

HIV/AIDS ACTIVITY IN THE SCHOOLS

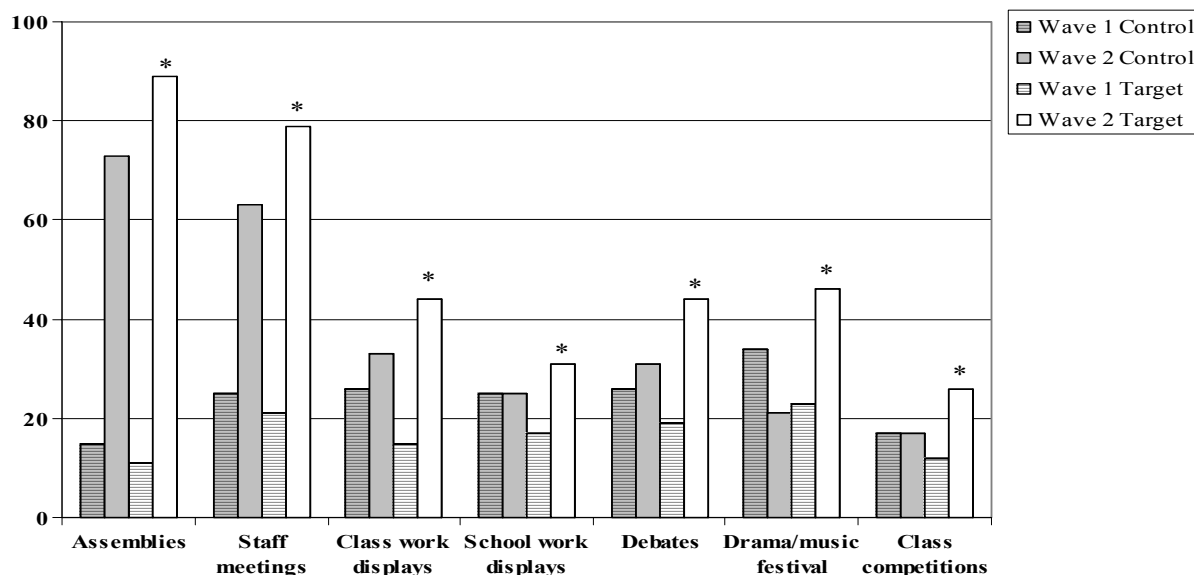
In evaluating a programme it is important to look not only at programme outcomes in terms of potential gains in knowledge, attitudes and behaviours (KAB), but to pay careful attention to implementation of the programme itself, since strong programme implementation is a necessary precondition to any gains in KAB. This is particularly important in short-term evaluation where changes in KAB are, at best, likely to be minimal.

The following section will report on programme implementation at both the individual and school levels. The individual level uses information from teacher and pupil observations of HIV/AIDS programming in their schools and their responses to it. This information was collected in surveys, interviews and focus groups. On the school level information from the school and community responsiveness surveys and data from PSC's and TSC's have been aggregated to provide a picture of programme implementation at the school level. This allows analyses to be done school by school and includes all information that has been collected as part of the PSABH evaluation.

Where is AIDS addressed?

Every school surveyed was doing some form of HIV/AIDS education. There were, however, statistically significant differences in what teachers in control and target schools reported in wave 2. These differences also represented some significant changes from wave 1 (see figure A below). By wave 2, there were significantly more teachers in target than control schools reporting HIV/AIDS was being addressed in every school activity listed.

