CHAPTER SEVEN

IMPLEMENTATION PROCESS – THE CHILD MIND PROJECT

7.1 Introduction

Faced with an omnipresent AIDS pandemic in South Africa the National Integrated Plan (NIP) envisages, as one of its key strategies, the introduction of a formal life skills programme in schools to prevent the further spread of HIV in the South African society (National Department of Health, 2001). The first priority is set on the fact that life skills programmes have to teach "qualities that are necessary to empower individuals and their communities to cope and engage successfully with life and its challenges in South African society" (De Jong, Ganie, Naidoo, & Prinsloo, 1994; Vergnani, Flisher, Lazarus, Reddy, & James, 1998, p. 52).

In relation to HIV preventive approaches with children such programmes should focus on the strengthening of individual and interpersonal skills and talents that result in risk-free behavioural intentions and in protective behaviour later (Pinquart & Silbereisen, 2004). It is therefore assumed that these programmes should reach children and youth before they have established behavioural patterns that place them at risk in terms of mental and physical well-being (WHO, 1992b; Vergnani et al., 1998).

The purpose of the presented study is therefore to evaluate the implementation of a non-governmental school-based life skills programme on AIDS and sex education, called the Child Mind Project (CMP). The project was aimed at pre-adolescent children, aged 10 to 11 years, at the Ikaya Primary School in Kayamandi. This chapter outlines the CMP as another preventive school-based learning intervention performed in cooperation between two non-governmental institutions working in the field of health promotion and a governmental public school. The implementation procedures of the programme are explained, together with programme planning and strategy development, performance within a classroom setting, and developed concepts, messages and materials. At the end of this chapter, attention is paid to influences and obstacles that confront such a health enhancing programme in the effective implementation thereof in an impoverished setting like Kayamandi.

7.2 The Child Mind Project – Planning and Implementation Strategies

7.2.1 Background of the Study

In 2002 I[20], the author of this thesis, independently contacted several stakeholders within the community in order to initiate and support the implementation and evaluation of a school-based life skills programme on HIV/AIDS at the primary school in the local township. In this phase I presented my research proposal to several non-governmental and governmental organisations in Stellenbosch, e.g. Stellenbosch AIDS Action (SAA), the Ikaya Primary School, the school clinics, the Child Welfare Organisation, and the Department of Social Work and the Department of Psychology at the University of Stellenbosch.

Finally, these institutions cautiously undertook to participate in the study. The Ikaya Primary School was especially keen on participating, because they felt incapable of implementing the governmental programme and, consequently, of fulfilling the governmental guidelines. Two things should be mentioned at this point: firstly, at the time of the preparations for the pilot study the governmental programme was still in its publishing process; secondly, although ten teachers at Ikaya Primary School received training on the governmental programme in August 2002, the Stellenbosch School Clinics stated that the teachers refused to teach this programme at their school (Stellenbosch School Clinics, 2002). As agreed with the SAA and this particular primary school, I made it my task to apply for overseas funding and for research permission from the Western Cape Department of Education in Cape Town and Paarl.

After all pre-preparations and the establishment of a coordination structure, the pilot study started in August 2002 as a cooperative initiative between two South African non-governmental organisations, Ikamva Lethu Centre and Joy for Life[21], and the governmental educational institution, Ikaya Primary School that supported the implementation of the programme. On the basis of the manual designed by the Planned Parenthood Association of South Africa (PPASA)[22], a new learning manual was developed that followed specific learning conditions, individuals' learning capabilities and demands during the pilot study. The

[20] For the purpose of comprehension it was decided to use a personal form in paragraph 7.2.1 and 7.2.2.

[21] Joy for Life became a second partner in the course of the intervention because the Ikamva Lethu Centre became embroiled in restructuring processes (reaching independence from SAA) and financial instabilities towards the end of the pilot phase.

[22] The same manual formed the basis of the later revised governmental Life Skills and HIV/AIDS Education programme, taking into consideration materials from Soul City published by the Western Cape Department of Education in 2002 (2002a, b, c).

project's name, Child Mind Project, is based on suggestions made by children in the intervention group at the end of the first intervention in August 2003. Because new funding could not be acquired and because of the death of one of the health promotion trainers, it was decided not to sustain the project in August 2004.

7.2.2 Coordination Structures

The structure of the pilot study can be divided into two columns with six levels regarding funding, the tertiary institutions involved in Germany and South Africa, South African governmental and non-governmental organisations, and the project team (Figure 7.1, see also Table 7.1).

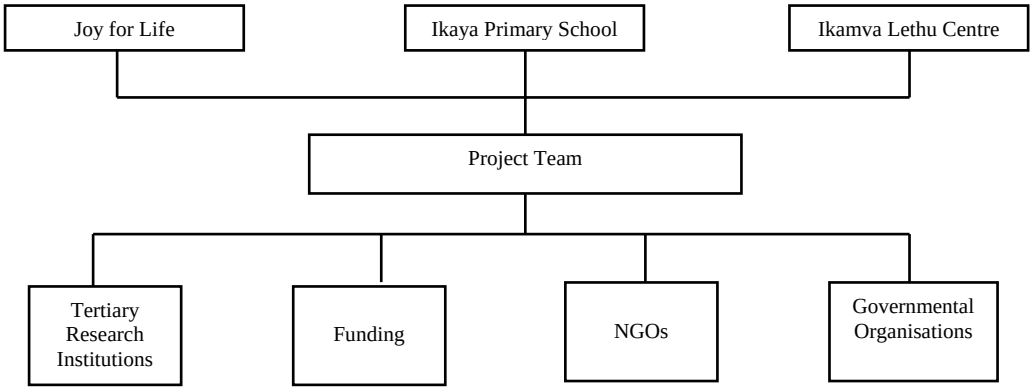


Figure 7.1. Project Structure of the Child Mind Project illustrating its six Levels.

The tertiary institutions involved were the German Universität Leipzig (2002-2004), the Freie Universität Berlin (2004-2006), and the Department of Psychology at the University of Stellenbosch, South Africa (2002-2006), in particular. This means that South African and German tertiary educational institutions supervised the evaluation of the pilot study and were involved in the cooperation agreements.

The research was funded by the German Academic Exchange Service (DAAD) (2002-2003) and the Rosa-Luxemburg-Foundation (RLS) (2003-2005). The project was funded by the German developmental aid policy NGO "Solidaritätsdienst-International e.V." (SODI) and private sponsors. The project had a total budget of R12, 387.42 and mainly consisted of the expenses for health promotion trainers.

