

## CHAPTER 1

### RESEARCH BACKGROUND

#### 1.1 Introduction to the chapter

Human Immuno-Deficiency Syndrome and Acquired Immuno Deficiency Syndrome (HIV/AIDS) are no longer a disease we just talk about or read about in newspapers. It is having a serious impact on the lives of many people in the world with an estimated figure of 60 094 374 infected people worldwide (Aids Barometer 2004:17). The pandemic is worse in Africa and in other parts of the developing world, with even worse statistics coming from sub-Saharan Africa. Jackson (2002:9) argues that Sub-Saharan Africa, especially southern Africa is the hardest hit region in the world. In Botswana, Swaziland and Zimbabwe, up to one in every three adults is estimated to have HIV (Jackson, 2002). For this reason in May 1993 the Ministry of Education, Sport and Culture with financial and technical assistance from the United Nations International Children's Education Fund (UNICEF) launched an HIV/AIDS and Life Skills Education Programme for schools in Zimbabwe as part of their initiative to combat the spread of HIV and AIDS. At that time the two co-operating organizations launched and distributed their first HIV/AIDS textbook for primary schools called *“Let's Talk” – An Aids Action Programme for Schools* for Grade 7 pupils with teacher's copies (UNICEF, 1993:1)

In mid-1995 they launched and distributed their second textbook in the “Let's Talk” series for Grade 5 teachers and pupils. These were the first publications in a series

intended to cover Grade 4 to Advanced Level. The programme was to be fully rolled out from Grade 4 to 7 for primary schools, and from Form 1 to Form 6 for secondary schools by the year 2000.

Using enrolment statistics and school addresses at the Ministry's Head Office, sufficient pupils' textbooks and teacher's copies were supposed to have been mailed directly to the schools by the Curriculum Development Unit (CDU) deliberately avoiding the perceived delay of sending these via the respective Provincial Offices of Education (UNICEF, 1993:1). At the time of distribution, the books were accompanied by the Chief Education Officer's Circular Minute No. 16 of 28 June 1993, directing heads of schools to arrange for HIV/AIDS and Life-skills Education to be taught in their schools as a separate subject, weekly, in a 30 minute lesson for primary schools and 40 minute lesson for secondary schools. According to O'Donoghue (1995:1) the actual strategies for implementation were left to the individual schools to work out. That circular gave other important guidelines on the teaching of HIV/AIDS and Life Skills Education in Zimbabwe as it relates to integration, methodology, capacity development for heads and teachers, materials, support for heads and teachers, AIDS Action clubs, networking, supervision, etc. This circular was cancelled and replaced by the Director's Circular Minute No. 2 of 2003 dated 16 January 2003 which further gave terms of reference for AIDS support organisations wishing to participate in the Ministry's HIV/AIDS and Life Skills Education Programme.

However, to assist schools, a comprehensive HIV/ AIDS and Life-skills education programme syllabi document for use from Grade 4 to 7 (primary schools) was

developed and mailed directly to the schools. This was also accompanied by another source material entitled 'Methods in Education' produced by UNICEF (O'Donoghue 1995:3). Schools were also encouraged to source other HIV and AIDS materials from other organizations engaged in the fight against HIV and AIDS. Furthermore, the Ministry of Education was supposed to hold training workshops at National, Provincial, District and at school cluster levels to train Education Officers, head teachers and teachers on the scope and possible delivery modes for the HIV/AIDS and Life Skills Education Programme. The Ministry of Higher Education (MOHE) was also to immediately incorporate HIV and AIDS in its training programme for teacher trainees at teachers' colleges countrywide. However, the programme did not roll out as planned because the Ministry of Education, Sport and Culture did not honour its part of the deal owing to the shortage of financial resources. All schools are reported to have been offering HIV/AIDS and Life-skills education as a subject by year 2000 but it cannot be confirmed if all received the books and other teaching materials and if the programme was effective.

### **1.2.2 Statement of the research problem**

UNICEF (1993:4) quotes the former Permanent Secretary for Education, Sport and Culture in Zimbabwe Dr Isaiah Sibanda as arguing that HIV and AIDS is having a serious impact on the lives of many Zimbabweans and other nations worldwide. He cited statistics published in September 1993 by the National AIDS Co-ordinating Programme (NACP) which reported a cumulative total of 25 332 AIDS cases in Zimbabwe alone. Zimbabwe's former Health and Child Welfare Minister Dr Timothy Stamps concurred with Dr Sibanda in the same publication when he observed that the

AIDS pandemic had become a public health problem of international proportions threatening to frustrate human efforts on all fronts.

Almost a decade later, (UNICEF 2002:21) reports that Zimbabwe has one of the worst AIDS epidemics in the world, currently with a 24,6% prevalence rate. The same publication names Zimbabwe as one of the four worst affected countries in the world in terms of HIV and AIDS prevalence. It is against this background that Zimbabwe and other nations of the world found it necessary to institute measures to counter its spread. With no immediate prospects of a cure or a vaccine, prevention of HIV transmission was thought to be the only way to arrest the course of the epidemic (UNESCO 1994:2). The Zimbabwean government therefore introduced HIV/AIDS and Life Skills Education into the school system in May 1993 through the Ministry of Education, Sport and Culture.

This study therefore seeks to establish whether the schools within Lupane Area Development Programme implemented the HIV/AIDS and Life Skills Education Programme for schools. If they did, the study seeks to establish as to what extent the programme was effective or not. To establish these facts the study will therefore survey the strategies and approaches used by different primary schools and/or school clusters in the implementation of the programme. The statement of the research problem therefore is:-

“To investigate whether the HIV/AIDS and Life Skills Education Programme for Schools was implemented. If it was implemented, how effective was it? If it wasn't implemented what were the constraints?”

### **1.2.3 Research objectives**

The study seeks to achieve the following objectives:

- Establish whether the HIV/AIDS and Life Skills Education Programme for schools was implemented in primary schools in accordance with the Director's Circular Minute No. 2 of 2003.
- Establish whether the programme was effective or not by identifying, examining and analysing the strategies, methods, techniques, principles and approaches that have been put in place for the implementation of the programme at the schools and/or clusters
- Establish constraints being experienced by the implementers and suggest possible alternatives to counter these.

### **1.2.4 Delimitation/ Scope of the study**

This study will specifically seek to establish whether the HIV/AIDS and Life Skills Education Programme was implemented in the seventeen primary schools within the Lupane Area Development Programme. It will also seek to establish whether the programme is effective or not by focussing and examining the strategies, methods, techniques and approaches being used in the implementation of the programme at randomly sampled primary schools in the Lupane Area Development Programme. The study will be confined to the implementation of the programme in the primary schools from Grade 4 to 7.

### **1.2.5 Importance of the study**

The importance of this study is two pronged. Theoretically, this study should prove invaluable to the educational personnel and its partners UNICEF as it will provide important information concerning HIV/AIDS issues in the district and beyond. First of all it will establish whether the programme was implemented in the first place. It will also give invaluable insights to the same stakeholders and other readers as to whether the programme is effective or not. It will also give them some of the best practices in the field of HIV/AIDS education from different countries and settings.

World Vision International, which recently started an area development programme in Lupane District, will also have an opportunity to identify gaps which it can seek to fill up through its HIV/AIDS initiatives. Some of those learnings could then be replicated in other schools within World Vision's Area Development Programmes and indeed in other different settings in Zimbabwe.

Practically, this study should prove very useful to the heads of schools, the cluster HIV/AIDS committees and the school based HIV/AIDS coordinating committees as well as to individual Grade 4 to 7 teachers as well as to other key stakeholders such as UNICEF and World Vision International. When the study is concluded, it should have discussed the strengths and weaknesses of the strategies and approaches in the implementation of HIV/AIDS and Life Skills Education Programme in schools. It will also have gone further to make practical recommendations on how the implementation of the programme could be strengthened on the ground.

In the same vein, the successes and failures of the implementation strategies should also provide useful ideas to all teachers, schools and to all the other stakeholders so that they may improve or modify their own implementation strategies. Cooperating partners may also review their funding and support levels on the strength of ideas coming out of this study.

### **1.2.6 Research methodology**

In this study, I propose to use the descriptive survey method, which according to Leedy (1980:97) is sometimes called or referred to as the normative survey. In this study I will do a literature review with extensive fieldwork. The descriptive survey method is the most frequently used method of research as opposed to other research methods such as the historical method, the analytical survey method and the experimental method among others (Leedy 1980:166).

Some of the advantages of this method according to Murimba and Moyo (1995:18) are that it focuses on the systematic description or exposure of the salient aspects of a phenomenon, with a focus on the patterns that emerge. They further argue that the descriptive survey method tries to paint a factual and accurate picture of a population, institution or other phenomenon as it is. In the descriptive survey research, the researcher has the latitude where necessary to use figures, numbers or statistics, if this is the best way to describe a phenomenon or to use words, symbols and pictures if these are the best descriptive tools in the given situation. Murimba and Moyo (1995:19) argue that there are situations where a combination of the two is ideal. The descriptive survey method therefore has the advantage of using a combination of

quantitative and qualitative research. According to Creswell (1994:118) the advantage of the descriptive survey method is that it allows the researcher to generalise from a sample to a population so that inferences can be made about some characteristic, attitude or behaviour of a population. He also identifies some of its advantages as the economy of the design, the rapid turnaround in data collection and the ability to identify attributes of a population from a small group of individuals.

The descriptive survey method is not the best there is. But for this particular study it would seem to be the best because it would allow the researcher to select a sample/small group of respondents from a large population and collect the data in a short space of time. Also the latitude to use different instruments in this type of research is an advantage as this may be used to cross-check facts and clean out biased data.

### **1.2.7 Research techniques**

In the literature review section, I will mainly use the library as the source of information. I have already joined the British Council Library, the National Free Library, and the local city council library and of course I have access to the UNISA Library. In addition to obtaining books from the counters, I have established a relationship with the librarians who are more than willing to assist with sourcing information from pamphlets, journals, documents, unpublished sources and so on. They are even assisting in linking me with appropriate organisations. I also frequently visit the UNAIDS website and other websites owned by AIDS service organisations such as Avert. I have also established links with local key stakeholders in the fight

against HIV/AIDS such as Matabeleland AIDS Council, Zimbabwe Council of Churches, UNICEF, Habbakuk Trust, Bulawayo City Health Department, Zimbabwe Teachers Association, National AIDS Council, peer educators and I am also using the Development Studies subject librarian at the University of South Africa. The information that has been obtained is overwhelming.

In terms of fieldwork, I will mainly use the questionnaires as the major tools/instruments for obtaining data. Tuckman (1978:196) defines a questionnaire as a document containing questions designed to solicit information appropriate for analysis. Questionnaires are therefore used by researchers to convert into data the information directly given by respondents. Questionnaires will be used largely to solicit quantitative data, which can be presented in tables, charts, graphs, statistically or narratively. Structured questions within the same questionnaires will be used to solicit qualitative data. According to Creswell (1994:145) qualitative data is concerned primarily with process, rather than outcomes or products. It is interested in meaning, that is, how people make sense of their lives, experiences and structures. For this reason, the questionnaire is the primary instrument for data collection and analysis.

The research instruments will be pre-tested before they are finalised. Once this has been done, the population will be sampled and the fieldwork will be done. The data so collected will be collated, analysed and presented. Findings will be highlighted and the way forward suggested.

