

**An exploration of Educators' experiences in implementing
Sexuality Education as Disease Prevention and a Health
Promotion Strategy in Selected eThekweni-Based
Secondary Schools**

by

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DECLARATION

I Busisiwe Khathazile Ruth Khathi declare that this research entitled “**An exploration of Educators’ experiences in implementing Sexuality Education as Disease prevention and a Health Promotion strategy in selected eThekweni-Based Secondary Schools**” is my own work. I have given full acknowledgement to the sources referred to in this text. This work has not been submitted for any degree or any examination in any university.

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DEDICATION

This study is dedicated to both sisters, my late sister **Nomandla Primrose Khathi** and my dear sister **Zilingene Roseline Khathi** who both made sure that I go through with my studies despite the hard circumstances they had to go through.

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LIST OF ACRONYMS

ABET	: Adult Basic Education and Training
ACRIA	: AIDS Community Research Initiative of America
ASSA	: Actuarial Society of South Africa
CSE	: Comprehensive Sexuality Education
AIDS	: Acquired Immune-Deficiency Syndrome
ECD	: Early Childhood Development
GP	: General Practitioner/ Family Practitioner
HIV	: Human Immune-Deficiency Virus
HoDs	: Head of Departments
HST	: Health Systems Trust
HTA	: High Transmission Areas
IPPF	: International Planned Parenthood Federation
KZN	: KwaZulu-Natal
LO	: Life Orientation
MEC	: Minister of Education
MRC	: Medical Research Council
NCS	: National Curriculum Statement
DoE	: National Department of Education
DoH	: National Department of Health
NHS	: National HIV Survey
NFP	: National Policy Framework
NSP	: National Strategic Plan

RH	: Reproductive Health
RHRU	: Reproductive Health Research Unit
TTC	: Teacher Training College
SA	: South Africa
STDs	: Sexually Transmitted Diseases
STIs	: Sexual Transmitted Infections
UKZN	: University of KwaZulu-Natal
UNAIDS	: The Joint United Nations Programme on HIV/AIDS
WHO	: World Health Organization

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ABSTRACT

Objective: This study sought to explore educators' experiences whilst implementing sexuality education as disease prevention and a health promotion strategy in classes for learners in secondary Schools. The critical question posed by the study was how the educators were identified and selected to present this subject? What training did the educator(s) receive to offer the sexuality education/ LO programme? What content of sexuality do they cover in classes when teaching LO? How have the educators experienced teaching sexuality education/ LO so far? What are the educators' views on DoE offering this program? What support do they receive and what barriers do they encounter?

Methodology: This study adopted an exploratory qualitative approach to explore educators' experiences in implementing sexuality education. The study was conducted at eThekweni-based Secondary schools. The purposive selection method was used. Six different schools from the Umgeni North Branch, North of Durban were selected. Educators' experiences were examined through the use of in-depth face to face interviews. An interview schedule was used to guide the interview process.

Findings: Altogether, seven Life Orientation (LO) educators were interviewed in this study. The study showed that there is continuous training and development of the LO educators which is done by the Department of Education (DoE) and through educators' network. It was learned from the LO educators that there are four learning outcomes in Life Orientation teaching and that sexuality education is embedded in Health Promotion or Personal Wellbeing learning outcome. Some LO educators commented that not much emphasis is placed on sexuality education. The LO educators indicated the need for educators to be trained on short skills courses like HIV counselling and Rape victim management.

Conclusion: The study highlights educator's experiences when teaching sexuality education as embedded in the Life Orientation curriculum. Educators verbalized that having sexuality education embedded in another aspect of LO limits the information

that is given as the educators are guided by the DoE guidelines. It also became evident that some educators experienced difficulties in dealing with the HIV positive learners and those that have been raped. This challenges the DoE to gradually train and update the educators on short courses like HIV counselling, dealing with rape and teenage pregnancies to improve LO educators' confidence when faced with such situations in a classroom during LO education.

Keywords: Sexuality education; sexual health; school educator/ teacher; scholar/ learner; secondary school; Disease prevention; Health promotion; Life skills programme/ life orientation (LO).

CHAPTER 1

BACKGROUND

1.1. INTRODUCTION

While the high rate of sexually transmitted infections, HIV/ AIDS and pregnancy is well documented among the South African youth (Lisa et al., 2004), only recently has the extent of educators' challenges when implementing sexuality education in schools been recognized. The need to develop a deeper understanding of the educators' experiences has been highlighted by the significant deviation in reported behaviour of scholars between what they learn and what they do. This is indicated in the study conducted to determine the baseline data on HIV/ AIDS/ STIs and sexuality knowledge of secondary school students in central KwaZulu-Natal Province, South Africa (James et al., 2004).

In an effort to understand the contradiction between what is known and what is practiced when providing sexuality education, this study explores the experiences of educators in providing the Life Orientation (LO) education to understand the environment in which they operate. This chapter provides a background to the study, and outlines the problem statement, research question, aims and study objectives, and significance of the study. It is followed by a short description of the definition of key terms, theoretical framework, study type and method, obtaining approval, an outline of what each chapter covers and summary of the chapter.

1.2. BACKGROUND

In a study of positioning research in Queensland, Barber (2004) argued that providing sexual health education requires an integrated approach with schools, public health, Planned Parenthood, (PPH), doctors, clergy, students, and parents. Resource dollars need to be shared to provide an integrated programme (Barber, 2004). The educators indicated that they could not do this without proper preparation and resources as all topics must be given more attention. Barber (2004) contended that it takes 30-50 hours of skills training to adopt new behaviours. Barber (2004) further argued that until and unless the DoE, school boards, teachers, parents, and

community treat sexuality education as a valuable part of a student's education, the students will not perceive it as such.

Barber (2004) further commented that sexuality education is often seen to be a complicated and controversial topic which has significant implications for its positioning in research and teaching practices. In Queensland, Australia, sexuality education is included in the Health and Physical Education (HPE) Syllabus (Queensland School Curriculum Council). However, school administrators choose how and when to implement it and are not required to report on what programs are used or to formally evaluate them. There is no state or national body that provides leadership or guidance, unlike countries such as the US and Canada (among others) that have Sexuality Information Board and Education Councils (Barber, 2004).

In a study to investigate how the principal and educators manage HIV/ AIDS awareness program in the North West Province School and the perspectives and experiences of the learners of these programs, Mkhonto (2005) argues that educators felt that insufficient means has been done to make HIV/ AIDS awareness programs a success as not enough material or the training of teachers is given, resulting in duplicating what the learners already know from media. Where workshops/ in-service training are done, no follow-up evaluation is performed.

1.2.1 Report since inception of LO

Southern Africa remains the region most affected by HIV/AIDS, and the HIV epidemic in South Africa is interlinked with epidemics occurring in neighbouring countries (UNAIDS, 2006). South Africa, Swaziland, Lesotho and Botswana reported the highest antenatal HIV prevalence levels in the world in 2006. HIV prevalence is relatively low in neighbouring Mozambique, although this is increasing rapidly along transport routes and there is some evidence that prevalence may have peaked in Botswana (UNAIDS, 2006). South Africa is one of the countries hardest hit by the AIDS epidemic, with approximately 5.5 million people living with HIV (UNAIDS, 2006).

According to the Provincial MEC for education in KZN, as quoted in Daily News (2006), the Minister of Education commented that the National Department of

Education has adopted a number of measures in a bid to remedy the issue of teenage pregnancy (Daily News, 2006:2). These measures include programmes such as life skill orientation and sexuality education. However, there are still some concerns that in spite of these programmes being in place, the number of new HIV infections and teenage pregnancies in school is on the increase (Daily News, 2006:2).

In studying the development of the LO education programmes in KwaZulu-Natal, the following were briefly assessed: a. Training opportunities for South Africans in Health Promotion, b. Health promotion position and disease burden in KwaZulu-Natal, c. General issues of concern from these studies, and d. Integrating sexuality into health services.

a. Training opportunities for South Africans in Health Promotion

Coulson (2000) argued that there still are very few training opportunities for South Africans in health promotion, although there was recently a national initiative through the Department of Health to establish a programme of health promotion training in tertiary institutions in South Africa. However, the slow development of training opportunity has lead to a capacity gap in health promotion in South Africa today. There are too few people in the health service who are adequately qualified to provide leadership in health promotion (Coulson, 2000). Coulson (2000) further argues that the national policy for health promotion practice in South Africa is based on the principles and approach of the 1986 Ottawa Charter for health promotion. It establishes five key action areas for health promotion practice:

- To promote safe environments for people to live and work in. Many of the health problems facing South African communities are caused or made worse by living and working in poor conditions. For example, having poor water and sanitation facilities, or working in dangerous conditions without any safety measures.
- To develop healthy public policy. This refers to legislation and policy that protects health. For example, this can range from tobacco control legislation through to ensuring that housing policies

protect the health of people by providing for adequate ventilation or sanitation facilities

- To promote community action. Health problems are often best addressed through community action. This could include community clean-up campaigns or setting up an HIV/AIDS support group in a community
- Develop personal skills. It is essential that each person is equipped with the information and skills to promote their own health. For example in South Africa everyone needs to know about AIDS, and young people need to learn how to negotiate safe sex or how to say no to sex.
- Re-orient the health service. Often the health service does not act in the best interest of people's health. Clinics are often not open in the early evening when it may be easier for working people to get to them and environmental health officers may over emphasize the role of inspections and law enforcement rather than education for food traders.

Coulson (2000) argued that one outcome of this five pronged approach (1986 Ottawa Charter) is that it is often more effective to promote health outside the health sector. For example, the government AIDS partnership strategy acknowledges that people are best reached through a range of channels and not just at the clinic. The health promoting schools project is a good example of a programme of health action outside the health sector. However this does not mean the health sector does not have a critical role to play in health promotion. The role of the health system should be:

- To provide leadership and strategy
- To ensure there is adequate research and training capacity in the country
- To set targets and guidelines for the practice of health promotion by health workers
- To ensure the development of all five approaches to health promotion at the national, provincial and district level.

b. Health promotion position and disease burden in KwaZulu-Natal

Health promotion interventions have been identified as one of the strategies that can empower people with skills that will assist them in making informed choices regarding their own health. In line with this strategy, the South African Government has identified schools as the most important setting for health promotion programmes through their health-promoting schools initiative (Coulson, 1999: 297).

Singh (2003) commented that the province of KwaZulu-Natal is widely categorized as the worst HIV/AIDS-affected region in the South Africa. Although the Human Science Research Council (HSRC) study has made different findings, geographic location along the trucking routes from the Southern African Development Community (SADC) countries to the major seaport of Durban certainly puts the province at risk of becoming an HIV/AIDS hotspot. The province has yet to experience the full impact of AIDS-related morbidity and mortality, which will follow over time.

Smith (2009) supported this notion as she contended that the KwaZulu-Natal (KZN) is one of the poorest provinces in South Africa. With a population of close to 10 million people, it comprises over 20% of the total population of South Africa. While on average 79.3% of households have access to piped water, there is disparity amongst the districts with some districts having close to 100% access, and four of the eleven districts having below 60% access. Only 11.8% of the population had access to a medical aid scheme in 2007, (4th lowest in the country after Eastern Cape, Limpopo and North West). Smith (2009) argued that KZN has a very high burden of disease, with the highest HIV prevalence, TB, STI and diarrhoea incidence rates in the country.

In a study conducted to determine the baseline data on HIV/ AIDS/ STIs and sexuality knowledge of secondary school students in the Midlands district of KwaZulu-Natal, South Africa. James et al. (2004) argue that the results of the study confirmed that knowledge levels were high for causes and spread of STIs and participants were well informed about issues relating to protection against STIs and seeking treatment. However, there was significant deviation

in reported behaviour (James et al., 2004). According to these researchers, a broader approach to sex education moves beyond dissemination of information but rather seeks to address the critical factors that impact on the factual knowledge and decision-making processes of young people (James et al., 2004).

Magnani et al. (2005) argues that life-skills training curricula and teaching methods vary significantly. He commented that it is fairly well done in some schools but not done well in others. While recommended national guidelines are important, he says, local provinces have to make financial and other commitments to implement the guidelines (Magnani et al., 2005).

Despite, these initiatives by the government, statistics still show that there is an increase in the number of school pupils in KZN that are running the risk of being infected with the dreaded HIV and AIDS scourge owing to the alarmingly high rate of teenage pregnancy in schools (Daily News, 2006:2). According to the report sent to the National Department of Education, a total of 5 349 school pupils fell pregnant in year 2005, while in 2004, 5 358 cases of teenage pregnancy were recorded by the department (Daily News, 2006:2).

Grant and Hallman (2006) argued that although pregnancy and motherhood do not always interrupt a young woman's education in South Africa, they introduce a new set of circumstances that influence future decisions related to schooling.

Sinkinson and Hughes (2007) argued that although some topics are historic components of the subject, such as drugs and alcohol; Sexuality education as notably on the Health Promotion Education (HPE) Curriculum Document goes well beyond being a subject. It has a much stronger focus on social literacy and emotional competencies as this covers topics such as dealing and understanding emotions, developing relationships, managing anger or bullying and understanding change, loss and grief (Sinkinson and Hughes, 2007).

c. General issues of sexuality education concern

A cry for proper preparation and resources; 30-50 hours of skills training versus teaching hours, whether sexuality education should be included in the Health and Physical Education (HPE) Syllabus or provided separately. Also looking at whether school educators should choose how and when to implement sexuality education. Whether means that has been done to make HIV/ AIDS, STIs, pregnancy awareness programs are a success and are sufficient and whether follow-ups following workshops and in-service training are performed.

It is not clear how the educators are coping with these challenges and meeting the school learners' needs after school hours and during holidays. No continuity of sexuality education is shown in collaboration between the school and the health care centres, such as clinics. As HST (2004) indicated, outreach activities and community involvement are essential if we are to reach youth group (HST, 2004).

d. Integrating sexuality into health services

Hans (2007) argued that promoting healthy sexuality requires the availability of adequate sexual health services. It also requires well trained health professionals who are equipped to handle issues around sexuality with sensitivity. However, both are often in short supply. In addition, in the context of health services, sexuality is often ignored, avoided or stigmatized. A positive and comprehensive approach to sexual health entails not only addressing its physical dimensions, but also taking into account emotional, social, cultural and even economic factors in the clients' lives (Hans, 2007).