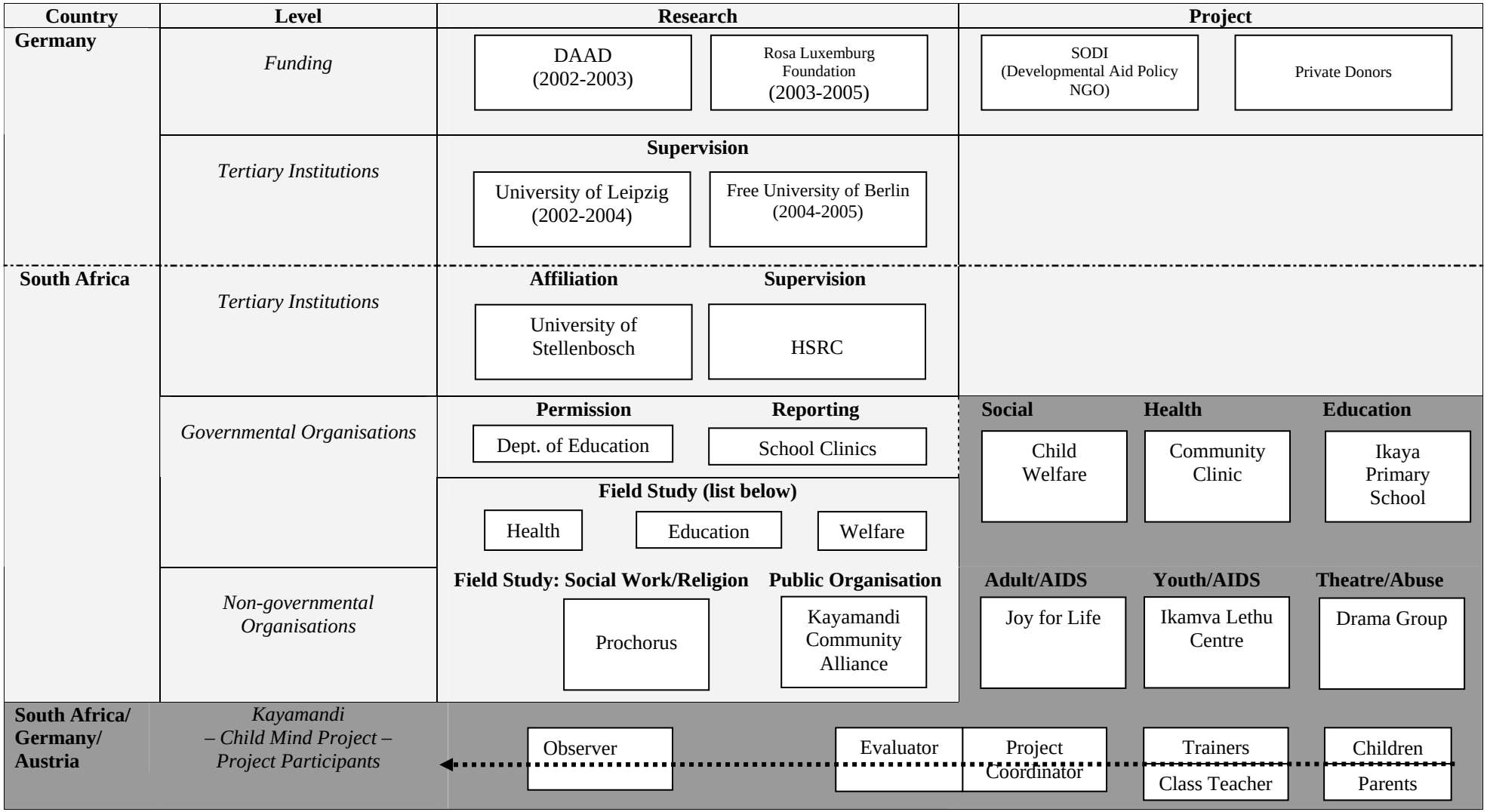
Two South African non-governmental organisations supported the pilot study. The first project partner, Ikamva Lethu Centre, is based within the Kayamandi community and at the

time was supervised by the Department of Sociology at the University of Stellenbosch. At the beginning of the pilot study, this organisation used to be part of the SAAC and became an organisation under Section 21 in 2003. The Ikamva Lethu Centre is both a youth centre and AIDS awareness centre that offers peer educational training. This organisation offered support in negotiating the project with several stakeholders in religious and cultural groups, and took over responsibility for the project within the community to safeguard the project and its staff members who were living in the community. In addition, the Ikamva Lethu Centre also offered its hall for the Drama on Abuse session and equipment for sports activities. Joy for Life, the second partner, is a long-established and experienced day-care and educational centre that encourages people infected with or affected by HIV/AIDS to live positively. The organisation also offers AIDS awareness workshops for adults at corporate, governmental and non-governmental institutions. Although the organisation is based in Cape Town, it played a crucial role in the project supervision, fundraising support, workshops for staff and teaching materials. The organisation also held a Mothers' Workshop on HIV/AIDS for mothers of the intervention group in August 2003; as the main role models for children, mothers were addressed on healthy living with or in the presence of HIV/AIDS.

The Ikaya Primary School, despite having extremely limited resources, acted as third partner and provided the platform for the CMP. The school management integrated the project in its weekly schedule, and provided the infrastructure (e.g. classroom, electricity), teaching materials (e.g. copies, television, video recorder) and personnel support (e.g. participating class teacher, official participation in parent meetings).

The project team consisted of two health promotion trainers who ran the sessions, one class teacher, one research assistant who supported participant observations and me, being responsible for the project management and evaluation of this study. In other words, on the one hand my areas of responsibility comprised the project management with the coordination of team meetings, the writing of assessments and project reports, and administration work concerning permissions, public relations (e.g. webpage) and fundraising. On the other hand, I coordinated the extensive pilot study with field studies, diverse research methods (questionnaire, participant observation, interviews, project documentation), the training of trainers and their supervision during the intervention phases, and network building within the Kayamandi community.

Table 7.1.
Organigram of the Child Mind Project



The protection of appropriate ethics and cultural values, as well as additional support in case study work and outdoor workshops throughout the evaluation process was ensured by constant contact and meetings with local experts from educational, health, welfare, religious-based and public organisations within the Kayamandi community.

