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YouthNet

Teacher Training: Essential for School-Based Reproductive Health and HIV/AIDS Education Focus on Sub-Saharan Africa



Tijuana A. James-Traore, William Finger,
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Tijuana James-Traore, a trainer and consultant who has worked with curricula for many years, developed a report for YouthNet on teacher training, based on interviews with more than two dozen stakeholders in Kenya and Uganda, a focus group in Uganda, and a review of the literature on teacher training. Stephanie Savariaud, a freelance writer based in Johannesburg, attended a meeting on teacher training held in South Africa in the fall of 2003. Forty experts from seven African countries attended the meeting, which was sponsored by InWent, a capacity-building agency funded by the German government. Her reporting from that meeting and those experts was integrated into this paper. YouthNet writers William Finger and Claudia Ruland contributed additional research and writing to the final paper.

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Table of Contents

Introduction	2
Chapter 1. Teachers Play Critical Role	3
Chapter 2. Teacher Training – Evidence and Impact	6
Chapter 3. African Setting Poses Challenges	8
Chapter 4. Teacher Training Projects in Africa	12
Chapter 5. Teacher Selection	17
Chapter 6. Assessing Teacher Training Curricula	18
Chapter 7. Observations and Conclusions	22
References	25

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Introduction

Teacher training in any subject is important. For teaching information and skills related to reproductive health (RH) and HIV/AIDS, teacher training is even more essential – and complex. In many countries of sub-Saharan Africa, the AIDS epidemic has spread to the general population, with up to half of all new HIV infections occurring among youth under age 25. Since most youth attend school at least for primary education, school-based programs are a logical place to reach young people. Understanding the importance and techniques of teacher training in sexuality education in Africa is particularly urgent.

The 2001 United Nations General Assembly Special Session on AIDS sought to ensure that by 2005, at least 90 percent of the world's youth have access to information and education necessary to reduce their vulnerability to AIDS. Teachers are a crucial link in providing valuable information about reproductive health and HIV/AIDS to youth. But to do so effectively, they need to understand the subject, acquire good teaching techniques, and understand what is developmentally and culturally appropriate. Teacher attitudes and experiences affect their comfort with, and capacity to teach about, reproductive health and HIV/AIDS. The *pre-service* setting offers an opportunity for future teachers to explore their own beliefs and concerns about these topics, while *in-service* training allows those already teaching to assess their views and increase their competence and confidence.

This paper addresses a topic that lacks extensive research and evaluation but is critical to advancing the needs of youth. The first two chapters put teacher training in the context of school-based RH/HIV education and summarize the limited research available on the topic. The paper then focuses on the African context, identifying particular challenges (Chapter 3) and summarizing teacher training projects in Ghana, Kenya, Uganda, and Zimbabwe (Chapter 4). The next two chapters assess two key aspects of the topic: the selection of teachers and the elements of a teacher training curriculum. The closing chapter presents summary observations and conclusions.

We hope this paper proves useful to ministries of education, teachers associations, teacher training schools, nongovernmental organizations working to expand RH/HIV education, and ultimately, through these groups to youth themselves. We welcome your comments on this report.

— Nancy E. Williamson, YouthNet Program Director

Chapter 1. Teachers Play Critical Role

Teachers are often the main adults other than family members with whom young people interact on a daily basis. In an era of HIV/AIDS, teachers play an even more critical role of being a source of accurate information and a person with whom young people can raise sensitive and complicated issues about sexuality. As the AIDS epidemic spreads, the need becomes more urgent for teachers to discuss AIDS in the context of human development, sexuality, and pregnancy prevention. Teachers also need to know how to protect their own health and the importance of not putting any of their students at risk through their own behaviors.

Ideally, as trusted gatekeepers of information, teachers can be instrumental in imparting knowledge and skills to young people. Teachers can function as role models, advocates for healthy school environments, guides for students in need of services, resources for accurate information, mentors, and effective instructors. But to meet these expectations in the AIDS era, teachers need skills and knowledge as well as support from the educational system and broader community.

Sexuality and reproductive health (RH)/HIV education are often controversial because some individuals believe that talking about sexuality in schools may increase sexual activity. However, according to two exhaustive reviews of studies by the World Health Organization (WHO) and the U.S. National Campaign to Prevent Teen Pregnancy, sexuality education programs do not lead to an increase in sexual activity among young people. Even more encouraging, the reviews found that effective RH/HIV education in schools can result in delaying first intercourse or, if young people are already sexually active, increasing use of contraception.¹

Both reviews found that teacher training — including the kind of preparation, training, and support a teacher receives — is a key component of a successful school-based RH/HIV program. The analysis of 250 evaluations of U.S. sexuality education programs identified one of the key elements that led to greater behavior change to be a teaching approach that actively involves students, is skill-based, and uses real-life situations.² A recent analysis of 11 school-based HIV prevention programs for African youth also identified teacher training as critical. “If a program is to be faithfully implemented, teachers must be properly trained for and committed to it,” the analysis concluded.³

The HIV/AIDS epidemic in developing countries has resulted in more attention to developing student curricula and training teachers to use the curricula. “All ministries of education are implementing one or more interventions to combat the epidemic in the education system,” reported the Association for the Development of Education in Africa in a 2001 review of regional



Teachers can serve as guides, role models, and resources for school children, such as these pouring out of a school in Mali.

programs. “There is need for policies and programs to impart requisite skills so that teachers may feel confident to teach about HIV/AIDS and issues of sexuality.”⁴ The report emphasized the importance of a supportive environment for teacher training, including the broader community as well as the education ministries.

Ideally, teacher training supported by nongovernmental organizations (NGOs) or international organizations would be linked to governments from the national to the local level. Working with the appropriate governmental agencies can help ensure that activities are coordinated across programs and that messages are acceptable and consistent. Government support and commitment can help the sustainability of teacher training so that such training is less dependent on donor funding and guidance.

Broad View of Training Important

The ultimate goal of teacher training for RH/HIV is to improve students’ knowledge, attitudes, and behaviors regarding reproductive health and HIV. But effective training first has to have an impact on the teachers themselves, helping them examine their own attitudes toward sexuality and behaviors regarding HIV prevention, understand the content they are teaching, learn participatory teaching skills, and gain confidence to discuss sensitive and controversial topics.

Increasingly, countries are beginning to offer RH/HIV education in schools for younger youth (i.e., ages 8 to 12). Some teachers will need to know how to relate to students of different ages and use different materials and strategies. In addition, meeting the needs of students requires an ability to relate to young people, build trust in the classroom, and be a good listener. No subject requires better communication skills with students than teaching about sexuality, reproductive health, and HIV/AIDS.