Berresford (2006) argued that before talking about integrating sexuality into health care services, it is useful to review the elements of a sexual health care service. The basic elements of sexual health care services include:

- Sexually Transmitted Infections/HIV prevention and HIV testing, counselling and treatment, including access to anti-retroviral therapy (ART), or referral services

- A range of contraceptive methods and education and counselling around contraceptive methods and choice
- Safe and accessible abortion services
- Prenatal and maternal health care
- Services or a referral system for sexual and gender-based violence

Sexual health services need to be affordable; offered during convenient hours (which may be different for different client populations); in safe and convenient locations; appropriately staffed; sufficiently equipped and stocked; and private and confidential (Berresford, 2006).

Hans (2007) supported this notion, as she commented that one major problem for Health Promotion development is infrastructure. Mechanisms for demonstrating evidence of health promotion effectiveness in terms of health, social, economic and political impact are lacking and occupational standards for health promotion education and training are needed (Hans, 2007).

1.2.2 Strategies for Action and Investment

In a study of Sexuality and Social Change by Ford Foundation Researchers (Berresford, 2006) identified five strategies of improving sexuality education:

a. Expanding the skills of health providers

To implement a positive sexual health model of service, providers need the following: an awareness of their own fears and biases in the area of sexuality; practical tools for sensitively addressing sexual health in their practices, such as specialized intake questionnaires and interviews to learn about their clients' sexual concerns and experiences; skills in couple and family dynamics; the ability to foster the sexual negotiating skills of women and young people; readiness to encourage men to evaluate and transform their roles and responsibilities in relationships, reproduction, sexual health and STI/HIV prevention; the ability to deal with their clients' experiences of sexual abuse and discrimination; and the ability to convey the concept of sexual rights (Berresford, 2006).

b. Incorporating comprehensive sexuality education into formal training programs.

Berresford (2006) argued that efforts need to be made to integrate new skills training and a comprehensive approach to sexuality into formal training programs for health professionals, as well as into ongoing, in-service training of doctors, nurses and other health practitioners

c. Educating advocates about the health care system.

Advocates can articulate the demand for attention to sexuality and sexual health in the health care setting as well as offer input for how that can be done. They may have limited understanding, however, of how health systems function, which constrains their ability to offer specific assistance in the design and implementation of policies and programs. Donors can make an important investment in creating opportunities for health professionals, advocates and community representatives to learn from each other (Berresford, 2006).

d. Developing community-based outreach programs.

Community based health education programs can be encouraged to address sexuality and gender in a healthy, constructive and comprehensive fashion. The nongovernmental and public sector institutions that conduct these programs can benefit from the provision of sexuality training, educational materials and tools for assessment (Berresford, 2006).

e. Using health systems research to document successful initiatives.

Berresford (2006) argued that research is needed on the best ways to integrate sexuality into health services in a variety of contexts. Examples of successful experiences of integration should be documented, analyzed and disseminated.

1.2.3 South Africa Policy Initiative

In response to the HIV/AIDS epidemic, the South African Departments of Education, Health and Welfare embarked on a national programme to implement life skills training, sexuality and HIV/AIDS education in secondary schools in 1995 (National Department of Health and Department of Education, 1997/1998). The goal of the

intervention was to increase knowledge and skills needed for healthy relationships, effective communication and responsible decision-making that would protect learners from HIV infection, and to promote positive and responsible attitudes towards people with HIV/AIDS. In planning the intervention, a position was taken to maintain a balance between the time needed to follow a scientific approach and the urgency of the HIV/AIDS crisis. Various sub-committees were formed to deal with curriculum development, teacher training, marketing and liaison and co-coordinating provincial efforts in implementing the intervention nationally (National Department of Health and Department of Education, 1997/1998).

The policy advocates that HIV/AIDS education be taught in the context of life skills education and be infused throughout the curriculum. Its primary objectives would be preventing the spread of the virus and reducing stigma and discrimination. It is proposed that HIV/AIDS-related education be introduced from as early as the pre-primary level, and such education is presently supposed to be part of all secondary school curricula (National Department of Health and Department of Education, 1997/1998).

Comprehensive school-based sexuality education is perceived to be the building block for sexual health during the lifespan of an individual and therefore requires particular attention (Schaalma et al., 2004). The researchers argued that School-based sexuality education complements and should augment the sexuality education children receive from their families, religious and community groups, and health care professionals. The primary goal of school-based sexuality education is to help young people build a foundation as they mature into sexually healthy adults. Such programs respect the diversity of values and beliefs represented in the community (Schaalma et al., 2004). Sexuality education seeks to assist young people in understanding a positive view of sexuality, provide them with information and skills about taking care of their sexual health, and help them make sound decisions now and in the future. Comprehensive sexuality education programs have four main goals:

- to provide accurate information about human sexuality
- to provide an opportunity for young people to develop, and understand their values, attitudes, and beliefs about sexuality

- to help young people develop relationships and interpersonal skills, and
- To help young people exercise responsibility regarding sexual relationships, including addressing abstinence, pressures to become prematurely involved in sexual intercourse, and the use of contraception and other sexual health measures.

In most countries, the school is the single institution that nearly every person comes into contact with at some stage in their life (WHO, 2003). As a result, some governments have identified the school as the ideal setting for providing sexuality education. In support of this, the researchers has also argued that as part of their training, school teachers need to receive the knowledge and the skills to deliver effective sexuality education (WHO, 2003). Failing to address the problems presented by sexuality poses a myriad of dangers that will affect millions of people worldwide (Berresford, 2006). Directing attention and resources to issues of sexuality can be a powerful means of achieving gender equity, improved public health and social justice (Berresford, 2006). Effective sexuality education therefore plays an important role in the prevention of STIs, HIV and unwanted teenage pregnancy and provides youth information and choice regarding family planning (Kluge, 2006; Aronowitz et al., 2006).

1.3. PROBLEM STATEMENT

When implementing sexuality education/ Life Orientation (LO), the school educator is often faced with unique challenges that go far beyond the normal requirements of teaching. Not only must the special needs of adolescents be addressed, but the parent-teacher interaction also needs serious consideration. Uncertainty about what between parent and teacher can be extremely stressful for the teacher (Waldman, 2004). Researchers have argued that the role of a LO educator can be both challenging and rewarding (Waldman, 2004). educators are responsible not only for providing comprehensive information to the learners, but also for managing the emotional and personal responses which the learners, fellow staff members, school administrators, parents, and people in the local community may have.

Now that nurses have been removed from providing health promotion in schools, the burden has been placed on educators. The process of implementing sexuality education/ LO in South African schools has until now not been evaluated, and it is unclear how they are coping under these circumstances and how this affects their productivity. There is therefore a need for a study that will explore teachers' experiences in implementing sexuality education/ LO in secondary schools.

1.4 RESEARCH QUESTION

In the context of this situation, the research question for the study was: What are the educators' experiences in implementing sexuality education as a disease prevention and health promoting strategy at eThekwini-based secondary schools in KwaZulu-Natal.

1.5 AIM AND OBJECTIVES

The aim of the study is to explore educators' experiences in implementing sexuality education as a disease prevention and health promoting strategy at eThekwini-based secondary schools in KwaZulu-Natal (KZN).

Study objectives:

The study had the following two objectives:

1. To explore educators' experience in providing sexuality education in eThekwini-based secondary schools.
2. To determine perceived barriers or support factors for educators when implementing sexuality education in schools.

1.6 SIGNIFICANCE OF THE STUDY

The Ottawa Charter (WHO, 1986) outlines five priority action areas for health promotion action: (a) Building healthy public policies, (b) creating supportive environments, (c) developing personal skills, (d) strengthening community action, and (e) re-orienting health services. South African policy mandated all schools to

offer sexuality education since 1999. The Department of Education embarked on a strategy to ensure that sexuality education/ LO is offered in all schools in South Africa.

In KwaZulu-Natal (KZN), studies relating to sexuality education in schools have mainly focused on learners as the recipients of the service. As mandated by the DoE, educators are responsible for disseminating sexuality education. No studies have focused on evaluating the process of implementing sexuality education by KZN educators. Such an evaluation can provide baseline information with regards to the effectiveness of the current educational approach in providing sexuality education in schools.

Researchers have argued that supporting teachers is the key to the successful delivery of sex and relationship education by teachers especially in the absence of school health services (IPPF, 2006; Campbell & Daria, 2004; Waldman, 2004). The findings of the study can be used as the baseline data to evaluate the existing school- based sexuality education/ LO programme. Moreover, they can contribute towards designing capacity building programmes for educators looking into a multi-collaborative approach.

1.7 DEFINITION OF TERMS

Experience: Experiences are defined as narratives of an encounter, or a series of encounter: something which has been participated in or lived through (Cohen et al., 2007). In this study experiences cover both the negative and positive skills gained from years of practice in providing sexuality education at the educator's present or former school. Knowledge and skills may be obtained from training, workshops, and in-service development workshops conducted within the department and teachers' training colleges.

Learner/ scholar: This will be a pupil included in the personnel development programme of sexuality education / LO and currently studying at a secondary school.

Life skills/ Life Orientation (LO): Life skills can be described as the ability for adaptive and positive behaviour that enables individuals to deal effectively with the demands and challenges of everyday life (World Health Organisation, 1997). This refers to any orientation programme that aims to assist learners to develop skills to protect themselves against STI/ HIV infection and to safeguard their reproductive health. The programme may focus on issues such as building a positive self-esteem; having a respectful relationships with others; communicating and listening; making friends; making responsible choices and decisions; dealing with feelings and emotions; decision making and growing up healthy.

School Educator/ teacher: This word refers to a person who trains and teaches in a secondary school and is involved in teaching sexuality education. Educators were previously known as the teachers. These two terms will be used interchangeably in this study.

Secondary School: This will be any public educational institution that offers secondary level of education

Sexuality education: This will be the sex education that identifies who the learners are, and empower them with intimacy and sexual relationships education, preparing them emotionally to be able to protect themselves not only from STIs, HIV, and pregnancy as well as from other harms. This will be used interchangeably with Life skills programme/ Life Orientation as sexuality education is embedded in the curriculum of this subject.

Disease prevention: Disease prevention covers measures not only to prevent the occurrence of disease, such as risk factor reduction, but also to arrest its progress and reduce its consequences once established. Disease prevention is sometimes used as a complementary term alongside health promotion. Although there is frequent overlap between the content and strategies, disease prevention is defined separately. Disease prevention in this context is considered to be action which usually emanates from the health sector, dealing with individuals and populations identified as exhibiting identifiable risk factors, often associated with different risk behaviours.

Health promotion: According to the Ottawa Charter (WHO, 1986), "Health Promotion is a process of enabling people to increase control over and improve their health". It is about: "helping people to gain and maintain good health through

promoting a combination of educational and environmental supports which influence people's actions and living conditions". In this study, this will be the tool used to empower school children and youth with sexuality skills so they can understand their own sexual health.

Sexual health: Sexual health is a state of physical, emotional, mental and social wellbeing in relation to sexuality. It is not merely the absence of disease, dysfunction or infirmity.

1.8 THEORETICAL FRAMEWORK INTRODUCTION

Donabedian's theory on structural, process and outcomes standards as applied to quality improvement (with regard to personnel development) will guide this study. This is described in detail in Chapter 2. The study acknowledges that evaluation is a key component of any strategy to develop resources to improve health promotion. It can ensure that resources are being used on the most cost-effective interventions, thereby maximising the available resources to achieve the most benefit. It also addresses issues of equity, ensuring that an intervention is reaching those in greatest need. Evaluation can also indicate where changes may need to be made to a service, in order to improve its effectiveness

1.9 TYPE OF STUDY AND METHOD

The study used an exploratory qualitative research design. This design offers the possibility of exploring human experience in a unique socio-cultural context from the perspective of the individual and provides an opportunity to gain insight into the participants' values and experiences with regard to the phenomena of interest (Wiaart and Burwash, 2007). An exploratory design is straightforward to describe, implement, and report (Creswell, 2009: 89).

1.10 OBTAINING APPROVAL

The researcher first obtained ethical clearance from the University of KwaZulu-Natal Biomedical Research Ethics Committee, UKZN. Thereafter, the permission was obtained from the KwaZulu-Natal Department of Education. Once this had been

granted, the researcher approached the principals and Heads of Departments at the selected schools to obtain their permission to communicate with the LO educators. Finally, the researcher obtained consent from the LO participants who were made aware of their rights to withdraw from the study at any stage should they wish to do so.

1.11 OUTLINE OF STUDY (OTHER CHAPTERS)

Chapter One: describes the background to education in South Africa after the introduction of sexuality education/ LO as mandated in (Department of Education and Department of Health, 1997/ 1998, Magnani et al., 2005). The chapter clarifies the problem statement and the purpose of this study. It also describes the significance of the study and explains operational definitions including the theoretical framework used for conducting this research. A brief discussion of what is expected will be covered.

Chapter Two: describes the literature review relevant to the study.

Chapter Three: discusses the research methodology of the study. It focuses on the paradigm and the approach in which the study is located. This is an exploratory study that adopted a qualitative approach. In this chapter, the sampling method, data collection and analysis processes, as well as ethical considerations, are discussed.

Chapter Four: includes the presentation of the major findings of the study. This will be achieved according to the themes that emerged during the data analysis. It also describes factors that influences or hinders the implementation of sexuality education/ LO.

Chapter Five: discusses the major findings of the study. The conclusion of the study is presented which includes the discussion of the findings and the recommendations for the service provider, the Department of Education and for further research.

1.12 SUMMARY

This chapter presented the background to sexuality education and its implementation in South Africa. The chapter highlights the area of focus as well as the purpose for the study. It also explains the rationale for this study, and contains a background review rationalising the need for this study. It also provides an overview of the whole study. Chapter two will provide a review of literature related to this problem and will describe the conceptual framework under which this study is framed.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The delivery of sexuality education in schools in South Africa started in 1999 and the responsibility rest upon the educators to do the best they can to assist learners in fostering this education in their lives. Supporting teachers is the key to the successful delivery of sex and relationship education. Teachers implementing the LO need to be well-versed in the standards set by the Department of Education (DoE) and be emotionally and socially prepared to deal with the challenges around the sensitivity regarding sex issues. This chapter outlines the disease burden in Africa; teaching health promotion and prevention in schools; implementing sexuality education/ LO programme; Approach to LO education and finally, a short review of effective programmes in countries outside Republic of South Africa (RSA).