7.2.3 Community-wide Implementation Procedures

For protective and strengthening matters a network with several stakeholders was established to ensure that a wide range of resources could be allocated. Networking with community stakeholders and services within the target community and the school setting was of special importance to mobilise people in charge of and experts in children's needs and demands (see para. 5.5.2). For this reason, the project is expected to become more popular and consequently more manifest and sustainable in the pool of other welfare and health approaches within the community after the pilot study. Finally, the project mobilised and made use of resources from seven non-governmental and governmental institutions. The Ikamva Lethu Centre and Ikaya Primary School were immediate partners of the CMP in its physical surrounding. The Kayamandi Community Clinic supported the project team in providing information on health, guiding a trip to the Community Clinic and supervising – in cooperation with the school and project team – cases of ill-treatment and other health problems surfacing in the intervention group (e.g. the epileptic fits of one learner).

With regard to instructions by the Department of Education to report every case of abuse to the existing child welfare system, contact was established with social workers of the Child Welfare Organisation in Kayamandi and the head office in Stellenbosch, although this organisation ought to have supervised the project team in the management of potential social cases (neglect and sexual abuse) within the intervention group during intervention.

The drama group, consisting of young actors from the community, organised a play on abusive situations linked to the lessons on sexual abuse. In addition, Prochorus, a religious-based NGO, organised field trips for the project manager, thereby providing useful grounds for discussion on the existing social and political atmosphere in the community and relations to officials in Stellenbosch. Finally, the Kayamandi Community Alliance, as the link between all organisations, functioned as a source of information on the political and social developments within the community.

7.3 The Learning Programme

As explained in the previous paragraph, the first step to realise a life skills programme that emphasises sensitive issues such as HIV/AIDS and sex, was to specifically focus on strong and supportive project implementation within its closer social context. Such a focus ensured to safeguard the holistic, cooperative and inclusive approach which is multidisciplinary, intersectoral and community-based (Magome et al., 1997/1998). The second step was the realisation of a practical and sustainable project character that pays special attention to the cultural background and the developmental stage of the participants (Magome et al., 1997/1998). Thus, the evaluated programme and its sessions and content were specifically designed for learners in the pre-adolescent stage (10 – 11 years) attending an impoverished public school in Kayamandi.

7.3.1 The Underlying Pedagogical Concept

The aims of the Child Mind Project were mutually agreed with national guidelines for life skills programmes on AIDS of the National Department of Education (2000). More specifically, the high-ranking aims of the life skills programme on AIDS and sex education or any other programme are to

- promote and develop positive values and attitudes so that [participants] understand and accept themselves as unique and worthwhile human beings,
- help [participants] to understand, acquire and practise relevant basic life skills and to display attitudes and values that improve relationships in the family, group and community,
- practise life skills and support decision-making skills with particular emphasis on assertiveness with regard to sexual issues and general life situations,
- develop necessary knowledge regarding HIV/AIDS,
- develop acceptance of different lifestyles and opinions and stimulate respectful behaviour towards different people and to hold personal beliefs and values in demonstrating values and respect for human rights as reflected in *Ubuntu*,
- support children's rights and their knowledge of child protection agencies,
- develop responsible and accountable behaviour and healthy lifestyles within the participating individual, and
- encourage learners to evaluate and participate in activities that demonstrate effective human movement and development (combined from PPASA, 1997; Magome et al., 1997/1998).

In other words, the individuals participating in a life skills programme are supposed to develop a life construct based on positive self-esteem, participation and individual opinions that enhance health-promoting behaviour. This also means that acquired cognitive, emotional and social competencies and skills be converted into active behaviour (Jerusalem, 2002b) that aims at the development of sound and positive mental health (Elias & Weissberg, 2000). Because the evaluated intervention is a life skills programme which aims to prevent later HIV infection of the participants, the programme contains three main components: the development of the values and attitudes of the participating individual (e.g. self-efficacy), the transfer of knowledge on health (e.g. HIV/AIDS) and the development of competencies (e.g. social responsibility) (Figure 7.2).

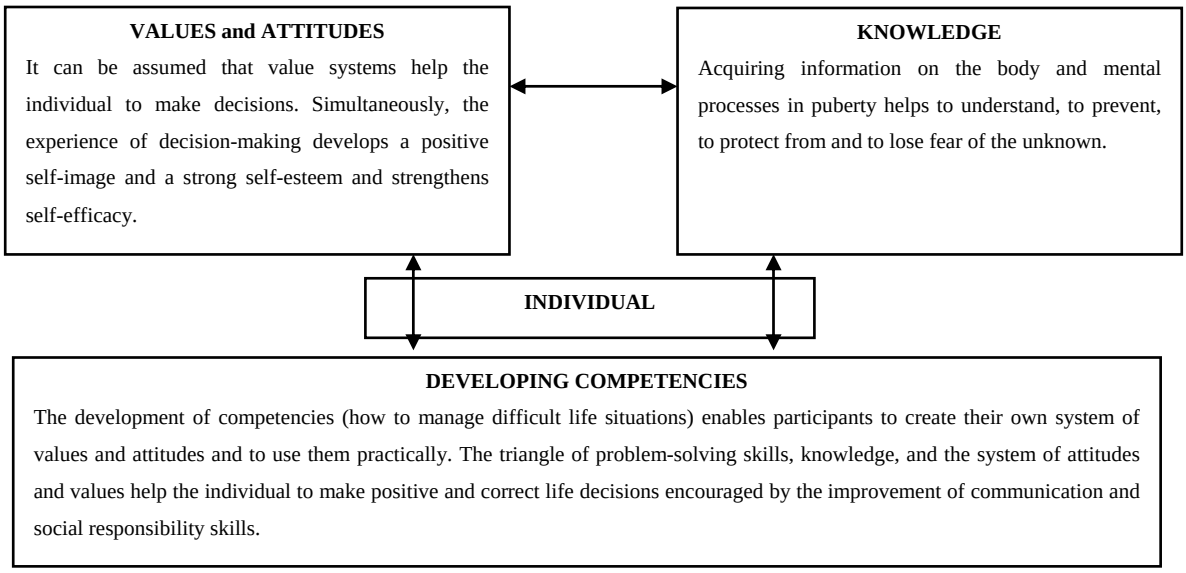


Figure 7.2. Three Basic Components (Values and Attitudes, Knowledge, Developing Competencies) of the Presented Life Skills Programme on AIDS and Sex Education (see also PPASA, 1997).

To deepen this construct, the main emphasis of the CMP is not only to give information on ways of transmission of and protection against the infection with HIV. In the centre of the intervention stands the conveying of competencies for the development of the personality of the individual (e.g. self-esteem and self-efficacy) and an increase in the belief in one's own competencies and decision-making skills (e.g. non-violent interaction and communication about taboo topics such as AIDS and sex between boys and girls). Acquiring such competencies will finally result in the development of protective sexual behaviour later in life.

