

## **CHAPTER THREE**

### *LIFE SKILLS INTERVENTIONS ON HIV/AIDS IN SOUTH AFRICA*

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#### **3.1 Introduction**

As explained in chapter 1, the International Convention on the Rights of Children and Youth declares that access to and fulfilment of education and information form a fundamental basis for the development of the social, psychological and moral welfare and the physical and psychological well-being of the next generation (United Nations [UN], 1989, para. 28, 17). According to the UN's (1989) declaration, it can be proposed that children and young people are especially in need of access to information because they know less of human nature and have fewer life experiences; they should therefore receive information before they are exposed to risky health situations. The WHO (1999a) agrees with the above conviction and refers to primary preventive approaches as an effective method to protect children's rights to enable them to live a healthy life. Life skills programmes, as health promoting instruments, are expressly recommended by the WHO (1999a) in the context of specific risk situations and situations where, for example, children and adolescents need to be empowered to promote and protect their rights.

Schools are considered a most suitable setting for health promoting initiatives. Because the majority of young people are of school-going age they can be better reached at this location. The following reviews present exclusively selected evaluations of school-based life skills interventions regarding AIDS and sex education in the sub-Saharan region that targeted upper primary school children. This discussion is followed by a description of one specific South African case. The chapter is concluded by a discussion on growing problems on personal, interpersonal, sociocultural and socioeconomic level problematic to the implementation of highly standardised life skills programmes and their proposed outcomes.

#### **3.2 Sub-Saharan School-Based Life Skills Initiatives on HIV/AIDS with Pre-Adolescents**

In recent years, behavioural training to enhance competences (life skills) for the prevention of HIV/AIDS in schools has turned out to provide a particularly efficient and varied form of intervention (see also WHO, 1999a; Jerusalem, 2002a; Bühringer & Bühler, 2004; Piquart & Silbereisen, 2004). Life skills programmes claim to develop and to positively support the

mental and physical health of individuals in their preparation for the developmental tasks and demands in life they are exposed to. Because learning about health and experiencing individual behaviour is promoted in social learning situations, these programmes have to equally combine teaching on health and the promotion of positive attitudes and values in a supportive learning environment (WHO, 1999a). Furthermore, this form of intervention has to cover a wide range of topics (e.g. teenage pregnancy, violence, and HIV/AIDS) and combine the conveying of information with the teaching of life skills in order to help the target group to adequately deal with specific developmental and life tasks designed for them. The range of topics are considered to function best if learning methods are participatory and convert real life situations into a social learning process that includes: (a) explanation of the skill in question, (b) observing the skill (modelling), (c) practising the skill in selected situations in a supportive learning environment, and (d) receiving feedback about the individual performance of skills (WHO, 1999a).

Schools constitute a main pillar of the socialisation of children and are therefore a better accessible setting for health-promoting interventions like life skills programmes. Schools provide frameworks in which additional learning programmes can be better implemented, for example, school hours, mode of operations, mechanisms for introduction of new programmes, number of learners, and measures for the assessment of participants (Gallant & Maticka-Tyndale, 2004). Primary schools in particular are considered to be good locations, especially in the developing world, because they accommodate the majority of children and youth (approximately 50%) (Gallant & Maticka-Tyndale, 2004), with reduced numbers in higher grades; 70% enter primary school and only 67% do still attend grade 5 (UNICEF, 2001). In their assessment of the effectiveness of AIDS reduction strategies, Stover, Walker, Garnett, Salomon, Stanecki, and Ghys (2002) identified school-based programmes as a necessary basis for other programmes to enhance and encourage mental and physical health amongst attending individuals.

Considering the scope of the AIDS pandemic and its related dangers for physical health and mental well-being, the implementation of such health promotion initiatives is considered to be of special importance. In a recent literature review by Gallant and Maticka-Tyndale in 2004, 32 reports on evaluated school-based intervention programmes were identified based on specific research criteria, namely that the programme (a) be designed to affect a change in AIDS-related knowledge, attitudes, behavioural intentions, and/or behaviours; (b) be evaluated using quantitative data; (c) be reported in a peer reviewed journal between 1990 and 2002; (d) targets youth under the age of 25; and (e) reports on school-based programmes

implemented in sub-Saharan Africa. Only 11 of the reviewed studies fulfilled these research criteria; only four learning or pedagogical theory-based programmes were found (Dalrymple & DuToit, 1993; Harvey, Stuart, & Swan, 2000; Klepp, Ndeki, & Seha 1994/ Klepp, Ndeki, Leshabari, Hannan, & Lyimo 1997; Shuey, Babishangire, Omiat, & Bagarukayo 1999) and only two studies out of eleven (Klepp et al., 1994, 1997; Shuey et al., 1999) that met the parameter of school-based sexual health interventions in sub-Saharan Africa in a primary school<sup>3</sup>. With reference to these research findings (Gallant & Maticka-Tyndale, 2004), only a relatively small number of utilisable evaluated studies have so far been carried out on school-based HIV/AIDS educational programmes in sub-Saharan Africa. Table 3.1 to 3.3 summarise the characteristics, evaluation methods and outcomes of these interventions presented in the following paragraphs. Another school-based intervention undertaken in Kenya (Maticka-Tyndale, Wildish, & Gichuru, 2004) fulfilled most of the research criteria, but has not been published at the time of this literature review. This study is included in the list of studies in the tables below.