2.2 THE DISEASE BURDEN IN AFRICA

In the third session of the African Union (AU) conference of ministers of health in 2007, the AU commented that the economic growth in many Africa countries, a decline in conflicts and important strides towards democracy and good governance were all contributing to improving health of the continents' population. However, African countries faces many health challenges, the main one being STIs, HIV/AIDS, Tuberculosis, malaria and disease of poverty all of which add to this burden of disease. While wide ranging interventions were being implemented and important progress was being made in addressing the root causes of the disease burden in Africa, the high disease burden continues across the continent because:

- Health systems are too weak and services too under-resourced to support targeted reduction in disease burden and achieve universal access
- Health interventions often do not match the scale of the problem
- People are not sufficiently empowered to improve their health nor adequately involved, while cultural factors play a role in health seeking behaviour

- The benefits of health services do not equitably reach those with the greatest disease burden
- There is widespread poverty, marginalisation and displacement on the continent
- Insufficient action is taken on the inter-sectoral factors impacting on health
- Environmental factors and degradation are not sufficiently addressed

There have been commendable efforts towards addressing the inter-sectoral challenges affecting health, particularly since the advent of the African Union and its New Partnership for Africa's Development. Nonetheless, shortfalls in agriculture, low literacy and lack of safe water, adequate sanitation, electrification and infrastructure, and ongoing conflicts all drive up the disease burden. And in turn, ill-health contributes to poverty. Investment in health to reduce the burden of disease could therefore contribute to economic development (The African Union, 2007).

Health system factors that continue to undermine efforts to reduce the disease burden are:

- Insufficient sustainable financial resources and the efficient allocation and use thereof;
- Lack of social protection for the vulnerable groups especially those in catastrophic situations;
- A shortage of appropriately trained and motivated health workers;
- Poor commodity security and supply systems and unfair trade practices favouring the rich countries;
- Weak health systems operations;
- Marginalisation of African Traditional Medicine in national health systems;
- Inadequate community involvement and empowerment;
- Capacity of the private sector, including NGOs is not fully mobilised;
- Paucity and inadequate use of available evidence and information to guide action including use of ICT;

- Effective co-ordination with other sectors and harmony with partners not yet attained;
- Lack of optimal inter-sectoral action and coordination;
- Restrictive and disruptive global policies (e.g. structural adjustment programmes and unfair terms of trade), conditional ties and actions that adversely impact on Africa's health systems; and
- Gaps in governance and effective leadership of the health sector.

The world is facing a global health work force crisis that is characterised by widespread shortages, mal-distribution between and within countries, poor working conditions, and a paucity of information and knowledge on best practice. Migration of health workers to rich nations is draining human resources for health in poor countries, which is exacerbated by insufficient training of adequate number of health workers. To compound this, Africa and the world face the emergence of new pandemics and resurgence of old diseases. While Africa has 10% of the world population, it bears 25% of the global disease burden and has only 3% of the global health work force. Of the four million estimated global shortage of health workers, one million are immediately required in Africa. This crisis has developed as a result of long standing neglect, unfavourable international development policies and practices (The African Union, 2007).

The mission of the African Health Strategy as developed by The AU, 2007 is to build an effective, African driven response to reduce the burden of disease and disability, through strengthened health systems, scaled-up health interventions, inter-sectoral action and empowered communities. This Strategy is underpinned by a set of principles:

- Health is a human right
- Health is a developmental concern requiring a multi-sectoral response
- Equity in health care is a foundation for all health systems
- Effectiveness and efficiency is central to realising the maximum benefits from available resources
- Evidence is the basis for sound public health policy and practice
- New initiatives will endeavour to set standards that go beyond those set previously

- Solidarity is a means of facilitating access for the poor
- Respect for culture and overcoming barriers to accessing services
- Prevention is the most cost-effective way to reduce the burden of disease
- Health is a productive sector
- Diseases know no borders and cross border cooperation in disease management and control is required (African Union, 2007).

In all the disease burden noted in SA, HIV/ AIDS has become an epidemic catastrophe. The statistics showed by National Department of Health (DoH) Based on the sample of 33,488 women attending 1,415 antenatal clinics across all nine provinces, the South African Department of Health Study estimates that 28% of pregnant women were living with HIV in 2007. The provinces that recorded the highest HIV rates were KwaZulu-Natal, at 37.4%. Mpumalanga, at 32% and Free State, at 33.5%. The Northern Cape at 16.1% and Western Cape at 12.6% recorded the lowest prevalence (DoH, 2008). This demands that health promotion and prevention need to be intensified and focus more on youth if we have to save the youth from harm.

2.2.1 Targeting Young people

Kluge (2006) in collaboration with school based researchers argued that HIV/AIDS education forms the core of sex education or sexuality education (Avert, 2005; Kluge, 2006; WHO, 2004). In HIV/ AIDS education, the aim is to develop young people's skills so that they make informed choices about their behaviour and feel confident and competent about acting on their choices (Avert, 2005:67). Kluge (2006) further argued that in promoting sexual health in adolescents, it is not adequate to only provide sex education, but young people should be empowered to determine their own healthy sexual behaviour (Kluge, 2006). Empowering young people should take the form of a comprehensive approach that provides knowledge, encourages the development of positive attitudes and self-esteem; and provides the skills to cope with negative social and cultural norms. Whereas large, organized STIs and HIV/ AIDS prevention programmes for teenagers remain the preserve of the education department, private media and family GPs have a vital role to play in the nation's fight against HIV/ AIDS (Kluge, 2006).

According to UNAIDS (2003), providing young people with the skills, information, tools and services to protect themselves from HIV infection is a critical factor in halting its spread. The UN Declaration of Commitment on HIV/AIDS reinforced this, specifically requiring that, by 2005, 90% of young people (aged 15–24) should have access to prevention, including services to develop the life skills needed to reduce vulnerability to HIV infection. Khau and Pithouse (2008) comment that the high levels of HIV/ AIDS among the youth (as noted in UNAIDS, 2007), have led to the growing expectation that teachers should integrate HIV/AIDS related education into their subject areas. In their own experience as teachers and education scholars, Khau and Pithouse (2008) suggested that such integration can be supported by teacher education that incorporates their experiences and viewpoints into pedagogic processes, and an acknowledgement of them as intellectuals and significant producers of knowledge.

2.3 TEACHING HEALTH PROMOTION AND DISEASE PREVENTION IN SCHOOLS

The UNAIDS Inter-Agency Task Team on Education has stressed that education for HIV prevention should begin early (before children and young people are exposed to risks) and should be sustained over time. In this regard, schools have an important role to play in reducing risk and vulnerability associated with the epidemic. Studies have shown that the better educated children are, the better able they are to use their knowledge, skills and confidence to protect themselves from HIV. In Zambia, where more than 20% of adults are living with HIV, adolescents with more years of schooling are less likely to have casual sexual partners and more likely to use condoms than are their peers with less schooling (UNAIDS, 2003:56).

The Inter-Agency Task Team has identified six areas that must be prioritized as school systems promote AIDS education:

- Efforts to ensure that teachers are well prepared and supported in their teaching on HIV/AIDS.
- Preparation and distribution of scientifically-accurate, high-quality teaching and learning materials on HIV/AIDS, communication and life skills.

- Promotion of life skills and peer education with children and young people, and among parents and teachers themselves.
- Elimination of stigma and discrimination, with a view to respecting human rights and encouraging greater openness concerning the epidemic.
- Support for school health programmes that provide a safe and secure school environment for both teachers and pupils, in combination with school health policies, skills-based health education and school health services that explicitly address HIV/AIDS.
- Promotion of policies and practices that favour gender equality, effective learning, peer education, and primary and secondary school completion.

Following the 1997 review of the South African response to HIV/AIDS, the DoH and the DoE developed an HIV/AIDS/STD Strategic Plan for South Africa 2000-2005, the purpose of which was to 'guide the country's response as a whole to the epidemic' (National Department of Health and National Department of Education, 1997/1998). The overarching goals of this plan centered on reducing the number of new infections (particularly among youth), and reducing the impact of HIV/AIDS on individuals, families and communities.

Ensuring that the youth of South Africa have as much information available to enable them to make informed choices regarding their sexuality and sexual behaviour is an important prevention strategy. This is achieved mainly through to what is known as the Life skills and HIV/AIDS education programme in primary and secondary schools and now termed Life Orientation (LO). This programme is managed primarily by the Department of Education.

2.4 IMPLEMENTING LO EDUCATION

James-Traore et al (2004) argued that developing and implementing LO education can be a stressful experience, both because it can be difficult to discuss sensitive topics with students and because community members, other school staff members,

or parents may be uneasy with some parts of or the entire programme. The researchers argue that to be best prepared for the role, educators should:

- Expect controversy. There are almost always two sides to an issue. Not everyone will be excited about your programme.
- Be pro-active. Share the programme goals, protocols, and activities with the community.
- Make it clear that you are a person, not a programme. You are an educator and a person. Make it clear that while you understand your opponents' objections to the programme, they should not attack you.
- Be honest and reasonable. Listen to concerns and address them with research-based facts. Have materials (such as fact sheets or research reports) to support your information and programme.

James-Traore et al (2004) proposed that to have an impact on behaviour, the delivery of the curriculum and teaching strategies must be of sufficient quality and intensity. The quality of implementation is probably more important than the detailed design of materials or curricula.

2.4.1 Educators' competences

Campbell and Daria (2004) suggested that a LO educator must be knowledgeable about sexual anatomy and physiology. The researchers commented that if adolescents perceived that a teacher was not personally and professionally prepared, chaos and confused discussions were likely to occur (International Planned Parenthood Federation [IPPF] 2006); Campbell and Daria, 2004; Waldman, 2004; Health Canada, 2003). These researchers argued that for some teachers, the content taught in LO education is new information and therefore, the educators are not able to go into more detail than is in textbooks or manuals (IPPF, 2006; Campbell and Daria, 2004; Waldman, 2004; Health Canada, 2003). Lack of appropriately trained educators can obstruct the implementation of LO education (Campbell and Daria, 2004). It is this very issue that causes concern among some teachers when LO education programmes are proposed or when a particular topic within the content is discussed (Campbell and Daria, 2004).

School-based study research has found that teacher training can positively affect teachers' attitudes to sexuality education and participatory techniques. In Thailand, 35 teachers received training that emphasized a better understanding of young people and their environment, the teachers' own attitudes and values related to HIV/AIDS and sexuality, and learning and practicing key skills in facilitating HIV/AIDS and sexuality training. Using pre- and post-tests and interviews, researchers found that after receiving training, the teachers had more knowledge and understanding of HIV/AIDS; more positive attitudes toward young people's sexuality and toward people living with HIV/AIDS; an increased willingness to use participatory methods; stronger facilitation skills; increased communication and better relationships with students; and a greater commitment towards teaching about sexuality and HIV/AIDS (James-Traore, et al., 2004). These researchers suggested that the topic of teacher training must include not only the training itself, but also what types of people receive the training, the degree of support for teachers by the school system and community, and the issue of teachers covering only certain aspects of a curriculum (e.g., omitting controversial segments). Fleisch (2008) argue that teachers are at the core of the content that is taught and the pedagogy that carries that content, and also the key to successful reading.

The International Planned Parenthood Federation(2006) researchers argue that regardless of who delivers Comprehensive Sexuality Education (CSE), ideally, they should have appropriate information, training, tools, skills and qualities; should have an understanding of young people and their agenda; should have the intention of enlightening, transforming and preparing others; should be someone who young people trust and feel comfortable with and who creates an enabling environment; should be someone who imparts knowledge and facilitates the development of skills; should be accessible and non-judgmental, with no personal agenda that they want to impose (IPPF, 2006:4)

2.4.2 Factors that affect curriculum implementation

A number of factors can either facilitate or hinder curriculum implementations. the discussed factors include: a. religious constraints, b. Support, c. teacher selection, d. teacher training content, e. teacher conditions, and f. sexuality education components

a. Religious constraints

Dube (2003) indicated that they often found out that when speaking about sex in public, they are faced with comments like, “Don’t talk about sex, we are Christians” or “Don’t talk about sex, we are Africans.” He argues that being serious about fighting the AIDS epidemic requires addressing this conspiracy of silence firmly and resolutely. Currently, instead of acquiring skills in talking about sex, the easy way out is to distributing condoms to children and adults alike without proper education in matters of sexuality (Dube, 2003). He argues that panic struck when HIV/AIDS struck and in the desperate process of trying to find a remedy unintended messages were sent. Dube (2003) argued that although every strategy deserves to be tried, flooding people with condoms, especially in South Africa, has not been much of a success. The number of infected people is increasing, not decreasing (Dube, 2003). The religious organisations claim to be the conscience of humanity and the custodian of moral values, need to lead in the campaign to break the conspiracy of silence. However, because of its history of silence on sexual matters, except in a critical and condemnatory way, these religious organisations find it difficult to address relevant (Dube, 2003).

b. Support

McLaughlin (2006), a leading researcher on the education policy implementation, identified four factors that have a decisive influence on the success or failure to the curriculum implementation:

- Local capacity: Implementation is more likely to succeed if support is provided in the form of finances, on condition that the support is substantial and continues over a period of time.
- Motivation and commitment: Changes do occur if local leaders show commitment to the project and convey a sense of enthusiasm to the school staff. In part, questions of motivation and commitment reflect an implementer’s assessment of the value of a policy or the appropriateness of the strategy.
- Internal institutional conditions: The climate within the school must be conducive to change. There must be a balance between pressure and support. Pressure is needed to concentrate attention on a specific innovation, but it must be balanced by support in the form of expert

assistance and finance. Pressure alone may be sufficient when policy implementation requires no additional resources or normative change. Pressure alone however, cannot effect those changes in attitudes, beliefs, and routine typically assumed by reform policies. Support alone is also a limited strategy for significant change because of the competing demands that operate with the implementation system. In particular, vague mandates and weak guidelines provide the perfect opportunity for dominant coalitions or competing issues to shape programme choices. Experience shows that delicate balance between pressure and support is essential. Pressure is required in most settings to focus attention on a reform objective while support is needed to enable implementation (McLaughlin, 2006).