7.3.2 Intervention Phases and Topics Covered

The learning programme was carried out in two intervention phases: The first intervention was the real programme and the second had the character of a booster tool to deepen the knowledge and skills participants had acquired in Intervention I. The first intervention phase took place from March 2003 until July 2003 and included sixteen sessions on eight topics to change individuals' perspectives from individual to group level and finally to community and cultural level. The second intervention phase contained topics on self-esteem, HIV/AIDS, sexual abuse, and death. The programme was taught one period (time slot in class schedule) a week on a voluntary basis. It was allocated on the timetable, according to the policy indicated in the Interim Curriculum (National Department of Education, 1997). To ensure meaningful discussions and understanding of the topic, each lesson in the classroom of the intervention group lasted 90 minutes.

The learning programme deals with a wide variety of topics, which are assumed to support the development of skills, and supports the coping mechanisms for developmental tasks and the necessary competencies. Several methods and topics were revised during the preparation of the sessions to make them more appropriate for the age of the participants and the learning and social conditions at the Ikaya Primary School.

Self-esteem was taught to develop confidence, assertiveness and a realistic self-concept in the learner. This also went hand in hand with creating motivation for making life decisions and providing the individual with coping strategies for difficult life situations. Lesson content included the identification and building of healthy bodies and healthy minds (Table 7.2).

Table 7.2.

Topic One – Self-esteem with Lesson Goal and Applied Methods.

	Topic One Self-esteem – Understanding myself (healthy bodies, healthy minds)
Session	**Method**
1	Black board teaching/explanation; Group work in mixed gender: Art/drawing a "Treasure Map"
2	Explanation on Code of Conduct; Group work in mixed gender: Art/drawing a "Treasure Map"; Homework: "Facts-about-my-body-table"
3	Performance/presentation of group results; Explanation: "Healthy bodies, healthy minds"/Discussion on healthy Lifestyle; Motivation activity: "Confidence Sentence"
16 (Booster)	Individual work: Personal "Body Map"; Presentation/performance of results; Discussion on self-esteem
Goal	Identifying and building a positive body image; finding a personal "confidence sentence"

The topic *Relationships to Family and Friends* taught different kinds of family systems, friendships and lifestyles that exist in South Africa. Ubuntu was introduced as a principle to respect other people. Children should learn how to relate to other people within their families, classrooms and communities by caring for others, sharing with others, cooperating with others, having compassion for others, acting with honesty, justice and fairness and be hospitable to others (PPASA, 1997). Related issues like peer pressure and the difference between love and sex were introduced during these sessions (Table 7.3).

Table 7.3.

Topic Two – Relationships with Family and Friends with Lesson Goal and Applied Methods.

	Topic Two My relationship with family, friends and the community
Session	**Method**
4	Motivation game/Fun; Explanation: "We are all part of a family" (different types of families that exist in SA); Group discussion: "Different Family Types"; Collage/Art: "My family?"
5	Motivation/Music: "Tree Song"; Decision-making: Collage displayed next to the correct family type; Discussion on friendship; Individual work: friendship web
6	Discussion: Results of friendship web; Brainstorming: "What else do you want to do in the life skills programme?"; Homework: Create a "Friendship card"
Goal	Definition of types of families and friendships

Sessions on *Understanding my body* explained the physical (internal and external organs, sexual intercourse) and mental development from childhood to puberty in relation to feelings, and the well-being of body and soul. In-between these sessions an extra outdoor event took place to the Kayamandi Community Clinic. The tour was guided and lectured by the manager of the Clinic (Table 7.4) with the goal to introduce this medical institution and its staff to the children and to make them feel more comfortable with it in case they needed medical support or advice.

Table 7.4.

Topic Three – Understanding my Body with Lesson Goal and Applied Methods.

	Topic Three Understanding my body
Session	**Method**
7	Introduction: Secret box; Explanation: "Understanding my body"; Group work in mixed gender: Physical and mental changes from childhood to puberty; Performance/presentation of group results
8	Division of class into two groups according to their gender; Explanation of internal and external organs, including reproductive organs; Individual work: Filling in copies with names and functions of body parts; Fun: Naming some embarrassing slang or silly names for the body parts or organs
9	Division of class into two groups according to their gender; Explanation: Sex education (slowly and sensitively); Explanation/story telling on sexual intercourse; Game/relaxation: soccer for boys and netball for girls
Goal	Examination of external changes from birth to puberty; Explanation of functions of the main body parts (internal/external); sexual intercourse and pregnancy

Topic four, *Keeping my body safe and healthy*, involved health promoting sessions on hygiene to protect the body against any kind of disease caused by germs and bacteria, and sexually transmitted infections (HIV/AIDS was not specifically outlined at this point). Information on risks of and protection against infections was given and risk awareness was encouraged. In one session a picnic was held in the classroom where several kinds of food (e.g. fruits, vegetables, dairy products, bread) were introduced as inexpensive alternative protection of the immune system (e.g. garlic, carrots), and as part of a healthy nutrition and lifestyle (Table 7.5).

Table 7.5.

Topic Four – Health and Hygiene with Lesson Goal and Applied Methods.

	Topic Four Keeping my body safe and healthy
Session	**Method**
10	Explanation: "Keeping you healthy"; function of the body defences/immune systems and hygiene; Food event/experimental learning: healthy food and its functions
Outdoor Trip	Introduction to the Kayamandi Community Clinic; Explanation of the functions of the clinic, rooms, and responsibilities of staff
Goal	Making responsible choices and taking responsibility for one's own health; understanding the body's defences or immune-system; prevention of the spread of diseases by germs and bacteria

The session on *HIV and AIDS* defined the disease and explained its transmission as well as available protection. The explanation of sexual intercourse and later of the transmission and prevention of HIV/AIDS included the A(bstinence), B(e faithful), C(ondoms) and D(elay

sexual debut) strategy as part of a free decision-making process of the individual (Table 7.6). The lessons also dealt with contraceptive methods, such as the use of male and female condoms and the antipregnancy pill. The objectives were to reduce fear and to empower the children to deal with the disease in everyday situations. Contraceptive methods such as condoms were introduced and explained; this was against the recommendation of the original manual (PPASA, 1997), which only introduces condoms in Grade 6. The decision to implement the condom distribution in this session was made after many learners requested information on these questions in the secret box. The questions proved that there was a great need for information on contraceptive and protective methods. Social aspects of the disease, such as stigmatising HIV-positive people were talked about in groups. The learners had to decide whether an HIV-positive child should be allowed to attend their school. This task and its results are outlined in more detail in chapter 9.

Table 7.6.

Topic Five – HIV/AIDS with Lesson Goal and Applied Methods.

