Education on the Sexual Behaviour of Young People: A Review Update." Prepared for UNAIDS. Geneva, Switzerland.

Hughes, J. and A. McCauley. 1998. "Improving the Fit: Adolescents' Needs and Future Programs for Sexual and Reproductive Health in Developing Countries." Studies in Family Planning 29: 2.

Human Rights Watch. 2001. "Scared at School: Sexual Violence against Girls in South African Schools." New York, NY.

Hunter, S. and J. Williamson. 1997. "Children on the Brink: Strategies to Support Children Isolated by HIV/AIDS." Prepared for USAID. Washington, DC.

Irvin, A. 2000. "Taking Steps of Courage: Teaching Adolescents about Sexuality and Gender in Nigeria and Cameroon." International Women's Health Coalition. New York, NY.

James-Traoré, T. 2001. "Developmentally Based Interventions and Strategies: Promoting Reproductive Health and Reducing Risk among Adolescents." FOCUS on Young Adults, Pathfinder International. Washington DC.

Jha, P. et al. 2001. "Reducing HIV Transmission in Developing Countries." Science Vol. 292.

Kelly, M. 2000. "Standing Education on its Head: Aspects of Schooling in a World with HIV/AIDS." Current Issues in Comparative Education, 3:1.

Kirby, D. 1997. "No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy." Prepared for the National Campaign to Prevent Teen Pregnancy, Task Force on Effective Programs and Research. Washington, DC.

Kirby, D. 1999. "Looking for Reasons Why: The Antecedents of Adolescent Sexual Risk-Taking, Pregnancy, and Childbearing." National Campaign to Prevent Teen Pregnancy. Washington, DC.

Kirby, D. 2001a. "Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy (Summary)." National Campaign to Prevent Teen Pregnancy. Washington, DC.

Kirby, D. 2001b. Personal communication. August 13, 2001.

Kirby, D. 1999. "Reducing Adolescent Pregnancy: Approaches that Work." Contemporary Pediatrics 16: 1.

Kipke, M., C. Boyer, and K. Hein. 1993. "An Evaluation of an AIDS Risk Reduction Education and Skills Training (ARREST) Program." Journal of Adolescent Health 14 : 533–39.

Lipovsek, V. et al. 2000. "Risk and Protective Factors for Unplanned Pregnancy among Adolescents in La Paz, Bolivia." FOCUS on Young Adults, Pathfinder International. Washington, DC.

Magnani, R. et al. 1999. "Correlates of Sexual Activity and Condom Use Among Secondary School Students in Urban Peru." FOCUS on Young Adults, Pathfinder International. Washington, DC.

Malambo, R. M. 2000. "The Views of Teachers and Pupils on the Teaching of HIV/AIDS in Basic Education: A Case Study of Zambia's Lusaka and Southern Provinces." Current Issues in Comparative Education 3: 1.

Mano Consultancy Services. 1998. "Adolescent Reproductive Health Evaluation Baseline Research." Prepared for Margaret Sanger Centre International Programme on Premature Parenting and STDs. Lusaka, Zambia.

Meekers, D. and G. Ahmed. 1997. "Adolescent Sexuality in Southern Africa: Cultural Norms and Contemporary Behavior." Population Services International Research Division Working Paper No. 2. Washington, DC.

Meekers, D. 1998. "The Effectiveness of Targeted Social Marketing to Promote Adolescent Reproductive Health: The Case of Soweto, South Africa." Population Services International Research Division Working Paper No. 16. Washington, DC.

McCauley, A. and C. Salter. 1995. "Meeting the Needs of Adults." Population Reports Series J: No. 41. Population Information Program, Johns Hopkins School of Public Health, Baltimore, MD.

National Academy of Science (NAS). 1996. "In Her Lifetime: Female Morbidity and Mortality in Sub-Saharan Africa." National Academy Press. Washington, DC.

Rwenge, M. 2000. "Sexual Risk Behaviors among Young People in Bamenda, Cameroon." International Family Planning Perspectives 26: 3.

Schenker, I. 2000. "Focussing Resources on Effective School Health: A FRESH Start to Improving Quality and Equity of Education: HIV/AIDS as a Model." World Health Organization. Presented at Workshop of the Impact of HIV/ AIDS on Education, September 2000. Paris, France.