McLaughlin (2006) commented that teacher training and support in facilitating implementation is more likely to succeed if support is provided in the form of finances and on condition that the support is substantial and continues over a period of time. Change in teachers' roles and classroom practices imply a specific kind of training and support that teachers will need in order to adopt the new change. Unless curriculum designers adequately prepare teachers to function in a changed curriculum context and provide them with necessary resources, any attempt to change may fail. James-Traore et al. (2004) agree that curriculum change will fail if it ignores the professional development of teachers because systems do not change themselves, they are changed by people. Ongoing training for teachers in the form of workshops will be useful to equip them with new skills for implementation of a new curriculum. According to Mdutshane (2007), the success of an implementation lies in establishing effective ways of measuring how well or poorly a change is going on in the classrooms. Therefore, teachers need to be visited and supported by specialists in their classrooms to gain a clear picture of how they are coping with the delivery of the new curriculum (Mdutshane, 2007).

The teachers can also receive support and advice from their peers if they interact by sharing their experiences. Mdutshane (2007) states that teachers need to see themselves as reflective practitioners and education departments

should provide teachers with curriculum guidelines. If there are no guidelines, teachers cannot see or reflect on whether their practices are in line with the intended new curriculum (Mdtshane, 2007).

c. Teacher selection

James-Traore et al. (2004) suggested that all school staff should receive at least an orientation to the new RH/HIV programme so that they have accurate information for themselves and their students. Those teaching the RH/HIV curriculum needed extensive training and should be selected from among those motivated to teach RH/HIV (James-Traore et al., 2004). The researchers contended that not all teachers are interested in, capable of, or well suited to teach sexuality content to adolescents, so selecting the right people to teach RH/HIV curricula is challenging. Teachers may not want to teach this topic because of their own issues related to sexuality, their personal beliefs, religious or community pressures and controversies, or concerns about their own HIV status. Adding RH/HIV content is often viewed as a burden to an already crowded curriculum. As financial resources are scarce, teachers must be motivated in other ways such as involving them in planning and facilitation, offering continuing education credits or certification, or acknowledging their efforts publicly. Those who want to teach the subject will bring their energy and dedication to the task and are likely to be more effective.

James-Traore et al (2004) argue that teachers who provide RH/HIV education need to have a capacity for 'health literacy', the capacity to obtain, interpret, and understand basic health information and services, and the competence to use this information to enhance the learning of concepts and skills by students, parents, and staff. Without this capacity, an ability to deal with the subject matter and with youth, teachers may be ineffective and lack confidence. In a study in Kenya, both parents and students reported higher levels of confidence in teacher competence than teachers had in them. Only 21% of parents and 14% of students felt that teachers did not have sufficient knowledge to teach about HIV, compared to 45% of the teachers themselves (James-Traore et al., 2004).

Teachers of RH/HIV content also need to be approachable to students, and have a healthy rapport and comfort level for difficult and sensitive questions. In a Ugandan focus group conducted by James-Traore et al., 2004: students reported that teachers were often judgmental and authoritarian, ruled by threats, and caused students to fear rather than respect the educators. Teachers often discourage questions by students and seldom acknowledge when they themselves do not know the answer. These factors make young people reluctant to confide in their teachers (James-Traore et al., 2004).

James-Traore et al. (2004) suggested teacher criteria checklist that can assist in identifying teachers who may be best suited for teaching RH/HIV content to young people. The list indicates that teachers should:

- Have a commitment to working with youth and teaching this material
- Have a healthy attitude toward their own sexuality
- Demonstrate responsible sexual behaviour
- Be approachable and have a healthy rapport with students
- Be nonjudgmental; respect others' values, attitudes, beliefs, and behaviours
- Respect others' confidential information
- Have a positive attitude about reproductive health and sexuality; believe that education about sexuality and HIV/AIDS is important
- Be sensitive to those who are infected with HIV
- Demonstrate competence and knowledge in the subject matter
- Be mature in years and attitude
- Possess good communication skills

In addition, teachers might:

- Be involved in youth activities
- Teach science subjects or be knowledgeable about the sciences

James-Traore et al. (2004) argued that knowledge of science subjects such as chemistry and biology may be helpful in teaching HIV/AIDS content, especially when it comes to having the confidence to answer medical questions. However, selecting teachers merely on the basis of subject of expertise limits the broader

selection process. Those who do not teach science can learn basic information about HIV transmission and other technical issues.

d. Teacher training and curriculum development

According to Mdutshane (2007), a clear picture of the desired outcomes is the starting point of curriculum instruction, planning and implementation, which must all be coherent (Mdutshane, 2007). Chisholm (2005) explains that in South Africa, when the curriculum review was introduced, it had complex language that was difficult for teachers to understand (Chisholm, 2005).

James-Traore, et al. (2004) suggested that when developing and using teacher training curricula for any RH/HIV programme managers, curriculum developers, education officials, and others need to be aware of four key aspects of the curriculum:

Goals and Guiding Principles

James-Traore et al. (2004) suggested that a teacher training curriculum for RH/HIV should be based on clearly stated goals and guiding principles. It should include the rationale for teaching RH/HIV to the youth and the values, beliefs, and practices that the curriculum is designed to promote. The content of the curriculum should ideally flow naturally from its goals and principles. When training teachers in RH/HIV the six goals are to:

- Provide accurate information about human sexuality
- Develop effective classroom skills
- Advise on teaching materials and methods
- Develop personal comfort with reproductive and sexual health issues
- Develop competence in reproductive and sexual health language
- Provide information on school and community policies

Guiding principles in a teacher training curriculum may vary depending on the sensitivities of the government and NGOs involved. Some principles embraced by NGOs may not be consistent with policies of other sectors, such as religious organizations or governments. James-Traore et al. (2004) suggested that principles for a teacher training curriculum could include the following:

1) Youth and Sexuality

Youth can make good decisions when provided with complete information and skills.

- Young people have a right to information and services.
- Individuals and society benefit when the youth are able to discuss sexuality with their parents, teachers, and other trusted adults.
- Sexuality is natural and a life-long part of being human.
- Young people should be encouraged to abstain from sexual intercourse as the only sure protection against unplanned pregnancy and STIs, but they should also be taught about contraceptives, including the use of latex condoms, for those who are or will become sexually active.

2) Teachers and Sexuality

- Teachers are more effective in communicating sexuality information when they have reflected upon their own attitudes, feelings, beliefs, experiences, and behaviours regarding sexuality and how these might affect their ability to communicate.
- Experiential learning is an important way to facilitate increased knowledge and changes in behaviour.

3) Human Rights and Sexuality

Every person has dignity and worth and should be free from discrimination based on gender, race, age, ethnicity, religion, culture, sexual orientation, or HIV status.

- No pressure, force, or coercion of any kind should be used to get people to participate in sexual activity against their will or to exploit them in any way.
- Culture, tradition, and religion serve as important cornerstones in the development of an individual, and their positive influence should be acknowledged, respected, and utilized.
- Young people have the right to privacy and confidentiality.
- People with HIV deserve compassion and support. These researchers argue that because teachers in training are adults, adult learning

theories should be incorporated throughout the curriculum. These include building on the existing knowledge and experiences of participants. In addition, clear learning objectives should be included to help teachers understand the changes in knowledge, attitudes, skills, and behaviours expected of them (James-Traore et al., 2004).

- Teacher-focused content.

According to Conco (2004), training is the process of changing the skills, attitudes and knowledge with the purpose of improving their level of competence. It is a planned process, usually involving a series of stages where incremental improvements can be identified (Conco, 2004 cited in Shezi 2008: 15).

According to James-Traore et al. (2004), teacher training should address the following:

1. include the reproductive health and HIV (RH/HIV) content, teaching methodologies, teacher skills, personal attitudes, and teachers' HIV-risk behaviours. The content should address the medical and physiological aspects of RH/HIV as well as the social and cultural environment that shapes young people's development and sexual and other relationships. Teachers need to have information about the full range of RH/HIV issues, including abstinence, contraceptive methods, and condom use so that they can teach those if appropriate (depending on the age of students and the community environment). Teachers need to learn participatory methods of teaching and develop communications, assertiveness, and any other interpersonal skills that are needed to work with clarity and confidence. Teachers need to reflect on their own attitudes and values about the topic and their behaviours regarding HIV risks.
2. address policies, administrative practices, and cultural norms that will affect the teaching of RH/HIV information. Teacher training should include summaries of laws, policies, and structures that govern their teaching of RH/HIV content. Teachers should be knowledgeable about the customs and traditions of the youth and the communities in which they work.

3. ensure that teachers are willing and motivated to teach RH/HIV and be trustworthy to the youth. While all teachers should have a basic level of knowledge about RH/HIV issues, those who have a strong motivation to help the youth navigate the challenges of adolescence should get special training opportunities. An initial exposure to the content can change the thinking of some, allowing other potential candidates to emerge. It could also be used to eliminate those who are not suited to the goals of RH/HIV programmes. Both male and female teachers should be trained so that the teaching of RH/HIV does not become associated with a particular sex. Boys and girls benefit from interactions with teachers of both sexes as they learn about gender roles, expectations, and relationships between males and females. Students are less likely to listen to, learn from, and confide in teachers who they feel are not credible, not approachable, or who take advantage of them.
4. be of adequate duration, as the duration and length of training appears to affect the effectiveness of teachers. Available evidence and anecdotal reports suggest a correlation between the duration of training and the degree of the content taught to students. Short term or one-time training courses are insufficient to affect teacher confidence and competence over the long-term. Teachers need periodic updates to reinforce learning, acquire new information, and satisfy ongoing needs. Teachers who receive initial training as part of both pre-service and in-service courses can be expected to benefit more.
5. ensure that teacher training has the support of national ministries, local school management, and communities. The highest levels of government should provide leadership and commitment to help improve sustainability, ensure that messages are consistent across programmes, and maximize limited resources. Support of the school administration adds legitimacy to RH/HIV programmes, increases teacher and community comfort, and helps ensure that the content is covered. It also helps to increase community and school ownership, and build an enabling environment. Parents and communities have legitimate concerns about what and when young people learn about sexuality in schools. School districts need to develop and nurture relationships

with them as part of teacher training to establish community support for school-based activities

6. training needs to be provided to teacher tutors (teachers of teachers), primary and secondary teachers, and to a lesser extent, other staff, principals, and administrators. Those who teach teachers a critical but often neglected group should receive adequate training to prepare them for their roles. Their comfort and abilities will influence new and impressionable teachers. Training primary school teachers offers an opportunity to reach young people before these youth become sexually active and helps those who are already active to protect themselves from pregnancy and disease. Introducing all teachers to RH/HIV content has value, especially where the content is infused throughout the school's overall curriculum. Exposing principals and administrators to the curriculum can help gain support for teachers in the classroom. Otherwise, some RH/HIV teachers may experience some of the stigma that HIV-infected people experience.
7. teachers receive ongoing support after the initial training. A variety of strategies, including refresher courses, mentoring, and supportive supervision, can help ensure long-term impact from training. Major changes in attitudes and behaviours are not likely to happen in a short period of time. Having teachers work in teams can help reinforce what they have learned, and can help people with complementary sets of skills and knowledge to learn from each other. Teachers need to feel safe when testing new methodologies.

The fear of making mistakes or receiving destructive criticism can be detrimental to achieving the goals and objectives of a programme. As teachers may see this as an additional responsibility when they are already overworked and underpaid and may be apprehensive about the subject, incentives need to be given, such as certificates, public recognition, continuing education credits, or opportunities to speak to their colleagues about their work. Ongoing support is also important in addressing teacher discomfort and challenges faced in the classroom or the community

8. teacher training embraces a policy of zero tolerance for the exploitation of students. Zero tolerance policies communicate clearly what is expected of teachers and help to create a safe environment for students. Zero tolerance for abuse and exploitation of students demonstrated by severe consequences for teachers can help change the current culture whereby these behaviours are met with silence.

James-Traore et al. (2004) describes many challenges to improving the teaching of RH/HIV information and skills, and documented the renewed and often successful efforts by governments, NGOs, and international agencies to make better use of teachers, schools, communities, and youth themselves to prevent HIV and reproductive health problems. The future of teacher training will improve through sharing information, supporting better programmes, undertaking better evaluations of these programmes, and calling greater attention to this critical aspect of RH/HIV education. Ultimately, not only the teachers but also the young people will benefit and have greater prospects for a healthy future (James-Traore et al., 2004).

e. Teaching conditions

Research points to several factors beyond teacher training itself that affect the impact on students. A project in rural Masaka, Uganda, provided five days of training to teachers, adapting portions of an AIDS prevention curriculum developed by the WHO. Surveys involving more than 2,000 students in intervention and control sites, plus 12 focus groups with 93 students, found very little impact on the students. The research found that the programme was not fully implemented and class time was too short. In addition, teachers did not address some of the major HIV/AIDS prevention issues due to fear of community disapproval and controversy and a lack of supportive guidance. The research team recommended that the programme be integrated into the national curriculum and that teachers be trained in participatory methods while still in teacher training college (James-Traore et al., 2004).

In Jamaica, teachers who were trained in using experiential teaching methods, exercises, role-plays, and the performing arts were more likely to use those

methods in their classrooms than those without the training. However, changes in behaviour in the students were not significantly different from those students not exposed to the new curriculum. Researchers attribute the lack of change at least partially to the fact that the intervention was implemented for only one semester of the school year. Other reasons included the lack of supplies, lack of administrative support, not enough monitoring of the teachers, and few refresher courses (James-Traore et al., 2004).

Maphumulo (2010) argued that the (DoE, 2007) stated that the crowded and dilapidated classrooms hinder the implementation of the National Curriculum Statement (NCS). High learner-educator ratios, combined with poor physical conditions and inadequate facilities for teaching and learning, such as inadequate instructional support materials, make it more difficult to deliver quality education (Maphumulo, 2010). Similarly, the researchers argued that sexuality educators/ LO educators are not well capacitated to monitor how learners perceive what is being taught during LO classes. Teacher training development and support are therefore a necessary means of facilitating sexuality education (Maphumulo, 2010).

f. Sexuality education/ LO components

The researchers (Smith et al., 2003) reported that in various school-based studies, Life Skills Topics should include:

- Reproductive biology; human growth and development and the life cycle; understanding sexuality/relationships with the opposite sex; self-esteem, assertiveness, and decision making;
- Relationships: communication and negotiation with your partner; HIV/AIDS transmission and prevention/condom use;
- HIV/AIDS: looking after people with AIDS; STDs: prevention and symptoms; drugs and alcohol; contraception/preventing unwanted pregnancy;
- Violence and sexual abuse /child abuse, incest, rape, and coercion (Smith et al., 2003).