Figure A¹: Percentage of Teachers Responding that HIV/AIDS Has Been Addressed in:

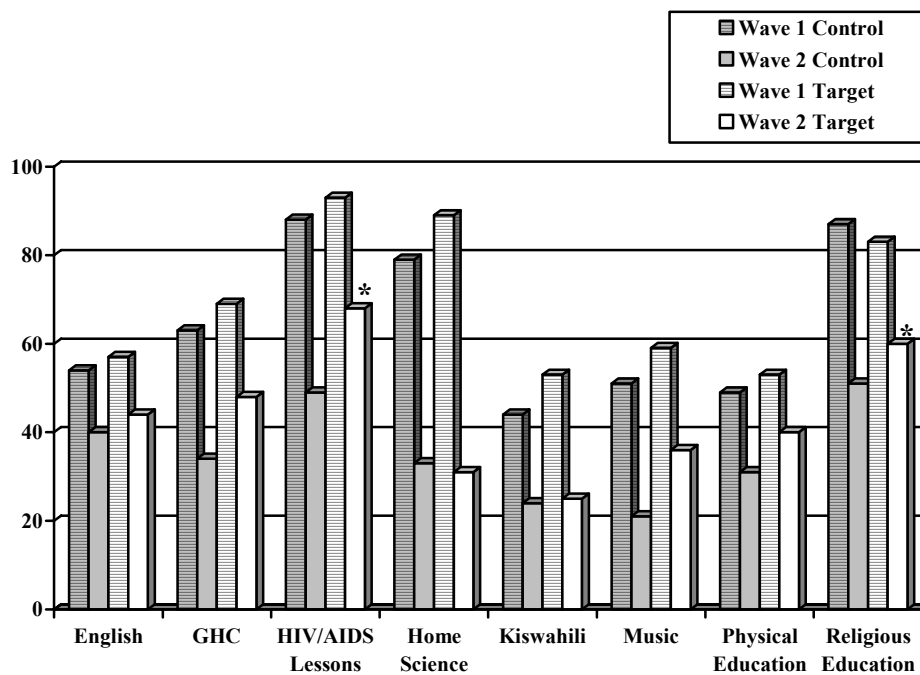


*increase from wave 1-2 significantly greater in target than control schools at $p \leq .01$

¹ Significance statistics in all figures relate to the comparison of the amount of change from wave 1 to wave 2 in control and target schools. This controls for the relative positioning of control compared to target at wave 1. If there are large gains from wave 1 to wave 2 in both sets of school they are only identified as significant if target gains are greater than control gains.

While almost all teachers said HIV/AIDS was addressed in school assemblies and staff meetings fewer than half cited activities where pupils were likely to be actively involved in learning –i.e. displays, debates, competitions and festivals. The lower level of direct involvement of pupils corresponds to the decrease in reports of teaching about HIV/AIDS in classroom subjects seen in the next graph. This decrease may be related to the disruptions experienced in schools (i.e. teachers’ strike and coping with large numbers of new pupils) and subsequent need to focus on the core curriculum. Of note is that the patterns seen in these figures related to where HIV/AIDS is being addressed were evident in both target and control schools with target schools showing greater HIV/AIDS teaching activities than controls at wave 2.

Figure B: For Teachers Who Have Taught Each of the Following Subjects, Percentage