According to the literature review in Gallant and Maticka-Tyndale (2004), an important determinant that influences programme outcomes appears to be the stage of sexual development amongst the participating individuals. In Africa it was measured that sexual debut amongst boys ranges from 12 to 15.5 years, while the corresponding range amongst girls is 13.6 to 15.9 years (Kaaya et al., 2002a, 2002b; WHO, 1992a). This means that the commencement of sexual activity starts with the entrance into adolescence. Consequently, the age of 13 to 14 years seems to be an important transition point for interventions that aim to delay the debut of sexual activity amongst the younger population, and to increase the adoption of risk reduction strategies in older populations (Kaaya et al., 2002a). Programmes targeting younger school children, for example lower secondary level, confirm these assumptions and were found to have had greater success in influencing sexual behaviours than those targeting older children, namely upper secondary level. Likewise there appears to be a differential success amongst youth who were virgins at programme initiation compared to those that were already sexually active (Shuey et al., 1999; Stanton, Li, Kahihuata, Fitzgerald, Neumbo, & Kanduuombe, 1998). With this in mind, school-based HIV prevention programming that start as early as primary school has been viewed as a necessary step to

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<sup>3</sup> Another review by Kaaya et al. (2002a) found in their literature study 47 articles reporting sexual behaviour of learners aged between 14 and 24 years and conducted between 1987 and 1999. Not one of those presented a health initiative targeting children in primary school-going age.

protect the general population from further infection (Barnett, de Koning, & Francis, 1995; Finger, Lapetina, & Pribila, 2002; Grunseit, 1997; Kaaya et al., 2002b; World Bank, 1993).

To give a more detailed view on research findings regarding the outcomes of life skills programmes targeting pre-adolescents, three studies working with upper primary school or lower secondary school learners are presented together with their outcomes<sup>4</sup>. The first two programmes, also listed in Gallant and Maticka-Tyndale's literature review (2004), were undertaken in Tanzania (Klepp et al., 1994, 1997) and Uganda (Shuey et al., 1999). The third programme was a school-based evaluation programme undertaken in Kenya (Maticka-Tyndale et al., 2004). The Kenyan (Maticka-Tyndale et al., 2004) and Ugandan (Shuey et al., 1999) programme controls were aimed at the standard national school health and educational curriculum (Gallant & Maticka-Tyndale, 2004). The Ugandan and Tanzanian programmes (Shuey et al., 1999; Klepp et al., 1994, 1997) were implemented with the support of health educators in cooperation with teachers and schools while the programme in Kenya (Gallant & Maticka-Tyndale, 2004) trained specific teachers and community representatives in an excessive two-cycle workshop on the content of the programme. All three programmes employed the greatest diversity of activities, namely health club, secret box, and multiple learning activities (Gallant & Maticka-Tyndale, 2004), and had sound programme and evaluation designs (providing confidence in their findings). The studies were carried out for one or two years respectively, before their outcomes were evaluated.

### **3.2.1 The Tanzanian Evaluation**

Klepp et al. (1994, 1997) evaluated an intervention programme which was carried out in Tanzania amongst learners with a mean age of 14 years. Their study was based on the theory of reasoned action and social cognitive learning. The study was designed to evaluate the knowledge, attitudes and communication regarding AIDS, susceptibility and condom use; however, sexual behaviour was not examined (Klepp et al., 1994, 1997). Changes in the desired directions were recorded in all of these areas. The study noted a significant effect on subjects exposed to AIDS information, who displayed positive changes in their attitudes towards persons with AIDS; communication on HIV/AIDS between the participants was found to have increased (Klepp et al., 1994).

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<sup>4</sup> The presented literature review does not include the 'South Africa and Tanzania Project' (SATZ) school-based HIV/AIDS intervention undertaken in South Africa and Tanzania (Aaro et al., 2005) because the study was still in progress at the time of the implementation and analysis phase of this survey.