Teacher training in the context of RH/HIV often challenges existing norms for educational institutions and the community. As communities take a greater interest in the topic, some may want to include only limited information, for example, eliminating any discussions of condoms from a curriculum. Sexuality education may not be considered as important as reading or mathematics, and given the usual limitations on resources and time, it may be the first subject to be reduced or eliminated from a school curricula. Reproductive health material is not usually on examinations because the content is often taught as part of an after-school club or is not part of the national curriculum, leading teachers to spend less time on it compared to those subjects on which their students will be tested. Teachers need preparation, skills, and support in dealing with all of these issues.



Teachers need training to use a variety of materials, including comic books that appeal to youth. These images are from *Good Health*, used by the Kenya Institute of Education.

Teachers may need to work within the community in order to facilitate their work in the classroom. During the 1980s, for example, “with a group of friends, we would go to a church service and ask the priest for ten minutes to talk about HIV/AIDS,” says Jane Mulemwa, now deputy chairperson of the Ugandan Education Service Commission. “We would do the same with doctors and nurses. Once the community is more open, it is easier in the classroom.”

Teachers also need skills in dealing with management issues in school systems and local schools. For example, teachers and schools may need to go beyond structured classroom settings and work with local NGOs on such issues as orphans and school fees. “Our thinking is trapped in the box of the conventional concept of a school being a supplementary institution, which presupposes that the pupils come from stable and secure homes that provide them with general care and support,” says Professor Wally Morrow, South Africa Ministerial Committee on Teacher Education. Conditions are far different in many countries, especially those in Southern and East Africa with high HIV prevalence, where orphans and others may not be able to attend traditional schools.

Involving the community in pre-service teacher training can also be helpful. Dixie Maluwa Banda, head of Education Foundations Department at the University of Malawi, tried to get a traditional chief to come and talk to students training to be teachers. “The chief said that he would rather have the students come to the village, and when they arrived he took them to see the graveyards. He explained that in his lifetime he had never seen so many recent graveyards,” says Maluwa. The visit to the village as a non-conventional teacher training method had great impact on these students.

Ultimately, teacher training should not be viewed in isolation from the larger community. David Mbetse, a geography teacher in South Africa, attended training in sexuality education over the objection of the head of the school. He then taught the subject to his pupils, whose parents reported him to the head of the school for non-Christian behavior. “From then on, I had to go and talk to people within the community to explain what this training was for and to sensitize

Terms Used in This Paper

In this document, the terms *teacher training curriculum* and *teacher training* refer to RH/HIV issues, and not to broader education reform issues or teacher training in general.

The term *reproductive health (RH)/HIV*, as used in this paper, refers to various types of curricula, some of which have more focus on HIV and AIDS, and some of which focus more closely on reproductive health issues. For clarity, RH/HIV refers to all curricula, whether they concentrate more heavily on RH or HIV. Please note that along with the catastrophic HIV epidemic, youth have important RH-related needs and issues, including sexual violence, treatment of other sexually transmitted infections (STIs), provision of contraception for sexually active youth, and elimination of harmful traditional practices such as female genital cutting and early marriage for girls.

them to HIV/AIDS,” he says. He subsequently managed to convince the head of the school to have some people living with AIDS talk to the pupils and to establish support groups.

Materials to assist teachers with these multiple tasks and to supplement formal teacher training curricula are beginning to emerge. For example, WHO together with Education International, a membership group of nearly 300 national unions of teachers and workers in education, produced a manual emphasizing how teacher training fits into the broader framework of teachers’ lives. The manual can be used in training workshops to help teachers gain skills to reduce HIV infection among themselves, skills to strengthen their ability to advocate and build support for effective RH/HIV prevention in schools, and skills in teaching developmentally appropriate curricula for young people.⁵

Chapter 2. Teacher Training – Evidence and Impact

Although reviews of sexuality education programs have emphasized the importance of teacher training, little research has addressed issues such as which type of training works best, how long the training should last, and how to involve the community in training. The topic of teacher training can include not only the training itself but also what types of people receive the training, the degree of support for teachers by the school system and community, and the issue of teachers covering only certain aspects of a curriculum (e.g., omitting controversial segments).

Research has found that teacher training can positively affect teacher attitudes toward sexuality education and participatory techniques. In Thailand, 35 teachers received training that emphasized a better understanding of young people and their environment, the teachers' own attitudes and values toward HIV/AIDS and sexuality, and learning and practicing key skills in facilitating HIV/AIDS and sexuality training. Using pre- and post-tests and interviews, researchers found that following the training, the teachers had more knowledge and understanding of HIV/AIDS, more positive attitudes toward young people's sexuality and toward people living with HIV/AIDS, an increased willingness to use participatory methods, stronger facilitation skills, increased communication and better relationships with students, and a greater commitment toward teaching about sexuality and HIV/AIDS.⁶



Some research has shown that teacher training incorporated into a broader school district intervention can influence students' behaviors. A project in the Soroti district of Uganda with students ages 13 to 14 included teacher training on RH/HIV in the existing structures of the school district, using a health educator, the local teacher training college, and other resources. Two years after the baseline survey, students whose teachers had received



the training reported a significant decline both in having sexual intercourse in the past month and in the average number of sexual partners. The control group did not have similar reductions. The study concluded, "to have an impact on behavior, the quality of delivery of the curriculum and [teaching] strategies must be of sufficient quality and intensity. The quality of the implementation is probably more important than the detailed design of materials or curricula."⁷ (For more detail on this intervention, see page 14.)

Life skills programs that addressed HIV/AIDS issues are more effective when teachers explore their own attitudes and values, establish a positive personal value system, and nurture an open, positive classroom climate.

Factors Beyond Training

Research points to several factors beyond teacher training itself that affect the impact on students. A project in rural Masaka, Uganda, provided five days of training to teachers, adapting portions of an AIDS prevention curriculum developed by WHO. Surveys involving more than 2,000 students in intervention and control sites, plus 12 focus groups with 93 students, found very little impact on the students. The research found that the program was not fully implemented and class

time was too short. Also, teachers did not address some of the major HIV/AIDS prevention issues due to fear of community disapproval and controversy and lack of supportive guidance. The research team recommended that the program be integrated into the national curriculum and that teachers be trained in participatory methods while still in teacher training college.⁸



In Jamaica, teachers who were trained in using experiential teaching methods, participatory exercises, role-plays, and the performing arts were more likely to use those methods in their classrooms than those without the training. However, changes in behavior in the students were not significantly different from those students not exposed to the new curriculum. Researchers

attribute the lack of change at least partially to the fact that the intervention was implemented for only one semester of the school year.⁹ Other reasons included the lack of supplies, lack of administrative support, not enough monitoring of the teachers, and few refresher courses.