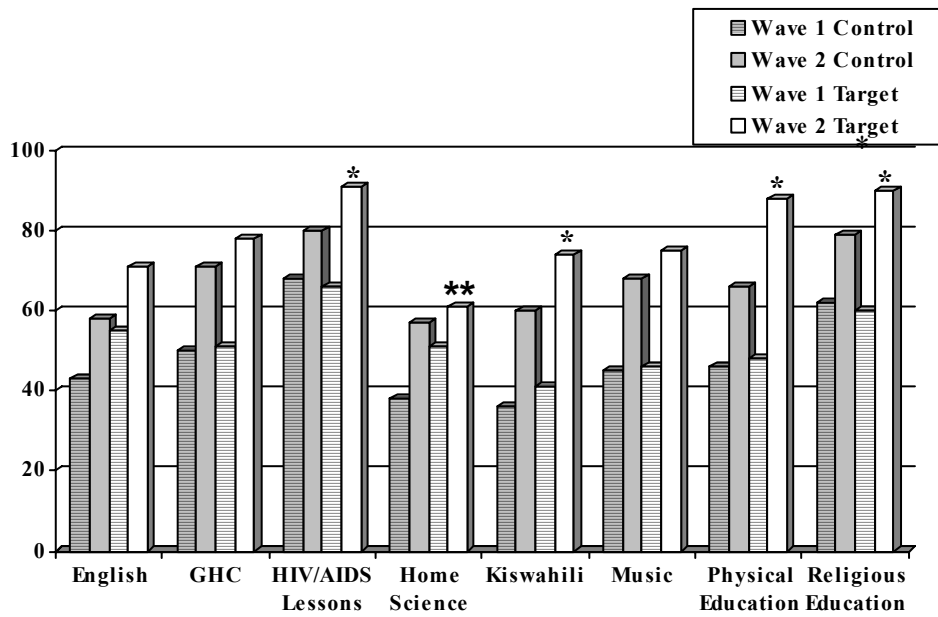


*decrease from wave 1 to wave 2 sig.< in target than control schools at $p \leq .01$

Who Have Addressed HIV/AIDS in:

An encouraging sign was that for teachers who included HIV/AIDS in classroom work, more did so three or more times in the semester. This change was significantly greater in target than control schools for HIV/AIDS lessons, Kiswahili, physical education and religious education. Of note is that teachers increased their teaching about HIV and AIDS significantly more in Home Science in control than in target schools. These results suggest a potential toward greater diffusion of HIV and AIDS lessons in target schools and concentration in Home Science in controls.

Figure C: For Teachers Who Have Taught HIV/AIDS in Each Subject, Percentage Who Have Addressed HIV/AIDS 3 or More Times in:

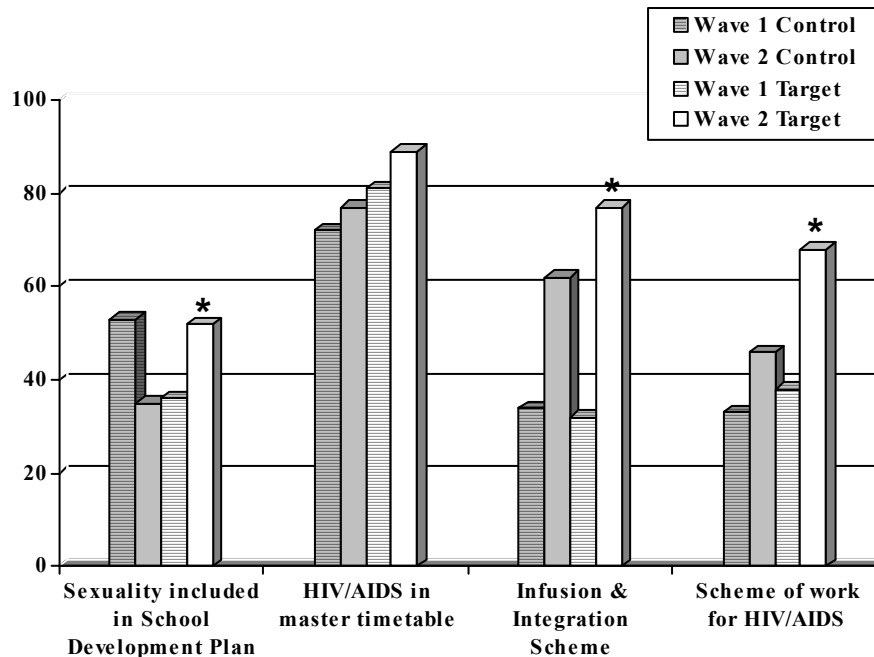


* increase from wave 1 to wave 2 sig. > in target than control schools at $p \leq .01$

** increase from wave 1 to wave 2 sig. > in control than target schools at $p \leq .01$

The pattern seen in teaching was also evident in the presence of HIV/AIDS in pedagogical planning and training. With the exception of placing HIV/AIDS in the master timetable, teachers in target schools moved well ahead of those in control schools.