Senderowitz, J. 2000. "A Review of Program Approaches to Adolescent Reproductive Health." Prepared for USAID, Bureau for Global Programs, Office of Population. Washington, DC.

Shepard, B. et al. 2001. "Youth Program Strategies in The Bill & Melinda Gates Foundation's Global Health Program: A Strategic Assessment." Prepared for The Bill & Melinda Gates Foundation. Seattle, WA.

Siamwiza, R. 1999. "A Situation Analysis of Policy and Teaching HIV/AIDS Prevention in Educational Institutions in Zambia." Prepared for the UNESCO/ UNAIDS Project on Integrating HIV/AIDS Prevention in School Curricula. Lusaka, Zambia.

Sloan, N., et al. 2000. "Screening and Syndromic Approaches to Identify Gonorrhea and Chlamydial Infection among Women." Studies in Family Planning 31: 1.

Smith, G., S. Kippax, and P. Aggleton. 2000. "HIV and Sexual Health Education in Primary and Secondary School: Findings from Select Asia-Pacific Countries." National Centre in HIV Social Research, The University of New South Wales. Sydney, Australia.

Stanton, B. et al. 1998. "Increased Protected Sex and Abstinence among Namibian Youth Following an HIV Risk-Reduction Intervention: A Randomized, Longitudinal Study." AIDS 12: 2473 – 2480.

Stewart, H et al. 2001. "Reducing HIV Infection among Youth: What Can Schools Do? Key Baseline Findings from Mexico, Thailand, and South Africa." Prepared for the Horizons Project. Washington, DC.

Swart-Kruger, J. and L. Richter. 1997. "AIDS-Related Knowledge, Attitudes, and Behavior among South African Street Youth. Reflections on Power, Sexuality, and the Autonomous Self." Social Science and Medicine 45: 6.

Tulane University and the Population Council. 2000. "Assessment of Life Skills Programmes: A Study of Secondary Schools in Durban Metro and Mtunzini Magisterial Districts." Prepared for the Horizons Project, Population Council, and FOCUS on Young Adults, Pathfinder International. Durban, South Africa.

UNAIDS Inter-Agency Working Group. 1997. "Integrating HIV/STD Prevention in the School Setting." Geneva, Switzerland.

UNAIDS. 1997. "Learning and Teaching about AIDS at School." UNAIDS Best Practices Collection. Geneva, Switzerland.

UNAIDS. 2000a. "Consultation on STD Interventions for Preventing HIV: What is the Evidence?" UNAIDS Best Practice Collection. Geneva, Switzerland.

UNAIDS. 2000b. "Men and AIDS—A Gendered Approach." UNAIDS Best Practices Collection. Geneva, Switzerland.

UNICEF/Myanmar and Population Council/Thailand. 2000. "A Participatory Evaluation of the Life Skills Training Programme in Myanmar." The Population Council, Inc. New York, NY.

USAID. 2001. "Promoting Youth Responsibility for Reproductive Health: Request for Assistance." Global Population, Health, and Nutrition Bureau. Washington, DC.

U.S. Bureau of the Census. 2001. Bureau of Census International Data Base. www.census.gov/cgi-bin/ipc/idbagg (online, cited September, 2001).

Van Rossem, R. and D. Meekers. 1999. "An Evaluation of the Effectiveness of Targeted Social Marketing to Promote Adolescent and Young Adult Reproductive Health in Cameroon." Population Services International Research Division Working Paper No. 19. Washington, DC.

Weiss, E., D. Whelan, and G. Gupta. 1996. "Vulnerability and Opportunity: Adolescents and HIV/AIDS in the Developing World." Findings from the Women and AIDS Research Program. International Center for Research on Women. Washington, DC.

WHO. 1993. "Sex Education Leads to Safer Behavior." Global AIDS News (Newsletter of the Global Program on AIDS of the WHO), No. 4.

Zabin, L. and K. Kiragu. 1998. "The Health Consequences of Adolescent Sexual and Fertility Behavior in Sub-Saharan Africa." Studies in Family Planning 29:2.