A recent UNICEF review of projects in East and Southern African concluded that life skills programs that addressed HIV/AIDS issues are more effective when teachers explore their own attitudes and values, establish a positive personal value system, and nurture an open, positive classroom climate. Programs appear to be more effective when teachers use a positive approach emphasizing awareness of values, assertiveness, relationship skills, decision-making, real-life situations, and self-esteem.¹⁰

Chapter 3. African Setting Poses Challenges

In the 1960s, population education programs sought to create awareness about the relationship between the benefits of smaller family size and national development. Family life education (FLE) or life planning skills education programs included parts of population education and added decision-making, family issues, and parental responsibilities. Few FLE programs, however, included sexuality and reproductive health information, such as sexual behavior and contraception. The few attempts to provide sexuality education in schools were seldom implemented, and when tried, controversy often led to their demise.¹¹

As the AIDS epidemic moved into the general population, many African countries embraced the need for a more formal education process to teach youth about HIV/AIDS, including, in some cases, broader issues of sexuality. A study by the Population Council in Kenya, for example, found that a large majority of primary and secondary school teachers, as well as parents and guardians, approve of the teaching of adolescent growth and development, including topics such as STIs and AIDS, family and gender roles, reproductive physiology, and puberty and menstruation. Support is weakest for teaching sexuality and family planning — though even family planning, the least popular subject, is supported by about 40 percent of primary teachers and parents. About 80 percent of secondary school teachers approve of teaching family planning in secondary schools.¹²

While the HIV/AIDS crisis has resulted in new attention to sexuality education in schools, Africa's educational system is struggling to adapt meaningful education tools. Inadequate funding and poor infrastructure plague education systems throughout sub-Saharan Africa. Teachers overwhelmingly report a shortage of teaching materials, and available materials are often outdated. In many countries a shortage of teachers has resulted in younger, less-experienced teachers who have not had training in teaching RH/HIV issues.

Increasing the emphasis on RH/HIV education in pre-service training programs is a cost-effective place to start and can go to scale through the mandates of ministries of education, reaching even remote areas within countries.¹³ While pre-service training offers an excellent opportunity to shape the thinking and style of teachers before they enter the profession, RH/HIV is not always covered at this level of training. So efforts at the pre-service level should be increased.

Meanwhile, in-service training programs for those already teaching are taking place in some countries, often sponsored by international organizations or local NGOs. Sometimes these initiatives are supported by the government and linked to its ministry of education. In other cases, they function as separate activities and lack sustainability. In-service training programs can vary from a few hours to several weeks.

Within the sub-Saharan African context, the goal of teachers to be a primary source of RH/HIV education faces three particular challenges. First, educational policies and local practices have to deal with community sensitivity to the topic of sexuality. Second, the issue of attrition of teachers related to the AIDS epidemic is becoming

more pronounced. Third, sexual abuse of students by teachers has become recognized as a major problem.

Policies, Practices, and Community Norms

All youth need information on abstinence and delayed sexual initiation as well as RH/HIV issues. Sexually active young people may need RH/HIV services such as STI treatment, condoms, other contraceptives, or voluntary counseling and testing for HIV. An important prerequisite to school-based programs themselves, and subsequently effective teacher training, are clear policies and guidelines supporting young peoples' access to both information and services. These policies should be widely known by teachers and service providers and should be implemented.

In a survey by Education International of its member teacher unions, 84 percent of those responding, most of them in Africa, said they received little or no support from reinforcing policies on the prevention of HIV/AIDS and related discrimination.¹⁴ Where supportive policies have not been adopted, administrators at the local level may have to cope with input from

religious groups and other stakeholders who may object to aspects of a curriculum, particularly discussions about condom use for those already sexually active.

Without clear guidance from mandated policies, teachers may avoid controversial areas. Evaluations of teacher training programs show that teachers frequently fail to teach topics in which they have been trained because they feel uncomfortable with the subject, they are inadequately trained, or they lack materials.¹⁵ A review of 11 African school-based HIV prevention programs identified selective teaching as a problem, especially regarding controversial areas such as condom use.¹⁶ An in-depth analysis of how an HIV/AIDS curriculum was taught in western Kenya (and in a state in India) by Action Aid, a United Kingdom-based group, found that some teachers select which messages to give, choose not to teach HIV at all, or rely "solely on messages on abstinence.... Sexually active youths will not only feel excluded from messages forbidding premarital sex, but will also have limited access to potentially life-saving information."¹⁷



An inadequate infrastructure contributes to the challenges facing teachers in this school in rural Kenya and other parts of Africa.

To change policies and social norms, policy-makers need to consider the factors that deter teachers from discussing controversial areas, including the influence of religious institutions, the fear of being fired, teachers' personal beliefs, and a general belief that discussions about condoms will encourage promiscuity. Clear policies and procedures, careful selection of teachers for training, ongoing training and support, and frequent teacher monitoring and supervision are required to minimize this problem.

When courses are not mandated nationwide, teacher training may be less uniform and more unpredictable. "Some reproductive health training in guidance and counseling courses cover more theory and concept rather than real situations with youth," says Joy Mukaire, former Ugandan country representative for the U.S.-based Pathfinder International. A teacher training program in Uganda includes training about sexuality in a course on "Christian Religion and Ethics," which emphasizes Christian approaches to marriage, dating, relationships, human sexuality, homosexuality, drug abuse, and other subjects, with less detail on contraceptive methods, including condom use.

Debates exist about whether RH/HIV training should be a separate course or integrated into the general curriculum.

The recent UNICEF review of life skills programs in Africa found that placing education about STIs and HIV within the context of personal development, health, and living skills often works better than integrating the material into other subjects where it may get lost.¹⁸

Policies in Africa are not clear on how long the teacher training needs to be, the role of refresher courses, and

needs for supervision and monitoring. A review of teacher training in Nigeria and Cameroon emphasized that developing expertise in sexuality education takes training, practice, feedback,

supervision, refresher training, and time.¹⁹ Also, refresher training solidifies and reinforces the gains made during initial training. When one trained teacher repeated the same basic training course after an interval of two years of teaching, she remarked that she learned more from the second course than from the first because now she knew exactly what she needed to know.

Teacher Attrition Due to AIDS

The HIV/AIDS-related attrition of teachers and managers in African educational systems is alarming. Mortality, morbidity, and absenteeism in high-prevalence countries are expected to increase rapidly over the next 10 to 15 years. The World Bank estimates that in Kenya, Zambia, and Zimbabwe, about 1.5 percent of the teaching profession is lost each year to AIDS, and that the percentage of teachers who are HIV-positive is more than 30 percent in Uganda and Malawi, 20 percent in Zambia, and 12 percent in South Africa.

Teacher attrition due to HIV/AIDS leads to deteriorating educational systems through stress on the human-resource base, worsening ratios of educators to students, loss of experienced teachers, increased demands on staff health benefits, and pressure on educator training colleges to keep pace with the demand for new teachers.

