FACTORS AFFECTING THE IMPLEMENTATION OF THE FAMILY LIFE AND HIV/AIDS EDUCATION CURRICULUM IN JUNIOR SECONDARY SCHOOLS IN ABUJA, NIGERIA

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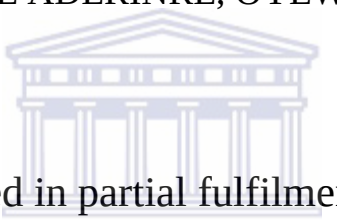

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
FCT	Federal Capital Territory
FCTUBEB	Federal Capital Territory Universal Basic Education Board
FGN	Federal Government of Nigeria
FLHE	Family Life and HIV/AIDS Education
FME	Federal Ministry of Education
FMOH	Federal Ministry of Health
HIV	Human Immunodeficiency virus
JSS	Junior Secondary Schools
NACA	National Agency for the Control of AIDS
NARHS	National HIV/AIDS and Reproductive Health Survey
NDHS	Nigeria Demographic and Health Survey
NERDC	National Educational Research Development Council
NGO	Non-Governmental Organizations
NPC	National Planning Commission
PABA	Persons Affected by AIDS
PLHIV	People Living with HIV
SPSS	Statistical Package for Social Sciences
UNAIDS	Joint United National Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNGASS	United Nations General Assembly
UNICEF	United Nations Children's Fund

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ABSTRACT

Factors Affecting the Implementation of the Family Life and HIV/AIDS Education Curriculum in Junior Secondary Schools in Abuja, Nigeria

The Family Life and HIV/AIDS Education (FLHE) curriculum was introduced into Junior Secondary Schools (JSS) in Nigeria to provide young people with life skills and knowledge essential for protecting themselves from HIV/AIDS. However, coverage of schools with the FLHE curriculum implementation is low. The purpose of this study was to determine the factors that affect the implementation of the FLHE curriculum in JSS in Abuja, Nigeria. This study was a quantitative descriptive cross-sectional survey. The study population were teachers from public JSS implementing the FLHE curriculum in Abuja, among whom 300 teachers selected using systematic random sampling constituted the sample size.

A close-ended anonymous questionnaire was administered to the research respondents as a self-administered questionnaire in English Language in their schools. A total of 300 questionnaires were administered of which 251 completed questionnaires were returned and analysed. Data analysis was undertaken using SPSS version 17 and included frequency distribution, mean score and standard deviation (univariate analysis), and cross tabulations of dependent variable (teaching of FLHE curriculum) and independent variables (awareness of HIV/AIDS policy and government directive; level of knowledge of the FLHE curriculum; level of comfort to teach FLHE curriculum; religious belief and affiliation; and cultural values of respondents). Chi-square tests and p-values were calculated to determine relationship between variables.

Throughout this study, the autonomy of the respondents and dignity were respected; and their participation was voluntary. There was full disclosure of the purpose of the study. The respondents were assured of the confidentiality and anonymity of the information collected; and their written consent were secured prior to participation in the study.

The majority (72%) of teachers in this study were aware of the National HIV/AIDS Policy and the government directive to mainstream topics in the FLHE curriculum into existing subjects (78%). Just above one-third (36%) of the teachers had ever seen a copy of the HIV/AIDS policy and knew all the content of the policy. The study revealed that only 5% of the teachers in schools implementing the FLHE curriculum had sufficient level of knowledge of the FLHE curriculum. Majority of the teachers (71%) knew the content of only one (HIV infection) out of the five themes in the curriculum, and 4 out of 5 of the teachers were comfortable in teaching the curriculum to students.

The lack of sufficient level of knowledge of the FLHE curriculum and the content of the HIV/AIDS policy and government directive among majority of the teachers were major factors that affected the implementation of the curriculum. Awareness of the government directive (P= 0.000) as opposed to the HIV/AIDS policy (P= 0.772) among the teachers was found to be an important factor to harmonize implementation modalities of the curriculum. The study also noted that personal perception (P = 0.000), cultural values (P = 0.000) and religious belief (P = 0.000) of the teachers as opposed to their religious affiliation (P= 0.218) were important factors in the teaching of FLHE curriculum to students.

This study has established that several factors among teachers that included awareness of the government directive to mainstream topics in the FLHE curriculum into subjects, knowledge of the content of the FLHE curriculum and personal perception to the teaching of the curriculum, as well as religious belief and cultural values affected the implementation of FLHE curriculum in JSS in Abuja, Nigeria.

CHAPTER 1
INTRODUCTION

1.1 BACKGROUND

According to the 2010 Global AIDS Epidemic Report, the Acquired Immune Deficiency Syndrome (AIDS) epidemic is currently in the fourth decade and the world is beginning to see a halt and reversal in the Human Immunodeficiency virus (HIV) related cases and deaths. This reversal has translated into fewer AIDS related deaths (UNAIDS, 2010). As at the end of 2010, an estimated 33.3 million people were living with HIV, while 2 million deaths occurred during the year and 2.7 million people were newly infected. Africa remains the epicenter of the epidemic with 22.4 million people infected with HIV. Nigeria with an estimated population of 3.3 million people living with HIV (PLHIV) is home to the second largest population of people infected and has contributed about 10% to the global HIV burden in 2009 (UNAIDS, 2010).

In 2008, the national HIV sero-prevalence among women attending ante-natal clinics in Nigeria was estimated at 4.6% by the Federal Ministry of Health (FMOH, 2008). The HIV prevalence among young people aged 15 – 24 years in Nigeria was estimated at 4.2% in 2008 (UNGASS, 2010). Thus, the need for the prioritization of young people focused HIV/AIDS prevention interventions. This was recognised for in-school and out-of school young people in Nigeria (FGN, 2003; NACA, 2005).

The Family Life and HIV/AIDS Education (FLHE) curriculum was introduced into Junior Secondary Schools (JSS) in Nigeria to provide young people with life skills

and knowledge essential for protecting themselves from HIV/AIDS (NERDC, 2003). However, coverage of schools with the FLHE curriculum is low with only 22% of JSS implementing the curriculum in Nigeria in 2006 (FME, 2006a). In Abuja, only 17 schools (26%) were implementing the curriculum in 2006 (FME, 2006a). Based on the monitoring report of the FLHE curriculum implementation in Abuja (FCTUBEB, 2010) the number of JSS implementing the FLHE curriculum in Abuja has increased to 30 schools (45%) in 2010.

The HIV/AIDS policy for the education sector and the government directive that introduced the FLHE curriculum (from here on the term *government directive* only shall be used) required the mainstreaming of topics in the FLHE curriculum into all subjects in schools. Although, the evaluation of the mainstreaming of topics in the FLHE curriculum into several subjects was yet to be done in Nigeria, the government directive has been documented by Aniche and Odukoya (2004) as a major limitation for teachers to implement the curriculum as teachers were under undue pressure to implement the curriculum without an adequate enabling environment.

1.1.1 Overview of HIV/AIDS among Young People in Nigeria

According to the National Adolescent Health Policy (FMOH, 1995) adolescents in Nigeria were defined as people between the ages of 10 - 24 years. The term 'young people' in this study is defined as individuals aged 10 – 24 years unless otherwise specified.

Young people have been known to be a highly mobile and sexually active population and have emerged as one of the most vulnerable groups to the AIDS epidemic in

Nigeria (FMOH, 2004). They indulge in risky sexual behaviours and experimentation. Young people have also been known to be involved in having sex for financial benefits, thus making them a high risk group for HIV/AIDS (Osotimehin, 2002).

The FMOH (2008) estimated that the age-specific prevalence of HIV for young people aged 15 – 24 years in North-Central Nigeria (where Abuja is located) ranged from 3.2% to 9.0% in urban areas; and from 2.0% to 9.7% in rural areas. Abuja, with HIV prevalence greater than 8% among ante-natal attendees in 2008, has one of the highest rates in Nigeria (UNGASS, 2010). Based on this burden, it is imperative to design HIV/AIDS prevention education programmes that target young people as it has been documented that the majority of individuals living with HIV were infected during adolescence and childhood (Sileo, 2005).

1.1.2 School-Based HIV/AIDS Prevention Intervention in Nigeria

The Nigeria National Education Sector HIV/AIDS Strategic Plan categorized school-based HIV/AIDS activities in Nigeria into curricular and co-curricular activities (FME, 2006a). Co-curricular school-based peer education programmes on HIV/AIDS were organized by civil society organizations and the National Young people Service Corp Scheme in Nigeria. HIV/AIDS peer education was implemented in 60% of JSS (FME, 2006b). Thirty-six per cent of JSS have anti-HIV/AIDS clubs which often served as the forum for the activities of trained peer educators in schools. Other co-curricular activities in JSS in Nigeria included health talks and community awareness programme on HIV/AIDS undertaken by students (FME, 2006b).

The curricular based intervention was implemented through the FLHE curriculum. The FLHE curriculum was introduced into all levels of the education system in Nigeria (NERDC, 2003) as a critical school–based strategy for combating HIV infection among young people. The goal of the FLHE curriculum was the promotion of preventive education by providing learners with opportunities to develop a positive and factual view of self; acquire information and skills they need to take care of their health including preventing HIV/AIDS; respect and value themselves and others; and acquire the skills needed to make healthy decisions about sexual health and behaviors (NERDC, 2003).

1.2 RESEARCH SETTING

Abuja, the Federal Capital Territory (FCT) of Nigeria occupies a land area of 713 square kilometres in the North Central region of Nigeria. Administratively, Abuja is made up of 6 Local Area Councils and had a population of about 1.5 million people in 2006 (NPC, 2007). Based on the 34% projected population of Nigeria who are between ages 10 – 24 years (US Bureau of Census, 2010) it is estimated that there are about half a million people below 24 years in Abuja.

According to the Nigeria Demographic and Health Survey (NDHS, 2008), the literacy rate among young people was 69.41% and the official secondary school age was 12 to 17 years (NPC and ICF Macro, 2009). During the 2004-2005 academic years, 67 JSS in Abuja were registered in the Nigeria National Education Databank and 39,302 school-children were enrolled in these schools (FME, 2006c). During the same period, there were 1,251 teachers teaching in JSS in Abuja. The Junior Secondary Schools used in this research are public government secondary school. The schools are

managed and run centrally by the FCT Universal Basic Education Board. The board is in charge of teachers' posting and payment of salaries, school inspection and monitoring systems. Each school is headed by a principal who is in-charge of the day to day administration of the school. The Parents Teachers Association also plays a pertinent role in the management of the school from time to time. The Junior Secondary Schools in Abuja are both co-educational and single sexed schools (FCT UBEB, 2010).

1.3 PROBLEM STATEMENT

Boonstra (2003) has recommended that a risk reduction approach to young people's sexual activity was vital for HIV/AIDS prevention, thus reinforcing the importance of effective implementation of the FLHE curriculum in Nigeria. Although the curriculum was introduced into all levels of the education system since 2003, several factors intrinsic and extrinsic to the school system have been reported (FME, 2006b; Bwakira, 2002; Ochiagha, 1997) to affect the implementation of HIV/AIDS education in Nigeria. Some of the identified constraining factors intrinsic to the school system included poor awareness of the content of the curriculum among teachers, scarcity of copies of the curriculum as well as limited knowledge and skills amongst teachers to implement the curriculum (FME, 2006b). Other factors extrinsic to the school system in Nigeria like other African countries were related to religious and cultural limitations of discussing sexuality with young people (Bwakira, 2002).

The fact that the studies in Nigeria were not focused on contraints affecting implementation of FLHE curriculum in Junior Secondary School (JSS) justified the reason for this research. The factors documented by Bwakira (2002) focused on HIV/AIDS education generally in Nigeria and not specifically on the FLHE curriculum implementation. Another study by Ochiagha (1997) focused on primary school and not JSS where young people at risk of HIV infection are mainly located (Osotimehin, 2002; FMOH, 2004).

Further justification lies in the fact that the studies in Nigeria did not approach the constraints affecting implementation of HIV/AIDS education with a comprehensive framework as was done in Asia-Pacific countries (Smith, Kippax, Aggleton, and Tyrer, 2003). In the Asia-Pacific countries, Smith *et al.* (2003) conceptualized the factors that affected the delivery of HIV/AIDS education into four areas namely:- policy; curriculum; teacher training; and delivery of the curriculum on HIV/AIDS education. An understanding of the factors affecting the implementation of the FLHE curriculum in JSS in Abuja using the conceptual framework by Smith *et al.* (2003) was desirable to increase the coverage of HIV prevention information and life skills education provided through the FLHE curriculum to young people in Abuja.

1.4 RATIONALE FOR THE STUDY

The purpose of this study was to determine the factors that affect the implementation of the FLHE curriculum in JSS in Abuja. The research attempted to answer the following research questions:

a. How does the level of awareness and knowledge of the HIV/AIDS policy and the government directive among teachers affect the teaching of FLHE curriculum in JSS in Abuja?
b. How does the level of knowledge of the FLHE curriculum among teachers affect the teaching of FLHE curriculum in JSS in Abuja?
c. How does the attitudes of teachers in JSS in Abuja affect the teaching of FLHE curriculum?
d. How does religion and culture affect the teaching of FLHE curriculum among teachers in JSS in Abuja?

1.5 THESIS OUTLINE

This research report is presented in six chapters as follows:

Chapter 1: Introduction – describes the background to the research including the problem statement, rationale for the research and the problem statement. In addition, a description of the research setting is also provided in the chapter.

Chapter 2: Literature Review - explored relevant literature and reports on school-based HIV/AIDS prevention interventions with focus on HIV/AIDS Education Curriculum; Policy Environment for HIV/AIDS Education Curriculum; Delivery of HIV/AIDS Education Curriculum; and Teacher Training on HIV/AIDS as factors that affect implementation of curricular based HIV/AIDS programmes in schools. In addition, the conceptual framework for the study is discussed in this chapter.

Chapter 3: Methodology - includes a description of the aim and objectives of the study, the research design, the study population, sampling approach and data analysis. In addition, steps taken to ensure this research complied with ethical standards are also discussed.

Chapter 4: Results - presents the findings from the study of the factors affecting the implementation of FLHE curriculum in JSS in Abuja. The results are presented in tables and graphs and included frequency distributions and cross tabulations.