### **3.2.2 The Ugandan Evaluation**

The second study was conducted by Shuey et al. (1999) in Uganda amongst learners aged 13 to 14. They employed a social cognitive learning theory approach. The study revealed that learners subjected to experimental conditions were more than three times less likely to be sexually active at posttest, regardless of location, with no significant changes in self-reported sexual activity amongst learners subjected to standard conditions. The same study found a significant desirable improvement in reports of sexual initiation and number of sexual partners (Gallant & Maticka-Tyndale, 2004). Learners that have been subjected to experimental conditions reported significantly more communication on issues of sexual health than those subjected to standard conditions. More favourable attitudes towards premarital abstinence were reported amongst experimental participants during post-intervention phases compared to control learners, the reasons for their abstinence being based on rational decision-making (Shuey et al., 1999; Mukoma & Flisher, in press).

### **3.2.3 The Kenyan Evaluation**

The third study was undertaken in primary schools in Kenya, called the Primary School Action for Better Health (PSABH) (Maticka-Tyndale et al., 2004). The intervention was undertaken with primary school learners with an approximate age range of 11 to (even) 16, teachers who attended a workshop on the programme content and messages, and people from the community (e.g. parents and head teachers). The Kenyan project evaluated knowledge, attitudes, intentions and behaviour. The study revealed that a significant increase in communication could only be reached in communication with others; no other significant changes were found. Although modes of abstinence were based on the A(bstinence), B(e faithful), C(ondom), and D(elay) approach, for example, no significant changes have been found in either the abstinence level or in condom use. However, Maticka-Tyndale et al. (2004) report that there was evidence that significantly fewer pupils, who completed the survey at the six-month evaluation stage, had initiated sexual activity compared to pupils who completed surveys prior to PSABH programming. The absence of a significant difference between control and target schools in sexual initiation makes it impossible to credit this change specifically to PSABH (Maticka-Tyndale et al., 2004).

The studies by Klepp et al. (1994, 1997) and Shuey et al. (1999) met almost all of their objectives regarding changes in sexual behaviour and particularly the number of learners initiating sexual activity (Gallant & Maticka-Tyndale, 2004) as compared to other studies with older target groups. Gallant and Maticka-Tyndale (2004) attribute the less positive

Table 3.1.  
*Characteristics of sub-Saharan School-Based Life Skills Initiatives on HIV/AIDS and Sex Education.*

Evaluated by	Theory	School	Implemented in x school	Community involved in design	Content		Form		Implementation		
					Targeted behaviour	Main activities	In/after school	Total exposure	Instructors	Instructor Training	Monitored
<i>Knowledge only</i>											
Dalrymple & DuToit (1993) Tanzania	Theories of play	Secondary	Not specified	KABP and participatory research		Participatory educational drama	In school	DK	Teachers and university Drama team	Not specified	No
Mac Lachlan et al. (1997) Malawi	Not specified	Secondary (boys $M = 17.7$ yrs; girls $M = 16.4$ yrs)	2	Qualitative survey, research in community	A	Board game	After school	4h	University students	Not specified	No
Nunodowafa et al. (1995) Zimbabwe	Not specified	Secondary (forms 2-3)	5	No	A and C	Student nurses teaching	In school	8h	Student nurses	12 days (twice/week, 6 weeks)	Yes
<i>Knowledge and attitudes</i>											
Fitzgerald et al. (1999) Namibia	PMT	Secondary ( $SD = 9$ and 11) (15-18yrs)	Entire country 10 evaluated	Curriculum altered to fit culture	A and C	Multiple activities	After school	28h	Teacher and out-of-school youth	40h	Yes
Stanton et al. (1998) Namibia											
Kinsman et al. (1994, 1997) Uganda	BCI	Primary ( $SD = 7$ and 8) Secondary (forms 1 and 2)	67	Some	A	Multiple activities	In school	19h	Teachers	3 sessions over 5 days	Informal