## 1.2.8 Chapter layout

### Chapter 1

#### Research background

Introduction to the chapter, Statement of the research problem, research objectives, delimitation or scope of the study, importance of the study, research methodology, research techniques, chapter layout, conclusion

### Chapter 2

#### The meaning and discussion of HIV/AIDS

- Introduction, an overview of the HIV/AIDS pandemic, definitions, literature review and discussion/analysis, overview of main findings.

In this chapter an overview of the HIV/AIDS world-wide is given. Key sources on the subject of HIV/AIDS are reviewed. A detailed review of the school prevention strategy is done with several intervention methods being discussed and suggested. Life skills development in schools is identified as a key intervention strategy.

### Chapter 3

#### Research methodology

- Introduction, research design, data collection procedures, sources of data, population, instruments, sampling, pre-testing,

instruments for data collection, data collection procedures, data analysis procedures, conclusion.

In this chapter I discussed three broad areas, namely research design, data collection procedures and the data analysis plan. Justification for the selection of the descriptive survey method as the research design is given. Its strengths and limitations are highlighted from academic sources. I went further to discuss data collection procedures where I explored sources of data, the population, sampling, piloting, instruments for data collection and the data analysis plan.

## **Chapter 4**

### **Presentation and discussion of data**

- Introduction, description of sample, data presentation, analysis and discussion, main findings, summary and conclusions

In this chapter I described the sample and then presented and discussed the data that was collected from the field. I discussed the trends as they were emerging and summarised the conclusions, deliberately highlighting the most interesting observations in order to use these in the formulation of main findings and recommendations.

## **Chapter 5**

### **Summary, conclusion and recommendations**

- Introduction, summary of findings, highlights and interpretation of main findings, suggestions of practical application for findings, pointers for further research,

In this final chapter of the study I started by making a summary of the main findings. An attempt was made to interpret the main findings. I also made very practical suggestions on how the programme could be strengthened for the benefit of the learners.

#### **1.2.9 Conclusion**

In this chapter a brief overview of the statement of the area of study was given, with a clear statement of the problem being stated. The research questions thereof were clearly outlined. A systematic approach to the question was developed, clearly delimited and the importance of the study highlighted. Issues relating to research methodology, research techniques and chapter layout were adequately addressed. The successful execution of the subsequent chapters depended largely upon this chapter, which laid a solid foundation these chapters.

## **CHAPTER 2**

### **THE MEANING AND DISCUSSION OF HIV/AIDS. AN IN-DEPTH DEBATE ON THE SCHOOL PREVENTION STRATEGY AND SOME ALTERNATIVE PREVENTION METHODOLOGIES**

#### **2.1 Introduction**

In this chapter, an overview of the AIDS scourge worldwide will be given. A survey of key sources on HIV/AIDS will be made. Literature that is relevant to the meaning of HIV/AIDS will be reviewed and discussed. The review and discussion will also centre on the need for life-skills for children and youths through a programme such as HIV/AIDS and Life-Skills Education Programme for Schools.

#### **2.2 An overview of the HIV/AIDS pandemic**

When one reviews current issues on HIV/AIDS it becomes clear that AIDS is the greatest humanitarian crisis of our time, or maybe of all time. No matter how much billions of dollars are spent by development agencies to address poverty, all such efforts will come to waste if the spread of HIV is not halted. These sentiments are collaborated by Okware (1990) quoted in AIDS: Action Now (1929:1) who argues, “It all started as a rumour. Then we found we were dealing with a disease. Then we realised it was an epidemic. And now we have accepted it as a tragedy.” Okware couldn’t have been nearer the truth. Such is the magnitude of the AIDS pandemic worldwide today which has highlighted in stark colours the needs of orphans and

vulnerable children (UNAIDS 2001:6). UNICEF (1992:2) argues that the AIDS pandemic is the world's most deadly undeclared war. While in her latest publication, Jackson (2002:vii) argues that never in history has there arisen such a widespread and fundamental threat to human development as HIV/AIDS. These arguments are further supported by Regan (2002:185) who argues that we now know from experience that AIDS can devastate whole regions, knock decades off national development, widen the gulf between the rich and the poor nations and push already stigmatised groups closer to the margins of society. These are just but some of the views on the AIDS pandemic worldwide today. Unfortunately the impact of the pandemic has been unprecedented. All sectors of the economy are adversely affected by the pandemic, unfortunately, reversing economic gains built over years in productive sectors such as industry and agriculture. Also gains made over years in areas such as social services, health and education have also been reversed. In its trail, the pandemic has left millions of people dead, millions are sick and cannot fend for their families. There are also hundreds of thousands of orphans and vulnerable children who are hungry, shelter less and whose education has been compromised.

### **2.3 What is HIV/AIDS?**

AIDS is short for Acquired Immune Deficiency Syndrome (Jackson 1992:xvii) It is said that this disease is acquired because it is a disease that is not inherited. It is caused by a virus (the human immunodeficiency virus or HIV) that enters the body from outside. The HIV is a virus that gradually damages the body's immune system and eventually causes AIDS (Casey 2002:3). He argues that a person is said to have AIDS once their immune system is so damaged that they develop opportunistic

infections (infections that take advantage of a weakened immune system). Because their body is not able to fight off these illnesses, they will die. The most common opportunistic infections include tuberculosis, pneumonia, skin cancer, meningitis, thrush, herpes, and bacterial infections that cause fevers, digestion difficulties, and weight loss (Casey 2002:4). Casey's argument is supported by Jackson (1992:xvii) who argues that AIDS causes gradual weakening of the immune system so that the body can no longer fight off infections. Avert (2003:2) argues that although we use the term AIDS when we talk about it, AIDS is not a specific illness. It is really a collection of many different conditions that manifest in the body because the HIV virus has so weakened the body's immune system that it can no longer fight the disease –causing agents that are constantly attacking it. For this reason it would be accurate to define AIDS as a syndrome of opportunistic diseases and infections which have the ability to kill the infected person in the final stages of the disease.

#### **2.4 How is the virus transmitted?**

According to Casey (2002:4) and Jackson (2002:7) HIV is transmitted when a person has contact with certain bodily fluids of a person who is HIV positive. Such bodily fluids can be:-

- Blood
- Semen
- Vaginal fluid
- Breast milk
- Fluid surrounding the brain and spinal cord
- Fluid surrounding bone joints

- Fluid surrounding the unborn baby

Of these ways, the authors underscore that the primary or most common ways in which HIV and AIDS is transmitted is through sexual activity, blood transfusion, sharing needles or syringes with someone who is HIV positive and also through mother to child transmission. These arguments are collaborated by REPPSI (2003:2) where it is argued that HIV infection is transmitted primarily by sexual intercourse, by HIV infected blood passing directly into the body of another person and by a mother to her baby during pregnancy or childbirth, or as a result of breastfeeding. Both Casey (2002:6) and Jackson (1992:33) emphasize that HIV is not transmitted through the following:-

- Kissing (unless there are open sores/exposure to blood)
- Touching/hugging
- Mosquito/insect bites
- Sharing food/utensils
- Sneezing or coughing
- Swimming pools or baths
- Sweat, saliva, tears
- Urine or faeces

## 2.5 What are the symptoms of HIV/AIDS?

In her publication, *AIDS: Action Now – information, prevention and support in Zimbabwe*, Jackson (1992:33) argues that in the early stages HIV and AIDS will manifest itself in the following ways:-

- Weight loss.
- Lack of energy.
- Chronic diarrhoea.
- Painful sores or rashes.
- Sores on the lips that do not heal.
- Fevers and night sweats.
- Swollen glands in neck, armpits, and groin.
- Thrush (a white rash) in the mouth or on the genitals.
- Repeated infections in throat or ears.
- Recurring shingles.

She advances the same argument in her other publication *AIDS Africa Continent in Crisis* (2002:39). Casey (2002:6) also advances the same argument.

In the latest stages, the above authors argue that people living with HIV and AIDS can develop any of the following opportunistic infections or symptoms:-

- Respiratory conditions such as tuberculosis and pneumonia.
- Further weight loss.
- Extreme fatigue.
- Dark blue or reddish brown marks on the skin (known as Kaposi's Sarcoma).

- Painful and itchy skin rashes.
- Prickly pain in the hands and feet.

## **2.6 Is there a treatment for HIV/AIDS?**

Burger (1993:4) observed that there is no known cure for HIV/AIDS. He suggested, “for the foreseeable future, the best way we can interrupt the spread of HIV will be by educating students to avoid personal behaviours that can transmit HIV”.

UNICEF (2000:6) argues that there is no known cure for HIV/AIDS yet. Scholars argue that despite worldwide research efforts, there is still neither a vaccine nor specific treatment for this disease.

Casey (2002:12) argues that there is no vaccine or cure for HIV/AIDS at this present time. The author points out that medicines are available that can slow down the reproduction and damage caused by the virus (this treatment is called antiviral therapy), but there is no way to eliminate the virus from an HIV-infected person’s body. Drugs do exist that treat certain opportunistic infections, but some other types of infections cannot be successfully treated.

Jackson (2002) argues that maintaining a healthful lifestyle can help prolong life by keeping the body strong and protecting it from infections. She further asserts that it is important for a person living with HIV/AIDS to eat balanced and nutritious meals, get plenty of sleep and exercise regularly.

From the afore-going arguments it can be argued that there is no known cure for HIV/AIDS at this time.

## **2.7 HIV/AIDS around the world**

In my overview I surveyed a number of authors who painted a gloomy picture of the HIV/AIDS pandemic worldwide. In his introductory remarks to his book 'HIV/AIDS Prevention and Education – a handbook for World Vision staff', Casey (2002:4) argues that seldom in the course of human history have we been confronted with a phenomenon that has had such far-reaching and devastating impact. This stands to show the magnitude of the HIV/AIDS pandemic globally. To show that the pandemic is pounding the whole world, the author further argues that there is no corner of the earth that has been spared from the onslaught of HIV/AIDS, for which there is no cure.

Alberta Federation of Teachers/Zimbabwe Teachers Association (AFT/ZIMTA 2002:4) quote UNAIDS figures for 2001 for adults and children estimated to be living with HIV/AIDS as follows:-

**Figure 1. 2 World-wide figures on HIV/AIDS (Source: AFT/ZIMTA 2002:4)**

<b>Region</b>	<b>Estimated figure</b>
New Zealand	15000
Caribbean	420000
North Africa and Middle East	440000
Western Europe	560000
North America	940000
East Asia and Pacific	1000000
Eastern Europe and East Asia	1000000
Latin America	1400000
South and South East Asia	6100000
Sub-Saharan Africa	28100000

**Source : AFT/ZIMTA (2002:4)**

Globally, therefore, the figure of infected people in 2001 was estimated to be around 33.6 million, and these were joined each year by millions of people newly infected, argues UNICEF (2002:2). According to UNAIDS (2003:3) by the end of 2003 there were approximately 37.8 people in the world living with HIV/AIDS. (Estimates range from 34.6 to 42.3 million). The publication argues that of these, about 35.7 million were adults, and 2.1 were children younger than 15. The publication concludes that the global epidemic has already killed more than 3 million people, and it is estimated that in 2003 alone, a further 5 million people acquired HIV. In the years 2004 and 2005 a lot seems to have happened as well with some estimates putting the worldwide infection rate at 60 094 374 (Aids Barometer 2004:17). Recently the same publication

gave the worldwide infection rate as 63 719 743 (Aids Barometer 2005:28). These estimates and the figures tabulated above show clearly that the pandemic is worldwide. It also shows quite clearly that the developing world is the hardest hit with sub-Saharan Africa being the worst. It maybe necessary at this stage to explore how hard Africa and the sub-Saharan Africa in particular has been hit by the pandemic.