	Topic Five HIV/AIDS in my world
Session	**Method**
11	Explanation of HIV/AIDS: Definition, ways of transmission and protection, living with HIV and healthy lifestyle; Protection methods (condom distribution) and presentation of several contraceptives (functions)
12	Group work (seven groups of same and mixed gender, on voluntary basis): Decide whether a HIV-positive child can attend their school if they were the principal; Presentation/performance of results; Explanation: Human Rights and law in the South African Constitution for people living with HIV
17 (Booster)	Group work in mixed gender: Answering questions on the definition of HIV/AIDS, transmission of and protection against HIV, testing; Presentation of results by learners; Explanation by HPTs
Goal	Definition of HIV/AIDS; transmission of and prevention against HIV/AIDS; Prevention of discrimination against people infected with HIV (Human Rights Aspect)

The session on *Abuse* covered any kind of abuse and aimed to improve the understanding of wanted and unwanted physical contact and the resistance to outside pressure to have sex. However, special attention was paid to sexual abuse due to the high number of child sexual abuse in South Africa according to official statistics (see also Human Rights Watch, 2004c). Behavioural guidelines and contact numbers were given to the children so that they knew where to find help (Table 7.7). In this regard, a local drama group invited the intervention group at the Ikamva Lethu Centre to attend a play on physical and sexual abuse stories of children, which the actors defined as typical for the location.

Table 7.7.

Topic Six – Sexual Abuse with Lesson Goal and Applied Methods.

	Topic Six Sexual abuse – Keeping safe from unwanted touch
Session	**Method**
13	The class was seated like in a theatre to watch the video (mixed gender); Explanation: Abuse of bad, confusing and good touch; Video: "Good and bad touches"; Card game: "touch" and "feeling" cards; Music/song: "That is nobody's body than mine" from the video with the learners
14 (Outdoor Trip)	The class was seated like in a theatre to watch the play (mixed gender); Drama play: Drama on physical and sexual abuse; Discussion of drama: What kinds of abuse exist (including sexual abuse)?; Who are abusers? / Who gets abused?; Explanation: Good and bad touches and feelings; Individual work/card game: Revision and "touch" and "feeling" cards; Explanation: Safety rules, behavioural procedures if abuse happens, and Help lines (no. Child Help Line)
18 (Booster)	Music: "Tree Song"; Explanation (Repetition): Abuse; Individual work: Personal "Action Plan"; Music: "That is my body"
Goal	Definition of (sexual) abuse; reviewing good and bad touches compared to related feelings; action plan (recognise, report, respond) against sexual abuse

The session on *Caring for an ill person* was introduced in terms of hygiene, nutrition and responsibilities, and explained standard procedures when taking care of a sick person at home (home-based care) (Table 7.8). In addition, information on and skills of first aid and hygiene were conveyed.

Table 7.8.

Topic Seven – Caring for an Ill Person with Lesson Goal and Applied Methods.

	Topic Seven Caring for an ill person
Session	**Method**
15	Explanation: Caring for someone (needs of a sick person, daily schedule, hygiene); Group work in mixed gender/experimental learning: Wound treatment; Role play by trainers: Visit at the doctor (explanations, instructions) Presentation/demonstration: Treatment of diarrhoea (mixture)
Goal	Caring for an ill person (needs, feeling of comfort) and planning a routine; hygiene – special topic: diarrhoea and making a simple oral anti-dehydration mixture

The last topic, *Dealing with Death* was introduced together with the previous topic and discussed rituals and beliefs in death and stages of grief, which were illustrated as part of the life circle (Table 7.9).

Table 7.9.

Topic Eight – Coping with Death with Lesson Goal and Applied Methods.

	Topic Eight When someone I love dies
Session	**Method**
16	Discussion: cycles of grief
19 (Booster)	Explanation: stages of grief; Discussion: different cultural beliefs in death and funeral traditions; Art: Drawing a memory card; Music/relaxation: "Tree Song"
Goal	Discussion on the circle of life from birth to death and different ways to mourn for somebody

The final event in the Intervention I phase was a day trip with the class to the Two Oceans Aquarium in Cape Town in August 2003. The class was informed one week before the excursion. The first goal of the class trip was to signal appreciation to the participating children for attending the project and secondly, to demonstrate the success of the project in equipping children with skills to adjust to new demands and behavioural patterns within a new setting.

In summary, because the main goals of the CMP was to build the foundation for the acquisition of appropriate and correct knowledge on HIV/AIDS, to encourage positive mental responses and resilience among individuals, and to develop protective health behaviours, it incorporated a positive and encouraging life philosophy reflected in the variety of topics and teaching methods.

7.3.3 Presentation Methods and Applied Language

As Bandura (1986, p. 21) states, human functioning is explained as a model of triadic reciprocity in which behaviour, cognitive and other personal factors, and environmental events all operate as interacting determinants. Human nature is characterised by a vast potentiality that can be fashioned by direct and observational experience into a variety of forms within biological limits. Thus, any intervention, learning model as Bandura calls it, must put special emphasis on its framework and methodology using mainly participatory and experiential methods to allow participants to observe and, at best, to test modelled behaviour for their own use. In the CMP consequently, special emphasis was given to the application of a vast variety of teaching methods during sessions which allowed participants not only to acquire new knowledge but also to observe action or to apply skills. The following methods were used.

Frontal teaching or black board teaching was applied when new topics and content were introduced or repeated to the learners to embed new knowledge, to deepen general knowledge

and to dispose of false knowledge or misunderstandings. Every lesson started with a revision of the previous lesson and its content, which gave the HPT's not only the chance to conduct the class but also to summarise for learners the learning result. This method in turn required from learners the ability to listen and concentrate. However, as Bandura (1986) also found, the children achieved significant gains in knowledge when instruction was interspersed with the demonstration of the principles, whereas they learned little when the same information was presented through verbal instruction alone. The decentralised methods in particular paid attention to the demand that new knowledge and skills are best acquired with participatory and active methods. Active learning approaches, on the one hand, are seen as the most effective way in which young people can learn health-related and social skills, and on the other hand, offer the opportunity to organise difficult sessions with more enjoyment and comfort to enlarge the emotional status of the participants.

The first active method, the *individual work* method was thought to be relevant when learners needed to assimilate the learned knowledge and interlink it with their personal belief system. This method was usually linked with artistic methods. Art (e.g. collage) and music (e.g. a song about abuse or the tree song) played a significant role in sessions on self-esteem, relationships or death in families. The method of *open discussion* was mainly used when an interaction between health promotion trainers and learners had to be encouraged. Open discussions especially, strived to develop the expression of an individual opinion, a positive self-esteem and the ability to participate in the context of a problem.