Chapter 5: Discussion - includes interpretation of the results of this research in relation to existing evidence as well as the limitations to the study. The discussion is outlined under the implications of the awareness of HIV policy and government directive on the implementation of the FLHE curriculum; the impact of the knowledge of the curriculum on implementation as well as socio-cultural factors affecting the teaching of the FLHE curriculum to students in schools.

Chapter 6: Conclusions and Recommendation - outlines the conclusions drawn on the factors that affect the implementation of FLHE curriculum in JSS in Abuja, based on the findings of this research. In addition, policy and programme recommendations for effective implementation of the curriculum and further studies to generate additional knowledge in this field are also made in the chapter.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

For this chapter, relevant literature and reports were reviewed on school-based HIV/AIDS prevention interventions. The review was limited to the rationale and coverage of school-based HIV/AIDS education, as well as factors that affect implementation of curricular based HIV/AIDS education in schools. The review of factors affecting implementation of curricular-based HIV/AIDS education focused on HIV/AIDS Education Curriculum; Policy Environment for HIV/AIDS Education Curriculum; Delivery of HIV/AIDS Education Curriculum; and Teacher Training on HIV/AIDS. In addition, the conceptual framework for the study was also discussed in this chapter.

2.2 SCHOOLS AND HIV/AIDS PREVENTION EDUCATION

In the global update on preventing HIV among young people, UNICEF (2011) categorised interventions that work to prevent HIV among young people into six groups (see box 1). According to the report, school-based HIV&AIDS education is one of the interventions within communication for social and behaviour change noted to improve knowledge and self-efficacy which are important foundations for HIV prevention.

Box 1: Interventions that work to Prevent HIV Transmission in Young People

1. Abstinence from sex and not injecting drugs;
2. Correct and consistent use of male and female condoms
3. Medical male circumcision
4. Needle and syringe exchange programme as part a comprehensive harm reduction programme
5. Using antiretroviral drugs as treatment (which lower the chance of transmission) or as post – exposure prevention
6. Communication for social and behaviour change

Adapted from UNICEF, 2011

A large number of sex education and HIV education interventions are being implemented in schools worldwide and they vary widely in terms of objectives, structure, length, content, implementation strategy and other characteristics (Grunseit, 1997; Kirby, Laris and Rolleri, 2007). The programmes are delivered either as curricular based or non-curricular based interventions. A study by Kirby, Obasi and Laris (2006) to review the impact of sex education and HIV education intervention in schools in developing countries advocated that schools are effective settings to achieve the ultimate goal of decreasing HIV prevalence among young people. They argued that in most societies, the school is the one institution that is regularly attended by most young people and therefore an ideal setting to reach them. The report also stated that the majority of young people who attended school do so before they began having sexual intercourse, and many were enrolled in school when they actually initiate sex. Thus, the report concluded that schools provided an opportunity for interventions to achieve high coverage of young people before or around the time they become sexually active. This conclusion is justifiable given that there is still no

known vaccine for HIV and education has been argued by Vandemoortele and Delamonica (2002) as the 'vaccine against HIV'.

Furthermore, Kirby (2000) noted that HIV education programmes for in-school and out-of-school young people provided readily available channels for consciously influencing them (young people) in relation to personal values and skills. These programmes will empower them to make correct and safe choices necessary to reduce their likelihood of contracting HIV. Similarly, the World Bank (2002) has documented that the education sector in countries have a strong potential to make a difference in the fight against HIV/AIDS. In Nigeria, NERDC (2003) revealed that significant percentage of the youth exposed to sexuality and reproductive health education postponed sexual initiation and less engages in risky sexual activity.

In addition, the International Technical Guidance on Sexuality Education (UNESCO, 2009), concluded that age-appropriate sexuality education can increase knowledge and contribute to more responsible sexual behaviour among young people. According to the technical guideline (UNESCO, 2009), around 50% of sexuality education programmes evaluated in 2006 showed decreased sexual risk-taking behaviour among young people. A global review of the impact of sex and HIV education on sexual behaviour of young people by Kirby, Laris and Rolleri (2007) also confirmed that sexuality education does not cause harm, nor does it lead young people to start having sex at an earlier age. For instance, Klepp, Ndeki, Seha, Hannan, Lyimo, Msuya, Irema, and Schreiner (1994) in their study in Tanzania reported that primary school pupils exposed to HIV/AIDS education intervention had more restrictive subjective norms regarding sexual intercourse and less intention to engage in sexual intercourse.

Globally, the percentage of schools providing life skills–based HIV education is on the increase (UNAIDS, 2010). According to the global report (UNAIDS, 2010) a nationwide programme in Estonia that combined school-based sexuality education with young people-friendly sexual and reproductive health services had led to dramatic improvements in reproductive health indicators among young people over the past two decades. The country recorded 59% fewer pregnancies and 61 % fewer abortions among 15–19 year-olds between 1992 and 2009. The number of registered new HIV cases in the same age group declined dramatically by 95 % - from 560 cases in 2001 to just 25 cases in 2009.

The evaluation of Jamaica's Health and Family Life Education programme by Tindigarukayu and Jimmy (2010) found much greater knowledge of HIV among sixth-grade students in schools that took part in the programme than among students whose schools did not participate. By the ninth grade, these differences in knowledge levels however disappeared, but students in the programme were less likely to engage in risky behaviours and more likely to refuse sex. The evaluation of the HIV/AIDS education delivered by trained teachers in Nyanza and Rift Valley in Kenya indicated that fewer pupils were having sex, more were delaying their sexual debut and more girls reported using condoms (Palmer, 2010). Similarly, Sayi (2003) noted that in Tanzania where HIV/AIDS curricula were available for primary, secondary and teacher college levels, a reduction in HIV/AIDS prevalence occurred, depicting the potential of curricular based HIV/AIDS prevention programmes. In Nigeria however, the low coverage of HIV/AIDS education in school remains a concern. As noted

earlier, at the end of 2006, only 26% of JSS in Abuja had implemented the FLHE curriculum (FME, 2006b).

2.3 IMPLEMENTATION OF CURRICULUM-BASED HIV/AIDS EDUCATION

Curriculum-based HIV/AIDS education is often more intensive and more structured than co-curriculum-based interventions. In addition, curriculum-based interventions are more likely to be based on theory and previous research and may have been extensively pilot-tested and sanctioned by the appropriate authorities as in the case of the FLHE curriculum in Nigeria (NERDC, 2003). Several factors that affect the teaching of curriculum-based HIV/AIDS education in schools have been identified (Smith *et al*, 2003; UNESCO, 2010; UNICEF, 2011), including the existence of supportive policies, dissemination of clear curricular, appropriate teacher training and commitment by teachers to deliver the curriculum. These factors are discussed further below.

2.3.1 HIV/AIDS Curriculum

The UNICEF global study on preventing HIV from early adolescence to young adulthood (UNICEF, 2011) reported that the teaching of appropriate sexual behavior and HIV prevention practices in schools was dependent on the content and dissemination of a clear curriculum. The curricula served to guide and inform teachers, and their usage may overcome or ameliorate some of the teachers' personal prejudices or limitations in teaching skills. Atto (2003) reported that the existence of HIV/AIDS curriculum guide for primary, secondary and pre-service teachers training

in Ethiopia greatly influenced the teaching of sexuality education in schools and improved some of the teachers' personal prejudices and limitations in teaching skills related to HIV/AIDS. The curricula also offered greater detail in terms of specific content and located that content in subject areas (Smith *et al*, 2003) as in the case of the FLHE curriculum which outlines the content of HIV/AIDS and Life Skills education to be taught in schools in Nigeria.

Relating to the content of the curriculum, Dailard (2001) reported that the content of the curriculum on sexuality education influenced the teaching of the curriculum by teachers in school in the United States of America. Further clarity on the content of the HIV/AIDS curriculum was provided by Smith *et al.* (2003) and Kirby, Laris, and Rolleri (2006). Smith *et al.* (2003) reported that the HIV/AIDS education curriculum was often composed of two features – one focused on the biology of sexual reproduction including HIV transmission and prevention, and the other focused on life skills development. For further clarity, the characteristics of the content of an effective curriculum-based HIV/AIDS programme in terms of goals and objectives of the curriculum activities and teaching methods defined by Kirby, Laris, and Rolleri (2006) is outlined in box 2.

A review of the content of the FLHE curriculum in Nigeria based on the criteria defined by Smith *et al.* (2003) and Kirby *et al.* (2006) showed that the goal and objective of each of the five themes of the FLHE curriculum (see box 3) have clearly defined behavioural objectives related to health, sexually transmitted infections (STI), HIV/AIDS and life skills.

The curriculum promotes multiple behaviours and life skills to reduce the risk and vulnerability of young people (NERDC, 2003). Thus, teachers are required to acquire new knowledge with regard to the content defined in the FLHE curriculum. The situation is further compounded for teachers in Nigeria by the directive to mainstream topics in the FLHE curriculum into several subjects requiring all teachers to upgrade their knowledge with topics in the FLHE curriculum. This challenge is similar to the findings in Smith *et al.* (2003) where teachers in Asian – Pacific countries were reported to face huge challenges in mainstreaming different topics in HIV/AIDS curriculum into different subject areas.

Box 2: Characteristics of effective curriculum-based programme

Curriculum goals and objectives:

1. Focus on clear health goals, such as the prevention of STIs and HIV and/or pregnancy
2. Focus narrowly on specific behaviours leading to these health goals (such as abstaining from sex or using condoms or other contraceptives); give clear messages about these behaviours; and address situations that might lead to them and how to avoid them.
3. Address multiple sexual–psychosocial risk and protective factors affecting sexual behaviours (such as knowledge, perceived risks, values, attitudes, perceived norms and self-efficacy).

Activities and teaching methods

4. Create a safe social environment in which young people can participate.
5. Include multiple activities to change each of the targeted risk and protective factors.
6. Use instructionally sound teaching methods that actively involve participants, that help participants personalize the information and that are designed to change each group of risk and protective factors.
7. Use activities, instructional methods and behavioural messages that are appropriate to the culture, developmental age and sexual experience of the participants.
8. Cover topics in a logical sequence.

Adapted from Kirby, Laris, and Rolleri (2006).

Box 3: Themes of the FLHE Curriculum

- Human development comprised of human physiology, body image and personal hygiene including reproductive health system
- Personal skills comprised of value clarification, self-esteem and life skills to promote adaptive behaviours among learners
- HIV infection comprised of HIV transmission and prevention as well as impact and stigma reduction
- Relationships comprised of family, friendship and relating to people in society

Society and culture comprised of religious and cultural values, and caring for one another

Adapted from NERDC, 2003

2.3.2 Policy Environment for HIV/AIDS Curriculum

Policy with regard to HIV/AIDS prevention interventions in schools reflects the extent of high-level governmental commitment to the intervention and is often articulated in a policy statement or document. In a systematic review of evidence from developing countries on the prevention of HIV/AIDS among young people (Ross, Dick and Ferguson, 2006), it was concluded that age-appropriate HIV and sexuality education requires a supportive environment for developing self-efficacy to reduce HIV risk and vulnerability among young people. Thus in a school setting, a policy supporting the development and implementation of appropriate curriculum on HIV/AIDS education in schools can create an environment which makes this possible.

In the United States, Dailard (2001) reported that school policy on sexuality education influenced the teaching of sexuality education by teachers as they felt more comfortable to teach sexuality education to their students without the fear of any adverse reaction from the community. Kirby *et al.* (2005) also stated that policies (on HIV/AIDS) provided the needed support or sanction for teachers who were delivering controversial topics in some cultures. Similarly, Smith *et al.* (2003) reported that the existence of a policy provided persuasive leverage to introduce or improve existing HIV/AIDS education in schools. In South Africa, Mathews, Boon, Flisher and Schaalma (2006) reported that the presence of a school HIV/AIDS policy was a forecaster for implementing HIV/AIDS education. Blake, Ledsky, Sawyer, Goodenow, Banspach, Lohrmann and Hack (2005) also found that a strong, state-level HIV prevention education policy affected how district level school health policies were formulated as well as positively influenced the reach and quality of HIV education provided in the school in the United States.

In Uganda the success story attributed to the fight against HIV/AIDS was through a vigilant open policy where the government and faith-based organizations spoke openly about the disease and supported implementation of HIV/AIDS education (Asiimwe, 2007). The same study reported that the timely implementation of HIV/AIDS education resulted in drastic reduction of HIV prevalence in the country from 15% in the early 1990s to around 5% in 2001. In the review of curricular based sex and HIV education programme among youth in schools in developing and developed countries, Kirby, Laris, and Rolleri (2005) reported that the approval of HIV/AIDS education articulated in policies by relevant authorities was one of the factors for effective programme implementation.

In the context of the current study, policy referred to the commitment of the government of Nigeria to ensure a positive environment for the success of HIV/AIDS interventions in the education sector. The Nigeria HIV/AIDS policy in the education sector (FME, 2005) defined clear roles and responsibilities for government, employers, workers, teachers, students and all stakeholders in the education sector in the following key areas:

- Prevention of HIV transmission including HIV/AIDS education;
- Access to care, treatment and support for people living with HIV (PLHIV) and People Affected by HIV & AIDS (PABA) in the sector;
- Access to education and socio-economic security for orphans and vulnerable children;
- Elimination of stigma and discrimination against PLHIV and PABA; and
- Promotion and protection of the rights of PLHIV in the sector.

While policies on HIV/AIDS education often recognize the importance of informing students about HIV and sexual health in both primary and secondary schools (Smith *et al.*, 2003), the concern remains the extent to which the policy enables teachers to deliver HIV/AIDS education. Thus, the exploration of the implication of the policy environment (HIV/AIDS policy and government directive) on the implementation of FLHE curriculum by teachers in Abuja in this study

2.3.3 Challenges in Delivery of HIV/AIDS Curriculum

Several challenging factors that impact on the delivery of the HIV/AIDS curriculum are discussed below.