## **2.8 HIV/AIDS in Africa and sub-Saharan Africa**

According to figures discussed earlier, Africa is home to more HIV/AIDS victims than any other continent in the world. Of these victims, more that three quarters of them are found in sub-Saharan Africa. According to Avert (2004:1) sub-Saharan Africa is the region of the world that is most affected by HIV/AIDS with an estimated 30 million people living with HIV/AIDS and approximately 3.2 million new infections having occurred in this region in 2003 alone. It is also estimated that in sixteen countries in Africa more than one tenth of the adult population aged between 15 and 49 years is infected with HIV (Regan 2002:187). The author further argues that in 7 countries (all in the southern cone of Africa), at least one adult in five is leaving with the virus. This view is also collaborated by Jackson (2002:2) who points out that in Botswana, Swaziland and Zimbabwe, up to one in three adults is estimated to have HIV, and in South Africa the epidemic has reached 25% in pregnant women and is continuing to rise. Regan (2002:187) argues that with a total of 4.2 million infected people, South Africa has the largest number of people living with HIV/AIDS in the world. Another author, De Villiers (2003:78) points out that it is estimated that 95% of all HIV infections are found in developing countries, with sub-Saharan countries accounting for 71% of all HIV positive cases. He goes on to name

Botswana, Swaziland, Zimbabwe, Lesotho, South Africa, Zambia and Namibia as the hardest hit countries with the disease not yet having reached its natural limit. The above arguments are further supported by UNAIDS (2004:5) which argues that although southern Africa has less than a quarter of the world's population, it is home to about 30% of the people living with HIV/AIDS. An even gloomier picture is painted by Avert (2004:1) which argues that an estimated eleven million children have been orphaned by AIDS in this region with approximately 95% of all AIDS orphans in the world living in sub-Saharan Africa. The publication also points out that almost 3 million children under 15 are living with HIV. Such is the magnitude of the epidemic in Africa and indeed the sub-Saharan Africa. It is a crisis that needs huge resources to fight.

## **2.9 The extent of the HIV and AIDS pandemic in Zimbabwe**

The first case of HIV was identified in Zimbabwe in 1985 (NACP 1999:2). Twenty years later 24.6% of the 14 million people are infected with the disease. The AIDS pandemic has so far left behind an estimated 780 000 orphans (Avert 2004:7). The publication further argues that it is believed that the worst affected children are those in rural areas, where there have been acute shortages of drugs, food and other resources. Zimbabwe is thus in the midst of a crisis. It has one of the worst HIV and AIDS epidemics in the world. In fact Zimbabwe's infection rate amongst adults is presently estimated at 24,6% (approximately one in every four adults). Globally it is ranked fourth highest, after Botswana, Swaziland and Lesotho which lead with infection rates of 38.8 per cent, 34.5 per cent and 31 per cent respectively (UNAIDS, 2003:4). Gregory, Zhuwau, Anderson and Chandiwana (1996:3) argue that the

HIV/AIDS epidemic in Zimbabwe has continued to severely decimate the society with rising infant, maternal and young adults mortality. They argue that it is estimated that well over 4000 Zimbabweans die of HIV/AIDS every week and that mortality will continue to rise. In another publication NACP (1999:1) observes that the HIV/AIDS epidemic is having a severely negative effect on Zimbabwe and has hurt both economic and social prospects. Millions of children have lost their parents. Another author, O'Donoghue (1995:1) argues that HIV/AIDS is the leading cause of death amongst Zimbabwean adults and is the major contributor to the rising rates of infant, child and maternal mortality not only in Zimbabwe, but also in other parts of Africa.

NACP (1999:2) went on to give an analysis of the HIV/AIDS cases in Zimbabwe. The publication argues that by 1999 up 4 000 cases of HIV had been reported in the 0-4 years age group. It is argued that the AIDS cases in this age group are mostly due to transmission of HIV from mother to child during pregnancy or delivery. In the 5-19 age group, there were hardly 500 cases reported. The discussion argues that there are small numbers of AIDS cases in this range, which represents window of hope. This group should therefore be targeted with effective information and education with the hope that it can retain a low prevalence of the disease throughout their lives. The next age group, that of 20-49 had over 12 000 reported cases of HIV infection. And yet this is the most productive group, economically.

The above discussion shows very clearly that Zimbabwe is really in the midst of a crisis and it is important that steps be taken to curb the spread of HIV/AIDS.

## 2.10 **The impact of HIV/AIDS**

The impact of HIV/AIDS is enormous. For instance, the impact of HIV/AIDS does not end by the deaths of millions of people alluded to earlier. Because those dying from AIDS are mainly people in the prime of their lives who are often parents, a less well known and calamitous effect of AIDS is the vast numbers of children orphaned by the disease (UNISIDA AND UNICEF 1999:2). These children get traumatised as they often lose both parents and often fail to get adequate support thereafter. The same publication argues that the worst is yet to come, in numbers both of deaths and children left behind. It argues that the lives already claimed by the epidemic are just but a fraction of those that lie ahead, in sub-Saharan Africa and many other countries of the world. Obviously, it is very difficult for African countries to cope with cumulative figures of orphans given their strained human and financial resources (UNAIDS 2001:6). The publication estimates that more than 14 million children under 15 have lost one or both their parents, with 95% of them living in sub-Saharan Africa. This goes to show the magnitude of the impact of HIV/AIDS particularly in sub-Saharan Africa.

The impact of HIV/AIDS on children includes, among other things loss of consistent parenting, lack of education, loss of property (e.g. shelter, material goods, inheritance, land, livestock and agricultural goods, hunger and psychosocial manifestations. This view is corroborated by REPSSI (2003:4) which argues that children affected by HIV/AIDS often experience loss of family and identity, psychosocial distress, increased malnutrition, loss of health care, increased demand for labour, reduced

educational opportunities, forced migration, homelessness and exposure to HIV infection themselves.

**Figure 2.2 : Average life expectancy in 11 African countries (age in years)**

<b>Country</b>	<b>Before AIDS</b>	<b>2010</b>
Angola	41.3	35.0
Botswana	74.4	26.7
Lesotho	67.2	36.5
Malawi	69.4	36.9
Mozambique	42.5	27.1
Namibia	68.8	33.8
Rwanda	54.7	38.7
South Africa	68.5	36.5
Swaziland	74.6	33.0
Zambia	68.6	34.4
Zimbabwe	71.4	34.6

**Source: Avert (2004:8)**

The table above further confirms that more and more children will be orphaned in the future, as the average life expectancy in 11 African countries will further fall by 2010.

On average the life expectancy will fall from 74 years to about 36 years.

HIV/AIDS has also negatively and severely impacted on household incomes and security since breadwinners are dying leaving orphans unattended. The economies of the countries also suffer as the economically active and skilled people die at the prime

age or are sick at home (REPPSI 2003:4). Such is the impact of the HIV/AIDS pandemic in Africa and the sub-Saharan Africa. There is therefore need to craft strategies to halt the further spread of the prevalence.

### **2.11 The way forward.**

To tackle HIV/AIDS in Africa is not an easy task. A lot of effort needs to be put in place. While the availability of resources is the biggest challenge there is still need to craft immediate turn-around strategies to combat the spread of HIV/AIDS. Strategies such as the provision of condoms, provision of Voluntary Counselling and Testing (VCT), advocacy, care and support have been suggested and are in several instances working very well. Over and above these strategies there is still need for long term planning to slow the epidemic. This view is collaborated by Avert (2004:8), a publication which argues that one of the best ways to tackle HIV/AIDS is prevention.

It was against this background that Zimbabwe and other nations of the world found it necessary to institute measures to counter the spread of HIV/AIDS. With no immediate prospect of a cure or a vaccine, prevention of HIV transmission was thought to be the only way to arrest the course of the epidemic (UNESCO 1994:2). The Zimbabwean government therefore introduced HIV/AIDS and Life Skills Education into the school system in June 1993 through the Ministry of Education, Sport and Culture. A survey will now be made on why so many governments thought this move would assist in interrupting this pandemic which a UNESCO director for Africa Dr Obayi Obanya described as “a phenomenon without precedent in our history”.

## **2.12 Discussion of the role of education and strategies for the implementation of the HIV/AIDS and Life Skills Education Programme in schools**

### **2.12.1 The role of education in the fight against HIV/AIDS**

There is no known cure for HIV/AIDS yet. Infection rates continue to rise unabated. There is therefore increasing consensus about the need for AIDS education for young people (WHO/UNESCO 1994:2). In another publication UNESCO (1989:1) argues that the need to educate school students on AIDS is beyond question. Burger (1993:4) suggested that, “for the foreseeable future, the best way we can use to interrupt the spread of HIV will be by educating students to avoid personal behaviours that can transmit HIV”. This view is collaborated by WHO/UNESCO (1994:2) who argue that studies have shown that sex and AIDS education may lead to a delay in the onset of sexual activity and to the use of safer sex practices among those students who are sexually active. These arguments stand to show that education has a critical role to play to halt the spread of HIV/AIDS.

### **2.12.2 Why are schools important?**

Many young people cannot talk about AIDS either at home or in the community, nor can they talk about the risk behaviours that can lead to infection. Neither can they access information from family planning clinics, as these are generally restricted to married women and couples. It is also true, from general observation that young people are reluctant to talk about sex to doctors and nurses, either out of

embarrassment or because they are worried that confidentiality will not be respected (Avert 2004:1). The publication also argues that these young people may feel equally uncomfortable talking to their parents, and their parents in turn may also be embarrassed or lack the confidence to discuss the subject with their children.

However most young people do attend school at some point and school is an entry point where these topics can be addressed. The potential strength of a school setting is that children have a curriculum. This argument is collaborated by Dommissie (2002:10) who argues that it is hardly surprising that schools are expected to take a lead in the fight against HIV and AIDS. She points out that this is so because schools are where young people can be found in large numbers every day and educators are on hand. Rugalema and Khanye (2002:25) add that the school-based education on HIV/AIDS and related issues reaches a wide audience of young people not only within school walls but also outside schools through interaction and sharing of information between pupils and their peers, siblings and parents. Visser (2002:130) also adds his voice when he argues that adolescents should be a prime target for AIDS education because they are at high risk of HIV infection. The school system is therefore seen as having potential strengths since children will have a curriculum, teachers and a peer group. The school can teach them not only information, but skills and can also shape their attitudes (WHO/UNESCO 1994:3)

### **2.12.3 Obstacles to HIV/AIDS education in schools**

Despite the desirability of HIV/AIDS Education in Schools, there are a number of obstacles that often stand in the way. In some countries there are no policies on

HIV/AIDS education while in others there can be policies specifically against HIV/AIDS education. While at the individual school level one major obstacle is that often the subject can be considered by adults such as policy makers, teachers and parents, as too sensitive for children or too controversial. This argument is advanced in Avert (2004:1). Another obstacle that can be encountered in schools is that the school curriculum is already too full and that it is therefore impossible to find a slot for HIV/AIDS education. Teachers and heads of schools mostly advance this argument. Other obstacles that may exist in schools may be lack of teaching materials for teachers and lack of training to organise classroom activities on sensitive issues. Schools may also give only one option in terms of avoiding contracting HIV infection, for example abstinence, regardless of the age of the students UNICEF (2003:14).