Group work, the third participatory method, was a particularly important method by which learners had the opportunity to discover the practical aspects of the information they were given. Group work is regarded as important for the development of identification, empathy and solidarity for one's own and the other gender and it should therefore encourage the skills for non-violent intergender communication and common decision-making processes. This method was also considered to encourage learners with low self-confidence to speak, open up, and get involved in discussion in smaller groups. In mixed gender group activities, learners mostly chose their group themselves. The use of gender specific group work came into effect in the session on sex education to create a more intimate atmosphere. At the end of each group work session, groups had to elect one learner who presented and/or performed the results to the class, which was supposed to encourage this specific learner's confidence and increase his/her language skills.

Another participatory method, *brainstorming*, was used when children had to make decisions with the whole class on, for instance, the type of outdoor trip or the name of the

project. *Physical activities* (e.g. games, sports, plays) were used to encourage individual expression and relaxation and/or to reduce stress, for example during sex education; sport (soccer and netball) was used after the first session on sex education. The *drama on abuse*, as another important active method, was important to communicate real life situations in a playful manner so that learners could observe and feel free and safe to openly ask questions about such a sensitive and often shameful issue. *Outdoor trips,* the last method, were seen as practicable to introduce the living environment into the educational setting of the children; a visit to the community, for instance, made the organisations more familiar to their community. Another outdoor trip was made to the Two Oceans Aquarium in Cape Town. The goal of this method was to allow the practising of recently acquired skills and competencies and the probation within a real life setting. The learners thus had the opportunity to feel part of a new experience outside their familial, school or community setting, and were encouraged to handle new demands successfully in the application of their newly learned skills.

Lastly, as the National Department of Education's Language-in-Education Policy suggests, learners should learn more than one language and use the language that they best understand as the language of learning and teaching (1996). In agreement with the school management and parents the sessions in the life skills programme on HIV/AIDS were taught in isiXhosa and English and used educational material designed in both languages. The first language of the participants, isiXhosa, was used in most of the culture related sessions about friends and families or the death of loved ones. English became relevant during sessions on cultural taboo issues such as sex, HIV/AIDS, physical development during puberty and sexual abuse. In this respect, English functioned as a bridge between taboo and accepted cultural topics.

7.3.4 Educational Material and Supplementary Teaching Material

Teaching materials were mainly used and/or copied from the PPASA manual (1997). Supplementary teaching material and additional information were taken from several sources: Joy for Life (2003), Educational Support Services Trust for the Department of Justice and Constitutional Development (2003), National Department of Health (2000), Soul City (unknown), Quaker Peace Centre (1999; 2002), Western Cape Department of Education (2002a, b, c), the National Film Board of Canada (Foon et al., 1984), and the German life skills and health promotion projects at schools by the German Bundesministerium für Gesundheitliche Aufklärung (BzGa).

7.3.5 Programme Performance – Creating a Safe Classroom

Specific instruments like the *code of conduct* or the *secret box* and a clearly defined temporal framework and embedding rituals were designed to create a supportive teaching environment and to encourage trust between the HPTs (role models) and the children. The code of conduct was compiled to create a place of emotional (Lourens, 2004) and physical safety during the sessions. Because personal standards of conduct provide a further source of motivation (Bandura, 1986), it is believed that the atmosphere had to be one of social appreciation and rewarding behavioural consequences without aversive actions or punishment. Consequently, it was of special importance to create an encouraging learning environment with HPTs as living models for participants to increase their observational learning and make the model more likely to produce good results (Bandura, 1986).

The code of conduct contributed to symbolising a living democracy with participation, representation, rights and duties for every individual involved. Eleven rules and regulations were presented as a valid and fixed behavioural guideline for every person present during the session (learners, trainers, class teacher and observers). In general, the rules, for example “We give everyone a chance to speak” or “We do not laugh about people” were also intended to ensure that trainers and learners did not use psychological or physical violence (e.g. “We do not use violence – here or outside the workshop – including hitting and being horrible to people”) to provide a guideline on how to solve problems within the classroom (Appendix G). The code of conduct was compiled according to the Peace Education Programme by the Quaker Peace Centre (2002) and the Primary School Kit of the United Nations (1995). The Commitments and Rules were printed on an A4 poster and made visible on the information board in the classroom. The outcome was regarded as positive; only one disciplinary incident occurred, which was when two boys were jumping on the tables. The class reacted with disregard, and reprimand was enough to manage the situation.

The secret box was introduced as an instrument to ask questions which the children did not want to ask trainers directly or in the presence of other learners; the box thus functioned as a mouthpiece. Although the box was located in the classroom, every question or comment was treated with confidence and only the health promotion trainers were allowed to open the box.

A special framework for each session was compiled with an *entry* and *exit* ritual. This framework was intended to ensure continuity and reliability of the project team as well as the time frame within a school day, given the often unpredictable time management and presence of teaching personnel. The sessions were opened with a *confidence sentence*, implemented in session three on self-esteem. The sentence read: “There is no one else like me. I will become

the best I can be in life because I am …" The learners had to find an appropriate adjective that described them best. The end of every session was symbolised by the handing over of an apple. This action was meant to encourage a positive group dynamic among the members of the class to encourage patience and self-organisation without using violence. For example, at the beginning of Intervention I the children fought for their position in the row to receive an apple. Through this procedure the children should have learnt, first and foremost, that they were all treated equally. Everyone thus received an apple as a symbol of equality.

The goal of every single instrument in creating a safe and encouraging atmosphere during sessions was to produce trust between the learners, the involved class teacher and the health promotion trainers, and to encourage a protective and empowering teaching atmosphere.

7.4 Involvement of HPTs, the Class Teacher and Parents

7.4.1 HPT Training and Preparation of Lessons

Two young unemployed women from the case study community were selected and trained as health promotion trainers in this specific life skills training on AIDS and sex education. One HPT had worked as a trained voluntary AIDS counsellor at the Kayamandi Community Clinic and the second HPT had received training in child development and protection from the Eye on Child Project at the Child Welfare Organisation in Kayamandi. The intention of this course of action was to empower young people to give them further training and to put them in a position to be role models in their community.