<b>Klepp et al. (1994, 1997) Tanzania</b>	<b>TRA, SLT</b>	<b>Primary (M = 14yrs)</b>	<b>18</b>	<b>Local health educator and community</b>	<b>A</b>	<b>Activities infused, includes peers</b>	<b>In school</b>	<b>20 h</b>	<b>Teachers</b>	<b>1 week</b>	
Retrospectively Kuhn et al. (1994) South Africa	PDB	Secondary (M = 18yrs)	2	Teachers, learners and parents	A and C	Multiple activities Create displays in AIDS awareness	In school	DK	Teachers	Not specified	No
Visser (1996) South Africa	HBM, TRA, SLT	SD = 6-9	11	National Health and Population Department	A and C	AIDS kit with varied activities	In school	8-18h	Guidance teacher	Not specified	
<i>Knowledge, attitudes and behaviour</i>											
Fawole et al. (1999) Nigeria	Not specified	Secondary (M = 17-18yrs)	4	Baseline KABP survey and NGO input	A and C	Multiple activities including condom use demonstrations	After school	12-36h	Physician and teachers	Not specified	Implemented by Programme Designer
Harvey et al. (2000) South Africa	Dram-in-education and an applied behavioural change framework	Primary (SD = 8) (M = 17.6yrs)	770 (tested in 14)	No	A and C	Drama in education (3 phases)	In school	DK	Teachers	Not specified	No
<b>Shuey et al. (1999) Uganda</b>	<b>SLT implied</b>	<b>Primary (age range 13-14 yrs)</b>	<b>95 (tested in 37)</b>	<b>Community sensitisation and input</b>	<b>A<sup>a</sup></b>	<b>Activities infused, School health club, peer led, question box</b>	<b>In school</b>	<b>&gt;100h</b>	<b>Teachers</b>	<b>Teachers 1 week, head teacher 1 day</b>	<b>Yes</b>
<b>Maticka-Tyndale et al. (2004)<sup>b</sup> Kenya</b>		<b>Primary (SD = 6-8) (age range 11-17 yrs)</b>	<b>1250 (tested in 80)</b>		<b>A, B, C, D</b>	<b>Question box, School health club, multiple activities, peer support activities</b>	<b>In school</b>		<b>Teachers, four peer supporters</b>	<b>Two cycled-training (DK)</b>	<b>Yes</b>

*Note.* DK do not know. Theories: PMT = Protective motivation theory; BCI = Behaviour change for intervention; TRA = Theory of reasoned action; SLT = Social learning theory; HBM = Health belief model; PDM = Psychological determinant of behaviour. Targeted outcomes: A = Abstinence; C = Condoms. Main Activities: Multiple activities = Lectures, role play, songs, poetry, essays, debates, poems, stories. Activities infused: multiple activities are infused throughout the curriculum. <sup>a</sup> Goal was a shift to rational decision-making about sexual activity. <sup>b</sup> Subject to Change. Sources: Gallant & Maticka-Tyndale (2004), Maticka-Tyndale et al. (2004).

Table 3.2.

*Summary of Evaluation Methods on sub-Saharan School-Based Life Skills Initiatives on HIV/AIDS and Sex Education.*

Evaluated by	Design	Sampling strategy	N base/post	Control group	Experimental / Control contamination	Time to evaluation	Local input in design	Pretest	Base effects controlled	Statistical procedures	Statistics or interpretation appropriate	Corrected Alpha level
Dalrymple & DuToit (1993)	Longitudinal Panel	Purposive <sup>a</sup>	72/72	No	n/a	Immed.	n/s	Yes	n/a	T-test	Yes	n/a
MacLachlan et al. (1997)	Repeated cross-section	Purposive	72/72	No	n/a	Immed. <sup>b</sup>	Yes	Yes	No	T-test	No	n/a
Munodowafa et al. (1995)	Longitudinal panel	Volunteer	285/285	Yes	No	Immed.	n/s	No	Yes	Chi-square ANOVA	Yes	No
Fitzgerald et al. (1999), Stanton et al. (1998)	Longitudinal study	Multistage random	515/437, 379, 359	Yes	Potential	Immed., 6 and 12 mos.	Yes	Yes	Yes	Chi-square ANOVA	Yes	No
Kinsman et al. (2001)	Repeated cross-section	Multistage random	2077/not stated	Post only	No	6 mos.	Yes	Yes	Yes	Bivariate linear regression	Yes	n/a
<b>Klepp et al. (1994, 1997)</b>	<b>Repeated cross-section</b>	<b>Multistage random</b>	<b>2025/1772, 814</b>	<b>Yes</b>	<b>No</b>	<b>6 mos., 12 mos.</b>	<b>Yes</b>	<b>Yes</b>	<b>Yes</b>	<b>ANOVA</b>	<b>Yes</b>	<b>n/a</b>
Kuhn et al. (1994)	Longitudinal panel	Purposive	567/482	Yes	Potential	Unspecified	Yes	n/s	No	Chi-square	No	No
Visser (1996)	Longitudinal Panel	Purposive	187/187	No	n/a	Immed.	Yes	Yes	Yes	Hotelling's $T^2$ and $t$ test	Yes	n/a
Fawole et al. (1999)	Longitudinal panel	Multistage convenience	440/440	Yes	No	6 mos.	Yes	Yes	No	Chi-square $t$ test	No	No
Harvey et al. (2000)	Longitudinal panel	Multistage random	1080/699	Yes	No	6 mos.	Yes	Yes	Yes	Bivariate linear regression	Yes	n/a
<b>Shuey et al. (1999)</b>	<b>Repeated cross-section</b>	<b>Multistage random</b>	<b>400/400</b>	<b>Yes</b>	<b>No</b>	<b>24 mos.</b>	<b>Yes</b>	<b>Yes</b>	<b>Yes</b>	<b>Chi-square</b>	<b>Yes</b>	<b>n/a</b>
<b>Maticka-Tyndale et al. (2004)<sup>c)</sup></b>	<b>Longitudinal panel</b>	<b>Multistage random</b>	<b>1200</b>	<b>Yes</b>	<b>No</b>	<b>30 mos.</b>	<b>Yes</b>	<b>Yes</b>	<b>Yes</b>	<b>Chi-square, anal. variance, hierarchal multivariate regression</b>	<b>Yes</b>	<b>Yes</b>