2.3.3.1 Social and Cultural Determinants

One of the challenges usually encountered in the delivery of HIV/AIDS education curriculum is related to the sensitive nature of the sexuality information to be taught to students. In the exploration of social and cultural determinants of the teaching of HIV/AIDS education among secondary school teachers in Eastern Nigeria, Oshi, Nakalema and Oshi (2005) reported that teachers were not passing on HIV/AIDS knowledge to students because of cultural and social inhibitions. Studies in South Africa (Peltzer,and Promtussananon, 2003) and Nigeria (FME, 2006a; Oyewale and Mavundla, 2008) reported that the personal disposition of teachers to sexuality issues affected their teaching of HIV/AIDS education. Peltzer and Promtussananon, (2003) reported that trained teachers in South Africa perceived that HIV/AIDS education may encourage early sexual experimentation among students. Similar findings were reported among teachers in Abuja where 12.5% of teachers who had taught HIV/AIDS issues to students held the same perception (Oyewale and Mavundla, 2008). It was reported that only 25% of teachers in Nigeria reported that they were comfortable with teaching the FLHE curriculum to their students (FME, 2006a).

According to Visser-Valfrey (2004), 27% of teachers in Mozambique reported that their intention to talk about HIV/AIDS in school was influenced by the fear of offending parents, religious people and village elders. The study also reported that the approval of parents and other influential community members was very important in

the decision of teachers to teach HIV/AIDS. In South Africa, almost half of teachers (47%) and students (44%) reported that their religion and culture were the most influential factors that affected the teaching / learning of HIV and sexuality education (Promtussananon, 2005). This finding led to the conclusion by Promtussananon (2005) that culture and religion interfered with the standard of HIV and sexuality education protocol provided to students. The study however did not establish the effect of such interference. On the contrary, another study by Cherian (2004) in South Africa reported that 43% of teachers stated that their religion and culture did not hinder their teaching of HIV/AIDS. This may infer that religious affiliation or organization of teachers may not affect their action, but rather their belief and perceptions that dictate their action (Promtussananon, 2005). According to Odimegwu (2005), religion played an important role in adolescent sexuality, and religious commitment was reported as an important factor affecting adolescent sexual attitudes and behaviours in Nigeria. In Turkey, Koral (1991) noted that the right to sexuality is upheld in Quranic teaching, but misinterpretations of Quranic teachings have however hindered the effort to plan an appropriate sexuality education programme.

The evidence above is consistent with the assertion by Oliver, Leeming and Dwyer (1998) that teachers who were uncomfortable with the HIV/AIDS education curriculum and parents who were uncomfortable in dealing with their adolescents' sexuality were potential stumbling blocks to successful delivery of HIV/AIDS education in schools. In Nigeria, the findings by Nwaorgu, Onyeneho, Onyegegbu, Okolo, Ebele, Ugochukwu, and Mbaekwe (2009) indicated that parents often do not discuss sexuality with their children. They felt this might expose them to immorality which prevented the young people from receiving correct knowledge on sexuality and

reproductive health issues. These assumptions often make parents to oppose the teaching of sexuality education in schools. These social and cultural constraints might explain the discrepancies between the large amount of effort invested in the HIV/AIDS curricula and training packages of the National Adolescent Education Programme in India and the low coverage of actual education (delivery) being carried out in many schools (National AIDS Control Organization, 2007).

2.3.3.2 Teaching Methods

In addition to cultural and social limitations experienced by teachers, the application of participatory learning methods for the delivery of HIV/AIDS curriculum poses additional constraint to teachers. While Kirby *et al.*, (2005) reported that application of multiple instructional methods was effective in the delivery of HIV/AIDS education curriculum, the lack of capacity to use participatory teaching methods among teachers remained a concern. In Nigeria, the activities and teaching methods in the FLHE curriculum are based on participatory learning methods that included brainstorming, storytelling, role play, drama, games, group work etc. to facilitate students to adopt protective behaviors and negotiate choices relevant to their development. Thus teachers are required to acquire new skills in participatory learning methodologies.

2.3.4 Training of Teachers on HIV/AIDS Education

Teacher training is crucial to the successful delivery of HIV/AIDS education in schools. The training of teachers on HIV/AIDS education requires the support of national ministries such as the Ministries of Health, Education and Information, local school management, and local communities to provide an enabling environment.

HIV/AIDS education often requires in-depth discussion of subjects such as sex, death and illness which requires special training by teachers. Classroom teachers are not likely to have experience dealing with these issues and so require special training to better equip them without allowing personal values to conflict with their teachings (UNESCO, 2009). In addition, after training, teachers often require ongoing support and motivation to teach reproductive health and HIV issues.

Teacher training was identified by Peltzer and Promtussananon (2003) to have significant impact on teachers' perceived ability to deliver HIV/AIDS education to their students. The study established relationships between the receipt of prior training on HIV/AIDS by teachers and their perceived behavioural control to teach HIV/AIDS education ($p < 0.005$); as well as their HIV/AIDS knowledge ($p < 0.01$). Additional information on the impact of teacher training on the implementation of HIV/AIDS education was provided by Mathews *et al.* (2006) in their study of factors associated with teachers' implementation of HIV/AIDS education in secondary schools in Cape Town, South Africa. The study reported that teacher training was one of the most important factors in the implementation of HIV/AIDS education in South Africa. The report, similar to findings in earlier studies (Blake *et al*., 2005; McCormick, Steckler, and McLeroy, 1995) postulated that the effect of training on the implementation of HIV/AIDS education may be mediated by self-efficacy which makes the teachers more capable of teaching about HIV/AIDS. They stated that teacher training raised the awareness of HIV/AIDS problem among teachers, encouraged teachers to have the belief that something can be done about HIV/AIDS as well as provided concrete information and ideas about interventions to be implemented in schools. Moreover, teachers in Malawi and Kenya were reported to

opt out of teaching HIV/AIDS education as a result of inadequate training (UNESCO, 2009).

The teacher HIV/AIDS education programme available in Nigeria is delivered as both in-service and pre-service teacher training programme. The in-service teacher training on FLHE curriculum in Nigeria is delivered by Non-Governmental Organizations (NGO) and the Ministry of Education. Judging by the outcome of the consultation on a similar approach to HIV/AIDS education in East and Southern Africa (Coombe, 2003), there were concerns that the in-service teacher training in Nigeria may neither be comprehensive nor systematic enough to deliver adequate knowledge and skills to teachers. Regarding the pre-service teacher training in Nigeria, the National Education Sector HIV/AIDS Strategic Plan has proposed the introduction of HIV/AIDS into the pre-service teacher education curriculum effective in 2007 to sustain the national pool of trained teachers (FME, 2006b). As a result, the majority of teachers currently in schools who received training before 2007 lacked pre-service training on the FLHE curriculum but might have received some ad hoc in-service training on HIV/AIDS.

In 2006, only 18% of teachers were reported to have been trained with the FLHE curriculum (FME, 2006a). Significant statistical relationship (p value < 0.001) was established between the receipt of training on FLHE curriculum and the teaching of HIV/AIDS issues to students among teachers in Abuja by Oyewale and Mavundla (2008), reinforcing the importance of teacher training on FLHE curriculum implementation in Abuja.

2.4 CONCEPTUAL FRAMEWORK FOR THE STUDY

Smith *et al.* (2003) have conceptualized the factors that affected the delivery of HIV/AIDS education into four areas namely: policy, curriculum; teacher training; and delivery of the curriculum on HIV/AIDS education. These concepts formed the framework for this study.

The following propositions illustrated in figure 1 were made to establish a relationship between the different concepts defined by Smith *et al.* (2003) to facilitate understanding of the factors affecting the implementation of FLHE curriculum in this study.

- The approaches for the implementation of HIV/AIDS curriculum are articulated in the National HIV/AIDS Policy for the Education Sector (from here on the term *HIV/AIDS Policy* only will be used) and the government directive from the Ministry of Education which has to be made available to teachers.
- The HIV/AIDS curriculum outlines what students are expected to be taught. The curriculum and teaching resources offer greater detail in terms of specific content (e.g. diseases, health, ethics, negotiation skills, practice skills, and reproduction) and locate that content in subject areas.
- New knowledge and skills for the implementation of the HIV/AIDS curriculum are acquired by teachers from teacher training on the HIV/AIDS curriculum.
- The teaching of HIV/AIDS curriculum is informed by several social and cultural factors which in turn influences teachers' disposition for delivery.

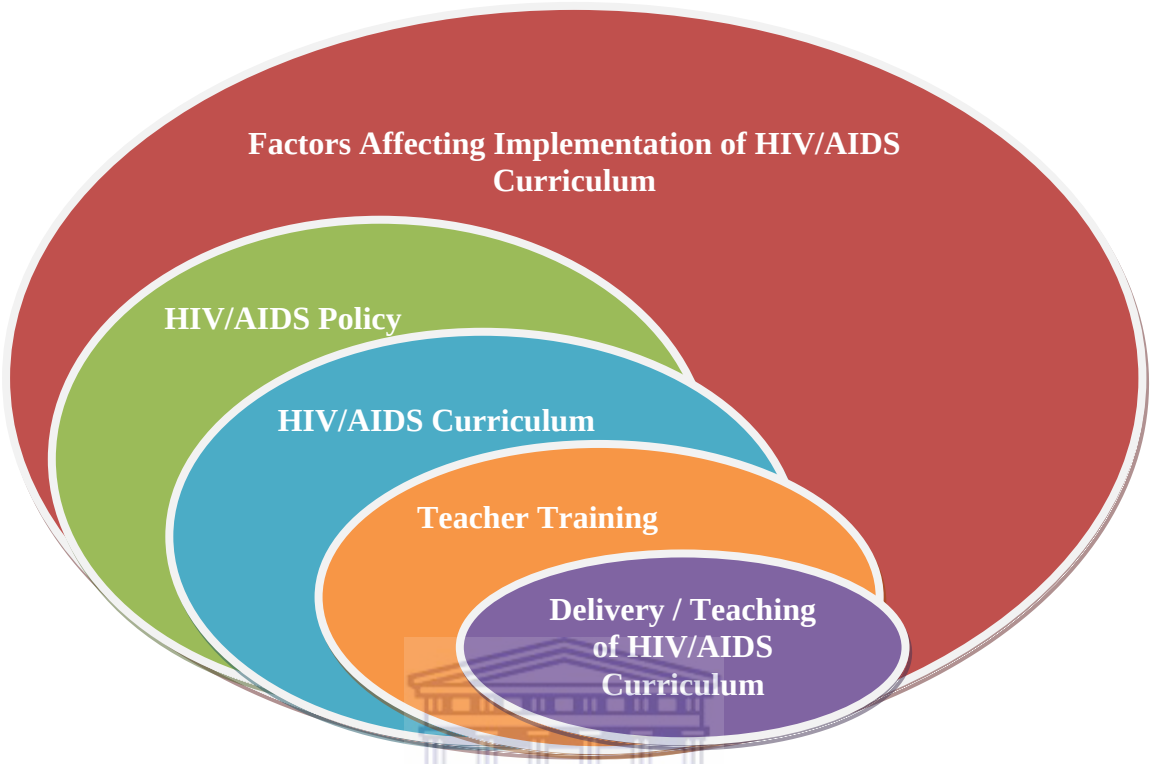


Figure 2.1: Concepts on the Factors Affecting Implementation of HIV/AIDS Curriculum

Because the influence of teacher training on the delivery of FLHE curriculum in Abuja has been studied recently (Oyewale and Mavundla, 2008), the current study will not further explore the impact of training on the implementation of the FLHE curriculum among teachers in Abuja but rather focus on the other factors that affect implementation of FLHE curriculum in Abuja as conceptualized by Smith *et al.* (2003).

2.5 CONCLUSION

The reviewed literature revealed several factors such as the content of HIV/AIDS curriculum; availability of enabling policy environment; teacher training; personal perception of teachers; religion and culture of teachers affected the implementation of

HIV/AIDS curriculum in schools. The methodology used for this study is presented in the next chapter.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

This chapter presents the methodology used for this study. It includes a description of the aim and objectives of the study, the research design, the study population, sampling approach and data analysis. In addition, steps taken to ensure validity and to ensure this research complied with ethical standards were also discussed below.

3.2 AIM OF THE STUDY

The aim of this study was to describe factors that affect the implementation of Family Life and HIV/AIDS Education (FLHE) curriculum in Junior Secondary Schools (JSS) in Abuja.

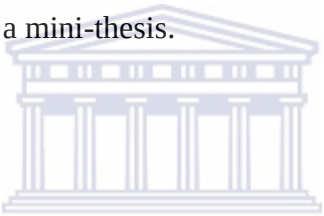
3.3 OBJECTIVES OF THE STUDY

In line with the aim of the study the specific objectives of the study were as follows:

1. To describe how the awareness and knowledge of the HIV/AIDS policy and the government directive affect the teaching of FLHE curriculum among teachers in JSS in Abuja
2. To ascertain how the knowledge of the content of the FLHE curriculum affect the teaching of FLHE curriculum among these teachers
3. To describe how the level of comfort of these teachers towards the teaching of FLHE curriculum affect the teaching of FLHE curriculum
4. To describe the influence of religion and culture on the teaching of FLHE curriculum among these teachers

3.4 STUDY DESIGN

This study was a quantitative descriptive cross-sectional survey. The research design was informed by the fact that quantitative descriptive research is suitable for describing situations and events (Araoye, 2003) and as such suitable for describing the factors that affect the implementation of FLHE curriculum in JSS in Abuja. Cross-sectional studies can be generalized and are suitable for generating information to improve planning (Araoye, 2003; Babbie and Mouton, 2001) and in this context, the implementation of FLHE curriculum in Abuja. In addition, cross sectional surveys are cheaper and quicker to undertake and applies to a study of limited scope like this study which is for purposes of a mini-thesis.



3.5 STUDY POPULATION

The teachers in JSS implementing FLHE curriculum contained in the FCT Universal Basic Education Board database constituted the study population. According to FCTUBEB (2010), there were 570 teachers from the thirty schools implementing the FLHE curriculum in Abuja.

3.6 SAMPLE SIZE

The sample size was estimated using the formula $n = z^2pq / d^2$ (Araoye, 2003), where: **n=** sample size, **z=** standard deviation set at 1.96 corresponding to 95%, confidence interval, **p=** the proportion in the target population estimated to have a particular characteristics estimated to be 50% or 0.50, **d** = degree of accuracy usually set at 0.05and **q = (**1 – p) i.e. $n= (1.96)^2 (0.5) (0.5) / (0.05)^2$ = **384.** The choice for a value

of 0.5 for ‘p’ and ‘d’ set at 0.05 was done to maximize the expected variance and as such indicated a sample size that is large enough for the study (Araoye, 2003)

Considering the fact that the study population (570 teachers) was less than 10,000, the sample size was corrected using the formula- nf = n/1 + (n)/(N) (Araoye, 2003) i.e. nf = 384 /1 + (384) / (570) = **230** teachers, where: **nf=** the desired sample size when population is less than 10,000; **n=** the desired sample size when population is more than 10,000; and **N=** the estimate of the population size. In anticipation of a response rate of 80% based on earlier studies (FME, 2006a), the sample size for the study was increased by 20% to 276 teachers. The sample size was further increased to 300 teachers to allow for equal allocation of samples to schools as further detailed under sampling procedure below.