To overcome some of these obstacles, it is important that policy makers, religious leaders, teachers and teacher's organisations engage each other and come to a consensus amongst them as to what could be taught. This kind of engagement is important because it can then influence the communities around the schools to accept the HIV/AIDS education programme in schools.

#### **2.12.4 The Window of Hope**

In a survey that was carried out in Zimbabwe just before the HIV/AIDS and Life Skills Education Programme for schools was rolled out, the NACP (1999:2) argues that there were smaller numbers of AIDS cases amongst people aged between 5 to 19 years. The report said that this group represented the "WINDOW OF HOPE". By

targeting this group with effective information, education, and communication strategies, it was hoped that this group could have a low prevalence of the disease throughout their lives (NACP 1999:2). The argument here is that the school has the capacity to educate the youths to change their attitudes and adopt responsible behaviour so as to avoid HIV infection. This thinking seems to be based on the fact that almost half the world's population are school going people who can therefore be reached and educated through the school system. In view of the argument presented above, as a researcher I concur that the school system could play a critical role in interrupting the spread of the AIDS pandemic.

In view of these perspectives, early in 1993 Zimbabwe's Ministry of Education, Sport and Culture recognising the enormous and urgent challenge the rapid spread of HIV infection poses to Zimbabweans, initiated the HIV/AIDS and Life Skills Education Programme for schools. According to UNICEF (1993:4) the statistics for Zimbabwe reveal that HIV and AIDS least affects the 5 to 14 age group and the aim of the programme is therefore to ensure that this group remains protected from HIV infection. By initiating this programme, the Ministry of Education, Sport and Culture with technical and financial assistance from UNICEF is acknowledging the huge potential of the school system to educate our next generation on the risk which HIV and AIDS poses to them.

### **2.12.5 The thrust of the HIV/AIDS and Life Skills Education Programme for schools**

The thrust of the HIV/AIDS and Life Skills Education Programme, which Zimbabwe implemented in June 1993, has been implemented elsewhere in the world, albeit under different names. In Uganda, for instance, it is called “School Health Kit on AIDS Control” while in Australia it is called “AIDS and other STDs Teaching Ideas”. In Asia and the Pacific it is called “Education to Prevent AIDS/STDs in the Pacific”. In South Africa it is called “The Life Skills and HIV/AIDS Education Programme”, while the rest of the Western world generally refer to the programme as “School Health Education to Prevent AIDS and STDs” (WHO 1994:5).

In Uganda the course outline of the School Health Kit on AIDS Control includes basic information about HIV and AIDS, how it is spread and the larger portion is on HIV/AIDS prevention. According to AFT/ZIMTA (2002:3) the Ugandans have developed a fixed programme for orientation for all teachers on HIV and AIDS, which is aimed at making them, appreciate the dangers of HIV/AIDS and thus change their attitudes. In this way they would perceive the need for and support for programme in schools. In each school there is also a committee which conscientises parents and influential religious or community leaders. These groups assist in the teaching of HIV/AIDS especially if they appreciate why the subject is being taught. Some of these groups include non-sectarian agencies and community based organisations (CBOs), the Young Men’s Christian Association (YMCA), the Young Women’s Christian Association (YWCA), the Rakai AIDS Information Network and many others have developed projects to educate special groups and to extend

education efforts throughout local communities (AFT/ZIMTA 2002:4). Some of their teaching strategies include a kit of colourful posters, definition cards, flip charts, information leaflets on facts about HIV/AIDS, puppet show activities and others. In my opinion, these teaching approaches stimulate the interest of pupils who may use these kits with peers or with their parents at home. Although the acquisition of such materials would be costly, Zimbabwe could adapt some of the techniques from Ugandan schools.

In Australia, the approach is completely different from that in Uganda while the focus of the programme is closely related. They do not teach HIV/AIDS as an isolated “subject or topic” but rather as a series of lessons within the context of broader programmes that deal with STDs, sexuality and human relationships (Shalffer 1994:17). The whole programme is seen as part of the Health Education Programme in the school system. The thrust of the programme is that it should develop students’ skills in such areas as enhancing the students self esteem, communicating effectively, clarifying values and making responsible decisions. Zimbabwe could also learn from the Australian experience. Even if HIV/AIDS and Life Skills Education is timetabled in Zimbabwean schools, opportunities could also be taken to integrate it in other subjects right across the curriculum. Such subjects could be health education, population studies, social studies and so on.

The programme in Asia and The Pacific is no different from that in Australia. It emphasizes the fact that the programme should be taught as part of a broad Health Education programme (WHO/UNESCO 1989:4). Here too, the lessons about AIDS and STDs could occur within subjects such as sexual health care, sex education, social

sciences and so on. It could also occur in any other appropriate subject area or be integrated across a number of subject areas and school levels (WHO/UNESCO 1989:5). Just like with the Australian experience, Zimbabwe could learn some lessons from Asia and the Pacific.

In neighbouring South Africa a programme similar to that in Zimbabwe was implemented. It is called “The Life Skills and HIV/AIDS Education Programme”. The focus of the programme is the prevention of infections through the Life Skills Programme (Ncgobo 2002:96) The strategy of the South Africans has been to train selected teachers who then teach the subject as specialists (Michael 1999:6). The development of specialist teachers per school to handle the programme is also worth a lesson for Zimbabwe.

The focus of the implementation of the HIV/AIDS programme in the countries noted above is closely related to the programme implemented in Zimbabwe in June 1993. This is so because the programme implemented in Zimbabwe aims to provide basic information to the learners and also to provide life skills. This study will show later on what sort of materials and methodologies are being used and if they are effective or not. Addressing an International Conference on “School Health and HIV/AIDS Prevention” on 24 July 1995 in Harare, Zimbabwe’s Health Minister Dr Timothy Stamps described the programme in Zimbabwe as, “ranging from basic information on HIV/AIDS to life skills designed to assist students develop appropriate coping mechanisms”. Let’s talk – Grade 7 Teacher’s book, authored by the Curriculum Development Unit (1993:5) synthesized the aims of the HIV /AIDS and Life Skills Programme, among others, as to:-

- (i) Develop the knowledge, attitudes and emotional support to maximise individuals, and their communities' commitment to the safest protective behaviour possible.
- (ii) Promote responsible behaviour in pupils that maximises protection from sexually transmitted diseases including HIV and AIDS.

So it can be concluded that the focus of the programme in all the countries cited is to develop life skills in youth to enable them to negotiate their way through high-risk situations related to HIV/AIDS.

Probably what Zimbabwe could learn from related studies carried out elsewhere is that education about HIV/AIDS and Life Skills is best given within a broad health education programme that provides an understanding of communicable diseases, community health, human relationships, sexuality, drug abuse and other related issues. HIV/AIDS and STIs lessons could also occur in any other appropriate subject area or be integrated across a number of subject areas or school levels (WHO/UNESCO 1989:5). The advantage of this approach is that general health problems affect everybody and pupils could therefore benefit from experience of all the people around them. They could also appreciate HIV/AIDS as a problem/killer disease among other problem/ killer diseases and not as an isolated disease.

Notwithstanding any weaknesses these approaches might have, I strongly believe that this would be a very beneficial approach.

### **2.12.6 Targeting**

A consensus statement adopted at an Asian Regional Planning Seminar on HIV and AIDS Education within the school system, organised in collaboration with WHO and SIDA from 10 – 14 January 1994 in New Delhi says that all participating countries would implement or target the HIV/AIDS education programme at learners from ages 12 to 25 WHO/UNESCO (1994:17). These are learners mostly in secondary schools and tertiary institutions. It was felt necessary that these people be given sufficient grounding on HIV/AIDS because they are in the high-risk category. If they could be educated earlier, a significant fraction of the world's population could possibly be saved from the AIDS pandemic.

Teaching materials for the programme in Asia and the Pacific were prepared for pupils in Form 4/10<sup>th</sup> Grade. “They can be adapted either up or down, as each educational system decides on the most appropriate time and place to teach about AIDS and STDs”, argues WHO/UNESCO 1989:7. Most other countries are running school health education programmes which itself is an indicator that the target group is the school going age child.

In Zimbabwe, authorities seem to have taken cognisance of this view. According to the Director's Circular Minute No. 2 of 2003 dated 16 January, 2003 Zimbabwe's HIV/AIDS and Life Skills Education Programme in schools is targeted at pupils from Grade 4 to Advanced level. This programme is COMPULSORY for all schools, primary or secondary. There is also an HIV/AIDS programme that is being undertaken by the Ministry of Higher and Tertiary Education at all institutions of

higher learning. Therefore it can be argued that in Zimbabwe learners from 10 years to 25 years of age are targeted at.

#### **2.12.7 Strategies for implementing the HIV/AIDS programme in schools.**

Countries in both the developed and the developing world utilised different strategies in the implementation of the HIV/AIDS programmes in their schools. Some of these strategies that have been successfully used in schools include, among others, the creation of a suitable classroom atmosphere, appropriate teaching methods, use of peer leaders, the involvement of specialist and support organisations, the participation of communities, poster/poetry/essay competitions and many others. Some of these strategies will now be discussed in detail below.

In Uganda all the teachers who teach the targeted school children go through a carefully developed ongoing training programme which is aimed at changing their attitudes so that they may perceive and appreciate the need for the programme in schools (AFT/ZIMTA 2002:3). Some of the content they cover pertain to the impact of HIV/AIDS on education and the society in general. They also deal with teaching strategies, methods, techniques and also the specific life skills that could be developed in pupils. Some of the participatory methodologies that they deal with include, among others, group discussion, questioning, brainstorming, role play, case studies, group work, debate, poetry, song, picture codes and so on. The advantages of such participatory methods are that pupils are presented with situations and they have the task of exploring how they could handle them. This approach helps them develop as

they work out the solutions themselves with the teacher playing the role of facilitator (WHO/UNESCO 1989:5).

What happens in Uganda is also similar to what happens in the Republic of South Africa. Here the teachers are trained and given the necessary skills and knowledge to teach the subject. In fact a tender is floated and awarded for the training of in-service teachers (Crewe 1996:19). Two teachers in all secondary schools were targeted to for training (Michael 1999:5). The model of training used is based on experiential learning and on the use of alternative methodology and activities. This specialist training is meant to enable teachers to impact on the behaviour of the learners. It is envisaged that the learners will have the ability to make informed, responsible choices. Life skills that are targeted to be developed through alternative methodologies include value clarification, assertiveness, problem solving and communication.

The second strategy to be discussed is the use of peer leaders. According to a case study carried out in a British school WHO (1994:15) it was established that young people listen more attentively and accept messages from respected peers more readily than from their teacher. Maybe this is so because pupils have similar experiences.