The United Nations, as part of its Millennium Development Goals, seeks to achieve "education for all" by 2015. This goal seriously strains the capacity of many educational systems in Africa to produce adequate numbers of trained teachers, says Bradford Strickland, senior education advisor at the U. S. Agency for International Development (USAID) Africa Bureau. "The strain on human resources from HIV-related illnesses and death makes it even harder to correct existing shortages. In Zambia, for instance, the Ministry of Education trains 2,000 teachers each year, while annual losses from all mortality average around 1,000 per year. Attrition from other causes still has to be added to the losses from mortality."

Sexual Harassment of Students by Teachers

A growing body of research has documented the problem of sexual harassment of students by teachers. In one Ugandan district, 31 percent of schoolgirls and 15 percent of schoolboys reported

While the HIV/AIDS crisis has resulted in new attention to sexuality education in schools, Africa's educational system is struggling ... inadequate funding ... poor infrastructure ... a shortage of teaching materials ... a shortage of teachers.

having been sexually abused, primarily by teachers.²⁰ During interviews and the focus group discussion in Uganda for this paper, students as well as teachers cited many instances of teachers and students engaging in sexual relationships, some of which resulted in pregnancies. Students stated that they generally knew which teachers were involved in sexual relationships or engaged in other inappropriate sexual behaviors. Thus, these teachers would have no credibility with students when teaching RH/HIV content. Many communities remain silent on this issue, either feeling pressured not to respond or feeling helpless to do anything about it.

The most common pattern is sexual relationships between male teachers and female students, which reflects traditional gender-based power differentials and patterns of cross-generational sex. In such situations, the female student will be the one who has to deal with a pregnancy resulting from this sexual exploitation and will likely have to quit school.

Attitudes of teachers are often shaped by a culture that promotes gender inequity or sexual harassment. However, past experiences can be

overcome. A project in South Africa revealed that after receiving training, teachers were less likely to support gender-based violence and felt confident to discuss this issue in the classroom. Of the teachers who received training, 47 percent were women who had previously experienced physical abuse from a partner, while 25 percent were male teachers who previously reported that they had been physically abusive to a partner.²¹

The South Africa project used both a “train the trainers model” and a “whole school” model. The “train the trainers” model educated two representatives from each of the selected schools and relied on these representatives to relay the training to others. The “whole school” model trained all school employees, including the administration and the cleaning staff. While both approaches led to significant changes in teachers’ perceptions about the role of school in addressing gender-based violence, the “whole school” model resulted in a greater commitment from school management. This finding suggests the important role that school administrators play regarding such sensitive topics as sex education and gender violence in the schools.

Chapter 4. Teacher Training Projects in Africa

A review of teacher training and curriculum design activities in 16 countries in sub-Saharan Africa revealed various stages of development. Below are short summaries of activities in Malawi, Mozambique, and Nigeria, followed by longer discussions of teacher training projects in Ghana, Kenya, Uganda, and Zimbabwe. Teacher training in RH/HIV is at various stages of development in Botswana, Burkina Faso, Cameroon, Ghana, Namibia, Rwanda, Senegal, Swaziland, Zambia, and other countries reviewed for this paper.

In Malawi, USAID, UNICEF, and the Ministry of Education are developing a pre-service training curriculum for use in the seven teacher training colleges in that country, adapting a life skills curriculum developed by UNICEF. At the same time UNICEF, the Swedish International Development Agency (SIDA), and UNFPA are developing an in-service curriculum for primary school teachers in standards 5 to 8.

In Mozambique, the Ministry of Education is revising its 1996 teacher training curriculum and has developed a strategy to train teachers in the new curriculum in all 410 teacher training centers in the country, both pre- and in-service.

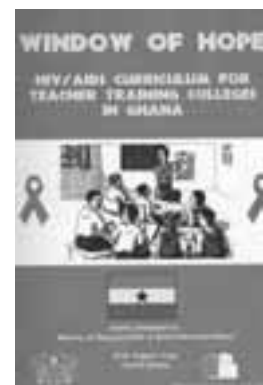
In Nigeria, guidelines for comprehensive sexuality education have been developed, using international guidelines developed by the Sexuality Information and Education Council of the United States (SIECUS). The Association for Reproductive and Family Health is training teachers in Oyo State to teach reproductive health in secondary schools.



Ghana

A project called Strengthening HIV/AIDS Partnerships in Education (SHAPE) has included teacher training as a key component of its efforts to improve HIV/AIDS education in schools. SHAPE is using a curriculum called “Window of Hope” to train teachers in HIV/AIDS issues at teacher training colleges. Sponsored by the Ministry of Education and USAID/Ghana, SHAPE is being implemented by World Education.

In 2003, the project conducted baseline research with teachers at 10 of the 41 teacher training colleges to gain understanding of the future teachers’ HIV/AIDS knowledge, attitudes, and practices. A total of 1,752 teacher trainees were randomly selected to complete the questionnaire, and qualitative data were obtained from 80 trainees who participated in eight focus groups. The findings will be compared to data gathered after the implementation of the Window of Hope curriculum at the colleges. As part of the larger effort, the project also conducted a two-day sensitization session on HIV/AIDS for the tutors, those who teach the curriculum to the trainees.



Findings indicate that myths regarding HIV transmission and prevention exist and that many trainees do not consistently practice HIV prevention in their own lives. Almost all trainees acknowledged that they are at risk of HIV infection. The majority of trainees knew of at least one situation when a student was having a sexual relationship with a teacher. The analysis of the assessment found that “education is needed specifically in the areas of myths of transmission, use of consistent prevention methods, stigma of people living with AIDS, student/teacher abuse, and confidence in discussing HIV-related issues with students.”²²

Late in 2003 and early in 2004, SHAPE and the Ministry of Education conducted monitoring and support visits to 37 of the 41 teacher training colleges. The visits sought to ensure that the Window of Hope training curriculum was being delivered properly and effectively, including the use of participatory facilitation techniques, experiential activities with supportive materials and exercises, and the proper amount of time. The monitoring found both positive and more challenging developments.

Among the positive findings were that some colleges have established relationships with local NGOs and community groups to supplement the curriculum and the work of the tutors. Younger tutors have embraced the experiential nature of the curriculum, but the older tutors tend to rely on traditional lectures and didactic methods. Some colleges have already added AIDS prevention clubs, which provide training for students wanting to be peer educators.

Challenging findings included the fact that some colleges lack the resources needed for all of the exercises, including flip charts, VCRs, and photocopiers. A lack of clarity existed in some colleges about whether the curriculum is to be integrated into other subjects or taught separately. Also, some tutors and students were not taking the curriculum seriously because it currently is not an examinable subject, although this may change next year.

“This is a new subject area with new materials, with newly trained tutors using new methodologies and institutions not experienced in these areas,” the recent report of the project

explained. “To expect smooth integration in the first year of implementation would be presumptuous. The need for refresher training, constant support, and institutional arrangements will continue to require the attention of the Ministry of Education and its partner in the fight against AIDS, the SHAPE project, for some time.”