*Note.* <sup>a</sup> Selected schools from the community where the university was located. <sup>b</sup> Re-tested learners 6 times over 6 weeks. Mos = Month. <sup>c)</sup> Subject to Change.  
Sources: Gallant & Maticka-Tyndale (2004), Maticka-Tyndale et al. (2004).



Table 3.3.

## Summary of Results on knowledge, attitudes, and intentions on sub-Saharan School-Based Life Skills Initiatives on HIV/AIDS and Sex Education.

Evaluation	Knowledge			Attitudes toward			Intentions		Other			Communication	Sexual intercourse behaviour			Condom use behaviour		
	General	Abstinence	Condom use	PHAs	Abstinence	Condom use	Abstine nce	Condom use	Perceived Susceptibility	Self-efficacy	Close friends sexually active	Ever sex	Recent sex	No. of partners	Ever use	Use at last sex	Always use	
<i>Knowledge only</i>																		
Dalrymple & DuToit (1993)	+																	
Mac Lachlan et al. (1997)	+																	
Munodowafa et al. (1995)	+																	
<i>Knowledge, attitudes and intentions</i>																		
Fitzgerald et al. (1999)	+	+f			0	0	0	+		+fm	0		0	0	0	+	+	
Stanton et al. (1998)							0/0/0	+0/0f	+fm			M: 0/+/0 F: +/0/0			0/0/+ (fbv)	0/0/0 (mbv) <sup>a</sup>		
Kinsman et al. (2001)	0	0	0	0	+	0	+	0										
Klepp et al. (1994, 1997)	+/+			+/+	0/+0		+/+					+	0					
Kuhn et al. (1994)	+		+	+				+x		+								
Visser (1996)	+	+	+	+m(f high pre)		0	+ <sup>a</sup>	+ <sup>a</sup>	+0									
<i>Knowledge, attitudes, intentions and behaviour</i>																		
Fawole et al. (1999)	+	+	+	+								0x		0x		0	0	
Harvey et al. (2000)	+			+	+				0	+		0		0	+		0	
Shuey et al. (1999)	+										+	+	-	+				
Maticka-Tyndale et al. (2004) <sup>b</sup>	-				-						+					-		

Note. M = males; F = females; + = a statistically significance programme effect ( $p < 0.05$ ) in the desired direction; 0 = no statistically significant programme effect; - = a statistically significant programme effect opposite to the desired direction; / results to left of / = for immediate post-programme; / results to right of / = for 6- and 12-month post; x = results reported here are corrected for errors in original statistics; fbv = experimental/control differences only for female baseline virgins; mbv = experimental/control differences only for male baseline virgins. <sup>a</sup> Exceptionally small sample sizes (experimental  $N = 11$ ; control  $N = 6$ ). <sup>B)</sup> Subject to Change. Sources: Gallant & Maticka-Tyndale (2004), Maticka-Tyndale et al. (2004).

results to the fact that the participants were older and that a larger number of them had already been sexually active. Kaaya et al. (2002a) support this finding and conclude that studies amongst pre-adolescents are essential to explore determinants of delayed sexual debut and to cast light on the appropriateness of primary school settings for sexual health interventions. The importance of initiating long-term prevention programmes in primary schools is evident from the conclusions of reviews of interventions, which demonstrate that programmes conducted prior to sexual debut are the most effective in reducing rates of sexually transmitted infections (see also Grunseit, 1997).

### **3.3 A Case of a School-Based Life Skills Programme in South Africa**

As outlined in the HIV/AIDS/STD Strategic Plan for South Africa (HIVSP) (2000-2005), the primary focus of every preventive strategy to avoid a further spread of HIV in the South African society should be 1) to reduce the number of new infections (especially amongst youth) and 2) to decrease the impact of HIV/AIDS on individuals, families and communities (Smart, 2002). Within the HIVSP for 2000 to 2005, life skills programmes should meet suggestions from the WHO (1999a), and are seen as a main preventive strategy to target young population groups in South Africa in particular.