The third strategy to be discussed is the involvement of stakeholders and other support organisations. Other terms that are used to describe the same concept are multi-sectoral approach, networking or collaboration. Besides the teachers, other people come into the school to assist in the implementation of the programme. Those groups may include AIDS Prevention Organisations, non-governmental organizations,

youth organizations, family planning organisations, art, theatre and cultural organisations. In Uganda support organisations like TASO and Church organisations are providing extensive HIV and AIDS education in communities and schools (AFT/ZIMTA 2002:4). Other organisations that have been playing the same role in Uganda include the Young Men's Christian Association, the Young Women's Christian Association and the Rakai AIDS Information Network, among others. What schools may need to do is to familiarise these groups with the thrust of their programme and then allow them to bring in their vast and varied experience for the benefit of the children.

In the programme implemented in the Republic of South Africa the concept of multi-sectoral approach or collaboration is very evident. Collaborative partnership saw the Department of Education, the Department of Health and other role players such as NGOs, and other organisations work together in the implementation of the Life skills and HIV/AIDS Education Programme (Michel 1999:5). In their collaboration, for instance:-

- ❑ The Department of Education is responsible for prevention of infections through the Life Skills Programme.
- ❑ The Department of Health would encourage voluntary counselling and testing using rapid test results.
- ❑ The Department of Social Welfare would focus on community and home base care, including the care of orphans (Ncgobo 2002:96)

In fact, Michel (1999:5) observes that there is an implementation committee in place called the National Life Skills Project Committee (NPC) formed in 1995. In my opinion the strategy of collaboration and networking is a very worthwhile strategy.

The fourth strategy is the participation of the school's immediate community in the teaching of the programme. The school may select its own resource persons to assist schools to teach HIV/AIDS. These may be local community experts such as doctors, religious leaders in the community, a specially selected group of teachers who visit all the schools in a community (Cilliers 1988:1). The advantage of involving the community in this manner is that lessons may continue under the guidance of these parents even at weekends or during the school holidays when the teachers are away. This strategy too seems to be very useful to the researcher.

The fifth strategy is the holding of poster/poetry/essay competitions on the subject. Some of the posters that have been produced in European schools are these, with the name of the country in brackets.

- AIDS: Suddenly sex has become very dangerous.(UK)
- There's a simple way to prevent AIDS. (Italy)
- It is a deadly reality! There is no cure. (US)

This approach is advocated for by WHO/UNESCO (1994:53). Debating participatory methodologies used in Ugandan schools AFT/ZIMTA (2002:5) also discuss the use of poster and poetry competitions as having been very handy. In some instances quiz questions such as those below could be utilised.

Do you agree or disagree?

- ❑ HIV/AIDS is not a big problem in West Africa?
- ❑ Countries with better road systems are more likely to have more HIV/AIDS cases?
- ❑ Only people living in poor countries get HIV/AIDS?
- ❑ Botswana has the highest adult infection rate than any country in the World?
- ❑ Very few people in the United States of America have HIV/AIDS?
- ❑ Southern Africa has the most severe HIV/AIDS crisis than any place in the world? (AFT/ZIMTA 2002:16).

Such competitions may be held within a school or schools.

In Zimbabwean schools the only known strategies for the implementation of the HIV/AIDS and Life Skills Education Programme for Schools included the creation of a single 30-minute lesson for primary schools or 40-minute lesson for secondary schools. This was contained in the Chief Education Officer's Circular Minute No. 16 of 28 June 1993. This circular was cancelled and replaced with the Director's Circular Minute No. 2 of 2003 dated 16 January 2003. CDU also mailed directly to the schools an AIDS syllabi document, and "Lets Talk" series textbooks for Grades 4 to 7. In addition to this, UNICEF financed workshops to introduce HIV and AIDS education at national, regional and district levels. These workshops, which were approximately one week long, were targeted at Education Officers, District Education Officers and head teachers. The District Education Officers and heads of schools were supposed to workshop their teachers in turn.

Besides these few strategies, the schools were directed to get on with the programme. Strategies and instruments for monitoring were left to individual schools to work out.

In light of related literature that has been explored on strategies and monitoring instruments, it is clear that Zimbabwean schools have a lot to learn from studies that have been reviewed above. In light of these gaps, the thrust of this research project was to establish whether the HIV/AIDS and Life Skills Education Programme was implemented in the schools. It also sought to establish whether the programme was effective or not by examining the strategies, methods and approaches that were adopted by the Zimbabwean schools in the implementation of the programme. The study also sought to establish the monitoring instruments that are being used in these schools. When these have been established it would then make recommendations on what strategies, approaches and techniques could be adopted by the Zimbabwean schools.

#### **2.12.8 Conclusion**

In this chapter, I have put in a clear perspective the threat posed by the HIV/AIDS pandemic to all nations of the world. I went on to clearly elucidate how and why the school system should play a role in interrupting the spread of HIV infection. From there I went on to demonstrate that all countries implementing HIV/AIDS education have as their thrust the development of life skills in youths. Next, I described the target group and went on to discuss the strategies that are being used in other countries. Consequently, it became clear that Zimbabwe could learn a lot from the experiences of other countries. I hope to make concrete recommendations on what strategies Zimbabwe could adopt at the conclusion of this project.

## CHAPTER 3

### RESEARCH METHODOLOGY

#### 3.1 Introduction

In this chapter I will proceed to design my own research methodology. Under the data collection procedures, I will discuss the sources of data, population, sampling, pre-testing, instruments for data collection and procedures. In the next instance, I will discuss the data analysis procedures showing how the data will be analysed and presented.

#### 3.2 Research Design

A research design is a blueprint or detailed plan for conducting a research study, (Schulze 2002:28). It can also be described as a framework for collecting data. This definition is shared by Mouton (2001: 55) who defines a research design as a plan or blue print of how you intend conducting the research. The point of departure for a research design is the research question. It focuses at the end product.

In this study, I will therefore use the descriptive survey method, which according to Leedy (1980:97) is sometimes called or referred to as the normative survey. For this study I will do a literature review and extensive fieldwork. For this type of study the descriptive survey method is the most frequently used research method as opposed to

other research methods such as the historical method, the analytical survey method and the experimental method among others (Leedy 1980:166)

Some of the advantages of this method according to Murimba and Moyo (1995:18) are that it focuses on the systematic description or exposure of the salient aspects of a phenomenon, with a focus on the patterns that emerge. They further argue that the descriptive survey research method tries to paint a factual and accurate picture of a population, institution or other phenomenon as it is. With the descriptive survey research method the researcher has the latitude where necessary to use figures, numbers or statistics, if this is the best way to describe a phenomenon or to use words, symbols and pictures if these are the best descriptive tools in the given situation. Mouton (2001:153) concurs with this view when he argues that in the analysis of large survey data sets, typical techniques would include tabulations, correlations, regression analysis, factor analysis and the use of statistical graphics (bar charts, plots, pie charts) for more visual presentation. Murimba and Moyo (1995:19) argue that there are situations where the use of a combination of quantitative and qualitative research is ideal. The descriptive survey research method has the advantage that it can use a combination of these. Creswell (1994:118) also points out that the advantage of the descriptive survey research method is that it allows the researcher to generalise from a sample to a population so that inferences can be made about some characteristic, attitude or behaviour of a population. He also identifies some of its advantages as the economy of the design, the rapid turnaround in data collection and the ability to identify attributes of a population from a small group of individuals. This view is also shared by Mouton (2001:152) who argues that the descriptive survey studies are usually quantitative in nature and aim to provide a broad overview of a

representative sample of a large population. However extreme care should be taken when this method is being used in order to minimise on limitations. Mouton (2001:153) argues that the limitation for the descriptive survey method is its perceived lack of depth. Care should therefore be taken when instruments of data collection are being thought out.

In this study quantitative data will deal with variables that are measurable and quantifiable. Such data could be statistically or mathematically manipulated. As argued earlier, quantifiable research design involves numerous respondents (a sample that is representative of a population) with the aim of generalising results to the whole population (De Vos et al 1998:343). Therefore the advantage of using quantitative research is that one can deal with large numbers at one time and come up with fairly reliable results.

Appendices 1 and 2, parts B, will deal with quantitative data, which is quantifiable or measurable. It will be possible to tell how many schools will have implemented the programme and how many teachers were work-shopped or trained in HIV/AIDS and Life-skills Education. With such information available one can stand up and address the identified gaps immediately. The objectives of quantitative research in this study will be, among other things:-

- To determine the number of schools that implemented the HIV/AIDS and Life-skills Education Programme for schools
- To assess the number of schools which received the HIV/AIDS and Life-skills Education series “Lets Talk” and the syllabi document.

- To determine the number of Grade 4 to 7 teachers who were workshopped or trained on the delivery mode of the HIV/AIDS and Life-skills Education Programme.

Similarly, qualitative data will deal with variables that are not measurable or quantifiable. This is found in appendices 1 and 2 part C. For instance, the researcher could wish to assess the level of support by head-teachers for the HIV/AIDS and Life-skills Education Programme. In this study some of the objectives of qualitative research will be:-

- To assess the extent to which participatory methods are being used in the teaching of HIV/AIDS and Life-skills Education Programme.
- To assess the focus of the HIV/AIDS and Life-skills Education Programme at the nine schools.

### **3.3 Data collection procedures**

#### **3.3.1 Sources of data**

The data that will be used in this project is of two types, primary data and secondary data. Primary data, according to the University of Zimbabwe (1994:57) is that data which is closest to the to the source of information. In this study the primary data is of two types, namely, the teachers and head teachers who will respond to the questionnaires on the implementation of the HIV/AIDS and Life-skills Education Programme for schools at the primary school level. The published studies or articles and texts dealing with HIV/AIDS are the author's secondary data. According to the University of Zimbabwe (1994:57) secondary data is not original. It is affected by

distortions such as communication. Mouton (2002:99) describes secondary data as archival or documentary sources. Here one may look at historical documents, diaries, letters, speeches, literary texts, narratives, official memoranda, business plans, annual plans and medical records.

### 3.3.2 **Population**

Murimba and Moyo (1995:32) define a population as any group of individuals that have one or more characteristics in common that are of interest to the researcher.

Schulze (2002:31) concurs with this definition when he argues that a population is the totality of persons, events, organization units, case records or other sampling units with which our research problem is concerned. In this study the target research population will be all Grade 4 to 7 teachers in seventeen primary schools (second school term 2005) within Lupane Area Development Programme who will be teaching HIV/AIDS and Life-skills Education. This population will also include their respective head teachers who are supervising the implementation of the programme. This means that different schools adopted different strategies in the implementation of the programme. Hence a random sample that will be done is likely to be fairly representative.

### 3.3.3 **Sampling**

Sampling means taking any portion of a population as representing that population.

Schulze (2002:31) defines sample as implying the existence of a population of which the sample is a small section. A sample therefore is the element of the population

included in the study. We study the sample in an effort to understand the population from which it was drawn.

The sample consisted of all Grade 4 to 7 teachers and their head teachers from nine primary schools randomly selected from seventeen primary schools found within the Lupane Area Development Programme. The randomisation aimed at picking just over 1/2 of the total school population. This means that nine primary schools were randomly selected from the seventeen primary schools within Lupane Area Development Programme.