Kenya

In six rural communities in western Kenya, from 1999 to 2003, a project targeting youth ages 10 to 19 sought to build the capacity of teachers to teach sexuality education. The effort was coordinated by the Population Council in collaboration with the Program for Appropriate Technology in Health (PATH) and the Kenyan ministries of education, health and gender, sports, and culture as part of a larger operations research project.

About 100 teachers from primary and secondary schools were trained in content and participatory methods. Teams comprised of three teachers and the headmaster from 33 schools, including five secondary and 28 primary schools, attended the trainings. Guidance and counseling staff were also trained to provide counseling, and each school was required to provide a designated room for counseling. Refresher courses were offered once a year, and bimonthly meetings were held for teachers on thematic areas using other technical experts. Each theme was also the area of focus for the teachers’ work with students for that quarter.

Each student was supposed to receive 12 to 33 hours of instruction in units of one to two hours, with the longer time preferable to allow for greater interaction with students. The curriculum was originally developed by PATH and included a full range of RH and HIV topics. In most schools, the RH/HIV content was taught as an extra-curricular



activity, although all students were expected to participate. Each school had its own arrangements for when the course was offered. Some offered it during physical education class, some on weekends, and others during lunch.

Religious leaders approached the project, asking to become involved. Consequently, about 80 of these leaders were trained in adolescent health and sexuality. Since many of the schools had a religious affiliation, agreement had to be reached on the curriculum content. As a result, issues like condom use and homosexuality were not included in the intervention, although the teachers still were expected to teach issues related to HIV/AIDS and other sexually transmitted infections.

Ministry of Education supervisors provided monitoring and support for the teachers once per term (there are three terms per year) using a monitoring checklist. These supervisors were trained in supportive supervision and were provided with additional skills to offer technical assistance should problems arise. More difficult problems were referred to the project's field coordinator.

The project did not analyze changes in teacher methodologies or attitudes as a result of the project but instead focused on knowledge, attitudes, and behaviors with students, who received other community interventions as well. The data suggested that teachers are the most reliable source

Teachers reported that their training helped them to carry out a Kenyan government mandate to provide students with information on HIV/AIDS.

of information for youth ages 10 to 14 and that the project promoted more openness and willingness to discuss issues at all levels of the community. In addition, while the project was underway, the Kenyan government mandated that schools provide students with information on HIV/AIDS. Teachers in the school intervention areas reported that their training in the life skills curriculum enhanced their ability to carry out this mandate.



Uganda

In the early 1990s, as part of a multisectoral, highly publicized AIDS prevention program endorsed by the president of Uganda, the Uganda AIDS Commission developed a National Operational Plan that emphasized abstinence, delayed sexual debut, and mutual faithfulness as the highest priority strategies for youth ages 11 to 20. The use of condoms was considered a secondary strategy. Efforts to train teachers to teach sexuality education operated in that context, with data indicating that substantial increases in abstinence among youth did occur where teachers were trained.

From 1994 to 1996, the African Medical and Research Foundation (AMREF) coordinated a school-based project in 95 primary schools in the Soroti district in northeastern Uganda, which has an overall population of about 450,000. The students were in their final year of primary school and had an average age of 14. The project trained about 5,900 head teachers, science teachers, senior women teachers, senior men teachers, peer educators, tutors, and final-year students of the teachers colleges. Each of the schools established a four-person core project team that mobilized other teachers so that all were involved in project activities. Senior women tutors and male science teachers (who also served as senior men tutors) received one week of training in sexuality-related content. Senior women and men tutors were designated by the schools to give advice to students. Senior teachers were responsible for counseling and answering day-to-day questions while other teachers taught the content. Local leaders and headmasters received a one-day training to sensitize them to the project.

The project had one full-time health educator and otherwise relied on the existing staff in the district. The project used a life skills curriculum developed by PATH and supplemental materials adapted from other sources. Trained teachers were supervised quarterly using a checklist, which was sent to AMREF and then to the district education system if there were problems. Support to teachers was also provided through

five- or six-day annual refresher training courses held during the December/January holidays.

The project worked through existing school structures including meetings of parents and school health committees, and through community resources such as district steering committees, technical staff, and district administrators for various governmental departments. School health clubs and trained peer educators helped develop activities such as songs, dramas, and poems related to HIV/AIDS. In addition, upper primary school students mentored lower primary students. Schools also had question-and-answer boxes, and questions were answered weekly or bimonthly during health parades or group sessions.

A study of the first two-year intervention in the Soroti District of Uganda found that teachers were the main source of information for youth. Among students in the sample from the intervention schools, the percentage that stated they had been sexually active fell from 43 percent in 1994 (123 of 287) to 11 percent in 1996 (31 of 280), while no significant change was reported in a control group.²³

The Soroti project continued to collect data through 2001, when a post-intervention report found further declines in sexual activity. Those in the intervention group reported increased communication and sharing of information among the pupils themselves, and between the pupils, their teachers, and their parents. A post-intervention study showed that 98 percent of the girls were not sexually active in 2001, compared to 94 percent in 1996 and 66 percent in 1994, according to Dr. Francis Oriokot, senior health advisor for AMREF/Uganda.²⁴ Reported pregnancies leading to school dropouts fell from an average of three per year per school down to none in about 70 percent of the schools. Teachers reported that the training helped them to improve lesson planning and teach and structure activities better.

In another effort in Uganda, UNICEF is working in 31 school districts, focusing on adolescent development, life skills, and sexual and reproductive health. Teacher training centers help teachers to communicate with adolescents using participatory methodologies and youth involvement

approaches adapted from UNICEF's guide, "Talking with Adolescents." The tutors at the training centers are attached to the Ministry of Education and provide ongoing support for 10 to 20 schools in an area. The project has other components, including the establishment of school- and facility-based youth-friendly services so young people can be referred for counseling and clinical services. No evaluation of this project is yet available.

These teacher training efforts in Uganda suggest that primary schools are viable entry points for health education; that mainstreaming HIV/AIDS information into the broader school health program facilitates a more free discussion of HIV among children and teachers, with less stigma than a separate course on HIV/AIDS; and that community involvement contributes to the success of a teacher training and sexuality education effort.



Zimbabwe

In Zimbabwe, a mandatory AIDS education curriculum has been integrated into related subject areas in all primary and secondary schools. More than 6,000 schools are now teaching the prescribed curriculum. All national, regional, and district education officers have received training through the program, along with more than 2,000 teachers, who have been trained in AIDS education materials as well as participatory methods. Some 5,000 trainees have begun similar training in teacher training colleges.²⁵

This successful training system began on a national scale in the mid-1990s. The Ministry of Education and Culture and UNICEF coordinated the effort, which included both in-service and pre-service training for teachers. The in-service program used a cascade model, training trainers at the national level who then trained other trainers at the next

“Participatory methods should be integrated into the whole training through the use of hands-on participatory training for teachers, with live teaching sessions with children.”