Figure D: Percentage of Teachers Responding:

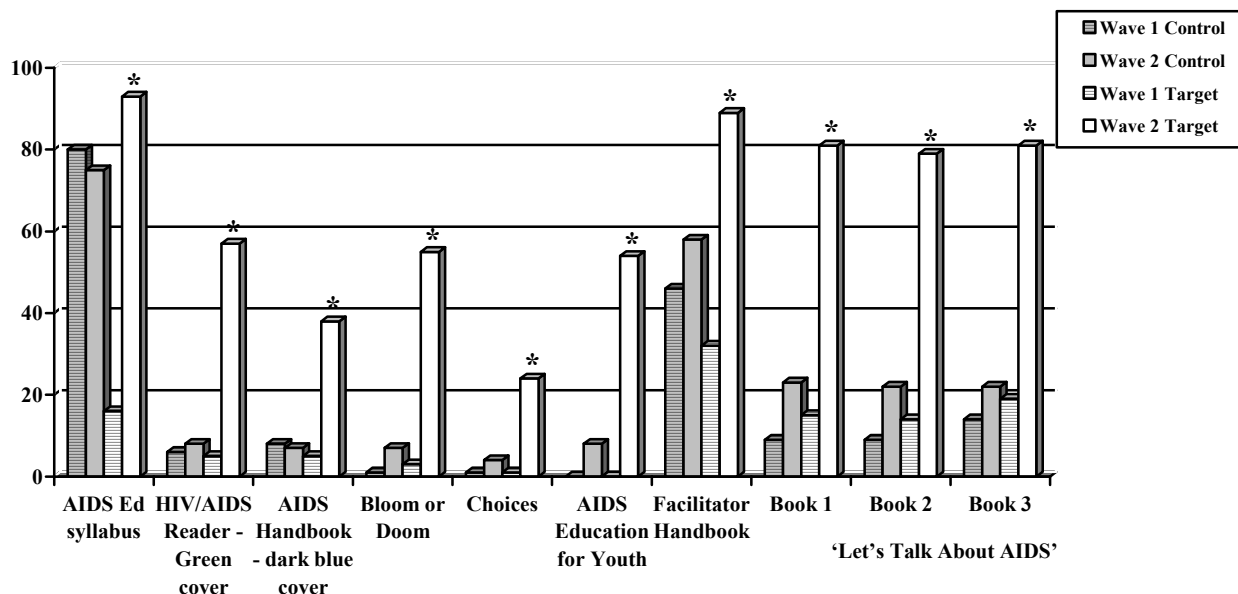


* increase from wave 1 to wave 2 sig. > in target than control schools at $p \leq .01$

Resources

All schools had access to the AIDS Education Syllabus from the MoEST even though not all teachers knew of its availability. Most other resources were provided by PSABH as part of teacher training, as evident in the figure E below.

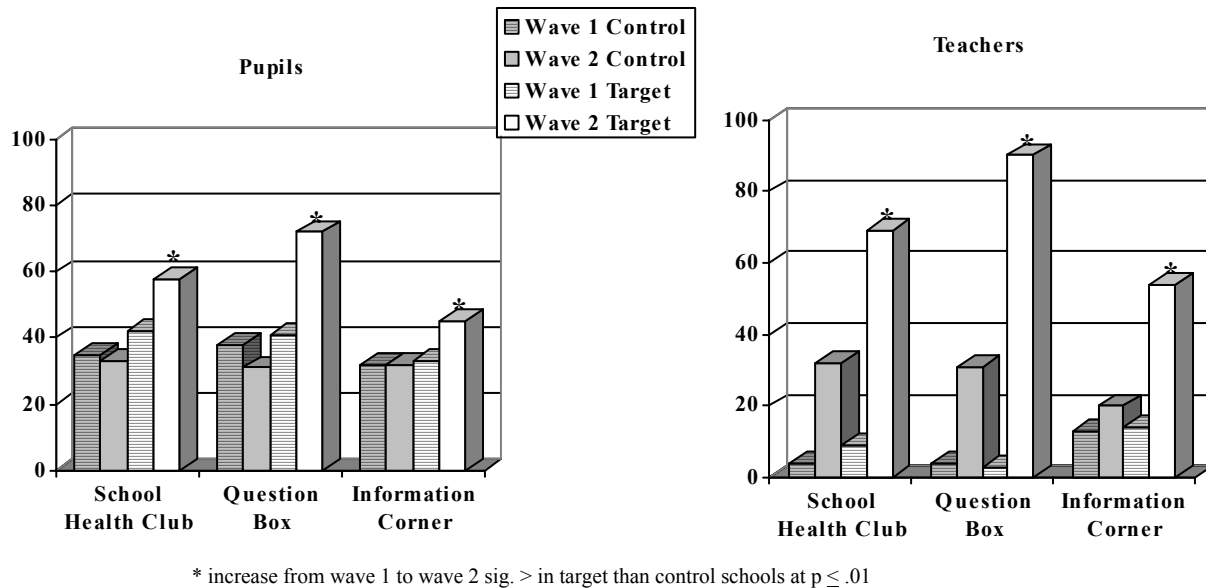
Figure E: Percentage of Teachers Responding That the School Has:



* increase from wave 1 to wave 2 sig. > in target than control schools at $p \leq .01$

The same pattern that is evident for the frequency of teaching about HIV and AIDS in classroom subjects is also evident for the *use* of these resources – i.e. they are used most by teachers in target schools. In addition, teachers in target schools use other resources such as posters, work sheets, storybooks, etc., and access human resources such as TAC Tutors, ZIs, parents, and Ministry of Health workers more than those in control schools. Both teachers and pupils in target schools were also more likely to report having a school health club, question box and information corner (see figure F).

Figure F: Percentage of Pupils and Teachers Who Say Their School Has:



Although this is encouraging, the picture becomes less clear when the qualitative data are explored. For example, in qualitative interviews and focus groups two schools mentioned having no Health Club at all while two admitted charging pupils a fee for enrollment.

Q: Is there a health club in your school?

No (all) (Boys8: 305-307).

We don't have one (Girls3: 873).

We are supposed to register as members of the club and pay some money so that people from outside the school can be invited to come and talk to us (Girls4: 465-467).

Question Boxes were spoken of as the most manageable and positive way to address HIV/AIDS. Pupils liked the question box and stated that it was a good way for them to ask questions anonymously.

You can ask any question that you do not know so that the answers can help and you do not get into problems (Girls5: 767-768).

You get answers to questions that keep bothering you (Boys1: 439).

The use of a question box, the students found it useful (Teacher2_M: 141).

However, pupils stated that they would have liked to have more of their questions answered. As was found in the SRS, it was not at all clear from either teacher or pupil interviews whether the question boxes were regularly being used.

They [teachers] answer a few [questions] the rest they leave unanswered (Girls3: 715-718).

We have a school question box... we haven't used it because of this and that (Teacher4_M: 255-256).

When we started there used to be so many questions but as time went by the questions started reducing (Teacher2_F: 219-220).

It [question box] was there but they removed it and we do not know why (Boys8: 192).

Programme Uptake

Teacher and pupil responses to questions about where AIDS is addressed, AIDS in classroom subjects and resources were combined into two implementation scales (see Appendix A). When scores for target and control schools at wave 1 and wave 2 were compared it was evident that there were significant and substantial gains in programme implementation in target schools.

As was evident from reviewing responses to individual questions, these gains reflected either an increase in the HIV content of co-curricular activities, greater use of resources and more frequent coverage of HIV/AIDS in the classroom, or less 'lost ground' in the number of teachers reporting coverage of HIV/AIDS in classroom teaching in target than in control schools.

The figures on the following page illustrate the kind of change that has occurred in the implementation of HIV and AIDS programming in target and control schools between wave 1 and 2. At wave 1, the distribution of implementation scores in both groups of schools overlapped completely with nearly identical mean scores (control $O = 3.90$, target $O = 4.00$). By wave 2 the target schools had pulled away from the controls (control $O = 4.50$, target $O = 5.60$). It is important to recognize, however, that some overlap remained (see shaded portion of graph for wave 2). Thus, 14% of control schools were doing as well as the upper half of target schools and 9% of target schools were doing as poorly as the lower half of control schools (see darker shading on graph for wave 2). It is this overlap and the fact that in both groups there is a range of scores on implementation, that explains why, in later analyses, it is often the *score* a school received on implementation rather than whether a school was a target or control school that influenced outcomes. These graphs, however, clearly show that 6 months after completing the full complement of teacher training, target schools are pulling ahead of controls.