While a variety of sexuality education curricula exist, each has its own focus and guiding parameters. Examples of the curricula are:

- Comprehensive sexuality education curricula generally cover anatomy, physiology, contraception, emergency contraception, sexually transmitted diseases (STDs), safer sexual behaviour, relationships, and abstinence.
- Abstinence-based curricula generally focus on abstinence as the number one way to prevent pregnancy and STDs. Little time is dedicated to contraception, condoms, safer sex, or STDs.
- Fear-based curricula generally use scare tactics as the main strategy for encouraging abstinence from sexual behaviour before marriage. Contraceptive information is omitted, and students are required to consider only the negative consequences of sexual activity.

2.5 APPROACHES TO IMPLEMENTING LO EDUCATION IN SCHOOLS IN SOUTH AFRICA

A life skills and HIV/AIDS education programme was implemented in secondary schools as a strategy to combat the spread of HIV/AIDS among school-going young people in South Africa. As part of a joint effort of the Departments of Health and Education, two teachers per school were trained to implement life skills training and HIV/AIDS education in schools as part of the school curriculum (Visser, 2005).

Description of the national life skills and HIV/AIDS education intervention

In response to the HIV/AIDS epidemic, the South African Departments of Education, Health and Welfare embarked on a national programme to implement life skills training, sexuality and HIV/AIDS education in secondary schools in 1995 (Department of Health and Department of Education, 1997/8). The goal of the intervention was to increase knowledge and skills needed for healthy relationships, effective communication and responsible decision-making that would protect learners from HIV infection, and to promote positive and responsible attitudes towards people with HIV/AIDS. In the planning of the intervention a position was taken to maintain a balance between the time needed to follow a scientific approach to the intervention and the urgency of the HIV/AIDS crisis. Various sub-committees

were formed to deal with curriculum development, teacher training, marketing and liaison and co-ordinating of provincial efforts in implementing the intervention nationally (Department of Health and Department of Education, 1997/8). The national committee agreed to the following content, training and implementation process to be implemented by the provincial departments.

Content of the intervention

A sub-committee developed guidelines for the content of the intervention aimed at the enhancement of health-protective behaviour and recommended that the following aspects should be included:

- information about sexuality and HIV/AIDS, especially on the transmission of and protection against HIV/AIDS, to facilitate critical assessment of personal risk for acquiring the HIV infection
- the development of life skills that would enable the learners to take up health-protective behaviour with regard to HIV/AIDS, such as self-awareness, decision-making, assertiveness, communication and negotiation skills
- the enhancement of a positive attitude among youth towards people with HIV/AIDS as preparation for interaction with and caring for infected people (Department of Health and Department of Education, 1997/8).

The programme was not developed as a single pre-prepared manual. The guidelines formed the core of the programme and programme material was provided to assist teachers in the development of interventions that addressed the needs of the learners in their own cultural context.

The approach system undertaken by the DoE when introducing LO education in schools will describe the following: a. Teacher training and b. LO dissemination to learners.

a. Teacher training

Visser (2005) study revealed that Teachers' training was done in small groups in each educational district and was presented in the afternoons after school. The

10 - 20-hour training focused mainly on knowledge and attitudes related to HIV/AIDS and how to use experiential learning techniques in life skills training.

The in-service training programmes for those educators already teaching LO took place in most in South African provinces, often sponsored by international organizations or local NGOs. These initiatives were supported by the government and linked to its DoE. In-service training programmes varied from those which lasted a few hours to those which ran for a week (Department of Education and Department of Health, 1997/ 1998).

The South African DoE used the cascade model approach. Training was first developed by the government officials was then passed on to heads of departments and then to the teachers (McDevitt, 1998). McDevitt (1998) outlines the advantages of cascade training model as a method of dissemination which works on the principle that the small team of trainers will train a larger group. The same package is used to train the next level of recipients (Thaanyane, 2010).

Conco (2004) argued that training introduces teachers to instructional processes and new methods of teaching. It also helps teachers who enter the teaching profession without having received specific training for curriculum development. Conco (2004) and Mbingo (2006) outlines the disadvantages of cascade model of training that it has failed because it proves impossible to guarantee the quality training which is essential for success throughout the levels of training and it might reach the last destination having lost value and the intended meaning. Thaanyane (2010) points out that those facilitators of the workshops may not be comfortable working with adults (teachers) themselves as opposed to working with learners (young people). Inadequately trained facilitators of curriculum change can seriously impact on how information is disseminated to the implementers (teachers) and this requires knowledge and experienced facilitators (Phakisi, 2008).

Mbingo (2006) argue that even those teachers who were trained by district staff who had indicated that they felt they were confident to deliver sessions at their own schools, were often disappointed at the poor quality of training they

received. Most teachers and presenters felt that the session on assessment was extremely weak and created a lot of anxiety and confusion. The master trainers were not given sufficient times to train the staff back at their schools and were only given time to report back on the training during break (Thaanyane, 2010).

A recent UNICEF review of projects in East and Southern African concluded that life skills programmes that addressed HIV/AIDS issues were more effective when teachers explore their own attitudes and values, establish a positive personal value system, and nurture an open, positive classroom climate. Programmes appear to be more effective when teachers use a positive approach emphasizing awareness of values, assertiveness, relationship skills, decision-making, real-life situations, and self-esteem (James-Traore et al., 2004).

Thaanyane (2010) argued that adaptive model of curriculum change is sensitive to local and individual schools. Teachers are placed at the centre of the innovation process to identify the problem and need for change. This researcher further asserted that freedom and exposure of members at the lower level of such organization enables innovative ideas to enter the organization and that implementation will depend on the approval or disapproval by lower level members (Thaanyane, 2010).

In South Africa, as the researcher explains, when Curriculum 2005 (C2005) was introduced workshops were run in various regions of the country. The implementation of C2005 caused considerable of anxiety among teachers as most of them were confused, felt insecure and lacked confidence, and felt they were not prepared for the transformation or change. This was because what was to be implemented was not made clear to teachers and meant that teachers had to implement what they did not understand (Goodwin, 2008).

b. LO dissemination to learners

When the National Curriculum was first conceptualized as Curriculum 2005 and then as The Revised National Curriculum revised, Life Orientation was introduced as one of the eight learning areas that became compulsory for all learners from grade R to grade 12 (Ferguson, 2005). Students are now taught

life skills, which have been incorporated into the curriculum under Life Orientation (Ferguson, 2005).

Visser (2005) indicated that to address some of the obstacles in implementing the intervention, the following interventions were put into place in the schools in the area:

- Workshops were conducted to inform the principals of the schools of the necessity of implementing HIV/AIDS education in schools. Suggestions on how to organise school activities to enable the implementation of the programme were discussed.
- An HIV/AIDS awareness programme was implemented in the schools. This involved a team of professionals (nurses, social workers and educationists) from outside the schools presenting a 2-day intervention at each school, informing the learners, teachers and principals about the dangers of HIV/AIDS, as well as life skills needed to enhance health-protective behaviour.
- After the awareness programme each school was asked to nominate an action committee consisting of learners, teachers and parents to assist the two trained teachers in implementing HIV/AIDS education in the school. This was done to encourage various role-players to take ownership and responsibility for the implementation of the programme in the schools.
- Thereafter, the implementation and outcome of the intervention were evaluated over a period of 1 year in the five selected schools. The results from these evaluations were used as recommendations to improve the implementation of the intervention.

Magnani et al. (2005) argue that school-based life skills education appears capable of communicating key information and helping youth develop skills relevant to reducing HIV risk. However, the South African national programme sexuality education has yet to be fully implemented, and whether this initiative will result in sustained behaviour modification among youth on a sufficient scale to affect the HIV/AIDS epidemic is uncertain (Magnani et al., 2005).

The Life Skills programme had been extended to many schools in South Africa, and significant progress has been made in building capacity among educators. Behavioural change, however, remains a problem. Reports indicate that consistent condom use among the youth is still not optimal. More intervention programmes have been implemented in high transmission areas (HTA) and have grown rapidly due to high demand. These include several regional initiatives such as the Corridors of Hope service on the major trucking routes in South Africa (National Department of Health, 2006). At the same time, increasing prevalence of HIV among young people resulted in an increase in sexuality education focused on HIV/AIDS education (National Department of Health, 2008).

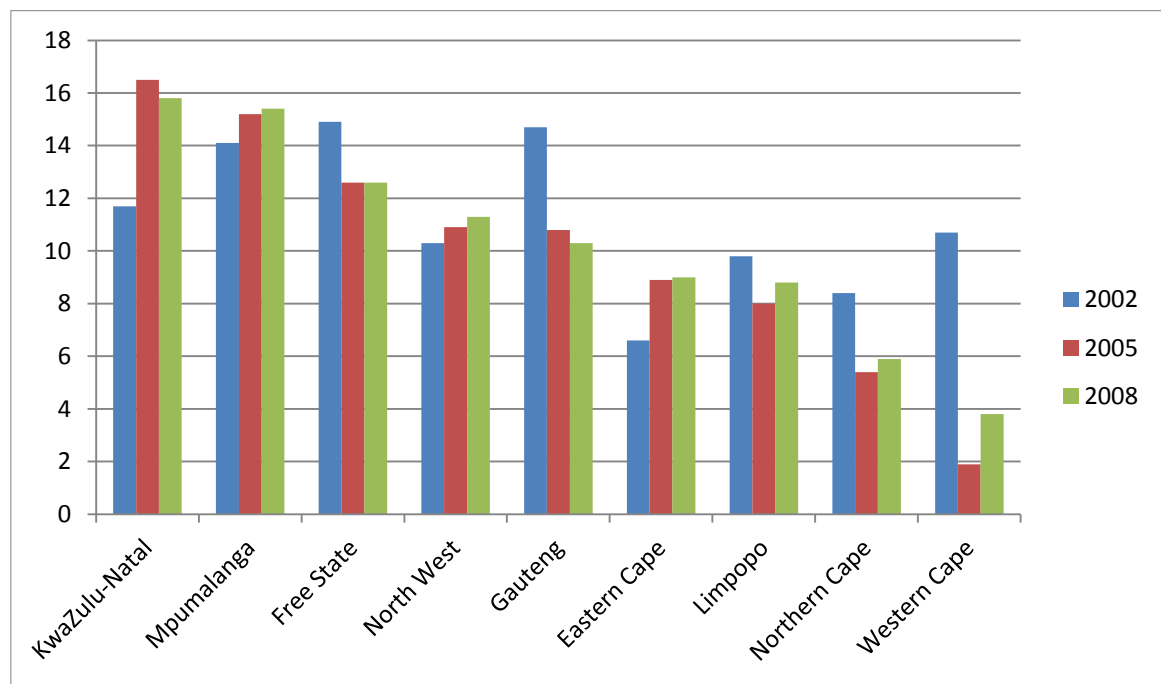


Figure 2.1 Provincial HIV prevalence study 2002-2008 (DoH, 2008)

HIV prevalence varies considerably throughout South Africa, with some provinces being more severely affected than others (DoH, 2008).

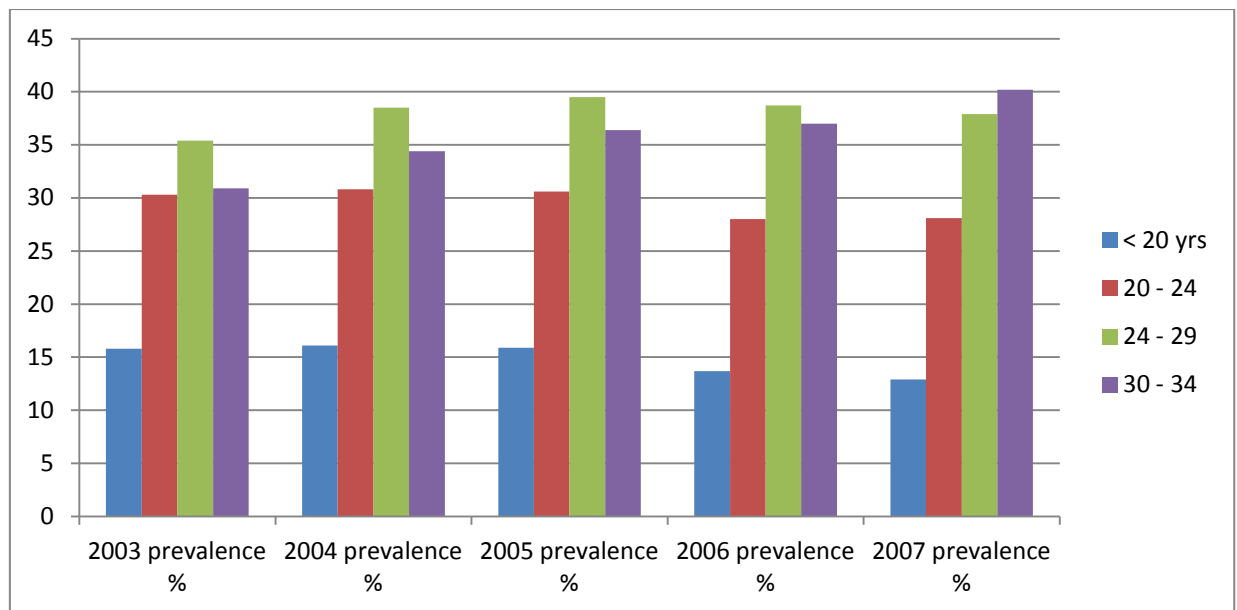


Figure 2.2 Estimated HIV % by age (DoH, 2008)

Based on a wide range of data, including the household and antenatal studies, UNAIDS estimated that HIV prevalence was 17.8% among 15-49 year old at the end of 2007. The high and low estimates were 17.2% and 18.3% respectively. According to their own estimate of total population, this implies that around 5.6 million South Africans were living with HIV at the end of 2007, including 300,000 children under 15 years old (UNAIDS, 2008; DoH, 2008).