Annex A: Additional Resources

The AIDS Badge Curriculum
World Association of Girl Guides and Girl Scouts
www.wagggsworld.org
Twenty-three pages with some activities for girls aged 10 and over.

Choose A Future!: Issues and Options for Adolescent Girls
and
Choose A Future!: Issues and Options for Adolescent Boys
Center for Development and Population Activities (CEDPA)
1717 Massachusetts Avenue, NW Suite 200
Washington, DC 20036
USA
www.cedpa.org/publications/index.html
For adolescents.

Developmentally Based Interventions and Strategies: Promoting Reproductive Health and Reducing Risk among Adolescents
FOCUS on Young Adults
1201 Connecticut Avenue, Suite 501
Washington, DC 20036
USA
www.pathfind.org/guides-tools.htm
This document may be especially useful for those working with pre-adolescents. Gives key developmental characteristics and suggested activities for children aged under 10, 10 to 14, and 15 and up.

www.pathfind.org/publications.htm
This site has documents with findings from the FOCUS on Young Adults Program, including school-based prevention programs, peer mentoring, and country level examples of successful programs.

The Handbook for Evaluating HIV Education
Centers for Disease Control and Prevention (CDC)
Division of Adolescent and School Health Information Service
1600 Clifton Road
Atlanta, GA 30333
USA
www.cdc.gov/nccdphp/dash/evaluation_manuals/hiv.htm
This large, bound document includes a booklet entitled "Appraising an HIV Curriculum" as well as policy formulation guidelines and assessment instruments.

Life Planning Education: A Youth Development Program
Advocates for Youth
1025 Vermont Avenue NW Suite 200
Washington, DC 20005
USA
www.advocatesforyouth.org/publications/catalog.htm
Geared toward adolescents but chapters on values, communications, relationships, goals, decision-making, etc. can be modified for young children.

Life Skills and HIV/AIDS Education, Department of Health
School Life Skills and HIV/AIDS Education Programme
HIV/AIDS Directorate
National Department of Health
Private Bag X 828
Pretoria
South Africa
Tel: +27 12 312 0048
Fax: +27 12 323 7323
Grades 1 - 7 training of master trainers manual, teacher resource guides, and student activity books for life skills curriculum.

NAFCI Values Clarification Facilitators Manual
Reproductive Health Research Unit, Chris Hani Baragwanth Hospital
P.O. Bertsham 2013
South Africa
kimdt@acenet.co.za
This manual is designed to be used with health care providers and allow them to confront negative attitudes towards adolescent sexuality. Many sections may be useful in teacher training.

National AIDS Programmes: A Guide to Monitoring and Evaluation
UNAIDS
20 Avenue Appia
1211 Geneva 27
Switzerland
www.unaids.org/aidspub/list.asp
Offers potential indicators for measuring impact as well as data collection instruments and guidelines.

Peace Corps Life Skills Manual
Center for Field Assistance and Applied Research
Information Collection and Exchange
1111 20th Street NW Fifth Floor
Washington, DC 20526
www.peacecorps.gov/publications/field_download.cfm
Geared toward adolescents.

School Health Education to Prevent AIDS and STD:
A Resource for Curriculum Planners
WHO and UNESCO
www.unesco.org/education/educprog/pead/CadAIDGB.html
For adolescents. Document includes Handbook for Curriculum Planners, Students' Activities, and Teachers' Guide.

Soul Buddyz Magazine and classroom activity materials
Soul City
77th Avenue Houghton
P.O. Box 1290
Houghton, 2041
South Africa
soulcity@aztec.co.za
Soul City has developed a range of activities for young people of all ages.

Training and Resource Manual on School Health and HIV/AIDS Prevention
Education International
World Health Organization
ei-ie.org/main/english/index.html
This manual is very long but very useful for those developing teacher training for pre-adolescent and adolescent life skills. Also designed for working with teachers' unions.

When I'm Grown: Life Planning Education for Grades K – 6
The Center for Population Options
1025 Vermont Avenue, NW Suite 200
Washington, DC 20005
A collection of discussions and participatory activities developed for use in the U.S. but several sections can be modified for African primary schools. Topics include self-understanding, family, growth and development, and sexuality.