See separate file for chart

Relationship Between Programme Components

The strength of the correlations between various measures of programme uptake (e.g. infusion, integration, use of question box, school health club, teaching in classroom subjects, assemblies, etc.) at wave 2 and in the SRS (e.g. use of books, posters, presence and content of factual and behaviour change messages, etc.) support the conclusion that schools that take up PSABH activities soon after training are those that are likely to maintain these activities over time (see Table S in Appendix B). It also supports the conclusion that schools that were incorporating HIV/AIDS programming were doing so in every way that was measured. Finally, it suggests that the assessment of zonal inspectors is comparable to that of teachers and pupils with respect to programme uptake.

What influences uptake?

In examining factors that influence programme implementation, PSABH training was found to have the most important influence on whether HIV/AIDS programming was present in schools and on the increase in programming from wave 1 to wave 2. Schools with trained teachers had more programming or more types of activities, teachers reported fewer barriers to teaching about HIV/AIDS, and there was a greater variety of resources put toward teaching about HIV and AIDS. Whether or not a school was in the target or control group, the implementation score based on pupil observations of school activities was influenced by:

- SES or level of general structural resources in schools;
- Average performance of pupils on KCPE exams;
- Presence and activities of churches in the school and community; and,
- Attitudes of teachers with respect to HIV and AIDS (see Table T, column 3; Table U, column 3).

All of these except church presence also influenced gains in implementation from wave 1 to wave 2. SES and average KCPE scores carried opposite influence. Schools with lower resources and higher KCPE scores and teachers with more accepting attitudes showed the greatest uptake and the greatest gains between wave 1 and wave 2. Clearly, such schools have already overcome their disadvantaged socio-economic status to produce pupils who learn and achieve. When they are helped by the positive attitudes of their teachers, they move forward with HIV/AIDS programming more than other schools. The need to be attentive to the influence of religion on HIV and AIDS programming and messages was evident in programme implementation with several indicators of church presence and activities found to influence implementation. Of note is the implementation scores based on teacher observations were only influenced by training (see Table T, column 2; Table U, column 2).

Teacher Attitudes

Important to consider as PSABH continues to be implemented and adjusted, are the survey and interview findings on teacher attitudes. What was evident in interviews was while some teachers still felt uncomfortable talking about sex, the training had made them much more open to doing so. As noted above, where teachers had more accepting attitudes related to AIDS and the full ABC² range of prevention messages, there was more evidence of programme implementation.

² Prevention strategies often presented as A: the first and best option is to Abstain; B: If you do play sex Be faithful to one uninfected partner; C: If you are not faithful, use a Condom.

Before, we had culture where talking to girls and boys about sex was hard, at least after the training we had a way of passing these material (Teacher2_M: 292-294).

[We are] very free [to talk about sex since the PSABH training]. What has made it easier are the skills that we have gained have really helped, how to communicate to get what you want from somebody (Teacher7_M: 557-561).

You see in the past, say for example the teachers they used to fear being open to the students about HIV/AIDS since it involves sex, they found it really immoral using certain terms. And after we sat down and realized that now it is a matter of life and death we chose life and what goes with life is being open, that is what could bring redemption (Teacher8_M: 203-207).

Despite this talk of change, in survey data there were no target/control or wave1/wave2 differences in attitudes. They remained slightly above the mid-point in all schools. Teachers' attitudes were, however, related to their perception of barriers to teaching about HIV and AIDS. When teachers saw fewer barriers, they also had more favorable attitudes. Of note, is that teacher attitudes improved most in schools with lower teacher/pupil ratios (see Table U, column 1).