Smith (2009) reports that the STI incidence rate in KZN, over the past five years, has consistently been the highest rate in South Africa, but has decreased to 6.4%. Despite this, the condom distribution rate has decreased to 7.4 condoms per male per year. Much greater prioritization needs to be given to this important HIV preventive activity.

2.6 A REVIEW OF APPROACHES FOLLOWED TO IMPLEMENT SEXUALITY EDUCATION IN OTHER COUNTRIES

To gain more insight into the school based sexuality education, a review of a number of relevant studies will be done to understand how the other countries are handling the task of sexuality education.

2.6.1 Sexuality educational approach in Canada by Health Canada (2003)

The study done by Health researchers, Health Canada (2003) on assessing the effectiveness of educational approaches in Canada specified five principles of sexual health education:

- Accessibility, It should be accessible to all people
- Comprehensiveness: It is a shared social responsibility that requires the coordinated effort of individuals, organizations, agencies, and governments.
- Effectiveness of educational approaches and methods: It incorporates the key components of knowledge acquisition, development of motivation and personal insight, development of skills that support sexual health, and development of the critical awareness and skills needed to create an environment conducive to sexual health.
- Training and administrative support: It is presented by well-trained individuals who receive strong administrative support from their agency or organization.
- Planning, evaluation, updating and social development: It is planned carefully in collaboration with intended audiences, evaluated on programme outcomes and participant feedback, is updated regularly, and is reinforced by an environment that is favourable to sexual health (Health Canada, 2003).

2.6.2 Schools Need Sexuality Education Programs Western Connecticut State University (2004)

Campbell and Daria (2004) suggested that to ensure that sexuality education programmes are effective, school administrators have to provide continuous staff development sessions for teachers and give them current resources. Teachers must feel comfortable teaching about sexuality and comfortable answering adolescents' questions about sexuality issues. Parents play an important role in a successful sexuality education programme. Campbell and Daria (2004) argued that parents should be included in the process and given an opportunity to ask questions and review materials (Campbell and Daria, 2004).

2.6.3 Sex education as Health Promotion in Queensland (2004).

Schaalma et al., 2004 identified Seven Essential Components of Comprehensive Sexuality Education:

- a. Gender: exploring gender roles and attributes; understanding perceptions of masculinity and femininity within the family and across the life cycle; society's changing norms and values; manifestations and consequences of gender bias, stereotypes and inequality
- b. Sexual and reproductive health: understanding STIs and HIV, what they are and how to prevent them; pregnancy options and information; sexual response; living with HIV; how to use condoms; anatomy; sexuality and the life cycle {i.e., puberty, menopause, sexual problems}
- c. Sexual citizenship: knowledge of international human rights and national policies, laws and structures; understanding that culture is dynamic; available services and resources and how to access them; participation; practices and norms; advocacy; choice; protection; consent and the right to have sex only when you are ready
- d. Pleasure: understanding that sex should be enjoyable and not forced; that it is much more than intercourse; sexuality as part of everybody's life; the biology and emotions behind the human sexual response; gender and pleasure; masturbation; love, lust and relationships; interpersonal communication; the diversity of sexuality; the first sexual experience; consent; alcohol and drugs and the implications of their use
- e. Violence: exploring the various types of violence towards men and women, and how they manifest; rights and laws; support options available and seeking help; community norms (power, gender) and myths; prevention, including personal safety plans; self-defence techniques; understanding the dynamics of victims and abusers; appropriate referral mechanisms for survivors
- f. Diversity: recognizing and understanding the range of diversity in our lives (e.g., faith, culture, ethnicity, socio-economic status, ability/disability, HIV status and sexual orientation); a positive view of diversity; recognizing discrimination, its damaging effects and being able to deal with it; developing a belief in equality; supporting young people to move beyond just tolerance
- g. Relationships: different types of relationships (e.g., family, friends, sexual, romantic, etc.), emotions, intimacy (emotional and physical), rights and

responsibilities, power dynamics, and recognizing healthy and unhealthy or coercive relationships

2.6.4 An assessment of whether schools are a good setting for adolescent sexual health promotion in rural Africa? Rural Tanzania (2005)

In the MEMA KwaVijana programme, the researchers, Plummer et al. (2005) argued that at a national level, improved teacher training and supervision are critical, combined with policies that better prevent, identify and correct undesired practices. At a programme level, intervention developers need to simplify the subject matter, introduce alternative teaching methods, and help improve teacher–pupil and teacher–community relationships, and closely supervise and appropriately respond to undesired practices (Plummer et al., 2005).

2.6.5 Sex and HIV Education Programs: Their Impact on Sexual Behaviours of Young People throughout the World (2007)

Fifty-six studies were conducted in the US, nine in other developed countries (Canada, Netherlands, Norway, Spain, and the U.K.) and eighteen (22%) in developing countries (Belize, Brazil, Chile, Jamaica, Kenya, Mexico, Nigeria, South Africa, Tanzania, Thailand, and Zambia).

In an in-depth analysis of effective programmes Kirby, Laris and Roller (2007) identified 17 common characteristics which they divided into the following three categories:

- a. Curriculum development
 - The researcher argued that involving multiple people with different backgrounds makes the programme more effective
 - Assessing needs of the target group
 - Using a logic-model approach
 - Designing activities consistent with community values and available resources; and
 - Pilot-testing the program would contribute to the programme success

b. Curriculum content

- The content of the programme should be focused on clear health goals and specific behaviours leading to those health goals
- The content should give clear messages, and
- Address the situations that might lead to those behaviours and how to avoid them
- The content should also address multiple sexual psychological risk and protective factors affect sexual behaviours and create a safe social environment for youth
- The curriculum should also include multiple activities
- Employ instructionally sound teaching methods that involves the participants, and behavioural messages that are appropriate to the youth culture, developmental age and sexual experience
- The content should cover topics in a logical sequence

c. Curriculum implementation

- Secured at least minimal support from appropriate authorities
- Carefully selects educators, trains them, and
- Provides monitoring, supervision and support
- If needed, implements activities to recruit and retain youth
- Implements virtually all activities with reasonable fidelity

Kirby, Laris and Roller (2007) concluded that to close the gap between curriculums developments and its effectiveness, the following needed to take place:

- Sexual health education should be more than prevention education
- A positive environment for sexual health must be created
- Connection to home and community must be strengthened.
- Sexual health educators must be qualified
- Funding and policies must provide more support for sexual health education
- Regular evaluation and community input are required elements for effective sexual health education

These researchers believed that the youth deserve the best-qualified sexual health educators that can be found and argued that Internet is not one of them. Defining and meeting those training expectations for every school, and supporting the educators who take on this challenging role, would improve the situation (Kirby et al., 2007).

2.6.6 Pre-service teachers' experiences and perceptions of school health education in New Zealand (2007)

Sinkinson and Hughes (2007) argued that education about sexuality was primarily described as physical differences between boys and girls, body changes, reproduction and pregnancy, contraception and sexually transmitted infections (STIs), with only small reference to the personal and interpersonal components that might be expected in sexuality education. Sinkinson and Hughes (2007) further argued that although some topics are historic components of the subject, such as drugs and alcohol; Sexuality education as notably on the Health Promotion Education (HPE) Curriculum Document goes well beyond being a subject. It has a much stronger focus on social literacy and emotional competencies as this covers topics such as dealing and understanding emotions, developing relationships, managing anger or bullying and understanding change, loss and grief, etc (Sinkinson and Hughes, 2007).

2.6.7 Qualities needed to teach Sexuality Education in Australian High Schools (2001)

An article by Milton et al. (2001) reports on the educator qualities that are valued by Australian teachers involved in sexuality education in high schools. Focus groups were conducted with school sexuality education teachers in 19 high schools in five Australian states. Data indicated that teachers valued being trustworthy, being open and honest, being willing to listen, having a sense of humour, and being able to relate to the students, especially being able to relate in a trustworthy and confidential way. Also valued were being comfortable with one's own sexuality, being approachable and being flexible. These qualities are similar to those recommended in the literature in the 1970s and 1980s and correspond closely to the qualities sought by today's high school students. Australian schoolteachers currently enjoy a

positive climate for teaching sexuality education, as do many European schoolteachers. This contrasts with the climate for many American teachers where Abstinence until Marriage programme requirements place many restrictions on what can be taught and may compromise the expression of teacher qualities such as being non-judgemental, flexible, open and honest. The findings have implications for teacher professional development, pre-service teacher education training, and the selection of teachers to teach sexuality education.

2.7 THEORETICAL FRAMEWORK DESCRIPTION

Donabedian's framework, cited here as foundational work adapted for the model presented in this document, includes five steps that are illustrated in Figure 2 below:

1. Obtain data on performance
2. Analyze patterns
3. Interpret and generate hypotheses specific to pattern analysis
4. Take action(s) based on the hypotheses
5. Subsequent status and performance: This entails assess the consequences of action(s) taken

Donabedian's model framework proposes that each component has a direct influence on the next, as represented by the arrows in the following schematic

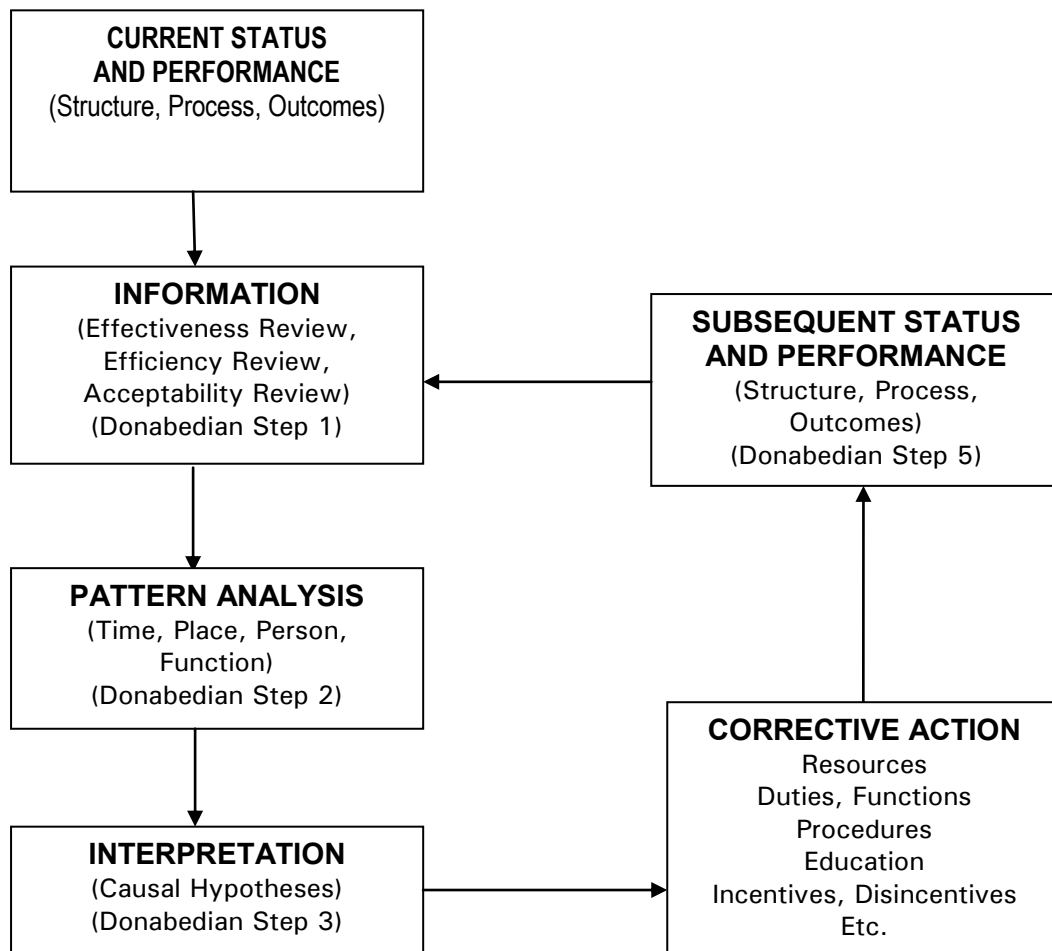


Figure 2.3. Quality monitoring cycle framework (adapted from Figure Intro 2, Donabedian, 2003, p. xxviii).

Donabedian's process of outcomes assessment involves five steps that make up an iterative cycle of goal setting, planning, implementation, analysis, and feedback. This process has been conceptualized through the analogy of providing sexuality education in schools. Identification and training of the sexuality educators, a problem list is identified, mutual goals are created, a plan selection and training is established, and the educators respond accordingly. Then the educators' response to the intervention is assessed: If the educators respond favourably and the goals in the plan of care are met, goal attainment is communicated and documented. If the educators fail to respond, adjustment is required based on data collected, a change to the plan is made, and the process begins again.

The framework developed for use in *Outcomes Assessment in Sexuality Education* includes five steps (figure 2.4) that parallel Donabedian's quality monitoring cycle framework:

Table 2.1 Outcomes Assessment in Sexuality Education

Sexuality education Program Outcomes Assessment Process	In this Document	Donabedian's Quality Monitoring Cycle framework
Step 1. Set program goals.	Chapter One	Current Status and Performance
Step 2. Develop an assessment plan.	Chapter Two	Information
Step 3. Implement the assessment plan.	Chapter Three	Information
Step 4. Analyze assessment results and discuss findings	Chapter Four Chapter Five	Pattern and Interpretation
Step 5. Close the loop/ Recommendations.	Chapter Six	Corrective Action
Set program goals.	<i>Recursive looping back to</i>	Subsequent Status and Performance

For a sexuality education program to set program goals, knowledge must exist on "current status and performance" (Donabedian). The development and implementation of an assessment plan by a sexuality education program parallels the information gathering step in Donabedian's quality monitoring cycle. Analysis of assessment results is encompassed by "pattern analysis" and "interpretation." Finally, Donabedian's "corrective action" is analogous to the feedback step of the Model.