The preparation phase of trainers and lessons covered the time from October 2002 until February 2003. This phase was divided into three parts: 1) workshops on the manual and related literature, 2) weekly meetings where the topics were discussed and questions about the topics were answered, and 3) final lesson planning, which was done one month before the intervention. During the school holidays the trainers attended workshops organised by the Planned Parenthood Association of South Africa (HIV/AIDS Advanced Training: Training-Of-Trainers), Brahma Kumaris – World Spiritual University (Living Value Workshop) and Joy for Life (Living positively with HIV/AIDS). The trainers were also encouraged to visit the intervention group during normal lessons and to observe the children's behaviour outside the intervention. The objective of such visits was to establish personal contact with teachers because health promotion trainers were expected to slowly take over responsibility for and ownership of the programme in phases following the pilot study.

Preparation of lessons was organised in two-weekly team meetings for two hours each. These sessions had the character of a workshop in which the content of the topics were discussed, literature was allocated to trainers to keep a stable and continuing training, and daily information between the coordinator and health promotion trainers were discussed. Problems with single learners, disciplinary issues, learners' reactions and social, educational or health problems were discussed in the follow-up sessions. The follow-up session took place immediately after the end of the lesson. Due to the non-pedagogical professional background of the health promotion trainers, effort was made to ensure a high quality of teaching style, accuracy of the taught knowledge and the constant progress of the programme. The meetings therefore functioned as a supervision of the ability and emotional state (e.g. building self-confidence) of the health promotion trainers.

The sessions were conducted by these two female health promotion trainers, firstly because the HPTs could support each other during the sessions with regard to knowledge, teaching skills and conflict management in the classroom setting. Consequently, they were put in a position to support and observe each other, which should encourage a further learning process on teaching qualifications and confidence. Another advantage was meant to be that teamwork made the classroom arrangement easier and allowed working in (gender-specific) groups. Furthermore, the HPTs could work with either girls or boys, according to their specific preferences. The mutual sympathy between the HPTs over the course of the intervention was a precondition for working together as a team.

7.4.2 Involvement of the Class Teacher

One class teacher was invited to attend the sessions so that her involvement ensured a flow of information from project team level to school management level in order to make project management easier. The other objective, similar to the request from the Stellenbosch School Clinics, was to identify a supporter of the CMP who was able to sustain the coordination of the programme at the school after the pilot study. The team and the class teacher held regular meetings where they discussed ways of assisting learners with social problems, organised parent meetings and meetings with management staff of the school, or where they discussed the applied teaching style and methods.

7.4.3 Parents' Collaboration

In the National Department of Education's Public School Policy of 1996, the relationship between parents and school is defined by a set of rights and responsibilities. In that respect,

the school has the responsibility to inform parents about their child's learning process or new learning activities and, whilst the parents have to liaise with school staff and have to monitor their child's educational process[23].

The pilot study as a learning activity on school property had to involve parents in four ways to safeguard the ethic codes. Firstly, more than five parent meetings were held before, during and after Intervention I and II. This was of special importance to encourage the acceptance of the project and to guarantee the protection of the health promotion trainers who lived in the community. For instance, the interim meeting took place after the sex education session to double-check with parents whether the children and the parents as their legal guardians felt comfortable with the methods used. More than half of the parents and the school governing body joined the last parent meeting where children presented their knowledge on healthy food and wound treatment. Secondly, the meetings guaranteed a flow of information from project to parents and allowed parents to ensure that the programme content was appropriate to their educational, cultural and religious convictions for their child. During meetings parents confirmed that they checked their children's homework and acquired new knowledge from children. This leads to the assumption that the communication between parents and children was encouraged during the pilot study. Thirdly, parents were put in the position of informed advisers, where informative material or advice was given to them in terms of child care, protection and medical support. All information and correspondence were provided in isiXhosa. Furthermore, a Mothers' Workshop was organised by Joy for Life because women tended to be quiet in parent meetings where men were also present. Therefore the project team decided to offer a workshop on HIV/AIDS for mothers, sisters or female legal guardians whose children were part of the intervention group. The goal of this workshop was to establish a personal and direct contact with the mothers or women and to give them the opportunity to get closer to their children. Lastly, parents were invited to meetings at school on case work, for example sexual abuse or medical problems of children. It was always made clear that the parents were fully in charge of their children's education; they were offered support in the hope that they would feel less dominated by officials from the school or the pilot project team.

[23] The policy also requests parents to support the school in disciplinary matters without clearly defining the content and procedure for this. This point shall become relevant in 7.5.3.

7.5 Special Influences and Events during the Pilot Study

7.5.1 Outcomes of the Secret Box

The work of the project team was not only limited to the implementation and realisation of the project. Much effort had to be put into case work in the intervention group. As explained in paragraph 7.3.5, the secret box was applied as a mouthpiece for those learners who were too shy or ashamed to ask specific questions in the presence of other classmates. However, during the process of the intervention, the secret box became not only a highly respected and frequently used instrument of learners who felt a need to ask (intimate or forbidden) questions but also to receive help in regard to family problems or personally experienced abuse.

The notes in the box can be divided into five categories: (a) pregnancy, (b) sex, (c) HIV/AIDS, (d) notes of thanks, and (e) letters explaining problematic situations within the children's families and life. Questions from categories (a) to (c) were answered without mentioning the name of the learner in front of the class during the relevant sessions; most of these letters were signed with the learner's name even though HPTs had made it clear that questions could be asked anonymously. Notes of thanks (d) and letters explaining problematic situations (e) were answered with a letter to the specific learner inviting him/her to speak with the project team.

7.5.2 Cases of Sexual Abuse in the Intervention Group

Six letters contained issues related to physical, mental and sexual abuse, or described situations of neglect, caused by the separation from parents, and poverty in the immediate family. All cases were first discussed in the project team and specific decisions were made to ensure confidentiality of information. Learners who had asked for help received a letter that invited them to speak to the members of the project team if they still wished to be supported. If a learner decided to speak and permission was given to carry on with the case work, the class teacher became involved in the case work. At this point one case shall serve as an example of what turned out to be the most problematic to handle. One girl wrote the following letter after the session on abuse:

> Misi, Uncle let us think that he will send us, me, P… and N…, to the shop, but instead he locks us up into room. He says to us we must give him that. I ask him what that is and I would say no. I do not want to. The others will do the same, too. I say I tell dad or scream he'll say, he is not afraid of him or mom. When I scream, he says shut up.

> When we opened the door, I got out the others followed me. When he says, we must come back or he says I'll give you money. I'll say, I don't want this money on anytime of him for that matter. The others don't say anything. They listen to me. (NM, female, 10 years old)

In the same week, the participating class teacher reported that two girls had come and reported a case of child sexual abuse to her. After receiving the letter and information, the team and class teacher invited the girls to a meeting. In the meeting the girls described an attempted sexual abuse. They stated that a third female cousin living in the same household was affected by the attack as well.