In order to ensure validity and reliability I used a method of randomisation called the lottery method (Murimba and Moyo 1995:33). A list of all the seventeen primary schools in Lupane Area Development Programme were written in alphabetical order and then each school assigned a numerical identification. I then marked on separate tabs corresponding numbers and then put them in a closed container. The tabs were then intermixed and then a tab bearing a number was selected from the total number of tabs in the container, without the selector seeing the pool. The number selected was recorded and the tab thrown back into the pool. This ensured that each school had an equal chance of being chosen (Best and Khan 1993:16). If the same number was drawn twice, the second drawing was ignored and the number returned to the pool. The numbers were mixed again until the nine schools were randomly selected.

This method of selection ensured that no school was chosen through favour. This reduced bias, as each school had an equal chance of being chosen.

### 3.3.4 **Pre-testing**

The questionnaires were pilot tested at one primary school within Lupane Area Development Programme late in January 2005. It was essential that the newly constructed questionnaires be thoroughly piloted before being used with the sample (De Vos et al 1998:160). This ensures that errors of any nature can be rectified immediately. It is therefore advisable that a small group is used for the pilot. In this pilot the school that was selected randomly from the pool of primary schools in this area, was then eliminated from the main study. The two questionnaires were then completed by the head teacher and by the Grade 4 to 7 teachers respectively. The subjects who numbered eight were asked to indicate which questions or words in the questionnaires they did not understand or were not clear. They were also asked to time themselves as they completed the questionnaires. On the basis of their comments, further scrutiny and discussion with fellow researchers the questionnaires were fine-tuned and finalised.

### 3.3.5 **Instruments for data collection**

To fulfil the objectives of both the quantitative and qualitative components of the study, one type of research instrument was developed and used. This instrument was a questionnaire. Questionnaires are the most widely used technique for obtaining information from subjects (McMillan and Schumacher 1997:252). Questionnaires are relatively economical, have the same questions for all subjects, can ensure anonymity and contain questions/statements written for specific purposes. The use of

questionnaires is also cheaper compared to interviewing the sample population. The use of the questionnaire also ensures one to avoid the problems of interviewer bias.

Two types of self-administered questionnaires were developed. There was a questionnaire for head teachers and another for ordinary classroom teachers, teaching grades 4 to 7 at the primary school level. Each type of questionnaire was divided into three parts. Part A dealt with the biography while part B dealt with quantitative data. Part C dealt with qualitative data. See appendices 1 and 2.

To construct both instruments I carefully wrote down in point form the key areas the HIV/AIDS and Life-skills Education Programme for schools focused on. I then used these key points to derive key questions, critical points, teaching methods, approaches and strategies that could be used to achieve the general aims of the programme. For an example among other things, the HIV/AIDS and Life-skills Education Programme aims to:-

- Give basic information to learners.
- Develop life-skills in pupils.

From this focal point I derived strategies to help achieve these aims such as:-

- The teaching methods to be used.
- The alternatives available to monitor the programme.
- The need for collective approach in the implementation of the programme.
- The need to mobilise resources (human, material and financial)

Questions in the questionnaires therefore sought to determine the teaching methodologies used by the teachers. The questions also sought to determine the

monitoring instruments used by the head teachers. The approaches used and the resources mobilised were also investigated through carefully designed questions in the questionnaires.

### **3.3.6 Procedures**

I personally went to Provincial Education Office in the Matabeleland North Region in January 2005 to seek for permission and clearance to carry out the study. The clearance was posted to me a few weeks later (Appendix 3). After that I went to consult the heads of the nine primary schools randomly selected for the study seeking for permission to visit their schools on specified dates during the month of April 2005. The targeted population, the nature or topic of the study and the actual assistance sought was specified. All the heads of schools were very helpful and a schedule of appointments was worked out at each school.

I then visited all the nine randomly selected primary schools on the appointed dates and times. After being introduced to members of staff, I assured the respondents that their responses would be treated in strict confidence and requested them to provide honest answers. They were also requested not to consult each other during the process of completing the questionnaires. All the questionnaires were collected after a period of about 20 minutes.

I believe that the above procedures gave me valid results, as there was no time for teachers to consult and in the process give untrue answers in the hope of giving the researcher the answers that they thought he wanted. This procedure also ensured a

100% return of questionnaires as opposed to posting questionnaires, especially in these days of apathy to national issues.

### 3.3.7 Data analysis procedures

Data from questionnaires was then coded and summarised, teacher questionnaires on their own and head-teacher questionnaires on their own. Findings were presented in the form of tables and/or percentages where possible.

**Figure 3.3 Example of how data was be presented**

Question	No of respondents	Yes	No	% Yes	%No
1	20	15	5	75%	25%
2	20	17	3	85%	15%
3	20	18	2	90%	10%
4	20	19	1	95%	5%
5	20	2	18	10%	90%
6	20	10	10	50%	50%
7	20	6	14	30%	70%

The findings were then analysed item by item and points emerging from the analysis were integrated and discussed. Finally conclusions were drawn.

### 3.4 **Conclusion**

In this chapter I discussed three very broad areas namely the research design, data collection procedures and the data analysis plan. In the first instance I demonstrated why I selected the descriptive survey method as my research design. Drawing from academic sources I argued for its use and also highlighted its strengths and limitations. I also delved into data collection procedures and discussed briefly but adequately on sources of data, the population and sampling, piloting, instruments for data collection, procedures and finally discussed the data analysis plan.

## CHAPTER 4

### PRESENTATION AND DISCUSSION OF DATA

#### 4.1 Introduction

In the previous chapter I discussed, among other things, the research design, data collection procedures, instruments for data collection, procedures for collecting data and data analysis procedures. In this chapter I will proceed to present and analyse the data collected in order to arrive at conclusions arising from the data.

#### 4.2 Description of the sample

The sample used in this research project was in two parts: teacher questionnaires and head-teacher questionnaires. Both parts of the sample came from nine randomly selected primary schools found within the Lupane Area Development Programme.

To ensure 100% return of questionnaires I physically went to all the nine primary schools, distributed the questionnaires and collected them after the subjects had responded. Heads of all the nine schools had been approached earlier for their consent and a schedule of appointments developed. The completion of the questionnaires lasted about 15 minutes at most, after which I collected the questionnaires. In all cases the respondents were requested not to consult during the process of completing the questionnaires.

A total of 58 Grade 4 to 7 teachers at the nine primary schools completed the teacher questionnaires, while the nine head-teachers of the same primary schools completed the head-teacher questionnaires. From the data collected I expect to obtain fairly reliable results since all the questionnaires were collected and the respondents completed the questionnaires without consulting each other.

## **4.2 Data presentation, Analysis and discussion**

The data will be presented under three distinct sub-problems. Findings will be presented in the form of tables and percentages. Analysis and discussion of data will be made based on the figures and percentages in the tables. The salient points emerging from the data will be exposed and summarised.

### **4.2.1 Was the HIV/AIDS and Life-Skills Education Programme for Schools in Zimbabwe implemented?**

The data needed to address this question is located at teacher questionnaire number 6, and head questionnaire numbers 6 and 7. At number 6 both the head-teachers and teachers were asked if they had implemented HIV/AIDS and Life-Skills Education in their schools/classes? In number 7 the head-teachers were asked in what year they had implemented the programme.

**Figure 4. 4 Implementation of the programme in schools**

Question Number	Number of respondents	Yes	No	% Yes	% No
6 (teachers)	58	42	16	72	28
6 (head-teachers)	9	7	2	78	22

Table 1 shows that 72% of the teachers and 78% of the head-teachers have implemented the HIV/AIDS and Like-Skills Education Programme for schools in their classes and schools respectively while 28% and 22% respectively have not.

In question number 7 of the head-teacher questionnaire heads of schools were also asked as to which year they had implemented the programme in their schools.

Responses for head-teachers ranged from the year 2001 to 2005. One head-teacher did not answer this question. It is worth noting here that the HIV/AIDS and Life-Skills Education Programme (UNICEF 1993:4), is supposed to have been launched by all schools in Zimbabwe in 1993 according to instructions contained in the Chief Education Officer's Circular Minute No. 16 of 28 June 1993.

#### **4.2.1.1 Summary**

The data emerging from the above analysis shows that seven out of nine schools implemented the HIV/AIDS and Life-Skills Education Programme for schools. It also shows that forty-two out of fifty-eight teachers actually implemented the programme in their classes. This represents 72% of the classes sampled. Given that more than 72%

of the schools and teachers implemented the programme in their schools and classes, it can reasonably be argued therefore that the HIV/AIDS and Life-Skills Education Programme for schools in the Lupane Area Development Programme was implemented. It also emerged from the head-teacher questionnaire that the programme was only implemented in these schools between 2001 and 2005 and not in 1993 as it was planned. The question could be asked as to why it took so long for the schools to implement the ministry's directive.

#### **4.2.2 If it was implemented, how effective was it?**

##### **4.2.2.1 What human, material and financial resources have been put in place for the successful implementation of the programme?**

In the teacher questionnaire the data needed to address this question is located at numbers 3, 4, 5, 7, 8, 9, 10, 11, 12, and 13. Teacher's responses to questions addressing the issues of human, material and financial resources that were put in place for the implementation of the programme are summarised below.

**Figure 5.4 Resources put in place in relation to teachers**

Question number	Number of respondents	Response choices	%
3	58	Standard 6 academic qualifications	1%
		O level academic qualifications	90%
		A level academic qualifications	9%

4	58	Untrained teacher Primary Teachers Higher Certificate Diploma in Education Bachelor of Education	48% 2% 47% 3%
5	58	0 – 5 years teaching service 6 – 10 years teaching service 11 + years teaching service	69% 17% 14%
7	58	I teach facts about HIV/AIDS I teach facts and life-skills No response given Not Applicable (inserted in the space provided)	9% 62% 26% 3%
8	58	Have you timetable HIV/AIDS and Life-Skills Education?   Yes No Nil response	   69% 29% 2%
9	58	If yes, how many periods a week?   One Two Nil response	   43% 28% 29%
10	58	Did you receive the HIV/AIDS syllabi document from the Ministry of Education?   Yes No	   12% 86%
12	58	Have you been trained or work-shopped on the delivery mode of the HIV/AIDS and Life-Skills Education Programme?   Yes No	   24 76

Table 2 shows that over 90% of the teachers have Ordinary level academic qualifications. This is commendable given the fact that this is the basic qualification for those who want to enrol at teachers' colleges to do a primary teachers course such as the Diploma in Education. However it is sad to note that 48% of the teachers sampled are untrained. This means that they do not have the basic training to teach. It is therefore difficult to imagine how they could handle HIV/AIDS programs, which need a high level of skill and tact to deliver. A total of 52% of the teachers are trained. This is good as these can easily adapt to methodologies suited for the delivery of HIV/AIDS and Life-Skills Education programmes. On teaching experience, 69% of the teachers are in the category of 0 – 5 years experience. These need a lot of support in terms of on-the job training so that they can gain experience and also adapt to varied teaching methodologies.

On the question of what is the focus of their lessons 62% of the teachers said that they teach basic facts about HIV/AIDS and life-skills. This is what is should be. However, 9% said that they teach basic facts only, while 29% either gave no responses or said the question was not applicable. This means that 38% of the respondents are not focussing on teaching life-skills at all. Asked on whether they had timetabled HIV/AIDS and Life-skills education in their classes, 69% of the teachers answered in the positive while 31% had not. The question went further to ask as to how many periods had been allocated to HIV/AIDS and Life-skills education per week. Only 43% had correctly allocated one period per week while 28% had incorrectly allocated 2 periods per week. A high percentage of teachers accounting for 29% did not answer this question. This leaves us with questions as to whether they are teaching the programme in the first place.