In this study, the Department of Education's (DoE) goal is to ensure that all schools offer sexuality education. This necessitates the following:

- a. The DoE preparing and training sexuality educators/ LO who will teach sexuality education in schools. The sexuality education taught in schools by educators demands a strong background in the sexual health issues, such as STIs and HIV/ AIDS skills as well as high moral and ethical standards. In addition to teaching expectations, sensitivity and research responsibilities are an integral part of the educational experience for educators to keep themselves updated with new information.
- b. Intensive planning of the programme for example, who and how is sexuality education going to be delivered? Working out of the communication transmission plan both vertically, i.e. getting guidelines, textbook from the DoE and horizontally, i.e. transmitting information to the learners.

To meet the study objectives of exploring the educators' experiences, and understanding the barriers and support factors available to them, the study will focus on the fifth step of Donabedian's framework.

2.7.1 Donabedian's approach to school sexuality education evaluation

With respect to Donabedian's Quality monitoring framework presented in Figure 2. 3 above, Step 5, the Subsequent Status and Performance component formed the bases for this research, which details the structures, processes and outcomes. Based on the literature review for this study, the first two components were sub-divided into a number of themes which were then used to inform the analysis undertaken in this research, the intention being to meet the study objectives. Completing this research therefore requires a comprehensive understanding of all three components, and how the first two impact on the Outcome.

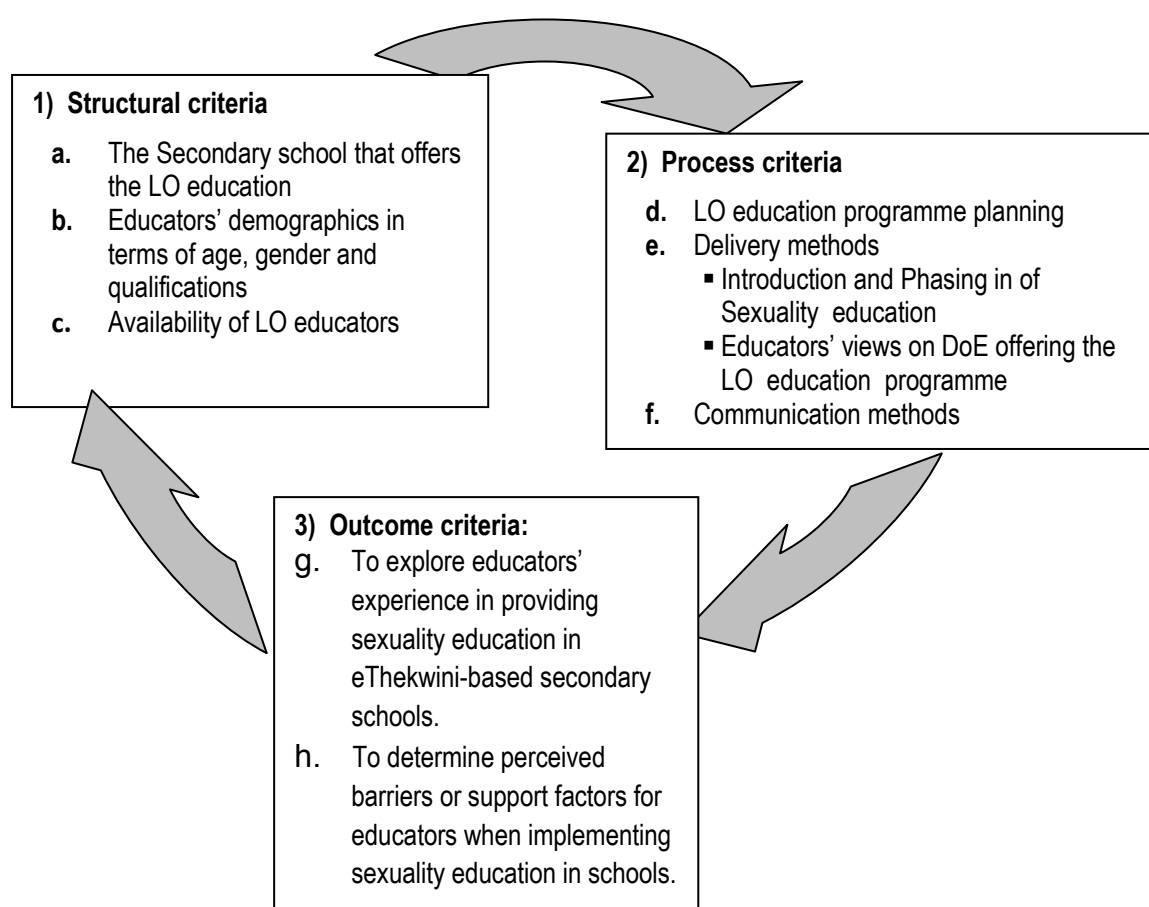


Figure 2.4 Structural-process-outcome model (modified Donabedian's theoretical framework, 2003)

Based on the Donabedian's framework, the Structural criteria, as determined by the DoE, and the Process criteria, as influenced by the schools educators', results in the Outcome criteria, which is the focus of this research. Each of the three criteria will be detailed below.

1) Structural criteria

With reference to this study, three important DoE roles were identified with respect to the DoE criteria identified in Figure 2. 4

- a. The mandate ensuring that all schools comply in offering the LO education
- b. The equity distribution of LO educators considering demographics such as age, gender and qualifications as well as personnel development
- c. The role of the DoE in training educators to teach LO education in schools to ensure availability of LO educators

With regard to the role of the DoE in training educators to teach LO education in schools, structural standards refer to the setting, the educational context and available resources. They include those antecedent conditions/ resources that make the educational effort possible, such as the organizational and administrative structures as well as human and material resources.

With regard to the personnel development programmes, structural aspects that could be included are:

- Facilities regarding comfort, convenience of layout and accessibility of support service
- Adequate supplies, state-of-the-art equipment and the ability of personnel to use equipment
- Personnel aspects such as credentials, experience and personnel: student ratios

Structural standards also address the integrative mechanisms of the school, such as those aspects that promote communication and decision-making. Regulatory bodies such as Sector Education and Training Authorities (SETAs), the National Qualification Framework and the DoE influence structural standards as these

structural standards will not ensure efficient personnel development, but will enhance the quality of programme content and the effective execution thereof.

The DoE has to ensure that LO education is offered to learners in all school in South Africa. The DoE identify and set criteria to selects and ensures availability of LO educators and prepares educators who will provide quality LO education. The professional services provided by educators demand a strong background in the sports organizing and career guidance as well as high moral and ethical standards. In addition to sexuality education dissemination practice expectations, teaching, service, and research responsibilities are an integral part of the educational experience.

2) Process criteria

The Process criteria refer to the activities carried out by educators to meet specific standards. Process elements are the actions and procedures used in conducting the programme, and include educational design, implementation, and facilitation of learning and assessment of achievements (Maepe, 2003). Process can also include leadership and managerial activities.

With reference to the study, three important educator roles were identified:

- d. LO education programme planning
- e. Identifying appropriate delivery methods
 - Introduction and phasing in of LO education
 - Educators' views on DoE offering the LO education programme
- f. Implementing relevant communication methods

The KZN Department of Education has a responsibility to educate and prepare educators for LO education service provision to KwaZulu-Natal and the nation, and to advance learner's understanding of the world. In this study, the researcher will look at the delivery method concentrating on the introduction and phasing in of LO education and identifying educators' views on DoE offering this programme. Furthermore, the researcher will look at how this was communicated to the educators.

3) The Outcomes criteria

Maepe (2003) argued that outcomes concern programme performance in relation to the achievement of programme objectives. With reference to this study, two important objectives are aimed to be achieved:

- g. To explore educators' experience in providing sexuality education in eThekweni-based secondary schools.
- h. To determine perceived barriers or support factors for educators when implementing sexuality education in schools.

In this study, the outcomes will evaluate the effectiveness of activities by assessing specific desirable changes in the actions of seven LO educators. These measurements are individual centred, and can be researched and identified with process standards or on their own, such as:

- By itself, 'Outcomes Research' is an analytic tool, (e.g. analyze a type of technology).
- Combined with Management sciences and to 'Outcomes Management', a strategy tool (e.g. how does adopting a certain technology impact the organization or larger system).

2.8 SUMMARY

This chapter has examined some of the available literature on the LO education programme focusing on the health promotion aspect where sexuality education is embedded, defined the theoretical framework and the concluded by discussing how Donabedian's theoretical framework is going to guide the study. The next chapter will look at the methodology and the research design for this study.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

This chapter presents a description of the research design process of this study and the steps taken in order to achieve the aim of the study. This will be outlined in the following subheadings: Study design, Study paradigm, Study area, Study population, Sample size, Inclusion/exclusion criteria, Data collection Instrument, Data collection Process, Data Management- storage and access, Data analysis, Trustworthiness of the study, Ethical issues addressed.

3.2 STUDY DESIGN

Research methods are defined as specific research techniques that are used to collect and analyze data (Wiersma and Jurs, 2009; Cohen et al., 2007). Phakisi (2008) argued that this also links data collection and analysis activities to the research questions that are being addressed. For the purposes of this exploratory study, a qualitative approach was used. The focus of qualitative research is on participants' perceptions and experiences, and the way they make sense of their lives (Holloway & Wheeler, 1996:2). The aim of the study was to explore educators' experiences when implementing sexuality education as a disease prevention and health promotion strategy in eThekweni-based secondary schools.

3.3 THE STUDY PARADIGM

Cohen et al. (2007) highlight the three paradigms that influence research, namely the positivist, the interpretive and the critical paradigms. As positivist and interpretive paradigms are seen preoccupied with technical and hermeneutic knowledge, this study adopted an interpretive research paradigm. Maree (2007) contended that interpretation focuses on people's subjective experiences, on how people "construct" the social world by sharing meanings, and how they interact with or relate to each other.

3.4 STUDY AREA

The study was conducted in the Umgeni North Branch radius area north of Durban, located in the eThekweni Municipality. This is a modern area with both upper and middle class communities in both urban and peri-urban who are largely conservative and follow a Christian faith. The area serves a community of more than 15 000 population (adapted from community profile study done in 2009) and is served by eight public secondary schools, one special school (catering for those mentally challenged), and four private secondary schools. There are four satellite clinics around this study area and two mobile clinic points running twice a week. The researcher had a list of all the schools from Department of Education that falls within the study area.

3.5 STUDY POPULATION

The schools selected were all public and fall under governmental structure. These schools cater for multiracial learners. Public schools serve mainly multiracial scholars with the majority being Coloureds and Indians, fewer Blacks and the least Whites. Most of the educators are Coloureds and Indians and few Blacks and Whites born and raised in Durban and live in the same study area.

The study was conducted in six schools which cater for pupils in secondary level grades, from grades 8 to 12. The total number of pupils in the selected secondary schools was 4 692. This was obtained when conducting the pupil count in preparation for the immunization campaign that took place on 16-23 April 2010, and was also confirmed by the school principals.

All schools started their sexuality education in grade 8. Each school had three or more LO educators who were rotating in teaching LO education from grade 8 to 12. Each of these schools beside school 4 and school 2 had devised a plan of having two LO educators teaching grade 8 to 11, and the other LO educator complementing this teaching in grade 12. In school 4, each grade had an LO educator and one LO educator in this school was a go in-between whilst in school 2, LO educators were sharing contents and teaching all grades.

3.6 SAMPLE SIZE

The researcher selected six schools within the Umgeni North Branch. The number of LO educators in each school (schools numbered from 1 to 6) were: school 1 (n=3); school 2 (n=2); school 3 (n=3); school 4 (n=6); school 5 (n=3); and school 6 (n=3). This brought the total number of LO educators in the chosen schools to 20.

In qualitative research, the researcher does not always know in advance the number of participants needed and identifying a sample size can therefore be done in a number of ways (Brink, 2001). The number of participants that were interviewed in this study was determined by the saturation point of the information gained through interviewing. It is for this purposive reason that the researcher interviewed seven LO educators. This small number of participants is sufficient in keeping with the nature of qualitative data.

3.7 SELECTION OF PARTICIPANTS

Non-probability sampling was used to select the sexuality/ LO educators, with participants being purposively selected because of their current engagement in teaching sexuality education/ LO programme. The researcher communicated with the chosen schools to find out how many LO educators were in each school.

3.8 INCLUSION/ EXCLUSION CRITERIA

The criteria for inclusion were the LO educator's willingness and availability to participate in the study.

3.9 DATA COLLECTION INSTRUMENT

To explore the LO educators' experiences of implementing LO education in secondary schools, in-depth interviews were conducted, these consisting of a sequence of themes and sub-themes that were explored through eight open-ended questions. The interview schedule was designed for this study as no previous research report could be found on this topic. The questions were derived from the literature and built around the theoretical framework and research questions. This

was to provide ideas on data to be collected. It was phased around the research questions and concentrated on facts, while allowing the interviewer the freedom of expression through probing for more information. The schedule was written in English which is the language medium used in the schools selected for the study (Annexure A). The intention was to allow the LO educators to express their views, concerns or opinions as freely as possible and this was done through the in-depth approach, thus emphasizing the focus of qualitative research (Polit & Hungler, 1995).

Interviews also allow certain safe guards to be built into the interview situation. By interviewing the participants at their premises, face to face, misunderstood questions can be quickly and easily clarified and the researcher can observe the level of interaction and understanding and co-operation. In addition, the researcher has a strict control over the order of questions (Creswell, 1994).

3.10 DATA COLLECTION PROCESS

Data collection began in April, 2010 and concluded in July 2010. The initial briefing of the LO educators was conducted at each selected schools with the permission from either the Principals or HoDs of the schools. Appointment was made with each LO educator for an assistant to personally deliver all the necessary information material (Information sheet and consent forms) which was collected by the researcher who also conducted all the interviews. The LO educators were given a week to decide whether to take part in the study or not. An appointment was made with each LO educator who agreed to take part in the study to set a date and time for the interview and they were reminded in advance of the date, time and venue of their appointment.

The interviews took place on school premises to avoid unnecessary delays and no shows. This was done so the researcher could appreciate and understand what goes on in the schools by observing the environmental setting before the actual interviews took place. The researcher greeted the interviewee and gave an introduction which provided an overview of the topic. The ground rules were outlined and the interviewer conducted the in-depth semi structured interviews so that the required

information could be obtained, but respondents were allowed to talk and cover the area in their own terms.