At that critical point, following regulations from the Department of Education and the School Clinics, the principal was informed about the case and was asked for advice. One day later, one of the mothers was invited to a meeting at the school. With her permission the principal, the class teacher and the project manager joined the meeting. The encounter also revealed that the attempted rape turned out to be a performed rape. The mother was apparently extremely overwhelmed by the situation and explained that the present sexual abuse was possibly done by her own 19-year-old brother. She also stated that one of the girls had already been raped by an old man (uncle) when she was eight years old. The mother reported that the girl had never been sent to a doctor but she had examined her daughter to see if she was still a virgin. The family background can be defined as extremely impoverished. Only the father had a part-time job financing his two children, the mother, his sister-in-law and his brother-in-law. The mother explained further that she had been asking for help at the local Child Welfare Office a few months before the last event, but social workers had sent her to the police station without any support. Mrs. M. confirmed that she knew of the abuse because the last time the girls had reported the new incident to her was three days before the girls decided to report the case to the class teacher and the project team.

During this meeting the principal tried to report the case to the social workers at the Child Welfare Office and the Community Clinic. However, as it was Friday afternoon and just before a one-week school holiday neither institution was available. Consequently, the result of the meeting was that the principal would contact the manager of the Stellenbosch Child Welfare Organisation after the school holidays. Mrs. M. stated that she would consult the social workers as well as the Community Clinic with her daughter for an examination. She also said that it would be of great help if the uncle was forced to leave the home. A new meeting was scheduled for after the school holidays. After the school holidays the situation was as follows (without external professional intervention): the family system, assumingly the

male head of the family, had decided to send one of the girls to the Eastern Cape Province; the two others still lived with their family in Kayamandi. The abuser was sent to an unknown place to live with other kinship.

With regard to this situation the project team decided to report the case and to send copies of the written report to the Child Welfare Office. In the meeting with one of the social workers it was confirmed that the mother had reported the case to them in April 2003. They had sent her to the police and the local clinic. One year later in August 2004, the project manager asked the same social workers about the case. They could not find the report files. As a result of this meeting, the project manager had a personal meeting with the Child Welfare manager in Stellenbosch who was surprised to hear about this case.

The final outcome of the case was disappointing. This case of child sexual abuse had never been reported to the police as the statistics from Stellenbosch revealed. The separation of the two girls, who were close friends, can be regarded as a secondary trauma. None of the three children have received any psychological or medical supervision at any time. The parents were left alone in their search for help, without adequate support by official institutions. The perpetrator has never been charged for his illegal action. Finally, the girl who was brave enough to report the case disappeared with her father from Kayamandi in January 2006. Her present location is unknown. In the end, the process came to a complete standstill; all attempts to support the girls, including those of the CMP team, failed[24].

7.5.3 Corporal Punishment as a Pedagogical Approach at Ikaya Primary School

This paragraph describes two incidences of observed corporal punishment at Ikaya Primary School performed by a teacher and a father. One incident occurred when the two observers entered the classroom for an observation session. Ten learners (boys and girls who attended the intervention group) were standing at the front of the class and were being beaten on their hands with an orange stick by their female teacher. The moment she noticed the visitors, she stopped the beating and all the learners went back to their chairs. The teacher put the stick in the cupboard next to the door (Lindner & Otto, 2004).

The second incident was observed on another observation day in front of the classroom. A young girl from Grade 4 ran past the observers, followed by three other children and a man with an orange stick who tried to catch her. When the man got hold of the girl he started to

[24] This particular case can be compared to many similar stories reported in Richter et al. (2004).

beat her heavily on her whole body. The observers did not intervene because one of the teachers held them back, explaining that this was the girl's father and he had the right to discipline his child. Several children from different classes observed the scene, most of them belonging to classes that were attended by participants for observation. Not one of the present teachers intervened (Lindner & Otto, 2004). As a consequence, the third observation phase that was scheduled for March 2004 was cancelled because such traumatic experiences are assumed to cause tremendous changes in the social behaviour of the participants, and also reduce the objectivity of observers. However, if the research question for participant observations would have been based on identifying health hazards in the school environment, which assumingly endangered the success of any health-promoting intervention, then it certainly would have been necessary to take those data into consideration. Therefore, in anticipation of the concluding chapter, the recommendation can be made that further evaluation research in this field should consider including the question of health hazards in the school environment as a fundamental part of the research design.

Furthermore, the description of observed scenes of corporal punishment, even on management level, depicts the practised pedagogical approach at the school. The majority of pedagogical approaches and disciplinary methods at the school demonstrate the strong contrast between the authoritarian and rigid approach that is still being practised in the everyday school setting on the one hand, and the applied life skills programme that follows an open and participatory approach on the other. These disciplinary practices are assumed to have indirectly influenced the project in regard to the enhancement of competencies like problem-solving or psychological factors life self-esteem among participants. The observation of physical abuse was reported to the Stellenbosch School Clinics in the half-yearly report sessions. Further remarks in this regard can be found in chapter 11.

7.6 Conclusion

Chapter 7 described the implementation process of the CMP. Coordination was based on educational cooperation between the primary school and two non-governmental organisations working in the field of health promotion on AIDS in South Africa, Joy for Life and Ikamva Lethu Centre. Several local institutions supported the CMP with their expertise and helped to implement it in its physical environment, the Kayamandi community. The pedagogical concept of the implemented CMP strictly followed national guidelines for life skills programmes on AIDS of the National Department of Education (2000). Because the goal of the programme was foremost to strengthen and increase the mental development of the

participants, it encompassed a magnitude of topics that surrounded the attendees' demands appropriate to their age and intellectual capacity. The participatory and active teaching methods (e.g. group discussion) followed Bandura's Social Cognitive Theory (1986) in order to allow participants to observe and to test modelled behaviour in their own physical and social context. Specific safety measures such as the code of conduct were introduced in the classroom to ensure an atmosphere that encouraged happiness and well-being.

The two health promotion trainers and the class teacher acted as educational personnel of the intervention group. The health promotion trainers were educated in this specific learning programme and teaching methods, whilst the class teacher, also a member of the project team, was responsible for the netting of the project with the school and needed to ensure the appropriateness of teaching procedures. Parents were invited to five parent meetings to inform them on the presently taught topics and to guarantee their full involvement in their child's educational process.

In addition, the CMP was confronted with several abuse cases that happened outside (e.g. child sexual abuse by a relative) and inside (e.g. corporal punishment) of the school environment. These cases are assumed to have had an additional influence on the project's effectiveness by endangering its main goal to empower and enhance mental health within the individuals.