Until 1997, school-based HIV/AIDS prevention and sex education programmes in South Africa were organised and managed by many non-governmental organisations such as the Planned Parenthood Association of South Africa or Love Life. Other well-published school-based interventions were designed and implemented by the Department of National Health and Population Development (Meyer, 1989; Visser, 1996) and by independent professionals (Mitchell, 1994; Page, 1990; Flisher et al., 2000) like the famous Drama Approach to AIDS Education (DramAide) (Harvey et al., 2000). These listed health promoting initiatives foremost targeted adolescents in impoverished communities, raised awareness of HIV/AIDS and offered peer education outside of or in cooperation with schools. Discrete projects, targeting in-school youth as well as out-of-school youth, offered hopes of success, but these had not been applied on a large scale to reach more children and young people.

Given this background, it became clear that the impact of such programmes in concurrence with the increasing number of young people infected by HIV could only be increased by implementing a national life skills and AIDS prevention programme as part of the curriculum in South African schools. The intention behind this plan was to expand the application of the programme to reach as many children and young people as possible to inform them about and

protect them against HIV infection, and to prevent the further transmission of HIV in the South African society. Against this setting, the South African Department of Education in cooperation with the South African Department of Health launched a national life skills programme on HIV/AIDS and sex education in secondary schools that was managed by the provincial departments in 1997/1998 and funded by the European Union (73%), the Department of Health (16%) and the Department of Education (5%) (Magome, Louw, Motlhoia, & Jack, 1997/1998). The pedagogical basis of the government programme and papers from the Love Life campaign formed the teaching manual of the life skills programme on AIDS and sex education from the Planned Parenthood Association of South Africa (1997). An extensive plan was developed to implement the programme in 27 864 primary and secondary schools, and to design learning materials and media for teacher and learner training (Magome et al., 1997/1998).

In actual fact, there is little data available on the national impact of the life skills programme, especially on primary school level. In an evaluation of the impact of the life orientation (life skills) programme on HIV/AIDS in Gauteng schools 16 secondary schools and four primary schools were interviewed. The survey revealed that only 70% of the schools had implemented life orientation in every grade; 30% have not implemented it at all or only taught it in higher grades (8 – 9) (Bhana, Brooks, Makiwane, & Naidoo, 2005). Given that in Gauteng, one of the most developed regions in South Africa, the implementation of the programme is still being carried out, it is assumed that the full implementation of the programme should be even more difficult in very poor provinces such as the Eastern Cape Province. Other studies conducted in 12 schools and six communities across South Africa in 1999 and 2001 showed that education on HIV/AIDS was conducted erratically and that in these contexts, life skills education is skeletal at best (Kelly & Parker, 2001; Kelly, 2001). With regard to the above mentioned findings, the existence of underlying obstacles, as well as little practical and adequate delivery of life skills education in the classroom, delays the full implementation of the programme at primary and secondary school level. The underlying obstacles are explained further in the following paragraph.

### **3.4 Factors Influencing the Implementation at South African School Level**

According to a report by the University of Sussex on the impact of school-based HIV/AIDS education at elementary and secondary schools in Botswana, Uganda and Malawi, there is “little hard evidence” to show that these primary preventive initiatives have a major impact on

sexual behaviour (Berger, 2002). The same report states that inappropriate implementation is due to a lack of time, resources and training of educators. In this report, researchers reported that curriculum-based education as well as counselling and peer education was inadequate because of inappropriate training of teachers in the programme topics, insufficient resources at schools, and an overloaded and examination-driven curriculum (Berger, 2002). Farquhar and Kanabus (1998) confirm that these findings are pertinent for the implementation of programmes in South Africa, and mention difficulties in the provision of life skills education that either lead to inadequate or inappropriate conditions of or significant institutional, political, religious and cultural barriers to school-based life skills education in particular and preventative education in general.

### **3.4.1 Minimal Resources in Public Schools**

In 2000, nearly 12 million learners were enrolled in South African schools (Education Atlas, 2000). A national audit of these public schools found them in poor condition and without the necessary amenities available on site (Education Atlas, 2000). A key problem in South African public schools is the high teacher-learners ratio; classes with 70 learners and more is not a rare occurrence, especially in poor provinces. The schools lack teaching materials and facilities. In addition, government schools in disadvantaged settings face a multitude of problems related to high drop-out rates, poverty and malnutrition, and crime and violence. Visser (1996) states that as long as schools are poorly equipped, teachers will find difficulty in fulfilling their task of bringing basic education to children, apart from implementing further programmes such as life skills programmes on AIDS and sex education. Other barriers to the implementation of health promoting programmes are the decline in teachers that results from teacher transfer, illness, absence, or death (including death by HIV/AIDS) (World Bank, 2002).