The teachers were also asked if they had received the HIV/AIDS and Life-skills syllabi document from the Ministry of Education, Sport and Culture. All the respondents answered this question. A total of 12% received the syllabi while 86% did not. It is surprising as to how the subject is being implemented if the majority of the teachers do not have a copy of the syllabi document. Asked on whether they were trained on the delivery mode of the HIV/AIDS and Life-skills education programme, only 24% said that they had been trained while 76% were not. This information raises questions about the effectiveness of the programme on the ground. How could the objectives of the programme be achieved if 86% of the teachers did not receive the syllabi document and 76% of them were not trained or oriented on the delivery mode of the programme?

In the head-teacher questionnaire, heads of schools were also asked questions addressing the issues on human, material and financial resources that were put in place for the implementation of the programme. Their responses are analysed in the table below.

**Figure 6.4 Resources put in place in relation to head teachers**

Question number	Number of respondents	Response choices	%
3	9	O Level academic education	89%
		A Level academic education	11%
4	9	Primary Teacher's Higher	11%
		Diploma in Education	67%

		Bachelor of Education	22%
5	9	0 – 5 years teaching experience	11%
		6 – 10 years teaching experience	22%
		11 + years teaching experience	67%
8	9	Did you receive the Chief Education Officer's circular minute No 16 of 28 June 1993?	
		Yes	22%
		No	67%
		Not sure	11%
9	9	Did you receive the Director's circular minute No. 2 of 16 January 2003?	
		Yes	22%
		No	56%
		Nil response	22%
10	9	Have you timetabled HIV/AIDS and Life-skills education in your school?	
		Yes	100%
		No	0%
11	9	If yes, how many periods a week?	
		Yes	100%
		No	0%
12	9	Did you receive the HIV/AIDS and Life-skills education syllabi?	
		Yes	11%
		No	89%

13	9	Did you receive <i>Lets Talk</i> booklets (4 to 7)	Yes No Nil response	89 0 11%
14	9	Do you have any other sources on HIV/AIDS and Life-skills education?	Yes No Nil response	33% 56% 11%
15	9	Did you attend any HIV/AIDS and Life-skills education orientation workshop?	Yes No Nil response	22% 67% 11%
16	9	If yes, how many days was it?	Five days Nil response	22% 88%
17	9	If no, what was the reason for not attending?	I delegated I was not invited No workshop took place I was not a head-teacher yet	11% 22% 22% 11%
18	9	If you attended, did you workshop your teachers?	Yes No Nil response	22% 0% 77%

19	9	Is there an HIV/AIDS and Life-skills education committee in your school?	
			Yes 22%
			No 67%
			Nil response 11%
20	9	Is there an HIV/AIDS file in your school?	
			Yes 22%
			No 67%
			Nil response 11%

On the question of qualifications, the analysis shows that 100% of the head-teachers have above the ordinary level academic qualifications and that in terms of professional teacher training 89% have either a Diploma in Education or Bachelor of Education degree. This is by any standards very high qualifications. In terms of experience, 89% of the head-teachers have taught for a period of over 6 years. It can be argued, therefore, that in terms of qualifications and experience, sufficient manpower was put in place for the successful implementation of the programme.

Asked whether they had received the Chief Education Officer's Circular Minute Number 16 of 28 June 1993 and the Director's Circular Minute number 2 of 16 January 2003, only 22% the heads said that they had received both. This is worrying since these are the policy circulars that were detailing how the programme was to be implemented on the ground. One wonders how 88% of the heads implemented a programme without policy guidelines.

Head-teachers also responded to the question of timetabling HIV/AIDS and Life-skills education. All the nine heads said that they had timetabled the programme. All had also correctly allocated it one period per week. However only 69% of their teachers said that they had timetabled the programme and only 43% had correctly allocated the programme one period per week. There could be a need here for the head-teachers to closely monitor the teaching of the programme in the classrooms in order to ensure that everyone has timetabled the programme.

On the availability of materials 89% of the head-teachers and 63% of the teachers acknowledged receiving the basic textbook entitled “Let’s Talk” for Grade 4 to 7 classes. Both groups also indicated that they hardly had any other sources on HIV/AIDS. It can be argued therefore that in terms of materials the schools were satisfactorily provided with basic materials to deliver the programme. However, only 11% of the head-teachers and 12 % of the teachers said that they had received the syllabi document for the programme. The discrepancy ties well with non-receipt of policy circulars alluded to earlier. This is a serious gap that would need to be filled up as quickly as possible by the Ministry of Education, Sport and Culture.

On the question of whether the heads were trained on the delivery mode of the programme, only 22% said that they were trained and only 24% of the teachers. It is clear here that there is need for financial resources so that these cadres can be sufficiently trained on the methodologies to deliver the HIV/AIDS and Life-skills education programme so that the objectives of the programme could be achieved.

#### **4.4.3.1 Summary**

In summary it can be concluded that human resources were made available for the successful implementation of the programme since qualified and experienced teachers are available in the schools to deliver. However the same cannot be said about material and financial resources. Key policy circulars need to be sent to the schools as well as syllabi documents. Also while the basic textbook “Let’s Talk” is available there is need to provide schools with varied literature on the subject of HIV/AIDS and Life-skills education. There is also need to mobilise more resources for training of head-teachers and teachers on the delivery mode of the programme. Training in life-skills is critical if the objectives of the programme have to be achieved.

#### **4.4.3 If the programme was implemented how effective was it?**

##### **4.4.3.1 A survey of approaches and strategies that were put in place.**

The data needed to address this sub-problem is located at teacher questionnaire numbers 15, 16, 17, 18 and 19. In the head-teacher questionnaire the data is located at numbers 19, 20, 21, 22, 23, 24, 25 and 26.

The Ministry of Education, Sport and Culture did not prescribe any strategies for the implementation of the HIV/AIDS and Life-skills education programme in the schools except that participatory teaching methodologies were to be used. The rest of the sticking points were to be addressed at the training workshops where the delivery mode of the programme was to be rolled out. But as it has already emerged such workshops hardly took place. In this research one of the objectives is to isolate the

strategies that were used and to evaluate how effective they were. Responses from both the teachers and head-teachers will be dealt with at the same time where this is possible.

Teachers and head-teachers were asked as to what methodologies and techniques they were using in the teaching of the HIV/AIDS and Life-skills education programme for schools. They named participatory methodologies such as drama, song, poems, discussions, field trips, plays, games, quiz debates and discovery. This looked commendable as these methodologies present pupils with situations and they have the task of exploring how they could handle them. This helps them to develop life-skills as they work out solutions themselves with the teacher playing the role of facilitator. These educators could add to their list by including such other participatory methodologies such as questioning, brainstorming, role-play, case studies and group work among others.

The teachers were also asked if they were being monitored in the teaching of the programme, while head-teachers were asked to mention any four instruments that they were using to monitor the programme. Only 36% of the teachers said that they were being monitored while the rest answered in the negative. The head-teachers mentioned monitoring instruments such as sit-in lesson observations, checking of scheme and plan books, evaluation books and timetables. The list of monitoring instruments mentioned by the head-teachers seems to show that the instruments being used are useful. To this list could be added other instruments such as checking of exercise books and subject committee minutes. However one wonders whether these

instruments are being used when only 36% of the teachers indicate that they are being monitored.

In terms of resource mobilisation, the head-teachers were asked if there were HIV/AIDS and Life-skills education committees at their schools and if there were HIV/AIDS files in their schools where policy documents and where all other forms of literature could be kept for reference purposes. Only 22% of the head-teachers said that they had such committees and files in their schools. This is an area of concern since the teaching of HIV is a new phenomenon in schools. There is need for a committee that would give technical support and backstopping to teachers and also mobilise material resources for both the teachers and students. Such a committee could also link up the school with service organisations that are involved in the fight against HIV/AIDS. Such service organisations could be invited to facilitate lectures and discussions with students in the schools. There is need for schools to move in this direction.

Both teachers and head-teachers were asked to mention any other strategies, approaches or techniques that they had undertaken as classes or schools in the implementation of the HIV/AIDS and Life-skills education programme. The strategies that were mentioned included workshops for teachers, establishment of school AIDS Action clubs, peer educators' clubs and the establishment of AIDS drama clubs. On the whole in terms of approaches and strategies, this area seems to be the weakest on the part of the schools. There are several approaches and strategies that the schools could take advantage of. Some of these could include class or school competitions in drama, music, quiz, use of the media, the use of specialist and support

organizations such as AIDS prevention organisations, youth organisations, art, theatre and cultural organisations. The immediate community too could second its own members who are knowledgeable in this subject area to work with the schools. Obviously teachers need a lot of help in terms of training and exposure in general if their approach to the teaching of HIV/AIDS and Life-skills education is to be effective.

Lastly, both teachers and head-teachers were asked as to what assistance they needed in order to successfully implement the HIV/AIDS and Life-skills education programme for schools. Their responses clearly underlined the need for orientation for both teachers and head-teachers in the facilitation of HIV/AIDS and Life-skills education, a variety of reading/learning materials including the basic workbook “Lets Talk”, syllabi documents, pamphlets and posters. If financial resources were available it would be a good route to invest so much in training and to expose teachers to organisations like Scripture Union Zimbabwe who are established leaders in the teaching of life-skills in schools. Their training package for primary school children include topics such as the adventure of life, I’m special, my family, making friends, talking sex, understanding HIV/AIDS, choices and consequences and a video film called Adventure unlimited. This would really compliment the teachers’ skills and work with the pupils.

#### 4.4.3.2 Summary and conclusion

To conclude this chapter, it must be mentioned that the approach to use participatory methodologies would succeed since most of the head-teachers and classroom teachers are conversant with these. It would be necessary to expand these methods to include others such as brainstorming, questioning, case studies, role-play, discussion and group work. On the question of monitoring instruments the head-teachers mentioned all the key instruments but there is need to use these since the majority of the teachers indicated that they were not being monitored. There is also need to establish HIV/AIDS committees in schools that will coordinate the training and mobilisation of material resources for the successful implementation of the HIV/AIDS and Life-skills education programme. In terms of the overall strategies for the implementation of the programme, this was found to be very weak. There is a need to train teachers and expose them to a variety of strategies and approaches that could be explored and used in the fight against HIV/AIDS.

## **CHAPTER 5**

### **SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

#### **5.1 Introduction**

In this chapter I will briefly summarise the substance of the first four chapters. I will proceed to outline conclusions emerging from the study. I will then conclude by making recommendations on how the HIV/AIDS and Life-skills education programme for schools in Zimbabwe could be strengthened.

#### **5.2 Summary**

The ground covered so far was to investigate whether the HIV/AIDS and Life-skills education programme for schools in Zimbabwe was implemented. If it was implemented, how effective was it? The focal point was a case study of schools in the Lupane Area Development Programme. In the first chapter, the area of study, clearly delimited, was specified. The purpose of the study, its importance and limitations were clearly spelt out. In the second chapter, I put up into clear perspective the threat posed by the AIDS pandemic and clearly elucidated how and why the school system should play a role in interrupting the spread of HIV infections. The thrust of HIV/AIDS education was identified as the development of life-skills in students. Approaches, strategies and techniques used worldwide for the implementation of similar programmes were explored and discussed.