3.7 SAMPLING PROCEDURE

Based on the calculated sample size, an equal number of 10 teachers were selected from each of the 30 schools implementing FLHE curriculum in Abuja. Teachers in each of the schools implementing FLHE curriculum in Abuja were selected using systematic sampling. The teachers’ roster where the surnames of teachers were arranged in alphabetical order was used for the sampling frame.

The sampling interval for each school was calculated as number of JSS teachers per school divided by the allocated sample size for that school. For example, in schools with 19 teachers, the sampling interval was calculated to be 2 i.e. 19 / 10 = 2.. The first teacher was selected through simple ballot; and every second teacher thereafter from the teachers’ roster was included in the study until 10 teachers were selected.

The selected 10 teachers agreed the first time around to participate in the study and there was therefore no need to select others further.

3.8 DATA COLLECTION

3.8.1 Data Collection Instrument

A close-ended anonymous questionnaire written in English language and based on three of the four key areas of HIV/AIDS school-based education identified by Smith *et al.* (2003) was developed for this study. The questionnaire was also informed by the literature review and used some question items from tools used in the survey of the national HIV/AIDS knowledge, attitude and practice among teachers in Nigeria (FME, 2006a). The question items in the questionnaire were close-ended with definite options as responses (See Appendix IV) and composed of four sections:

1. Background information which focused on demographic characteristics of the respondents and their school,
2. Policy environment for HIV/AIDS curriculum which focused on information on the HIV/AIDS policy in Nigeria and the government directive,
3. HIV/AIDS curriculum which comprised of questions on the content of the FLHE curriculum including HIV/AIDS transmission and prevention, and life skills education,
4. Challenges in the delivery of HIV/AIDS curriculum which comprised of question items that included the teaching of FLHE curriculum in schools, and how attitude, religion and the culture of teachers in relation to the community affects the teaching of the curriculum.

3.8.2 Pre-Testing of the Questionnaire

The questionnaire was pre-tested among 18 teachers from two JSS implementing the FLHE curriculum in nearby Nasarawa State, Nigeria in December, 2010. The pre-testing was used to ascertain if the questions were comprehensible and unambiguous. Although the majority of the question items were comprehensible and unambiguous to the teachers, the exercise noted some confusion in the understanding of instruction not to answer some question item based on the category of response to earlier question (‘SKIP'). In addition, the respondents during the pre-test exercise also had difficulty in responding to questions with multiple choice answers. These findings were used to refine the final research instrument. Some issues related to the data collection process during the pilot-testing exercise such as the prior notification of the school principal were addressed during the eventual data collection exercise.

3.8.3 Data Collection Process

The study used a self-administered questionnaire in English which is the official language of communication in Nigeria. Data collection took place in the schools implementing FLHE curriculum in Abuja during the months of April and May, 2011 - the beginning of the last term of the 2010/2011 school year when the majority of the teachers were relatively less busy. Five data collection personnel including the researcher undertook the exercise. The researcher trained the data collection personnel prior to data collection.

Each questionnaire took about 15 to 20 minutes to complete. The questionnaires were administered to respondents during school hours in the staff room. The data collection personnel stayed with the respondents and explained the purpose of the research to

them and clarified any issues they raised. In addition, the data collection personnel reassured the respondents of the confidentiality and relevance of the process.

A total of 300 questionnaires were administered during the field work of which 259 were returned. The researcher reviewed the returned questionnaires of which eight were blank and therefore not included, resulting in 251 questionnaires being analysed.

3.9 VALIDITY AND RELIABILITY

Validity and reliability are the factors which pertain to "… the standards of truth value as well as neutrality of the research" (Mouton, 2001).

3.9.1 Validity

Several means to assure validity in this research were undertaken as follows:

- the design of the questionnaire was based on the conceptual framework for this study derived from the work of Smith *et al.* (2003) to ensure that all the relevant areas for the research were covered,
- question items were based on tools used in a similar situation among teachers in Nigeria (FME, 2006a) to ensure that the question items were relevant to the context and respondents,
- the pilot-testing of the questionnaire was done to ascertain the question items were understood by respondents,
- the questionnaire was reviewed by a technical expert in the field of HIV/AIDS education in Nigeria and research supervisor who provided judgement on the face value of the research instrument; and their comments were used to finalise the questionnaire.

3.9.2 Reliability

In order to ensure reliability of the data during the phase of data collection, the researcher addressed the following measures which can hinder the reliability of data if neglected:

- The respondents: Babbie and Mouton (2001) pointed out that the respondents should be asked about the issues that are relevant to them for the research to be reliable. The respondents in this study were teachers from schools where FLHE was taught and therefore assumed to possess relevant knowledge to respond to the questions for the research.
- The Measuring Instrument: Babbie and Mouton (2001) stated that the questions asked should be comprehensible by respondents. As mentioned earlier necessary modifications were made to the questionnaire based on the pilot-testing exercises to ensure that all the question items were clear and comprehensible to respondents.
- Questionnaire designed for the study was used in the data collection from all the sampled teachers

3.10 DATA MANAGEMENT AND ANALYSIS

The completed questionnaires were collated and coded prior to data entry. Each question item was assigned a coded variable name for the purpose of data entry. Pre-assigned codes in the questionnaire were used for the data entry of the response variables, these included common codes for categorical variable like '1' for Yes, '2' for No, '8' for Others and '9' for Don't know. In addition, scores (Hancock, Mikhail, Santos, Nguyen, & Nguyen, 1999; Huang, Bova, Fennie, Rogers & Williams, 2005) were assigned to the response variables for the knowledge of FLHE curriculum by

coding the correct response as 1 and the incorrect answers as 0. A total score for knowledge of FLHE curriculum was then calculated by summing all the responses. Since there were 22 question items on the knowledge of FLHE curriculum in the questionnaire, the maximum possible score was 22. Higher score indicated more accurate knowledge of the content of FLHE curriculum by respondents. An additional ordinal variable was created for the categorization of knowledge level of FLHE curriculum among the respondents using the knowledge score into three levels (sufficient, average and insufficient). The knowledge level was categorized as sufficient if the respondent scored above the upper limit of the mean; average if the score was within the upper and lower limits of the mean; and insufficient if the score was below the lower limit of the mean as further detailed in chapter 4. Data entry was done using the Statistical Package for Social Sciences (SPSS) version 17.

The researcher entered and checked the data from the 251 questionnaires to ensure that there were no wrong entries and that all values were listed against the correct entities. As part of the data cleaning, a listing of the frequency distribution of each of the variables was done and checked for completeness. Prior to data analysis, dummy tables were developed based on the research questions to guide analysis. Data analysis focused on univariate analysis and bivariate analysis.

The univariate analysis included frequency distribution of the demographic characteristics of the respondents, their educational qualification and teaching history, the frequency of variables related to the policy environment for HIV/AIDS curriculum, knowledge of FLHE curriculum and delivery of FLHE curriculum. In

addition, the mean score and standard deviation of the knowledge score were done (Hancock et al., 1999; Huang et al., 2005).

Cross-tabulations of dependent variable (teaching of FLHE curriculum) and independent variables (awareness of HIV/AIDS policy and government directive; level of knowledge of the FLHE curriculum; level of comfort to teach FLHE curriculum; religious belief and affiliation; and cultural values of respondents) were also done to establish associations between the variables. Chi-square tests were run and p-values were also calculated to determine the relationship between the awareness of the policy environment / government directive, content of the FLHE curriculum and delivery of FLHE curriculum on the implementation of FLHE curriculum. The Chi-square test was used to test if the observed difference in dependent and independent (categorical) variables were representative of the teacher distribution (Patten, 2002). A probability value of 0.05 was acceptable as significant. The results were presented in tables and graphs in chapter 4.

3.11 ETHICAL STATEMENT

The researcher ensured that the ethical codes of behaviour guiding research programmes were applied in the course of this research. The autonomy of the respondents was respected and they were assured that participation in the study was voluntary. The respondents were also informed about the study verbally based on an information sheet (See Appendix I) prepared by the researcher. The information included a full explanation of what the research entailed, its purpose and what was expected of the research respondents. The respondents were made aware that they could withdraw from the study at any time without any negative effects to themselves.

The basic human rights and dignity of respondents in this research were also respected and upheld.

The respondents were assured of confidentiality and anonymity. The data collection personnel were trained to respect the confidentiality of the respondents under all circumstances. The questionnaires did not reflect the names of the respondents. The identification codes on the filled questionnaires were confidential and not linked to the research respondents in any way. The written consents of respondents were also sought before eliciting information from them and the consent form (Appendix II) were duly signed and collected prior to the administration of the questionnaires.

Ethical approval for the study was secured from the FCT Universal Education Board through the Planning, Research and Statistics department (Appendix III). In addition, the research protocol was approved by the Research Ethics Committee of the University of Western Cape, South Africa.

CHAPTER 4

RESULTS

4.1 INTRODUCTION

The findings from this study were presented below. Two hundred and fifty one (251) out of 300 questionnaires were completed giving a response rate of 83.7%, similar to earlier studies in Nigeria, such as the School-Based Baseline Survey on HIV/AIDS Knowledge, Attitude, Practice, Skills and School Health in Nigeria (FME, 2006a).

4.2 DEMOGRAPHIC CHARACTERISITCS OF RESPONDENTS

The basic socio-demographic characteristics of the respondents are presented in Table 4.1. The Table shows that 27.9% of the respondents were aged 30 – 34 years; 25.1% aged 35 – 39 years; and 17.9% were aged 40 – 44 years and 11.2% were aged 45 years or older. The majority of the respondents were Christians (76.1%), while 23.9% were Muslims. Majority (78%) of the respondents were married and only 25.6% of the respondents do not have any child.

4.3 EDUCATION AND TEACHING HISTORY

The distribution of the education qualification of the respondents indicated that the majority of the teachers had either a National Certificate in Education (47.4%) or a Bachelor's Degree (46.2%). The majority of the teachers (37.5%) had taught for between 5 and 10 years. In line with teaching practice in Nigeria, the respondent taught more than one class at a time and about half of the respondents had taught in JS 1, 2 and 3 classes. Almost all the schools (98.4%) where the respondents taught were mixed schools i.e. had both female and male students. (See Table 4.2)

Table 4.1 Socio - Demographic Characteristics

Characteristics	Total (N = 251) n (%)
Age (Years)	
20 – 24	11 (4.4)
25 – 29	34 (13.5)
30 – 34	70 (27.9)
35 – 39	63 (25.1)
40 – 44	45 (17.9)
45 and above	28 (11.2)
Gender	
Male	84 (33.5)
Female	167 (66.5)
Religion	
Christianity	191 (76.1)
Islam	60 (23.9)
Marital Status	
Married	196 (78.1)
Single	49 (19.5)
Separated	2 (0.8)
Widow / widower	4 (1.6)
Number of Children of Respondents	
None	65 (25.9)
1 – 2 children	67 (26.7)
3 – 4 children	96 (38.2)
5 or more children	23 (9.2)

Table 4.2 Education Qualification and Teaching History

Characteristics	Total (N = 251) n (%)
Education Qualification	
National Certificate in Education	119 (47.4)
Bachelor's Degree	116 (46.2)
Master's Degree	11 (4.4)
Others like HND, PGD	5 (2.0)
Teaching Experience (Years)	
Less than 1 year	14 (5.6)
1 – 5 years	94 (37.5)
More than 5 years – 10 years	75 (29.9)
More than 10 years	68 (27.1)
Classes Taught	
JS 1	127 (50.6)
JS 2	118 (47.0)
JS 3	120 (47.8)
Type of School where Respondent Taught	
Mixed school (boys and girls)	247 (98.4)
Boys only	2 (0.8)
Girls Only	2 (0.8)

Table 4.3 presents the distribution of the subjects in which the FLHE curriculum had been integrated and is taught by the respondents. The majority of the teachers taught Integrated Science (22.1%), Social Studies (19.3%) and English Language (14.1%). All the teachers taught more than one subject. In addition to the subject areas listed in this study, the respondents also taught other subjects in line with the practice in schools in Nigeria.

Table 4.3 Distribution of the Subjects Taught by Respondents

Characteristics	**Total (N = 251) n (%)**
Subject Taught†	
Mathematics	25 (10.0)
English Language	35 (14.1)
Social Studies	48 (19.3)
Religious studies	17 (6.8)
Home Economics	23 (9.2)
Physical and Health education	22 (8.8)
Integrated Science	55 (22.1)
Other Subjects like agricultural science, business studies, civic education, guidance and counselling, French	251 (100.0)

† All the respondents taught more than one of the subjects listed, as well as other subjects

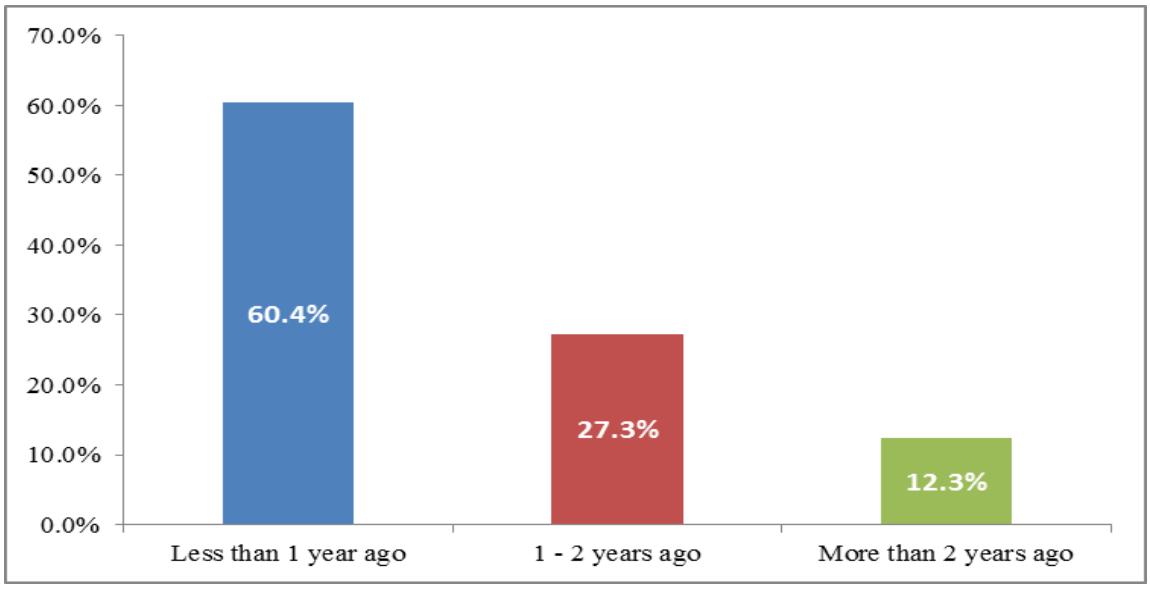


Figure 4.1 Distribution of the Time When FLHE Training Received (N = 227)

Almost all the respondents 90.4% had attended FLHE training, of amongst whom the majority were last trained in the last year before this study. About half (50.6%) had attended other training/orientation on sexuality education/HIV/AIDS prevention. The time of the last FLHE training among the 227 trained teachers is presented in figure 4.1 above.