### **3.4.2 Work-overstrain and Attrition of Teachers**

There are excessive demands relating to low-level educational standards for teachers and the complete remodelling of the South African educational system in regard to Curriculum 2005. The national reform creates a working and learning system that easily overburdens or even burns out teachers with psychosocial, structural and organisational demands in school work and contributes to a high attrition rate among those professionals. A comprehensive survey of factors determining educator supply and demand in South African public schools supports these assumptions (Phurutse, 2005) and has found that educators are leaving the profession in

large numbers for the following reasons: low morale; low job satisfaction and stress and a correspondingly high absenteeism rate; AIDS and other diseases; and premature death (Education Labour Relations Council, 2005).

In relation to the HIV status of teachers it was found that especially African educators were very likely to be HIV positive compared with other groups working in rural and disadvantaged school environments. From this, it follows that they seem to be exposed to risk factors regarding their personal health (Education Labour Relations Council, 2005). A World Bank report suggests that at least 12% of the country's teachers are HIV positive (Education Foundation Trust, 2002). This, together with the psychological impact of the illness, reduces contact time, performance and the quality of teaching and worsens the learner-teacher ratio (Badcock-Walters, 2002). These conditions decrease the chance of high quality education amongst children from disadvantaged communities and their access to life-prolonging and protecting information that result in a lowering of their future expectations.

### **3.4.3 Resistance to Teach about Condom Use**

Information barriers from teacher to learner level are considered another hurdle for the implementation of school-based life skills programme on AIDS. Visser (1996) mentions that teachers did not address some of the major HIV/AIDS prevention issues due to their fear of community disapproval, their reluctance to discuss sex and HIV, curriculum overload, and their general preference for doctrinaire instruction. The same was found in many other sub-Saharan studies (Kinsman, Nakiyingi, Kamali, Carpenter, Quigley, Pool, & Whitworth, 2001; Klepp et al., 1994, 1997; Shuey et al., 1999). Furthermore, this resistance can be linked to existing community norms and the strong beliefs that education on condoms implicitly condones or encourages sexual activity (see also Visser, 1996) or addresses high levels of learners' sexual activity (Fawole, Asuzu, Oduntan, & Bieger, 1999). Maticka-Tyndale et al. (2004) support these findings and report that teachers in their programme held true to the community focus on abstinence as the only acceptable method of prevention reinforced by fear (i.e. if you don't abstain you will die of AIDS). According to Gallant and Maticka-Tyndale (2004) the dramatic approach (Dalrymple & Du Toit, 1993) in South Africa and the after-school programme (Fawole et al., 1999) in Nigeria were the only two reported programmes to have successfully included condom presentation as an element in prevention programmes outlined in cooperation with 'non-teachers'.

### 3.4.4 School Atmosphere and Violence Levels

Another very important obstacle for a highly holistic physical and mental health promoting approach, such as life skills programmes, is the widespread presence of emotional, physical and sexual violence in South African schools. Morrell (2004) calls this condition a “Culture of Silence” to conflict sharply with the official frequently used slogan “Breaking the Silence” about AIDS. Morrell (2004) applies the term silence to the suppressed discourse about taboo-related issues surrounding gender-related issues and violence, sexuality or sex, and the stigma of AIDS at school. A violent school atmosphere does not only tremendously influence any kind of AIDS prevention initiative by blocking its message but puts teachers and especially learners in a situation where power is unequally distributed (Morrell, 2004).

Two examples shall be given at this point to clarify what is meant by an ‘atmosphere of silence’ and ‘unequal power’ in school settings. First, as Morrell (2004) states in his article, Calvinist traditions combined with the authoritarianism of apartheid produced a silent society that existed until the end of Apartheid in 1994. Schools were the main pillar of socialisation of future ‘valuable’ citizens in the system; however, instruments such as corporal punishment were used to oppress any signs of curiosity or independence which were understood as impertinence (Morrell, 2004). At present, the South African Schools Act 84 of 1996, Section 10, prohibits corporal punishment in schools and imposes criminal sanctions. However, positive attitudes to and beliefs in those methods of education are still prevalent and practised, as several studies uncovered (see also Dawes, Kropiwnicki, Kafaar, & Richter, 2005; Morrell, 2001; Human Rights Watch, 2001). Corporal punishment<sup>5</sup> has harmful effects on the physiognomy and psychology of individuals. As Bower (2005) states, physical insurance can be accompanied by bruises and cuts, broken bones, knocked-out teeth, permanently disfigurement or disabling or even death. Mental outcomes, on the other hand, can include antisocial behaviour which results in the escalation and encouragement of violence in school settings; this stand in sharp contrast to interventions that aim to enhance the mental and physical health of individuals.

Second, in regard to sexual violence and harassment at South African schools, a Human Rights Watch study (2001) undertaken in three South African provinces revealed multiple forms of sexual violence at schools, committed most often by fellow learners or teachers. Another study by the Department of Health (1998) underlined those findings and revealed that 38% of rape victims said that they had been raped by a schoolteacher or principal

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<sup>5</sup> Emotional abuse will not be described in this study. It is recognised as most prevalent and inherent in physical and sexual abuse.