Teachers in Kenya get training on new materials and facilitation skills.

level, and so on through five stages until the local-level teachers were finally reached. The model could, in theory, reach the 35,000 teachers involved in AIDS education. The pre-service component included the introduction of AIDS education curriculum into the 27 tertiary colleges under the Ministry of Higher Education in 1994.

An evaluation of the project found that it underestimated the challenges involved in an in-service training program that relied on five stages of cascading down to the local level. It suffered from turnover of trainee teachers and lack of links between the in-service and pre-service efforts, such as coordination of materials. The evaluation concluded that teacher training needs detailed planning and careful monitoring. “Participatory methods should be integrated into the whole training through the use of hands-on participatory training for teachers, with live teaching sessions with children,” the analysis concluded. “A close link should exist between in-service training and pre-service training, and between training and materials.”²⁶

Chapter 5. Teacher Selection

All school staff should receive at least an orientation to a new RH/HIV program so that they have accurate information for themselves and their students. Those teaching the RH/HIV curriculum itself need more extensive training and should be selected from among those motivated to teach RH/HIV.

Not all teachers are interested in, capable of, or well suited to teach sexuality content to adolescents — selecting the right people to teach RH/HIV curricula is challenging. Teachers may not want to teach this topic because of their own issues related to sexuality, their personal beliefs, religious or community pressures and controversies, or concerns about their own HIV status. Adding RH/HIV content is often viewed as a burden to an already crowded curriculum. Since financial resources are scarce, teachers must be motivated in other ways such as involving them in planning and facilitation, offering continuing education credits or certification, or acknowledging their efforts publicly. Those who want to teach the subject will bring their energy and dedication to the task and likely be more effective.

Teachers who provide RH/HIV education need to have a capacity for “health literacy” — the capacity to obtain, interpret, and understand basic health information and services and the competence to use this information to enhance the learning of concepts and skills by students, parents, and staff.²⁷ Without this capacity and an ability to deal with the subject matter and with youth, teachers may be ineffective and lack confidence. In one study in Kenya, both parents and students reported higher levels of confidence in teacher competence than teachers had themselves. Only 21 percent of parents and 14 percent of students felt that teachers did not have sufficient knowledge to teach about HIV, compared to 45 percent of the teachers.²⁸

Teachers of RH/HIV content also need to be approachable to students and have a healthy rapport and comfort level for difficult and sensitive questions. In the Ugandan focus group conducted for this paper, students reported that teachers are often judgmental and authoritarian, rule by threats, and cause students to fear rather than respect them. Teachers often discourage questions by students and seldom acknowledge when they themselves do not know the answer. These factors make young people reluctant to confide in their teachers.

Teacher Selection Criteria Checklist

The following checklist of selection criteria can assist in identifying teachers who may be best suited for teaching RH/HIV content to young people.

Teachers should:

- Have a commitment to working with youth and teaching this material
- Have a healthy attitude toward their own sexuality
- Demonstrate responsible sexual behavior
- Be approachable and have a healthy rapport with students
- Be nonjudgmental; respect others' values, attitudes, beliefs, and behaviors
- Respect others' confidential information
- Have a positive attitude about reproductive health and sexuality; believe that education about sexuality and HIV/AIDS is important
- Be sensitive to those who are infected with HIV
- Demonstrate competence and knowledge in the subject matter
- Be mature in years and attitude
- Possess good communication skills

In addition, teachers might:

- Be involved in youth activities
- Teach science subjects or be knowledgeable about the sciences*

*Knowledge of science subjects such as chemistry and biology may be helpful in teaching HIV/AIDS content, especially in having the confidence to answer medical questions. However, selecting teachers merely on the basis of subject of expertise limits the broader selection process; those who do not teach science can learn basic information about transmission and other technical issues.

Chapter 6. Assessing Teacher Training Curricula

In developing and using teacher training curricula for RH/HIV, program managers, curriculum developers, education officials, and others should be aware of four key aspects of the curriculum: goals and guiding principles, teacher-focused content, methodology and facilitation skills, and management and structure.

Goals and Guiding Principles

A teacher training curriculum for RH/HIV should be based on clearly stated goals and guiding principles. It should include the rationale for teaching RH/HIV to youth and the values, beliefs, and practices the curriculum is designed to promote. The content of the curriculum, ideally, should naturally flow from its goals and principles.

Six goals in training teachers in RH/HIV are to:

- Provide accurate information about human sexuality
- Develop effective classroom skills
- Advise on teaching materials and methods
- Develop personal comfort with reproductive and sexual health issues
- Develop competence in reproductive and sexual health language
- Provide information on school and community policies

Guiding principles in a teacher training curriculum may vary depending on the sensitivities of the government and NGOs involved.²⁹ Some principles embraced by NGOs may not be consistent with policies of other sectors, such as religious organizations or governments. Principles for a teacher training curriculum could include the following:

Youth and Sexuality

- Youth can make good decisions when provided with complete information and skills.
- Young people have a right to information and services.
- Individuals and society benefit when youth are able to discuss sexuality with their parents, teachers, and other trusted adults.
- Sexuality is natural and a life-long part of being human.
- Young people should be encouraged to abstain from sexual intercourse as the only sure protection against unplanned pregnancy and STIs, but they should also be taught about contraceptives, including the use of latex condoms, for those who are or will become sexually active.

Teachers and Sexuality

- Teachers are more effective in communicating sexuality information when they have reflected upon their own attitudes, feelings, beliefs, experiences, and behaviors regarding sexuality and how these affect their ability to communicate.
- Experiential learning is an important way to facilitate increased knowledge and changes in behavior.

Human Rights and Sexuality

- Every person has dignity and worth and should be free from discrimination based on gender, race, age, ethnicity, religion, culture, sexual orientation, or HIV status.
- No pressure, force, or coercion of any kind should be used to get people to participate in sexual activity against their will or to exploit them in any way.
- Culture, tradition, and religion serve as important cornerstones in the development of an individual, and their positive influence should be acknowledged, respected, and utilized.
- Young people have a right to privacy and confidentiality.
- People with HIV deserve compassion and support.

Because teachers in training are adults, adult-learning theories should be incorporated throughout the curriculum, such as building on existing knowledge and experiences of participants. In addition, clear learning objectives should be included to help teachers understand the changes in knowledge, attitudes, skills, and behaviors expected of them.

Teacher-Focused Content

The content of the teacher training curriculum can be divided into four general areas: personal feelings and attitudes, knowledge, skills, and other issues.