In the last one year, 185 teachers (73.7%) had taught the FLHE curriculum to their students.

4.4 POLICY ENVIRONMENT FOR HIV/AIDS CURRICULUM

Amongst the 251 respondents, 72.1% were aware of the existence of the HIV/AIDS Policy and 78.1% were aware of the government directive. However, only 35.5% of the respondents had seen a copy of the policy (See Table 4.4). There was no significant statistical relationship between the awareness of HIV/AIDS policy and the teaching of FLHE curriculum by the respondents (p value = 0.772); and neither between seeing a copy of the HIV/AIDS policy and the teaching of FLHE curriculum by respondents (p value = 0.077).

A significant statistical relationship was however established between awareness of the government directive and the teaching of FLHE curriculum by respondents (p value = 0.000) (Table 4.4 below).

Table 4.4 Cross Tabulation of Awareness of HIV Policy and Directive with having Taught FLHE Curriculum in the Last 1 year

Characteristics		Taught FLHE Curriculum in the Last 1 year (N = 251)			
		Yes n (%)	No n (%)	Total n (%)	p value
Aware of HIV Policy	Yes	132 (52.6)	49 (19.5)	181 (72.1)	
	No	53 (21.1)	217(6.7)	70 (27.9)	0.772
	Total	185 (73.7)	66 (26.3)	251 (100.0)	
				Yates Chi-Square = 0.084	
Seen a copy of the HIV Policy	Yes	72 (28.7)	17 (6.8)	89 (35.5)	
	No	113 (45.0)	49 (19.5)	162 (64.5)	0.077
	Total	185 (73.7)	66 (26.3)	251 (100.0)	
				Yates Chi-Square = 3.129	
Aware of Government directive	Yes	156 (62.2)	40 (15.9)	196 (78.1)	0.000 *
	No	29 (11.6)	26 (10.4)	55 (21.9)	
	Total	185 (73.7)	66 (26.3)	251 (100.0)	
				Yates Chi-Square = 14.651	

According to Table 4.5 below, about half (51.9%) of the respondents who were aware of the HIV/AIDS Policy knew prevention of HIV/AIDS was one of the strategies in the policy. The respondents who were familiar with the policy also knew that reduction of stigma and discrimination (45.3%), voluntary counselling and testing (40.9%), and treatment, care and support (36.5%) were strategies in the policy.

Table 4.5 Distribution of Respondents Aware of the Different Strategies in the HIV/AIDS Policy

Characteristics	Total (N = 181) n (%)
Strategies	
Prevention of HIV/AIDS	94 (51.9)
Voluntary Counselling and Testing	74 (40.9)
Reduction of Stigma and Discrimination	82 (45.3)
Treatment, Care and Support	66 (36.5)
Orphans and Vulnerable Children	62 (34.3)
Programme management	45 (24.9)
Gender Rights and Ethics	50 (27.6)

The majority of the respondents who were aware of the HIV/AIDS policy or government directive attended FLHE training close to the time of conducting this study. Amongst the respondents who were aware of the HIV/AIDS Policy, about half (55.7%) attended their last FLHE training less than 1 year before this study.

Similarly, 65.4% of the respondents who were aware of the government directive also attended FLHE training during the same period (Table 4.6).

Table 4.6 Distribution of Respondents who are aware of HIV/AIDS Policy and Directive by Time of Last FLHE Training

Characteristics Time of last FLHE Training (Years)	Aware of the HIV/AIDS Policy (N = 181) n (%)	Aware of the Government Directive (N = 196) n (%)
Less than 1 year ago	101(55.7)	128 (65.4)
1 – 2 years ago	56 (31.1)	48(24.7)
More than 2 years ago	24 (13.2)	19 (9.9)

4.5 KNOWLEDGE OF FLHE CURRICULUM

Varying proportions of the respondents knew the different topics in the FLHE curriculum (see Table 4.7) Majority of the respondents (70.5%) knew that HIV infection was one of the topics in the curriculum. The teachers also knew other topics such as human development (49.4%), relationships (46.2%) and society and culture (39.8%). While 84.9% of the respondents knew that HIV was different from AIDS, only 20.7% knew that the Acronym HIV did not refer to Human Immune Virus, but rather Human Immunodeficiency Virus.

Table 4.7 Knowledge of the content of FLHE curriculum

Characteristics	Total (N = 251) n (%)
Knew Topics in the FLHE Curriculum	
Human Development	124 (49.4)
HIV Infection	177 (70.5)
First Aid	59 (23.5)
Life Building Skills	95 (37.8)
Relationships	116 (46.2)
Society and Culture	100 (39.8)
Environmental Health	83 (33.1)
Knew HIV is different from AIDS	
Yes	213 (84.9)
No	38 (15.1)
Knew the Meaning of the Acronym HIV	
Yes (HIV is the acronym for Human Immune Virus) – Wrong Response	199 (79.3)
No (HIV is the acronym for Human Immune Virus) – Correct Response	52 (20.7)
Knew of Methods of HIV Transmission	
By Having Unprotected sexual Intercourse	228 (90.8)
Transfusion of Unscreened blood	223 (88.8)
Sharing of contaminated Razor Blade / Needle	225 (89.6)
From Infected mother to her baby	211 (84.0)
Knew of Methods of HIV Prevention	
Abstaining from sex	178 (70.9)
Stay Faithful to Spouse / partner	227 (90.4)
Use Condom during all sex	164 (65.3)
Avoid sharing sharp objects	205 (81.7)
Mis-conception about HIV Transmission	
Kissing	26 (10.4)
Witch Craft	8 (3.2)
Knew of Life skills	
Assertiveness	102 (40.6)
Communication	120 (47.8)
Negotiation	100 (39.8)

Although more than 80% of the respondents (table 4.7) were aware of the methods of HIV transmission, 10.4% and 3.2% of the teachers still held misconceptions that kissing and witchcraft respectively were methods of HIV transmission. The majority of the respondents (90.4%) identified staying faithful to a spouse/partner as a method of HIV prevention. Eight in ten (81.7%) of the respondents also identified avoiding sharing sharp object as another HIV prevention method. Less than half of the

respondents however knew each of the life skills tested in this research. Specifically, 47.8% of the teachers identified communication as a life skill, 40.6% identified assertiveness and 39.8% identified negotiation as a life skill. (Table 4.7)

The level of knowledge of the FLHE curriculum among the respondents is presented in table 4.8. Initial analysis of the knowledge score (sum of the number of correct responses to the twenty-two (22) question items on content of the FLHE curriculum) was done by calculating the mean knowledge score (M = 13.89; sd = ±5.95).

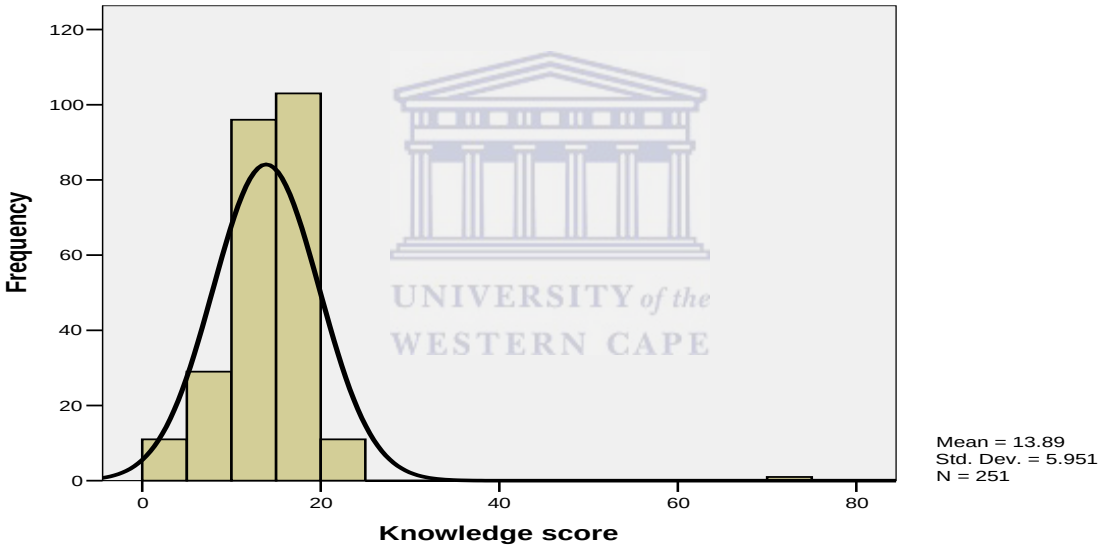


Figure 4.2 Normal Distribution Curve of Knowledge Score of FLHE Curriculum

Further analysis was done by categorizing the knowledge level into three categories as explained in chapter 3. The knowledge scoring was rated sufficient if the respondent scored above the upper limit of the mean (M > 19.84); average if the score was within the upper and lower limits of the mean (19.84 > M > 7.94); and insufficient if the score was below the lower limit of the mean (M < 7.94). Analysis of the result showed only 4.8% of the teachers had sufficient knowledge of FLHE curriculum,

84.5% had average knowledge and 10.8% had insufficient knowledge. However, the noted difference was not statistically significant (p = 0.083)

Table 4.8: Cross Tabulation of Level of Knowledge of FLHE Curriculum with having Taught FLHE Curriculum in the Last 1 year (N=251)

Characteristics		Taught FLHE Curriculum in the Last 1 year (N = 251)			
		Yes n (%)	No n (%)	Total n (%)	p value
Level of Knowledge of FLHE Curriculum	Insufficient	16 (6.4)	11 (4.4)	27 (10.8)	
	Average	158 (62.9)	54 (21.5)	212 (84.5)	0.083
	Sufficient	11 (4.4)	1 (0.4)	12 (4.8)	
	Total	185 (73.7)	66 (26.3)	251(100.0)	
				Pearson Chi-Square = 4.979	

4.6 DELIVERY OF FLHE CURRICULUM

Amongst the 185 teachers who have taught FLHE curriculum to their student in the last one year before this study, 163 (88.1%) used participatory learning methods. The teachers used songs (62%), role play (49.1%) and demonstration (43.6%) as participatory learning methods to teach FLHE curriculum to their students (Figure 4.3).

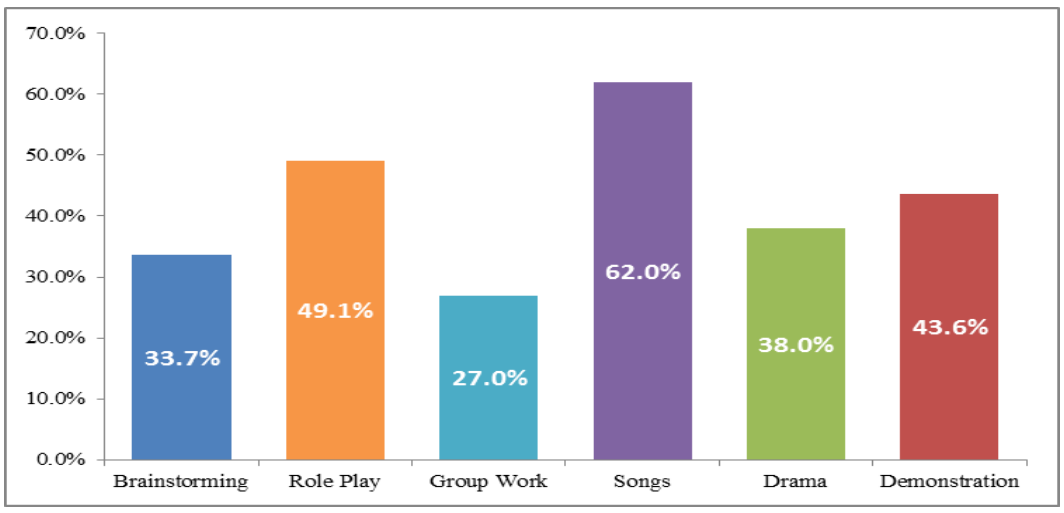


Figure 4.3 Distribution of the Participatory Learning Methods Used by Respondents (N = 163)

Table 4.9 below shows that 80.1% of the teachers were comfortable in teaching the FLHE curriculum to students, indicating a significant statistical relationship (p value = 0.000).