(Kenyon et al., 2000). Brooks, Shisana, and Richter, (2004) agree that sexual harassment in South African schools is a serious problem. They report in their survey that 40% of the children surveyed said that boys sexually harassed girls and 15% of the children reported that male educators proposed relationships with girl learners. This survey was based on results amongst 12- to 14-year-old primary school learners (Brooks et al., 2004). Other studies have reported girl learners having their school fees paid by a teacher in exchange for sex (Jewkes & Abrahams, 2002; World Bank, 2002). A disturbing finding by Kinsman et al. (1999) indicated that such problematic structures influence life skills programmes too. According to this study a teacher attending a life skills programme on AIDS was found to have impregnated a female learner and was imprisoned.

From the previous description it is clear that barriers and hurdles to adequately implement and produce outcomes amongst individuals participating in school-based life skills programmes on AIDS and sex education are manifold and varied in nature. Badcock-Walters (2002) concludes that irrespective of the quality of curricula and education-driven interventions, the success of these programmes will be limited by the structural stability and comparative functionality of the system in which they take place. In addition, Kenyon et al. (2000) deduce that the quality of a life skills programme depends on adequate initial teacher training and/or continued teacher support, cooperation with other teachers at the school and open-minded ideologies and practices, amongst others. Under-resourced public school settings, the daily management of social and psychological problems, and the existence of emotional, physical, and sexual violence make it necessary to consider the actual implementation of life skills programmes on AIDS and sex education by school personnel. Personnel are often expected to act in conflicting and overburdened learning and operational settings without external conducive support. Many of the factors listed above have been cited as barriers to the effectiveness of HIV/AIDS intervention, not only in South Africa and the rest of the sub-Saharan region, but worldwide (Applegate, 1998).

### **3.5 Conclusion**

Twenty years after the existence and effects of HIV/AIDS on individuals and societies became known, all interventions tackling HIV/AIDS in sub-Saharan Africa seem to experience wide-ranging problems to fully and effectively implement programmes at school level. The only instrument to deal with this pandemic is health promotion methods such as life skills programmes. However, the quality of implementation and the outcomes of every intervention strongly depend on the interrelation of the distal, proximal and individual

domain, which can be immense when such programmes are implemented in a setting with a magnitude of socioeconomic and sociostructural problems.

Twelve studies fitting the research criteria set by Gallant and Maticka-Tyndale in a literature review in 2004 have been conducted on school-based life skills programmes on HIV/AIDS and sex education in the sub-Saharan region. Only three of the evaluated programmes also targeted children under the age of 12 despite the research finding that preventive approaches are more effective if implemented at an early life stage and before sexual debut (viz. Polce-Lynch, Myers, Kliwer, & Kilmartin, 2001). In other words it is proposed that the most appropriate time for the implementation of intervention programmes targeting primary school children is early adolescence and before the onset of unsafe behaviour.

Other factors that were found to hinder the implementation of school-based life skills programmes or affect the outcomes of such health promoting initiatives are highlighted by Kelly, Ntlablati, Oyosi, Van der Riet, and Parker (2002):

- Problems of prioritising life skills programmes;
- Intensive activity in an environment where there is much pressure to improve school performance;
- Lack of follow-through on the mandate to provide life skills education;
- Lack of follow-up training of teachers;
- Little promotion of the value of the concept of teaching life skills amongst teachers; and
- Perceptions that it is a soft teaching option which is not highly appreciated amongst teachers.

These findings may suggest that the focus of studies should not only be on methodological aspects and outcomes of interventions, but also on sociodemographic and proximal psychosocial determinants of various sexual and risk reduction practices in order to provide a broader framework within which adolescent sexuality in the region can be understood and more realistically addressed (Kaaya et al., 2002a). Furthermore, Kaaya et al. (2002a), amongst others, suggest that method triangulation of both quantitative and qualitative data sources be used to explore local contextual factors in order to enhance the adaptation of instruments to suit local circumstances.

In the knowledge that the politically, economically and socially developing countries are hit especially hard by the AIDS pandemic, the fact must also be emphasised that the dimensions of this pandemic are beyond the experience of everyone involved, as it demands that psychological barriers are overcome and it creates personal stress for every human being involved. Consequently, the overburdened school system should consider educational



cooperation between governmental and non-governmental organisations to receive support and relief. There is great concern that if not, due to the lack of appropriate protection and preparation of children for such an enormous and often incomprehensible pandemic with all its short-term and long-term effects, another generation in South Africa will be hard hit by the dimensions of the AIDS pandemic.