In the research methodology chapter, I discussed my research design and data collection procedures. Under data collection procedures I dealt with sources of data, population, sampling and pre-testing. I went further to discuss instruments for data collection, procedures and finally, data analysis procedures.

In the fourth chapter, I described the sample of the data that I was going to present. I went on to present the data, where possible in tables and percentages. I analysed and discussed the data under the specific sub-problems. I concluded by presenting findings and then summarised these based on the data presented.

### **5.3 Conclusions and Recommendations**

The findings emerging from the data are that most schools that formed part of study implemented the HIV/AIDS and Life-skills education programme. The majority of the teachers teaching Grades 4 to 7 also implemented and timetabled the programme. However a significant number of schools and teachers have still not implemented the programme. Given the fact that more than 33 million people in Southern Africa are infected and that approximately 24.6% of the people in Zimbabwe are infected (approximately one in every three) efforts should be found to ensure that every school implements the programme without any further delay. Some lives could be saved through such timely interventions.

On the question of provision of human resources it emerged that the majority of the teachers are highly educated, professionally trained and experienced. Those that are not professionally trained have high academic qualifications such that if they were

properly oriented in the delivery mode of the programme they would be able to successfully implement the programme. It is recommended that the Ministry of Education, Sport and Culture should take advantage of this scenario and orient the head-teachers and classroom teachers so that the programme could be successfully implemented.

The main focus of the HIV/AIDS and Life-skills education programme is the development of life-skills and not mere provision of basic information on HIV/AIDS. In this study only 62% of the teachers said that their facilitation was focused on HIV/AIDS and the development of life-skills. Urgent steps should be taken to orient and support the teachers so that all of them could focus on the objectives of the programme. The main focus should be to present pupils with situations and task them to explore how they could handle them. This approach helps them to develop their own solutions, which in turn helps them develop life-skills to use in their journeys of life. Most teachers seemed to be aware of participatory methodologies. It would be necessary to orient them to use these in varied scenarios and to link them with a whole range of support organisations who would assist with the provision of relevant literature and resource persons to give talks to teachers, pupils and even the community members so that the pandemic could be fought from all possible fronts. Such support could be available from non-governmental organisations; church organisations, peer educators, the medical fraternity and other HIV/AIDS support organisations such as Scripture Union Zimbabwe.

On the question of key documents, it also emerged that very few schools and teachers had copies of key policy circulars and syllabi documents. This was found to be a

serious gap and the Ministry of Education, Sport and Culture should move with speed and avail these documents to the schools. Otherwise even those schools that have implemented may not know what they have implemented if they do not know the main purpose and specific objectives of the programme. They may not even know the suggested approaches, strategies and methodologies.

It also emerged from the study that not all teachers had timetabled HIV/AIDS and Life-skills education programme. Some had inappropriately timetabled the programme. The majority of the teachers also confessed that their teaching was not being monitored. Yet the head-teachers appeared to be aware of the monitoring alternatives available to them. Further research should be done on how monitoring could be made an integral part of the implementation of the programme in schools. Otherwise there may be no meaningful facilitation of the programme taking place at all.

In terms of resource mobilisation it emerged that the majority of schools had been provided with the basic workbook series. However it became clear that there is need for more of these. There was also need for the provision of more and varied reading materials on HIV/AIDS. In related literature other countries have also shown us that the schools themselves can actually produce a lot of learning materials. A case in point is that from Ugandan schools where a kit of colourful posters, definition cards, flip charts and information leaflets on HIV and AIDS are being produced and used (AFT/ZIMTA 2002:5. In the case of South Africa we also saw the collaboration between the Ministries of Education, Health and Social Welfare. These ministries put together a National Life Skills Project Committee (NPC), which is tasked with

coordination and support for the schools (Michel 1999:5). One of the objectives of this committee is to mobilise resources to support the Life-skills and HIV/AIDS education programme in the schools.

On approaches and strategies this is one area where the situation in our schools looks weakest. There is need to learn from experiences from other countries where, for instance, the school's immediate communities join hands with the schools in facilitating education in HIV/AIDS and Life-skills. HIV/AIDS is too big to be the school's business alone. In countries such as Australia HIV/AIDS has been integrated into the school curriculum and is taught as part of a larger Health Education Programme. This is very helpful as the impact of the programme can easily be felt. Zimbabwe's schools could very well learn from such an experience.

#### **5.4 Conclusion**

I would like to conclude this research study by suggesting that there is need to conduct a bigger research on this topic so that findings are written and circulated to all schools in the region with the aim of improving the facilitation of the HIV/AIDS and Life-skills Education Programme in schools. It is very likely that the findings and recommendations of such a research study would be similar with those of this study.

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## **APPENDIX 1 QUESTIONNAIRE (Teacher)**

*“confidential”*

### **The HIV/AIDS and Life-Skills Education Programme for Schools in Zimbabwe. A case study of primary schools in the Lupane Area Development Programme**

Please answer as freely as possible **ALL** questions listed in this questionnaire. All responses given will be treated in strict confidence.

*Answer by putting a tick in front of your preferred alternative or write in the spaces provided.*

#### **A. BIOGRAPHY**

1. Gender

- (i) male
- (ii) female

2. Position

- (i) teacher
- (ii) head/deputy

3. Highest academic qualifications

- (i) Std 6
- (ii) J.C.
- (iii) “O” Level
- (iv) “A” Level
- (v) B.A.
- (vi) M. A.

4. Highest professional qualifications

- (i) Untrained
- (ii) PTL
- (iii) PTH
- (iv) DipEd/CE/T3
- (v) BED
- (vi) MED

5. How long have you been teaching?

- (i) 0 – 5 years
- (ii) 6 – 10 years
- (iii) 11<sup>+</sup> years

**B. QUANTITATIVE QUESTIONS (teacher)**

6. Have you implemented HIV/AIDS and Life skills education in your class?  
(i) Yes  
(ii) No
7. If yes what do you teach?  
(i) Facts about HIV/AIDS.  
(ii) Facts about HIV/AIDS and Life skills.  
(iii) Others, specify.....
8. Have you timetabled HIV/AIDS and Life skills education?  
(i) Yes  
(ii) No
9. If yes how many periods a week?  
(i) one period  
(ii) two periods  
(iii) three periods  
(iv) four periods
10. Did you receive the HIV/AIDS and Life skills education programme syllabi document?  
(i) Yes  
(ii) No
11. Name basic resources/textbooks that you use for the HIV/AIDS and Life skills education lessons.  
(i) .....  
(ii) .....
12. Have you been trained or work shopped on the HIV/AIDS and Life skills education delivery mode?  
(i) Yes  
(ii) No
13. If yes by whom?  
(i) .....  
(ii) .....
14. Are you confident to handle HIV/AIDS and Life skills education lessons?  
(i) Yes  
(ii) No

**C: QUALITATIVE QUESTIONS (teacher)**

15. Name at least two things the HIV/AIDS and Life skills education programme in your school aims to do?  
(i) .....  
(ii) .....

16. Name at least four teaching methods that you can use in the delivery of this programme.

- (i) .....
- (ii) .....
- (iii) .....
- (iv) .....

17. Are you being monitored in the teaching of the programme?

- (i) Yes
- (ii) No

18. List any two plans/strategies that you have made as a school or classes to help you implement the HIV/AIDS and Life skills education programme.

- (i) .....
- (ii) .....

19. List areas in which you need assistance in the implementation of the HIV/AIDS and Life skills education programme.

- (i) .....
- (ii) .....
- (iii) .....
- (iv) .....

***Thank you for answering the questions***

## **APPENDIX 2 QUESTIONNAIRE (Headteacher)**

*“confidential”*

**The HIV/AIDS and Life-Skills Education Programme for Schools in Zimbabwe.  
A case study of primary schools in the Lupane Area Development Programme.**

Please answer as freely as possible **ALL** questions listed in this questionnaire. All responses given will be treated in strict confidence.

*Answer by putting a tick in front of your preferred alternative or write in the spaces provided.*

### **A. BIOGRAPHY**

1. Gender

- (iii) male
- (iv) female

2. Position

- (iii) teacher
- (iv) head/deputy

3. Highest academic qualifications

- (vii) Std 6
- (viii) J.C.
- (ix) “O” Level
- (x) “A” Level
- (xi) B.A.
- (xii) M. A.

4. Highest professional qualifications

- (vii) PTL
- (viii) PTH
- (ix) DipEd/CE/T3
- (x) BEd
- (xi) MEd

5. How long have you been teaching?

- (iv) 0 – 5 years
- (v) 6 – 10 years
- (vi) 11<sup>+</sup> years

**C. QUANTITATIVE QUESTIONS (headteacher)**

6. Have you implemented HIV/AIDS and Life skills education in your school?  
(i) Yes  
(ii) No
7. If yes when? (give the year e.g. 2003.....)
8. Did you receive the Chief Education Officer's Circular Minute No. 16 of 28 June, 1993?  
(i) Yes  
(ii) No
9. Did you receive the Director's Circular Minute No. 2 of 16 January 2003?  
(i) Yes  
(ii) No
10. Have you timetabled HIV/AIDS and Life-skills education in your school?  
(i) Yes  
(ii) No
11. If yes, how many periods a week?  
(i) one period  
(ii) two periods  
(iii) three periods  
(iv) four periods
12. Did you receive the HIV/AIDS and Life-skills education syllabi document?  
(i) Yes  
(ii) No
13. Did you receive "Lets Talk" series for Grades 4 to 7?  
(i) Yes  
(ii) No
14. Do you have any other sources on HIV/AIDS and Life-skills education in your school?  
(i) Yes  
(ii) No
15. Did you attend any HIV/AIDS and Life-skills education orientation workshop?  
(i) Yes  
(ii) No
16. If yes how many days was it?  
(i) one day  
(ii) two days  
(iii) three days  
(iv) four days  
(v) five days
17. If no, what was the reason for not attending?  
(i) I was occupied

- (ii) I delegated
- (iii) I was not invited
- (iv) No workshop took place
- (v) I was not a head yet
- (vi) Any other reason, specify.....

18. If you attended, did you workshop your teachers?

- (i) Yes
- (ii) No

19. Is there an HIV/AIDS and Life-skills education committee in your school?

- (i) Yes
- (ii) No

20. Is there an HIV/AIDS file in your school?

- (i) Yes
- (ii) No

**C: QUALITATIVE QUESTIONS (Headteacher)**

21.. *If there is an AIDS Committee in your school, list any three of its functions in order of priority.*

- (iii) .....
- (iv) .....
- (v) .....

22. *What is the focus of the HIV/AIDS and Life-skills education programme in your school? List any two-priority areas.*

- (v) .....
- (vi) .....

23.. *Name any four teaching methods that you could use in the HIV/AIDS and Life-skills education programme.*

- (iii) .....
- (iv) .....
- (v) .....
- (vi) .....

24. *Name any four instruments, which are being used at your school to monitor this programme.*

- (iii) .....
- (iv) .....
- (v) .....
- (vi) .....

25. *List any two strategies that you could use in the implementation of this programme.*

- (v) .....
- (vi) .....

26. *List areas in which you need assistance as a school in the implementation of the programme.*

- (i) .....
- (ii) .....
- (iii) .....

***Thank you for answering the questions***