Table 4.9 Cross Tabulation of Comfortable in teaching the FLHE curriculum to students and having Taught FLHE Curriculum in the Last 1 year

Characteristics		Taught FLHE Curriculum in the Last 1 year (N = 251)			
		Yes n (%)	No n (%)	Total n (%)	p value
Comfortable in teaching the FLHE curriculum	Yes	164 (65.3)	37 (14.7)	201(80.1)	
	No	21 (8.4)	29 (11.6)	50 (19.9)	0.000*
	Total	185 (73.7)	66 (26.3)	251 (100.0)	
				Yates Chi-Square = 30.374	

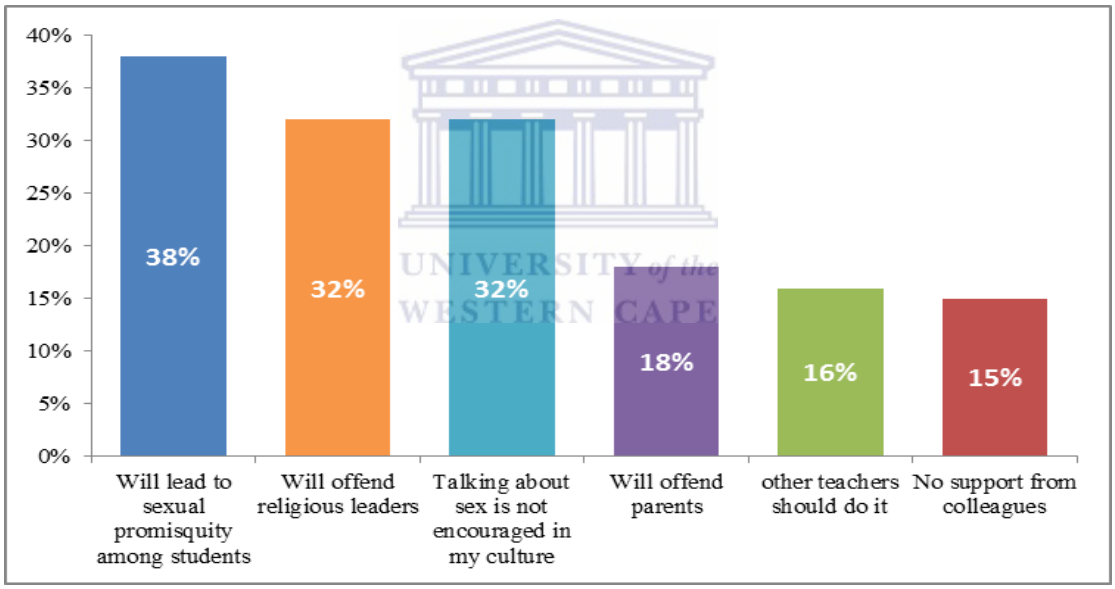


Figure 4.4 Reasons why Respondents were Uncomfortable Teaching the FLHE Curriculum to Students (N = 50)

The respondents who were not comfortable to teach the FLHE curriculum held the view that the curriculum will lead to sexual promiscuity among students (38%), talking about sex was not encouraged in their culture (32%) and that it (HIV/AIDS education) would offend religious leaders (32%) (See Figure 4.4).

According to table 4.10, the majority of respondents (80.5%) however stated that they felt comfortable in teaching FLHE curriculum based on their religious beliefs.

Table 4.10 Cross Tabulation of Religious affiliation and Religious Belief of Respondents and the Teaching of FLHE Curriculum

Characteristics		Taught FLHE Curriculum in the Last 1 year (N = 251)			
		Yes n (%)	No n (%)	Total n (%)	p value
Religion of Respondents	Christianity	145(57.8)	46 (18.3)	191(76.1)	
	Islam	40(15.9)	20 (8.0)	60 (23.9)	0.218
	Total	185(73.7)	66 (26.3)	251(100.0)	
				Yates Chi-Square = 1.5206	
Comfortable to teach FLHE curriculum based on religious belief	Yes	163 (64.9)	39 (15.5)	202(80.5)	
	No	22 (8.8)	27 (10.8)	49 (19.5)	0.000*
	Total	185 (73.7)	66 (26.3)	251(100.0)	
				Yates Chi-Square = 21.968	

Although there was no significant statistical relationship between the religious affiliation of the respondent and the teaching of FLHE curriculum (p value = 0.218), a significant statistical relationship was established between the religious belief of respondents and the teaching of FLHE curriculum (p value = 0.000) (See Table 4.11).

Table 4.11 Cross Tabulation of Cultural Values and the Teaching of FLHE Curriculum

Characteristics		Taught FLHE Curriculum in the Last 1 year(N = 251)			
		Yes n (%)	No n (%)	Total n (%)	p value
Comfortable to teach FLHE curriculum based on cultural values	Yes	156 (62.2)	34 (13.5)	190(75.7)	
	No	29 (11.6)	32 (12.7)	61 (24.3)	0.000*
	Total	185 (73.7)	66 (26.3)	251(100.0)	
				Yates Chi-Square = 26.709	

In relation to the cultural values of the respondents, 75.7% stated that they were comfortable with discussing sexuality issues including HIV/AIDS with their students (Table 4.11). A significant statistical relationship was established between the cultural value of the respondent and the teaching of FLHE curriculum (p value = 0.000).

4.7 CONCLUSION

The findings of this study have been presented in this chapter as a basis for the analytical discussion, conclusions and recommendations discussed in chapters 5 and 6.

CHAPTER 5

DISCUSSION

5.1 INTRODUCTION

The analyses of the findings of this research in relation to existing evidence are presented in this chapter. The discussion focused on the awareness of the education sector HIV/AIDS policy and the government directive for the implementation of FLHE curriculum; and the knowledge of the FLHE curriculum among the respondents. The discussion of the factors that affected the delivery of the FLHE curriculum in this report included the attitude of the teachers, their socio-cultural perspective and their usage of participatory learning methods. The chapter ends with a presentation of the limitations of the research.

Evidence from Nigeria indicated that teachers are an important group that can reach young people with HIV/AIDS prevention information (NPC, 2004; FME, 2006a), and therefore the focus of this study on teachers in schools implementing the FLHE curriculum. The study gathered information about the different factors that affected the implementation of the curriculum by teachers. Furthermore, the respondents in this study constituted a credible cohort to establish factors that affect implementation of the curriculum in schools in Abuja due to the fact that more than half of them had teaching experience of more than 5 years; 90.4% of them had received training in FLHE curriculum and 73.7% of them had taught FLHE curriculum to their students in the last one year before this study. Below are the identified factors that affected the implementation of the FLHE curriculum in JSS in Abuja in this study.

5.2 FACTORS AFFECTING IMPLEMENTATION OF FLHE CURRICULUM

5.2.1 Implication of the Awareness of HIV/AIDS Policy and Government Directive

Several studies (Dailard, 2001; Kirby, Laris and Rolleri, 2005; Mathews, Boon, Flisher and Schaalma, 2006; Ross *et al.*, 2006; Smith *et al.*, 2003) had indicated that the existence of a supportive environment for HIV/AIDS curricula articulated in policies and guidelines were necessary for effective implementation. In this study, the policy environment for the FLHE curriculum implementation were explored through the awareness of the National HIV/AIDS Policy and the Government directive to mainstream topics in the FLHE curriculum into existing subjects among the respondents. While the policy sought to establish the sectoral HIV/AIDS response in the education sector, the government directive (which was derived from the HIV/AIDS policy) outlined the implementation guidelines for the FLHE curriculum.

It was encouraging to see that larger proportions of teachers in this study were aware of the National HIV/AIDS Policy (72%) and the government directive (78%). This proportion was higher than the 41% of teachers from primary and secondary schools who were reported to be aware of the education sector HIV/AIDS policy in Kenya (Kiragu, Kimani, Manathoko, and Mackenzie, 2006). Considering the fact that basic information on the HIV/AIDS policy and government directive were contained in the introductory section of the teaching guides for the FLHE curriculum (NERDC, 2007) used for teacher training in Nigeria, the higher proportion of teacher who were aware of the policy and government directive was not surprising as the majority (90%) of the teachers in the current study had received training in the FLHE curriculum. The findings of this research also indicated that the majority of the trained teachers in this

study attended their last FLHE training within two years since this study (i.e. between 2009 and 2011) after a standard set of FLHE teaching guide (NERDC, 2007) was introduced.

Only 36% of the teachers reported ever seeing a copy of the HIV/AIDS policy, which was similar to the low proportion (26%) of teachers in Kenya who had seen a copy of their HIV/AIDS policy (Kiragu *et al.*, 2006). It was therefore not surprising that less than half of the respondents knew of the different strategies in the policy. This finding raised concerns about the consistency in the modalities for teaching FLHE curriculum by teachers in schools. Although the government directive required topics in the curriculum to be taught as part of existing subjects, the FME (2006a) had reported that more teachers in Abuja (42%) taught the topics that were in the FLHE curriculum through other means such as in school clubs, through health talks and through peer education programme, compared to the 26% of teacher that taught the FLHE curriculum in subject areas. This suggests that there were confusion in the implementation modality of the curriculum occasioned by the lack of knowledge of the content of the HIV/AIDS policy and government directive among teachers.

This study found that there was statistically significant difference between the proportion of teachers who were aware of the government directive and those who had taught the FLHE curriculum (P= 0.000), suggesting that awareness of the government directive among teachers was an important factor to address the confusion in the implementation modality of the curriculum. This may be explained by the fact that the government directive outlined the subject areas where the different topics in the FLHE curriculum were to be taught and included guidelines for

developing lesson plans by teachers. The broad scope of the content of the HIV/AIDS policy and its target group (employers, workers, teachers, students and all stakeholders in the education sector) unlike the government directive which is focused specifically on the FLHE curriculum and teachers, might explain the fact that the difference in the proportion of teachers who were aware of the policy (P= 0.772), or had seen the policy (P = 0.077) and had taught the FLHE curriculum or not were not statistically significant in this study.

Thus, the findings of this study suggested that the awareness of the government directive on the implementation of the FLHE curriculum as opposed to the HIV/AIDS policy was an important factor to harmonize implementation modalities of the curriculum by teachers.

5.2.2 Impact of the Knowledge of FLHE Curriculum

Findings from this study indicated that the proportion of teachers with sufficient knowledge of the FLHE curriculum (5%) was very low, 85% of the teachers had average knowledge and 11% had insufficient knowledge. Several factors responsible for this finding were further discussed below.

a. *Knowledge of the content of the FLHE curriculum*

The FLHE curriculum is comprised of behavioural objectives related to the content areas of health, STI, HIV/AIDS, as well as life skills for social interaction (NERDC, 2003). Often the knowledge of teachers in these two areas is not even. Other than the topic on HIV prevention, more than half of the teacher in this study did not know the other topics in the FLHE curriculum that were tested. The low proportion of teachers

that knew the topics in the FLHE curriculum reported in this study was similar to the findings in the FME (2006a) where the proportion of teachers that knew the topics in the FLHE curriculum ranged from 20% for life skills to 33% for human development. The high proportion (70.5%) of teachers in this study who knew the topic on HIV prevention may be an indication that the training on the FLHE curriculum provided to the teachers was dis-proportionately focused on HIV prevention compared to other components of the curriculum. As such, the high proportion of teachers in this study who knew the methods of HIV transmission and prevention as well as who knew the pathogenesis of HIV to AIDS was not surprising as these issues were contents in the topic on HIV prevention. Further investigation of the effectiveness of the allocated time to each component of the FLHE curriculum during teacher training is therefore required.

b. Teacher learning method

The use of experiential learning methods in teacher training for HIV/AIDS education in Africa had been argued to contribute to the competency of teachers to implement HIV/AIDS programme by James-Traore, Finger, Ruland, and Savariaud, (2004). Inferring from the finding in South Africa by Peltzer and Promtussananon, (2003), Oyewale and Mavundla (2008) argued that the use of traditional teacher-centered instructional methods for HIV/AIDS education contributed to the lack of adequate knowledge of HIV/AIDS among teachers in Abuja, Nigeria. Thus, the high proportion of teachers with insufficient knowledge of FLHE curriculum in this study can be attributed to the traditional teacher center instructional method for teacher training in HIV/AIDS education as argued by Oyewale and Mavundla (2008).

Similarly, Ghosh, Chhabra, Springer and Sharma (2008) had argued that the low HIV knowledge among teachers in India was due to the fact that teacher training was focused on cognitive knowledge development and not based on experiential learning that uses simulations of real-life situation necessary for teaching subjects such as public health and HIV/AIDS.

The arguments above complements the assertion by Smith *et al*. (2003) and Kirby *et al.* (2006) that HIV/AIDS education (including teacher education) requires participatory learning methodologies. While noting that standard teaching guide for FLHE curriculum (NERDC, 2007) was recently introduced, it is important to explore the learning methodology for conducting teacher training on FLHE curriculum to address this concern.

c. Misconceptions about HIV Transmission

Misconceptions on HIV transmission are still high among teachers. Although very few teachers in this study had misconceptions on methods of HIV transmission, earlier studies in Nigeria had reported higher rates. Among teachers in Abuja, Oyewale and Mavundla (2008) reported that 18% of teacher lacked the knowledge to clarify misconception on HIV transmission, while the FME (2006a) reported 15% of teachers nationwide in Nigeria lacked the same knowledge (FME, 2006a). The sizeable minority of teacher with misconceptions on HIV transmission had been identified by (Peltzer and Promtussananon, (2003) as one of the reasons for the low HIV/AIDS knowledge level among some teachers in South Africa. Therefore an additional focus on addressing local myths and misconceptions on HIV transmission needs to be prioritized in future training of teachers on the FLHE curriculum.

Findings from this study indicated that there was no significant difference in the proportion of teachers with the different level of knowledge of the FLHE curriculum and who had taught the FLHE curriculum or not (P = 0.083) as respondents were teaching the curriculum to their students irrespective of their level of knowledge. This finding raised concerns on the quality of HIV/AIDS prevention information and life skills education provided to students. This assertion was based on the argument by Kirby, Obasi and Laris (2006) that insufficient knowledge (of sexuality and HIV education) among teachers in developing countries (like Nigeria) prevents effective skill building for HIV prevention among students. It is therefore important that relevant government agencies take action to address this challenge through continuous teacher training on FLHE curriculum and school-based supervision of teachers. This proposal is consistent with the recommendation by James-Traore *et al.,* (2004) that refresher training for teachers in sexuality and HIV/AIDS education solidifies and reinforces the gains made during the initial training and improves their level of knowledge.

The finding of this study suggested that teachers in school implementing the FLHE curriculum were teaching the curriculum to their students irrespective of their level of knowledge of the curriculum, with the risk of poor quality knowledge transfer to students. Several factors such as equitable time allocation to the different component of the FLHE curriculum, the use of experiential learning method and clarification of local myths and misconceptions in teacher training which were argued above therefore needs to be addressed for effective implementation of the curriculum.