This was supported in interviews with teachers where they generally described themselves as struggling and overwhelmed by their HIV/AIDS teaching tasks. As noted earlier, in surveys teachers generally rated the training positively with the exception of how 'easy' it was to understand where only 42% of teachers found it 'easy.' In interviews they similarly spoke of the training as covering far too much for them to absorb. Consequently, they still felt insufficiently prepared.

There are some teachers who feel that it is over burdening them when teaching about HIV/AIDS (Teachers6_M: 498-504).

When we went for the training we were congested...I suggest it should be divided into smaller parts to give you time to attend all of them, so I think we need more information on the training and infusion of HIV/AIDS. It was so complicated that even now we find it hard to incorporate it in the syllabus (Teacher2_M: 84-89).

When we are planning on the content to be taught, we were told to include this information along with what has been there like we can have a topic in Science and we have to include this. So I find it a bit difficult (Teacher3_F: 137-139)

In the regression analysis, the most important influences on barriers to teaching about HIV and AIDS were:

- PSABH training;
- School SES; and,
- Average KCPE scores (see Table T, column 1).

KCPE scores and school SES seem to be operating the same way here as in programme implementation. These results suggest that barriers can be overcome with training, particularly in schools where pupils are performing well, academically. Good academic performance of pupils

may be a reflection of schools and teachers that are better able to motivate and teach pupils, i.e. schools where teachers are less likely to see barriers to any new curriculum. They may also reflect schools where pupils themselves are more motivated and able to learn, which, in turn, influences teachers to feel positively about new materials, since they feel their pupils can master it. As educators know, the influence that flows between teachers and their pupils is not unidirectional. We know that good teaching can contribute to good pupil performance however good pupils can also contribute to good teaching.

Combining all data sources, the picture emerges of teachers who have a desire to help pupils avoid HIV infection and who generally have positive attitudes toward teaching about HIV and AIDS, however, they find this teaching difficult given their other responsibilities, their level of training, and their lack of comfort in teaching about sexual matters. PSABH training and being in a school where pupils are doing well academically can help overcome practical barriers to adding HIV and AIDS to the school curriculum.

Pupil Responses

Although some teachers continued to express the feeling that they were inadequately prepared to teach about HIV/AIDS, 65-75% of pupils found the lessons about HIV/AIDS to:

- Be very useful;
- Have told them everything they needed to know;
- Have helped them make the right decisions; and,
- Have helped them protect themselves from disease.

Responses on these items formed a *Usefulness Evaluation* sScale (see Appendix A p.) which measured how pupils rated practical utility of the HIV/AIDS programme in their school.

Only a minority (30-40%) found the lessons:

- Difficult to understand;
- A bit shameful; and,
- Boring.

Responses on these items formed an *Affective Evaluation* scale (see Appendix A) which measured pupils' affective responses to HIV/AIDS programming in their schools. The feelings of pupils were the same in all schools and across both waves of data collection supporting the statements made by youth in focus group discussions.

They [teachers] say the truth...They are of help to us...When you follow the teachings you do not get yourself in problems (Girls4: 314-322).

It [PSABH programme] is good...because teachers have talked to us about many things we did not know (Girls3: 1618-1621).

*Q: What do you think is the best part about the HIV/AIDS program in your school?
The periods or lessons on HIV/AIDS.*

Q: Why?

They teach young people on how to protect themselves against HIV/AIDS (Boys8: 756-761).

*Q: What do you think is the best part about the HIV/AIDS program in your school?
You will find teachers telling us to be careful because the world is a place with no hope,
many people are dying and we do not know the origin of this disease that has struck us
(Boys6: 785-791).*

When Usefulness and Affective Evaluation scale scores were examined school by school, it was surprising to find that pupils rated HIV/AIDS programming as *less* useful in target schools and *less* affectively positive in schools with higher overall implementation scores (see Table T, columns 6 and 7). However, in schools where teachers were teaching specifically about how to resist pressures to play sex (see chapter on abstinence) the overall ratings on both scales were higher and positive. The pupil profile of schools also influenced the rating of the HIV/AIDS programming. Schools with predominantly Luo pupils had higher average scores on Affective Evaluation. Those with predominantly Kisii pupils had higher scores on Usefulness Evaluation. Finally, schools with higher proportions of Protestant pupils had higher scores on both scales and higher teacher/pupil ratios produced more positive affective responses. Of note is that gains in scale scores between waves 1 and 2 were influenced by the same factors (see Table U, columns 6 and 7).