Personal feelings about sexuality and attitudes toward young people are critical. The curriculum needs to engage teachers in examining their own experiences, biases, and judgments about youth and sexuality and raise their level of tolerance and comfort in discussing sensitive issues. The curriculum should help teachers to assess their own risk of HIV infection and encourage them to learn their own HIV status. This process gives teachers a greater investment in the issue and hence a

greater commitment to helping youth. “Training must first and foremost enable teachers to protect themselves and train themselves before they can effectively train children in prevention,” reported the Education International survey in Africa.³⁰

The curriculum should provide teachers with basic reproductive health knowledge, including information related to the transmission, diagnosis, and treatment of STIs and HIV/AIDS. Teachers should be able to explain clearly the dangers arising from STIs and HIV, provide basic information about the infections, and give clear instructions about the actions needed to prevent STIs or treat them effectively. Basic information on pregnancy prevention, the fertile period during the menstrual cycle, and contraception is also needed. Ideally, teachers would also receive information on sexual expression and orientation, although this area remains controversial. Training should also help teachers understand a broader range of adolescent behavioral and psychosocial development issues, so they can assist students with problem-solving, critical thinking, interpersonal relationships, empathy, and the ability to cope with stress.



AIDS educators work on materials for youth.

Teachers need to learn new skills to teach RH/HIV, including conflict management and negotiation skills for RH/HIV issues, critical for teaching young people problem-solving and decision-making skills. Teachers need to learn assertiveness skills as well so they can model them for students. “How can teachers teach a topic like assertiveness when they themselves are not assertive and when teachers and society do not value assertiveness?” asks Jacqueline Nshemereikwe, a university lecturer in Uganda.

Curriculum content might also include other elements such as how RH/HIV could be presented to various ages, religions, and ethnic groups. The different needs of boys and girls require special emphasis, along with the cultural and gender

RH/HIV curricula that could be taught in primary and secondary schools.

Methodology and Facilitation Skills

The training curriculum needs to cover the methodology, techniques, approaches, and activities best suited to teaching sexuality content to young people. The curriculum ideally would model participatory and experiential teaching techniques so that teachers will use those techniques with students. The development of facilitation skills requires both instruction and opportunities to practice them.

Participatory teaching methods cover a wide range that include: brainstorming, group facilitation, use of media (newsprint, videos, etc.), role-plays, case studies, debates or structured discussions, games, exercises, and visual and performing arts (singing, dancing, drama, and drawing). For such methods to work, teachers need to learn how to develop visual aids and other materials, how to integrate student content into lesson planning with participatory methods, and how to create a coherent classroom environment that is conducive for learning.

In a review of lessons learned from life-skills-based education for preventing HIV risks, UNICEF found that a range of teaching and learning methods have helped to improve knowledge, attitudes, skills, and risk behaviors.³¹ WHO has developed a briefing kit for teachers on STIs that offers various participatory techniques that go beyond providing basic information.³² Through participatory methods, teachers can impart valuable skills to their students, such as negotiation skills, communication skills (including refusal skills), and other techniques that young people can use to negotiate their way through sexual situations and to avoid risky situations.

Teacher training should prepare teachers for the challenges of using participatory methodologies, such as working with large classes in restricted spaces, coping with teaching environment that may seem more chaotic than a lecture format, and building the confidence to cope with student questions that they may not be able to answer. Many teachers are accustomed to didactic styles of teaching and come from cultures where young people do not question adults or interact with them openly. The training

UNIT TWO MODES OF HIV TRANSMISSION

SPECIFIC OBJECTIVES

At the end of this Unit the learner should be able to:

- Explain the modes through which HIV and STDs are transmitted.
- Distinguish between facts, myths and misconceptions about HIV/AIDS.

How HIV is Transmitted

In order to successfully fight an enemy we need to identify their operation. In this part of this study let us look at how HIV is transmitted.

HIV has very specific routes of transmission. There is a lot of talk and misconceptions about how HIV is spread. In the following activity we are going to dispel any myths and establish facts about HIV transmission.

Activity

The teacher should prepare the following resources before the activity

- A copy of statements suggesting how HIV spreads.
- Three large sheets of paper marked AGREE, DISAGREE and UNDECIDED.
- Pins and Glue.

Instructions

1. Designate three areas of the room to be called “AGREE”, “DISAGREE” and “UNDECIDED”. Put up signs to indicate them as such....

Excerpt from Kenya Institute of Education. *AIDS Education – Facilitator's Handbook*. Nairobi: Kenya Institute of Education, 1999.

dynamics with which males and females must cope. Curricula and class exercises may need to differ by gender and in some settings, boys and girls may need to be taught separately. Attention should be given to social and cultural factors that influence RH/HIV and to assessing and meeting the needs of youth, including those with special needs or living in special circumstances. Ideally, teachers would learn about the different types of

methodology needs to provide opportunities to practice their skills, use their knowledge, and examine their attitudes and values, just as students will have to do.

A project by WHO and UNESCO trained tutors and 100 primary and 32 secondary school teachers in using participatory methods. The evaluation of its impact a year later found that teachers did not feel confident to carry out experiential learning activities such as role-plays and reverted to more conventional teaching methods.³³

Teacher training on participatory methods can be supplemented by the involvement of local NGOs and community groups with appropriate skills and services. This might include presentations by the staff of health facilities, youth-serving organizations, theater and drama groups, and peer educators. These additional resources could be especially useful for sensitive areas such as providing information on correct condom use, hearing from people who are HIV-positive, or learning from those who care for HIV-infected persons.

Management and Structure

The curriculum should include information on the structure of the school environment, resources available within the school and community, and established policies that will affect the teachers. Other overall management issues in the curriculum could include:

- Leadership, management, and coordinating mechanisms for program delivery
- National and local policies
- School policies and procedures for handling sensitive issues
- Guidance on other sources of information, available community-based services for student referral, and links to these resources
- Roles and responsibilities of key players
- Sufficient time for teachers to master new teaching methodologies
- Provision for ongoing training and support to encourage and reinforce learning through peer coaching, working with a mentor teacher, peer support groups, or in-service training

Ideally, a curriculum would include a clear plan for supportive supervision. That can provide

important feedback and help teachers identify areas of weakness so they can improve their performance. Such supervision can help teachers address problems or concerns and modify teaching techniques to meet student needs. This requires time and effort but will help assure greater teacher competence.

Establishing a system during the training that will assist teachers in the future is also very important. Having teachers work in teams, obtain periodic observation for constructive feedback, and attend refresher courses can reinforce new skills and knowledge and help teachers address issues and concerns. In Thailand and Mexico, trained teachers observe others teaching, then hold discussion sessions to talk about

UNIT EIGHT
METHODS OF TEACHING IN AIDS EDUCATION

SPECIFIC OBJECTIVES

At the end of this Unit the learner should be able to:

- Demonstrate communication skills of assertiveness, negotiation and decision making.
- Assist the youth/children in coping with high risk situations.
- Select and use appropriate methods of teaching AIDS Education.
- Prepare and use suitable teaching/learning resources.
- Plan and teach AIDS Education lessons effectively.