5.2.3 Factors Affecting the Delivery of the FLHE Curriculum

This study found that the majority of teachers were comfortable with teaching the FLHE curriculum to their students irrespective of their religious belief and/or cultural values. The high proportion of teachers with a positive personal disposition to the teaching of the curriculum in this study was similar to the high proportion of primary school teachers reported in the neighbouring Nasarawa state who were reported to be comfortable with giving HIV/AIDS education (Ssengozi, Schlegel, Anyamele and Olson, 2004) . The FME (2006a) had previously reported a lower proportion (51%) of teachers nationwide who were comfortable with teaching HIV/AIDS and sexuality issues. Since stigma reduction was addressed under the topic on HIV prevention (NERDC, 2003), which the majority of the teachers (70.5%) in this study knew, it was not surprising that a significant difference between the proportion of teachers who were comfortable to teach the FLHE curriculum and those who had taught the curriculum (P= 0.000) was established in this study. The same significant difference was also established between the proportion of teachers who were comfortable with teaching the FLHE curriculum based on their religious belief (P = 0.000) or cultural value (P = 0.000), and the teaching of the FLHE curriculum to students. Thus, personal perception, religious belief and cultural values of teachers were important factors in the teaching of FLHE curriculum to students. These findings were in line with the conclusion by Promtussananon (2005) in the study among teachers and students in South Africa where religious beliefs and cultural values of teachers and students were identified as major influential factors that affect teachers in the teaching of HIV and sexuality education.

Another finding from the current study showed that there was no significant difference between the proportion of teachers who were either Muslims or Christian, and who had taught FLHE curriculum (P= 0.218). This was similar to the findings by Cherian (2004) in South Africa and reinforcing the earlier argument that religious affiliation (P= 0.218) was not an important factor in the teaching of the curriculum among teachers. Rather, religious beliefs (P= 0.000) was the important factor.

This study further showed that the limited number of teachers who were not comfortable with teaching the FLHE curriculum to students held the perception that FLHE will lead to sexual promiscuity among students. Interestingly, Peltzer and Promtussananon (2003) reported similar finding among teachers in South Africa. The South African study reported that teachers were moderately comfortable to teach HIV/AIDS education (M=3.89, SD = 1.13) (rating from 1 = very uncomfortable to 5 = very comfortable) as they held the perception that HIV/AIDS education would encourage early experimentation with risky sexual behaviour among students. Oyewale and Mavundla (2008) had earlier reported that there was no significant statistical relationship between the teaching of HIV/AIDS issues to students and the feeling by teachers in Abuja that HIV/AIDS education promote sexual promiscuity among learners (P = 0.111). Similarly, a review of studies by UNAIDS (1997) found that human sexuality education does not increase the likelihood that students will begin sexual activity earlier. Special actions are therefore required to address this concern by making available evidence on the relationship between HIV/AIDS education and sexual promiscuity to teachers, and holding special sessions to address concerns of teachers during the training on FLHE curriculum.

This study also found that 88% of the teachers in this study used participatory learning methods in the delivery of the FLHE curriculum. This rate was higher than the 49% of teachers reported in earlier studies in Abuja by FME (2006a). The introduction of a standard FLHE teaching guide (NERDC, 2007) after the 2006 study as well as the fact that majority of the teachers in this study were trained on the curriculum, and were teaching in schools implementing the FLHE curriculum contributed to the higher proportion reported in this study. The high proportion of teachers who reported using participatory methods in this study has the potential to positively contribute to the delivery of the curriculum in schools. This assertion was based on the argument by Kirby, Obasi and Laris (2006) that the uses of participatory, student–centered techniques were necessary for effective HIV/AIDS education. This was confirmed by the findings of Smith *et al.* (2003) which showed that the lack of skills to embrace participatory learning approaches was one of the difficulties in the implementation of the HIV/AIDS prevention education in Myanmar.

5.2.4 Conclusion

The discussion above revealed that several factors around the enabling policy, the knowledge of the curriculum and actual delivery of the curriculum affected the implementation of the FLHE curriculum in Abuja Nigeria. Specifically, findings from this study indicated that there were concerns in the implementation modalities of the FLHE curriculum due to the lack of awareness of the government directive among majority of the teachers. The low proportion of teachers with sufficient knowledge level of the FLHE curriculum in this study also posed a major challenge to the quality of HIV/AIDS education provided to students. Regarding the delivery of FLHE curriculum, this study noted that the majority of teachers were comfortable to teach

the curriculum to their students based on their personal, religious and cultural perception and values.

While the limitations of the study were discussed in the next section of this report, the conclusions and recommendations from this study were presented in the next chapter.

5.3 LIMITATIONS

The study was conducted among teachers in 30 JSS implementing FLHE curriculum in Abuja and excluded teachers from other schools. This limits the generalization of the findings of the study. However, the large sample size used in this study strengthens the application of the findings of this study to all JSS teachers implementing FLHE curriculum in Abuja.

The descriptive nature of the research design also limits the ability of this study to establish causal relationship between the factors that affected the implementation of FLHE curriculum in JSS in Abuja. This research has however established relationships between the implementation of the FLHE curriculum and awareness of government directive; implication of the level of knowledge of the FLHE curriculum among the teachers; and the influence of religious belief and cultural values on teachers to teach the FLHE curriculum on the implementation of the curriculum.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter outlined the conclusions and recommendations from this study. The conclusions made on the factors affecting the implementation of FLHE curriculum in JSS in Abuja were presented in the first half of this chapter. The second half of this chapter included policy and programme recommendations for effective implementation of FLHE curriculum in JSS in Abuja as well as further studies to generate additional knowledge on the factors affecting the implementation of the curriculum.

6.2 CONCLUSIONS

Guided by the research questions and objectives, conclusions on the factors that affected the implementation of FLHE curriculum in JSS in Abuja were drawn below. The conclusions were presented based on the proposition made in the conceptual framework for this study (in chapter two) to establish the relationship between the different concepts defined by Smith *et al.* (2003) as factors affecting HIV/AIDS curriculum implementation.

6.2.1 Impact of Knowledge of FLHE Curriculum

The FLHE curriculum is a comprehensive outline of what students are expected to be taught on HIV/AIDS education in Nigeria with clearly defined behavioural objectives related to health, STI, HIV/AIDS and life skills (NERDC, 2003) like other curricula reviewed by Smith *et al.* (2003) and Kirby *et al.* (2006). However, very few teachers

in schools implementing the curriculum had sufficient knowledge of the FLHE curriculum. As such the majority of the teachers in Abuja were not taking advantage of the teaching resources on learning objectives, content and methodology (NERDC, 2003) offered in the FLHE curriculum. Thus, this study concludes that the limited proportion of teachers with sufficient knowledge of the FLHE curriculum was a negative factor affecting the quality of implementation of the curriculum, especially as the majority of the teachers in this study were teaching the curriculum to their students irrespective of their knowledge level. This study also concludes that the knowledge gap of the curriculum among most of the teachers in Abuja were attributable to the lack of equitable time allocation to the different components of the curriculum. Another factor attributable to the gap in knowledge is the use of traditional teacher-centred learning methods as opposed to experiential learning during training. The lack of knowledge to clarify teachers' misconceptions on HIV/AIDS also needs to be addressed.

6.2.2 Implication of the Awareness of HIV/AIDS Policy and Government Directive

Although more than seven in ten teachers in Abuja were aware of the HIV/AIDS policy and the government directive, the lack of knowledge of the content of the policy and government directive had been argued to contribute to the confusion in the implementation modality of the curriculum among teachers. More so, this report argued that higher proportion of teachers in Abuja (FME, 2006a) who taught topics in the FLHE curriculum through other modalities other than the one stipulated in the government directive were indication of the prevailing confusion on implementation modalities among teachers. The findings of this study however concluded that

awareness of the government directive on the implementation of the FLHE curriculum as opposed to the HIV/AIDS policy was an important factor to harmonize implementation modalities of the curriculum; as such copies of the directive should be made available to teachers implementing the curriculum.

6.2.3 Factors affecting the Delivery of FLHE Curriculum

Findings from this study also indicated that a high proportion of the teachers were comfortable with teaching the FLHE curriculum to their students. Specifically, this study concluded that personal perception, religious belief (irrespective of their religion) and cultural values of teachers were important factors in the teaching of FLHE curriculum to students and these factors needs to be reinforced for effective implementation of the curriculum.

This study also reported that a high proportion of teachers in this study reported the use of participatory learning methodology in the teaching of FLHE curriculum to their students. Considering the importance of participatory learning methodology in effective HIV/AIDS education (Kirby, Obasi and Laris 2006), this study concluded that the use of participatory learning methodology by teachers was another factor affecting the implementation of FLHE curriculum in schools.

Although training in FLHE curriculum was not explored in this study, findings from this study however indicate that the timing of attending the last FLHE training was not an important factor on the knowledge of the HIV/AIDS policy and directive. This study has shown that the four factors identified by Smith *et al.* (2003) that affect implementation of HIV/AIDS curriculum were relevant in the context of

implementation of FLHE curriculum in Abuja but to a varied extent for each of the factors as discussed earlier in this report. Policy and programme recommendations for effective implementation of the FLHE curriculum as well as further studies for better insight into the issues are presented below.

6.3 RECOMMENDATIONS

6.3.1 Policy and Programme Recommendation for the Effective Implementation of the FLHE Curriculum

- In view of the strength of the evidence that support the awareness of the government directive in the harmonization of implementation modalities for the curriculum, it is recommended that copies of the directive be made available to all teachers in schools implementing the curriculum to enable better understanding of the implementation modalities for the curriculum. Programme decisions are also required to allocate adequate time to explore the implication of the directive during FLHE training to teachers as well as during school level planning of HIV/AIDS education.
- Although this study did not establish any relation between the HIV/AIDS policy and the implementation of FLHE curriculum, the low proportion of the respondents who knew the content of the policy remained a concern for broader sectoral HIV/AIDS response. It is recommended therefore that copies of the policy be produced and largely disseminated to schools implementing the FLHE curriculum as additional reference documents to provide them with a broader overview of the expected education sector response to HIV/AIDS.
- To effectively achieve the objective of the FLHE curriculum, a series of refresher training courses for teachers implementing the FLHE curriculum in JSS is

recommended to increase the low proportion of teachers with sufficient knowledge of the curriculum. The recommended training needs to adequately cover all the topics in the curriculum; clarify local misconceptions and myths on HIV/AIDS; and delivered through experiential learning methods to allow the teachers relate their training to real life situations.

6.3.2 Recommendations for Further Studies

An evaluation of the FLHE curriculum training programme among teachers in Abuja is recommended in view of the low proportion of teachers with sufficient knowledge of the FLHE curriculum. The evaluation will help to provide further insight into the quality of training with respect to content, time allocation to the different topics/concepts as well as training methodology. This will contribute to improving the understanding of the factors that affect the implementation of FLHE curriculum among teachers in JSS in Abuja.

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APPENDIX I

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959, Fax: +27 21-959

INFORMATION SHEET

Project Title: Factors Affecting the Implementation of Family Life and HIV/AIDS Education in Junior Secondary Schools in Abuja

What is this study about?

This is a research project being conducted by OYEWALE BIMPE ADERINRE at the University of the Western Cape. We are inviting you to participate in this research project because you are a teacher in one of the schools implementing the Family Life and HIV/AIDS Education curriculum (FLHE) in your area council. The purpose of this research project is to describe factors that affect the implementation of Family Life and HIV/AIDS Education curriculum in Junior Secondary Schools in Abuja..

What will I be asked to do if I agree to participate?

You will be asked to fill in a questionnaire with questions relating to the implementation of the Family Life and HIV/AIDS curriculum in your school. The questions will cover the areas of policy on HIV/AIDS education, content of HIV/AIDS education curriculum, delivery of HIV/AIDS education and attitude related to delivery of HIV/AIDS education. The process of filling the questionnaire will not be longer than 30 minutes.

Would my participation in this study be kept confidential?

We will do our best to keep your personal information confidential. To help protect your confidentiality, I would like to assure you that everything you say will be kept confidential and your identity will not be revealed to anyone. You are not required to put your name on the questionnaire instead a code will be placed on the survey and other collected data and through the use of an identification key, the researcher will

be able to link your survey to your identity and only the researcher will have access to the identification key. If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

What are the risks of this research?

The interview may touch on issues you may feel uncomfortable with such as issues of sexuality and HIV/AIDS.

What are the benefits of this research?

This research is not designed to help you personally, but the results from this survey will be used to better plan programs and initiatives in the education sector. We hope that, in the future, other people might benefit from this study through improved understanding of factors affecting the implementation of the FLHE curriculum in Junior Schools in Abuja.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify. The interview may touch on issues you may feel uncomfortable with or you would prefer not to discuss, please feel free to say so. I will not be offended and there will be no negative consequences if you would prefer not to answer a question.

What if I have questions?