Taken together, these results suggest that specific teaching about how to remain abstinent is found useful and affectively desirable, but other components of the programme may not be. They also suggest that schools with mostly Protestant pupils are finding the programme most acceptable and useful, that schools where Luo and Kisii pupils predominate respond differently to the programme and that the time teachers have for each pupil may be most important for overcoming pupils' sense of shame and boredom and dealing with different material.

Peer Supporters

Peer supporters were also identified as a source of information for youth. Teachers commented that peer supporters were actively talking to fellow pupils but that adults were unaware of the content of such discussions. What needs to be recognized is that none of the schools appear to be providing support for the peer supporters – they are left on their own to convey information.

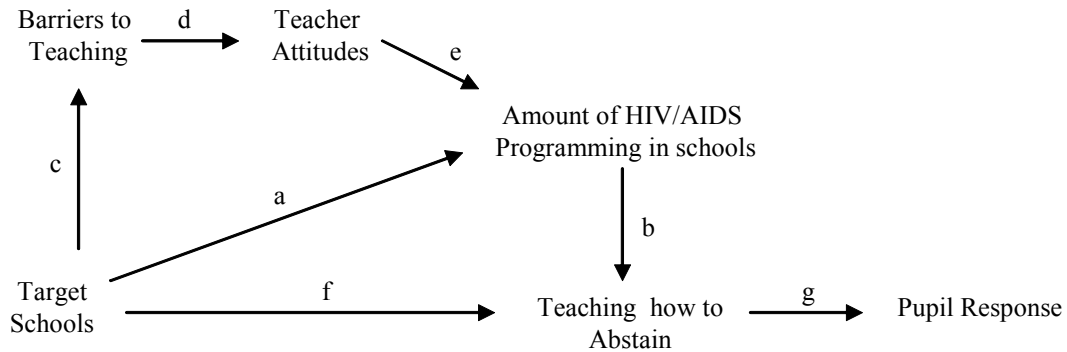
*[Peer supporters] meet with their peers to talk about having sex before marriage,
counseling them on bad behaviors. It is easier for one who has trained to know their
weaknesses and help them out (Teacher2_M: 277-279).*

*These pupils [peer supporters] you know they are free to one another compared to the
parents and teachers (Teacher8_M: 681-685).*

Paths of PSABH Influence on School-Based Programming

The ways in which the various components of HIV/AIDS programming that were present in the schools influenced each other were examined using path analysis. The diagram below portrays the results of this analysis. Arrows represent where statistically significant influences were found

when all factors were taken into consideration. Letters on the arrows correspond with the explanations below the diagram³.



Effect of PSABH Training on HIV and AIDS Programming

What the above diagram shows is that being in a target or control school affects the various aspects of HIV/AIDS programming both directly and indirectly.

Target compared to control schools have

- C Greater amounts of programming (see arrow 'a' above).
- C More teaching about how to abstain (see arrow 'f' above).
- Teachers who see fewer barriers to teaching about HIV & AIDS (see arrow 'c' above).

In schools where teachers see fewer barriers to teaching about HIV & AIDS

- C Teachers also have better attitudes toward HIV/AIDS teaching (see arrow 'd' above).

In schools where teachers have better attitudes toward HIV/AIDS teaching

- C There is more HIV/AIDS programming (see arrow 'e' above).

In schools where there are greater amounts of HIV/AIDS programming,

- There is also more teaching about how to abstain (see arrow 'b' above).

Finally, in schools where there is more teaching about how to abstain

- C Pupils respond more positively to the programming, evaluating it as more useful and affectively more acceptable (see arrow 'g' above).

³ The analyses summarized in this diagram are described in Appendix A (p.). For statistical results used to create this diagram see Table T, columns 6 and 7.