General Teaching Methods

What are some of the methods you use in teaching your class. List them down. I hope some of the methods you have listed include the following:

Discussion	Games	Talks
Role plays	Projects	Visits
Stories and	Poems	Dramatization
Story telling		
Songs		

Excerpt from Kenya Institute of Education. *AIDS Education – Facilitator's Handbook*. Nairobi: Kenya Institute of Education, 1999.

ways to strengthen their skills.³⁴ A project through the Kenya Ministry of Education supervisory structure uses a monitoring checklist to provide supportive supervision and follow-up to trained teachers.

Educators in Jamaica and Zambia, among other countries, have organized a refresher course system after teacher training.

Chapter 7. Observations and Conclusions

Research and evaluation of teacher training for RH/HIV education in developing countries is limited. More research on the impact of teacher training is needed, as are case studies of how national ministries and local districts have developed and incorporated teacher training for RH/HIV curricula. More needs to be learned about elements of curricula that are effective in producing high-quality teachers. Various models should be evaluated, and the results should be made available to the field.

The development of indicators for teacher training programs could make a significant contribution to this effort. While most school-based studies focus on outcomes for students, more research needs to analyze outcomes for teachers regarding their own knowledge, attitudes, skills, and behaviors. Such efforts will help program planners and managers to make the best use of limited resources.

The eight recommendations below are based on the material presented in this paper, interviews conducted for the paper, experiences of the authors, and comments by reviewers of earlier drafts. They are designed to serve as guidance for future efforts in this field.

While most school-based studies focus on outcomes for students, more research needs to analyze outcomes for teachers regarding their own knowledge, attitudes, skills, and behaviors.

1. *Teacher training should cover RH/HIV content, teaching methodologies, teacher skills, personal attitudes, and teachers' HIV-risk behaviors.* The content should address medical and physiological aspects of RH/HIV as well as the social and cultural environment that shapes young people's development and sexual and other relationships.

Teachers need to have information about the full range of RH/HIV issues, including abstinence, contraceptive methods, and condom use so that they can teach those if appropriate (depending on the age of students and the community environment). Teachers need to learn participatory methods of teaching and develop communications, assertiveness, and other interpersonal skills needed to work with clarity and confidence. Teachers need to reflect on their own attitudes and values about the topic and their behaviors regarding HIV risks.

2. *Teacher training should cover policies, administrative practices, and cultural norms that will affect the teaching of RH/HIV information.* Teacher training should include summaries of laws, policies, and structures that govern their teaching of RH/HIV content. Teachers should be knowledgeable about the customs and traditions of the youth and communities in which they work.

3. *Teachers need to be willing and motivated to teach RH/HIV and be trustworthy to youth.* While all teachers should have a basic level of knowledge about RH/HIV issues, those who have a strong motivation to help youth navigate the challenges of adolescence should get special training opportunities. An initial exposure to the content can change the thinking of some, allowing other potential candidates to emerge. It could also be used to eliminate those who are not suited to the goals of RH/HIV programs. Both male and female teachers should be trained so that the teaching of

RH/HIV does not become associated with a particular sex. Boys and girls benefit from interactions with teachers of both sexes as they learn about gender roles, expectations, and relationships between males and females. Students are less likely to listen to, learn from, and confide in teachers they feel are not credible, are unapproachable, or who take advantage of them.

4. *The duration and length of training appears to affect the effectiveness of teachers.* Available evidence and anecdotal reports suggest a correlation between the duration of training and the degree of the content taught to students. Short-term or one-time training courses are insufficient to affect teacher confidence and competence over the long-term. Teachers need periodic updates to reinforce learning, acquire new information, and satisfy ongoing needs. Teachers who receive initial training as part of both pre-service and in-service courses can be expected to benefit more.

5. *Teacher training needs the support of national ministries, local school management, and communities.* The highest levels of government should provide leadership and commitment to help improve sustainability, ensure that messages are consistent across programs, and maximize limited resources. Support of the school administration adds legitimacy to RH/HIV programs, increases teacher and community comfort, and helps ensure that the content is covered. It also helps to increase community and school ownership and build an enabling environment. Parents and communities have legitimate concerns about what and when young people learn about sexuality in schools. School districts need to develop and nurture relationships with them as part of teacher training to establish community support for school-based activities.

6. *Train tutors (teachers of teachers), primary and secondary teachers, and to a lesser extent, other staff, principals, and administrators.* Those who teach teachers — a critical, often neglected group — should receive adequate training to prepare them for their roles. Their comfort and abilities will certainly influence new and impressionable teachers. Training primary school teachers offers an opportunity to reach young people before these youth become sexually active and to help those who are already active to protect themselves from pregnancy and disease. Introducing all teachers to RH/HIV content has value, especially where the content is infused throughout the school's overall curriculum. Exposing principals and administrators to the curriculum can help gain support for teachers in the classroom. Otherwise, some RH/HIV teachers may experience some of the stigma that HIV-infected people experience.

7. *Teachers need support after the initial training.* A variety of strategies, including refresher courses, mentoring, and supportive supervision, can help ensure long-term impact from training. Major changes in attitudes and behaviors are not likely to happen in a short period of time.



Young people receive a lesson on safe sex.

Having teachers work in teams can help reinforce what they have learned and can help individuals with complementary sets of skills and knowledge learn from each other. Teachers need to feel safe in testing new methodologies. Fear of making mistakes or receiving unconstructive criticism can be detrimental to achieving the goals and objectives of a program. Because teachers may see this as an additional responsibility when they are overworked and underpaid and may be apprehensive about the subject, incentives need to be given, such as certificates, public recognition, continuing education credits, or opportunities to speak to their colleagues about their work. Ongoing support is also important in addressing teacher discomfort and challenges faced in the classroom or the community.

8. *Teacher training should embrace a policy of zero tolerance for exploitation of students.* Zero tolerance policies communicate clearly what is expected of teachers and help to create a safe

environment for students. Zero tolerance for abuse and exploitation of students demonstrated by severe consequences for teachers can help change the current culture whereby these behaviors are met with silence.

These eight recommendations and the entire paper have described many challenges in improving the teaching of RH/HIV information and skills. But the paper has also documented the renewed and often successful efforts by governments, NGOs, and international agencies to make better use of teachers, schools, communities, and youth themselves to prevent HIV and reproductive health problems. The future of teacher training will improve through sharing information, supporting better programs, undertaking better evaluations of these programs, and calling greater attention to this critical aspect of RH/HIV education. Ultimately, not only teachers but also young people will benefit and have greater prospects for a healthy future.

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