This research is being conducted by OYEWALE BIMPE ADERINRE of the School of Public Health, at the University of the Western Cape. If you have any questions about the research study itself, please contact OYEWALE BIMPE at:

School of Public Health
University of the Western Cape
ojixba@yahoo.com
+234-8027874604

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department:
Dean of the Faculty of Community and Health Sciences:
University of the Western Cape
Private Bag X17
Bellville 7535

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee

APPENDIX 11

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959, Fax: 27 21-959

CONSENT FORM

Title of Research Project: Factors Affecting the Implementation of Family Life and HIV/AIDS Education in Junior Secondary Schools in Abuja**.**

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

1.1 Participant's name……..

1.2 Participant's signature……

1.3 Witness……..

1.4 Date……

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Suraya Mohamed

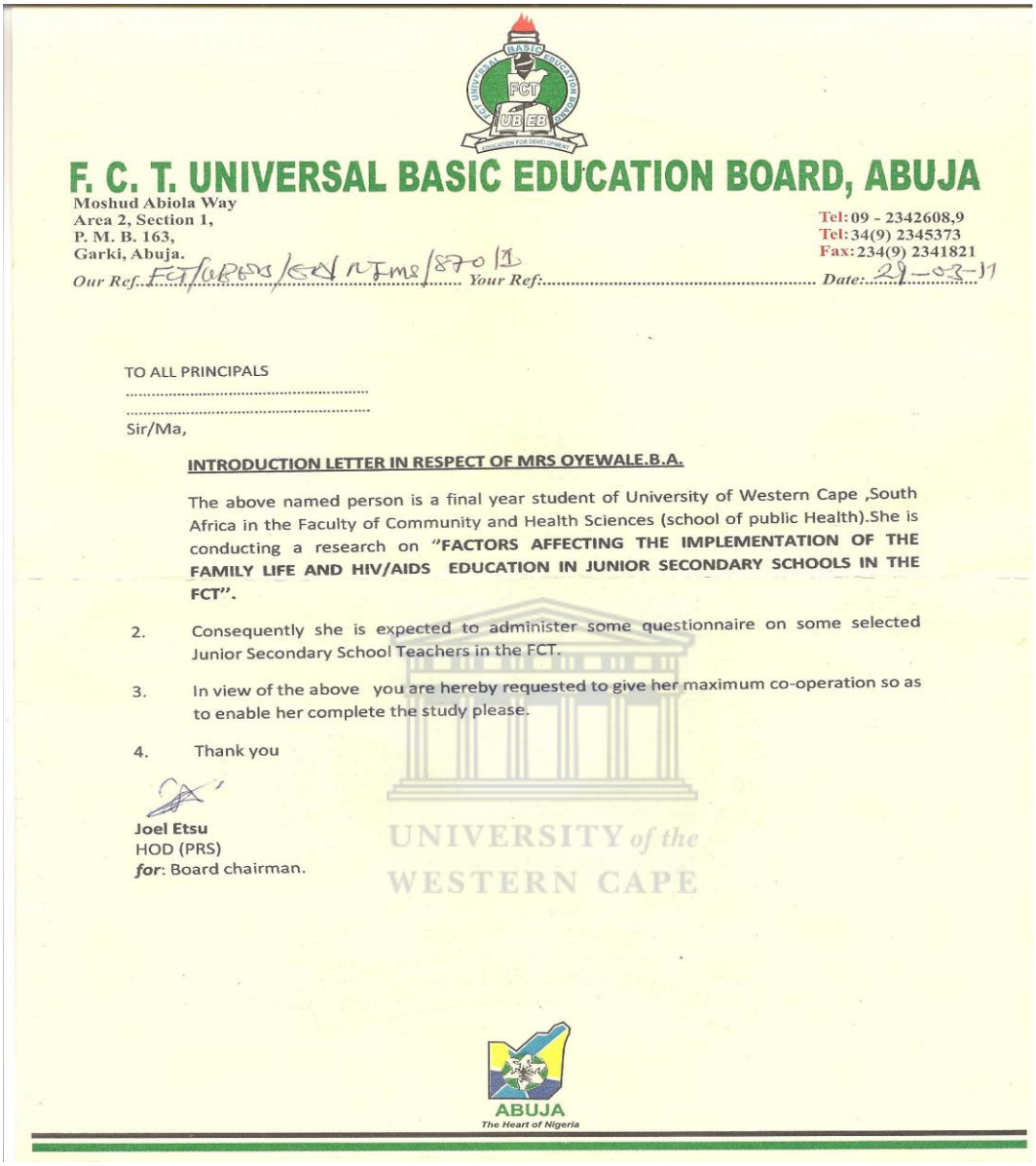
University of the Western Cape, Private Bag X17, Belville 7535

Telephone: +27 21-959

Fax: +27 21-959
Email: sumohamed@uwc.ac.za

APPENDIX III

INTRODUCTION LETTER



F. C. T. UNIVERSAL BASIC EDUCATION BOARD, ABUJA

Moshud Abiola Way
Area 2, Section 1,
P. M. B. 163,
Garki, Abuja.

Tel: 09 - 2342608,9
Tel: 34(9) 2345373
Fax: 234(9) 2341821

Our Ref.: FCT/UBEB/EDV/TMS/870/11 Your Ref:..... Date: 21-03-11

TO ALL PRINCIPALS
.....
.....

Sir/Ma,

INTRODUCTION LETTER IN RESPECT OF MRS OYEWALE.B.A.

The above named person is a final year student of University of Western Cape ,South Africa in the Faculty of Community and Health Sciences (school of public Health).She is conducting a research on **"FACTORS AFFECTING THE IMPLEMENTATION OF THE FAMILY LIFE AND HIV/AIDS EDUCATION IN JUNIOR SECONDARY SCHOOLS IN THE FCT".**

2. Consequently she is expected to administer some questionnaire on some selected Junior Secondary School Teachers in the FCT.

3. In view of the above you are hereby requested to give her maximum co-operation so as to enable her complete the study please.

4. Thank you

Joel Etsu
HOD (PRS)
for: Board chairman.

ABUJA
The Heart of Nigeria

APPENDIX IV

QUESTIONNAIRE

IDENTIFICATION: **QIN** ☐☐

AREA COUNCIL: _____ ☐

SECTION 1: BACKGROUND INFORMATION

Q/No	Questions	Response Option	Code	Leave Blank
1.1	What is your sex?	Male Female	**1** **2**	[ ]
1.2	How old are you as at your last birthday?	20 – 24 years 25 – 29 years 30 – 34 years 35 – 39 years 40 – 44 years 45 years and older	**1** **2** **3** **4** **5** **6**	[ ]
1.3	What is your highest educational level?	National Certificate in Education (NCE) Bachelor's Degree Masters Degree Others, please specify _____	**1** **2** **3** **8**	[ ]
1.4	Please indicate your current marital status?	Married Single Divorced Separated	**1** **2** **3** **4**	[ ]

		Widow / Widower	**5**	
Q/No	**Questions**	**Response Option**	**Code**	**Leave Blank**
1.5	How many children do you have?	None 1 – 2 Children 3 – 4 Children 5 children or more	**1** **2** **3** **4**	[ ]
1.6	How long have you been working as a teacher? (in completed years)	Less than 1 year 1 – 5 years 5 – 10 years More than 10 years	**1** **2** **3** **4**	[ ]
1.7	What class (es) do you teach? **[Tick all classes that you teach]**	JS 1 JS 2 JS 3	**1** **2** **3**	[ ]
1.8	What subjects do you teach? **[Tick all that apply]**	Mathematics English Language Social Studies Religious studies Home Economics Physical and Health education Integrated Science Others, please specify: _____	**1** **2** **3** **4** **5** **6** **7** **8**	[ ]

Q/No	Questions	Response Option	Code	Leave Blank
1.9	How will you classify your school with regards to the gender of your students?	Girls Only Boys Only Mixed (Girls and Boys)	**1** **2** **3**	[ ]
1.10	When did you attend the last training on FLHE curriculum?	Less than 1 year ago 1 – 2 years ago More than 2 years ago	**1** **2** **3**	[ ]
1.11	Have you ever received any other orientation/training on sexuality education or HIV/AIDS prevention education?	Yes No Please specify …….. ……	**1** **2** **8**	[ ]

SECTION 2: Policy on HIV/AIDS Education

Q/No	Questions	Response Option	Code	Leave Blank
2.1	Are you aware of the National HIV/AIDS Policy for the Education Sector in Nigeria?	Yes No → **Go To Question 2.4 and continue**	**1** **2**	**[ ]**
2.2	Have you seen a copy of the National HIV/AIDS Policy for the Education Sector in Nigeria?	Yes No→ **Go To Question 2.4 and continue**	**1** **2**	[ ]
2.3	What are the strategies in the National HIV/AIDS Policy for the Education sector in Nigeria? **[Tick all that apply]**	Prevention of HIV/AIDS Voluntary Counseling and Testing Reduction of Stigma and Discrimination Treatment, Care and Support Orphans and Vulnerable Children Programme management Gender Rights and Ethics Others, please specify_____	**1** **2** **3** **4** **5** **6** **7** **8**	[ ]
2.4	Are you aware of the Government directive to mainstreaming topics in FLHE curriculum into existing subjects	Yes No	**1** **2**	**[ ]**

Q/No	Questions	Response Option	Code	Leave Blank
2.5	In your school, topics in FLHE curriculum are mainstreamed into which subjects? **[Tick all that apply]**	Mathematics English Language Social Studies Religious studies Home Economics Physical and Health education Integrated Science Others, please specify: _____ Don't Know	**1** **2** **3** **4** **5** **6** **7** **8** **9**	[ ]

SECTION 3: Knowledge of Content of FLHE Curriculum

Q/No	Questions	Response Option	Code	Leave Blank
3.1	What are the topics in the FLHE curriculum?	Human Development HIV Infection First Aid Life Building Skills Relationships Society and Culture Environmental Health	**1** **2** **3** **4** **5** **6** **7**	[ ]

Q/No	Questions	Response Option	Code	Leave Blank
3.2	Is HIV different from AIDS?	Yes No Don't Know	**1** **2** **9**	[ ]
3.3	HIV is the acronym for Human Immune Virus?	Yes No Don't Know	**1** **2** **9**	[ ]
3.4	How can HIV be transmitted? **[Tick all that apply]**	By having unprotected sex Transfusion of unscreened blood Sharing contaminated razor blades/needles From an infected mother to her baby Through kissing Through witchcraft Don't Know	**1** **2** **3** **4** **5** **6** **9**	[ ]
3.5	How can HIV be prevented? **[Tick all that apply]**	Abstain from having sex Stay faithful to spouse/partners Use condoms during all sex Avoid sharing sharp objects Other, please specify_____ Don't Know	**1** **2** **3** **4** **8** **9**	[ ]

Q/No	Questions	Response Option	Code	Leave Blank
3.6	Can you correctly identify 3 life skills in this list? **[Please Tick any Three Response ONLY]**	Assertiveness Chastity Aggression Communication Self Confidence Negotiation Relationships Don't know	**1** **2** **3** **4** **5** **6** **7** **9**	[ ]

SECTION 4: Delivery of FLHE Curriculum

Q/No	Questions	Response Option	Code	Leave Blank
4.1	In the last one year, have you taught FLHE curriculum to your students	Yes No → **Go To 4.7 and continue**	**1** **2**	[ ]
4.2	What class(es) did you teach topics in the FLHE curriculum? **[Tick all classes that you taught HIV/AIDS]**	JS 1 JS 2 JS 3	**1** **2** **3**	[ ]

Q/No	Questions	Response Option	Code	Leave Blank
4.3	Which carrier subject(s) did you use to teach topics in the FLHE curriculum to your students? **[Tick all that apply]**	Mathematics English Language Social Studies Religious studies Home Economics Physical and Health education Integrated Science Others, please specify:_____	**1** **2** **3** **4** **5** **6** **7** **8**	[ ]
4.4	Which section(s) of the FLHE curriculum did you teach to your students? **[Tick all that apply]**	Human Development HIV Infection Life Building Skills Personal Skills Relationships Society and Culture Environmental Health Others, please specify: _____	**1** **2** **3** **4** **5** **6** **7** **8**	[ ]
4.5	Did you use any participatory learning methods when teaching FLHE to your students?	Yes No → **Go To 4.7 and continue**	**1** **2**	[ ]

Q/No	Questions	Response Option	Code	Leave Blank
4.6	Which participatory learning methodology did you use for the teaching of FLHE to your student? **[Tick all that apply]**	Brainstorming Role Play Group Work Songs Drama Demonstration Others, please specify _____	**1** **2** **3** **4** **5** **6** **8**	[ ]
Attitude Related to the Delivery of HIV/AIDS Education				
4.7	Do you think HIV/AIDS education encourage early sexual experimentation among students?	Yes No Don't Know	**1** **2** **9**	[ ]
4.8	Do you feel comfortable to teach the FLHE curriculum to your students?	Yes → **Go To Question 4.10 and continue** No → **Go To Question 4.9 and continue**	**1** **2**	[ ]

Q/No	Questions	Response Option	Code	Leave Blank
4.9	Why do you feel uncomfortable to teach the FLHE curriculum to your students? **[Tick all that apply]**	Will lead to sexual promiscuity among students No support from colleagues Will offend parents Other teachers should do it Will offend religious leaders Talking about sex is not encouraged in my culture Others, please specify:	**1** **2** **3** **4** **5** **6** **8**	[ ]
Influence of Religion on the Delivery of HIV/AIDS Education				
4.10	What is your religion?	African Traditional Religion Christianity Islam Others, please specify	**1** **2** **3** **8**	
4.11	Based on your religious belief, are you comfortable to discuss HIV/AIDS issues with your fellow teachers in your school?	Yes No	**1** **2**	

Q/No	Questions	Response Option	Code	Leave Blank
4.12	Based on your religious belief, are you comfortable to teach FLHE curriculum to your students?	Yes → **Go To Question 4.14 and continue** No → **Go To Question 4.13 and continue**	**1** **2**	
4.13	Based on your religious belief, why do you feel uncomfortable to teach FLHE curriculum to your students? **[Tick all that apply]**	It is immoral It will encourage students to sin It will offend my religious belief It will offend religious leaders Others, please specify:	**1** **2** **3** **4** **8**	
4.14	Do you have any religious activity that encourages the congregation to discuss about HIV/AIDS?	Yes No If yes, Please specify…….	**1** **2**	
Influence of Culture on the Delivery of HIV/AIDS Education				
4.15	Based on your cultural values, are you comfortable to discuss sexuality issues in public?	Yes No	**1** **2**	

Q/No	Questions	Response Option	Code	Leave Blank
4.16	Do you have any cultural activity that encourages the discussion of sexuality issues and HIV/AIDS in the public?	Yes No If yes, Please specify…….	**1** **2**	
4.17	Are you comfortable discussing sexuality issues with older people?	Yes No	**1** **2**	
4.18	Based on your cultural values, are you comfortable to discuss sexuality issues including HIV/AIDS with your fellow teachers?	Yes No	**1** **2**	
4.19	Are you comfortable discussing sexuality issues with younger people?	Yes No	**1** **2**	
4.20	Based on your cultural values, are you comfortable to discuss sexuality issues including HIV/AIDS with your students?	Yes → **GO TO 4.22and continue** No → **GO TO 4.21 and continue**	**1** **2**	

Q/No	Questions	Response Option	Code	Leave Blank
4.21	In line with your cultural values, why do you feel uncomfortable to discuss sexuality issues including HIV/AIDS with your students? **[Tick all that apply]**	The students are too young to discuss sex issues It will encourage students to initiate sex It is a taboo in my culture It will offend traditional leaders Others, please specify:	**1** **2** **3** **4** **8**	
4.22	Are you comfortable discussing sexuality issues with members of the opposite sex?	Yes No	**1** **2**	

THANK YOU