The interview questions were designed to elicit a description of the LO educators' experiences when implementing LO education. The interview sessions, with the LO educator's permission, were tape-recorded. In this way, the researcher was able to observe the educators expression relating to their experiences. The researcher proceeded with no preconceived ideas in order to avoid any bias in the study. Tape recording the interview allowed the researcher to concentrate on the process of the interview, focused her attention on the interviewee, and engaged in an appropriate eye contact and non-verbal communication. Tape recording does, however, present a few disadvantages in that it can make the respondents anxious and less likely to reveal confidential information (Katzellenbogen et al., 1997). This was minimised by a thorough explanation and assurance to the participant. The interviews lasted approximately 30-45 minutes depending on the participants' willingness to share information on the scheduled questionnaire (Annexure A).

After the interviews, the researcher transcribed the information into electronic form on a computer using Microsoft Word. The researcher took into consideration the fact that tapes take a long time to transcribe and analyze and that transcribing the data from one language into another can prove to be very demanding and frustrating. This has the potential to influence both the reliability and the validity of the final results. For this reason, a second researcher was used to analyze the data to avoid bias and enhance the reliability. The analyzed data was taken back to the LO educators to confirm that their statements had been accurately captured (Creswell, 1994).

The researcher invited the participants after the first transcript had been made available to them to make sure that it reflected their words before concluding. The researcher thanked the LO educators who had participated in the study and explained to them what would happen to the information that had been gathered during the interview.

The following data was collected:

1. Demographic details: age, gender, years teaching LO, additional skills

2. The eight question were grouped into seven question categories:
- The identification of the subjects and selection process into become an LO educators; the factors that influenced their decision to become an LO educator.
 - The training they received before teaching LO
 - The subjects they cover in their LO classes
 - Their experiences in implementing sexuality education at secondary school
 - Their views on DoE providing sexuality education in secondary schools
 - Their opinions about the support system they are provided with to facilitate LO education in schools
 - The barriers they encounter in implementing LO education

This data was then reduced to themes, which were then categorized and coded. The meaning units were grouped for processing and the emerging themes were extracted (see Table 4.1).

3.11 DATA MANAGEMENT

After completing the transcription, the tapes were kept locked in a safe, where it will be kept for a period of five years before being destroyed. The notes will be filed and stored in a locked room to be used as a resource when conducting the final interpretation of the data and will be kept safe in Nursing Department for a period of five years.

3.12 DATA ANALYSIS

Polit and Hungler (1999) argue that collecting qualitative data is a very intensive activity that requires insight, ingenuity, creativity, conceptual sensitivity and sheer hard work and is more demanding than quantitative analysis. Qualitative data can be analyzed in a number of ways but irrespective of the kind of method chosen, the researcher has to keep in mind the phenomenon known as 'bracketing'. This is a process of suspending personal beliefs so that the researcher can enter the world of the research participant (Polit and Hungler, 1999). Qualitative research can contain

a large amount of data to analyze resulting in the inductive nature of this data analysis. This is an important perspective given the interpretive nature of the analysis and the emergent nature of qualitative research designs in general (Airasian & Gay, 2006).

In this study, the analytical process was guided by Corbin & Strauss (2008). Description process was guided by Marshall & Rossman (1995) non-linear model for analyzing qualitative data using a manual data analysis method of identifying the meaningful segments. In this method, the phenomenon is examined to discover what it is and how it works. The process includes generating, developing and verifying concepts that build over time (Corbin & Strauss, 2008). The analytic process began by following the transcription of the initial interview. Corbin & Strauss (2008) outlined the following process to outline the data:

The general process that was followed in this study was the following:

- Familiarisation: Immersion in the raw data;
- Identifying themes: Key issues, concepts and themes derived from the raw data. The data will be labelled into manageable chunks;
- Indexing: Linking these identified themes or concepts throughout all respondents' data;
- Charting: Rearranging the data into 'charts' containing the relevant data from various respondents;
- Mapping: Using the charts to define the phenomena, find associations and provide explanations relating to the original aims or research question.

The initial phase of the analytical process included reviewing data for categories. The researcher used conceptual ordering to organize the data or concepts according to their properties and dimensions. Each transcribed interview was read thoroughly so that both researchers became familiar with it. In this way, the researcher becomes immersed in the data (comprehending). Significant statements and phrases directly related to the LO programme were identified and noted. The researcher attempted to spell out the meaning of each significant statement (synthesising). Significant statements were collected and organized into clusters of themes (theorizing). The

themes were used to produce a full description of Sexuality educators/ LO educators' experiences in implementing sexuality education.

Data analysis was an ongoing process throughout the entire research project. Informal steps involve gathering data, examining data, comparing prior data to newer data, and developing new data to gain perspective. The data was progressively narrowed into small groups of key data. (Airasian & Gay, 2006) argued that interpretations were based on connection, common aspects, and linkages among data, categories, and patterns. The process of breaking down data into small units, determining the importance of these units, and putting pertinent units together in a general interpretive form helped in interpreting and synthesizing data into general written conclusions (Airasian & Gay, 2006). The description were returned to the LO educators to confirm whether it accurately reflected the essence of their lived experience, thereby enhancing the trustworthiness of data.

3.13 TRUSTWORTHINESS OF THE STUDY

The aim of trustworthiness in a qualitative inquiry is to support the argument that the inquiry's findings are worth paying attention too (Lincoln & Guba, 1985). As Lincoln and Guba recommended and Polit & Hungler (1995) suggested, that to establish the trustworthiness of any study, four issues of trustworthiness need to be attended to, namely credibility, transferability, dependability and conformability.

The following measures were taken:

a. Credibility

Polit & Beck (2006) assert that credibility refers to confidence in the truth of the data and the interpretation thereof (Polit & Beck, 2006:332). The researchers argue that credibility is an evaluation of whether or not the research findings represent a "credible" conceptual interpretation of data drawn from the participants' original data (Lincoln & Guba, 1985).

In this study, credibility was obtained by prolonged engagement in data collection and interpretation. Sufficient time was dedicated for data collection activities. The researcher performed an individual in-depth understanding of the interview of

each participant and allowed the information to unfold naturally. The researcher maintained trust and rapport with participants. This was achieved by maintaining contact with the research participants both before and after the interviews. Members who participated in the study were provided with feedback on the emerging themes and were asked for clarification in order to get the most accurate reflection of their views.

Finally, the researcher enlisted the help of her supervisor who constantly reviewed the progress of this study. The supervisor received regular progress reports of the project, and posed questions regarding the research question, methodology, ethics, trustworthiness, and other research issues. The supervisor made pointed observations and suggestions and was the additional researcher in the study.

b. Transferability

Transferability refers to the potential of transferring the findings to other settings (Polit & Hungler, 2006: 430). The researcher achieved this by producing a rich, detailed description of the methods used in data collection, analysis, as well as the setting where the study took place. This would enable another researcher to apply the findings to another setting and come up with similar results.

c. Dependability

Polit & Beck (2006) refer to dependability of qualitative data as data stability over a period of time and over conditions. It is comparable to validity in quantitative studies (Polit & Beck, 2006:335). This was achieved by keeping detailed records of the research process. Dependability is an assessment of the quality of the integrated process of data collection, data analysis, and theory generation. The researcher relied on an independent audit of the research methods by the supervisor.

d. Conformability

This refers to the objectivity or neutrality of the data, that is, the potential for congruency between two or more independent people about the accuracy of data (Polit and Beck, 2006). Conformability measures how well the inquiry's findings are supported by the data collected. In this study, the interviews were conducted by the researcher and recorded on audio-tape (with the participants' consent). Having one interviewer conducting interviews helped to avoid differences in interviewing styles and techniques. Once transcribed, the researcher together with the research supervisor agreed on the emerging themes. Although complete conformability is impossible in research, the researcher made every effort to ensure that her personal values and beliefs did not influence the research findings (Polit and Beck, 2006:337).

3.14 ETHICAL ISSUES

Ethics in research can be considered to be the degree to which the research conforms to moral standards, including issues related to professional, legal and social accountability. Phenomenological enquiry is largely dependent on the participation of carefully selected individuals in order that a particular phenomenon may be truly visualized. As with all research participants, harm and exploitation must be avoided (Polit & Hungler, 1997) and therefore, beneficence needs careful consideration.

In this study, the participants' rights and decisions were protected by the researcher by way of adhering to the ethics of research through mainly, a. Maintaining confidentiality and b. obtaining consent. These measures are described as follows:

Participation was on a voluntary basis. Confidentiality was assured by not using either the names of the schools or the participated LO educators' names. The schools were identified not by name but by the numbers 1-6.

- a. After obtaining ethical clearance (Annexure B) from the University KwaZulu-Natal Biomedical Research Ethics Committee, the researcher obtained permission from the KwaZulu-Natal Department of Education (Annexure C).

Permission was further obtained from the principals and Head of Departments (HoDs) in selected schools (Annexure E).

- b. Informed consent was obtained from the participants (Annexure I) who were assured that the interviews will be entirely confidential and the results will be published anonymously. Informed consent also included the provision for the participants to withdraw at any time during the interview and to feel free to ask for further explanations when the need arises. Privacy and confidentiality were maintained by not using their names or the school names.

Verbal and written consent was obtained from each participant and once they had agreed to participate, a verbal explanation was given to them. The following was emphasised:

- The right to choose not to participate;
- The right to terminate their participation at any point;
- Encouraged to ask for explanations at any time.

3.15 SUMMARY

This chapter provides information concerning the research methods used and the various stages of the research process to respond to the critical questions asked in the study. The study was conducted at six schools in the area along Umgeni North region, in eThekweni District. Participants involved seven LO educators that were currently teaching sexuality education in these schools. In the next chapter will present the findings.

CHAPTER 4

DATA PRESENTATION AND ANALYSIS

4.1 INTRODUCTION

This chapter provides the research findings of the study which was conducted to explore the teachers' experiences in implementing Sexuality education/ LO in eThekweni-based secondary schools. It presents the findings in two sections, the first being the demographic details, and the second being the themes that emerged from the analysis. These themes emerged as a result of the questions asked during the interviews to address the study's two objectives as stipulated in chapter 1.

4.2 DEMOGRAPHIC DETAILS

Of the seven LO educators, two were males and five were females. The ages of the LO educators ranged from 22-51 years with a mean age of 37 years. Most of the LO educators had been teaching LO for more than two years, with only one having taught the subject for less than two years. All participating LO educators either had a teaching diploma, degree or both. Two of the selected educators were currently pursuing master's degrees in the education field. Two of the seven LO educators had been trained as HIV counsellors and one of the two was also trained on how to counsel rape victims.

4.3 DESCRIPTION OF THE CHOSEN SCHOOLS

Each selected school had a principal and HoD on site. The medium language used in all the chosen schools was English. These were all formal schools that were well fenced and all electrified, had piped water and flushed toilets. All these schools had good infrastructures which included telephone, fax, photocopier, email system. They all had a teachers' conference room, a library, a laboratory and a hall. Each of the school had a security guard at the entrance, and a wide sport field area within the premises. They were all in close proximity to one of the four clinics and other recreational facilities outside schools that were noted in close proximity included swimming pools, a public library and sports fields.

4.4. EMERGING THEMES

The 8 questions were reduced to 7 categories within which a number of sub-themes were identified as presented in Table 4.1 below. These are discussed further below.

TABLE 4.1 EMERGING THEMES

Questionnaire categories	Themes
1. Identification and selection of LO educators	1. Becoming an LO Educator <ul style="list-style-type: none"> a. Guidance and or sport experience b. Academic qualification c. Responded to an advert of the position d. Role model e. Friends' referral
2. The training offered to educators in preparation to provide sexuality education	2. Training and preparation to teach LO <ul style="list-style-type: none"> a. DoE in-service b. Block training c. Guidance Mentored by other LO educators
3. Introduction of sexuality education/ LO Program	3. Introduction and Phasing in of the sexuality education <ul style="list-style-type: none"> a. Scarcity of sexuality component on LO content. b. replacement
4. Experiences shared by the LO educators:	4. LO educators' experiences when teaching LO <ul style="list-style-type: none"> 4.1 Adapting and finding purpose <ul style="list-style-type: none"> a. Relating to LO fellow educators b. Regarding LO training 4.2 Differing expectations <ul style="list-style-type: none"> c. Seeing experts in sexuality education d. Need for short skills courses e.g. HIV counselling e. LO educators overwhelmed f. Time shortage 4.3 The cost of the LO education experience <ul style="list-style-type: none"> g. Career advancement h. Frustrations i. Need for more short course skills e.g. HIV/ Rape victim 4.4 Bridging pedagogies <ul style="list-style-type: none"> j. Youth involvement
5. Educators' views on DoE offering sexuality education	5. DoE LO initiative described as an excellent move <ul style="list-style-type: none"> a. Vital programme b. Need for mutual support and consultation c. Need for Expansion on Sexuality education content
6. Supporting factors that facilitates Sexuality/ LO programme	6. Identified Support system <ul style="list-style-type: none"> a. DoE guidelines b. Health club initiative c. Educators' networks
7. Some Factors that hinders effectiveness of LO programme	7. Identified Barriers <ul style="list-style-type: none"> a. Cultural diversity b. Poor teaching conditions c. Poor capacity d. Poor resources and lack of privacy.

4.4.1 Theme. 1: Becoming an LO educator

The participants mentioned that while they responded to an advert calling for LO educators, the main motivation for becoming an LO educator was their previous teaching experience. Five main categories emerged under this category: a. Guidance and sport experience, b. Academic qualification, c. responded to an advert of the position, d. Role model, and e. Friends' referral, each of which will be reviewed.

a. Guidance and or sport experience

"I had the qualities and skills with proven experience as I was the sports organiser of the school" (LO educator, school 4:1).

"In the teaching that I've done, there's always been a career educational side to it. The only thing I felt I was qualified for and that I felt like I had the ability to do was to teach I always knew it was going to be teaching or sports and career guidance. I always had that feeling I didn't feel like I was settling for something. I felt like I was doing the other thing...as capable and probably enjoy doing just as much. Finally, I decided to become the LO educator because LO forms part of career guidance, and I thought I should give this a try. I knew I will be good at it. I knew I would enjoy it, but I also wanted to keep my foot in the door of sports organizing as well, I didn't want to rule one out. I'd like to juggle both of them if I could" (LO educator, school 6)

b. Academic qualifications

A few educators indicated that they had the qualities and skills with proven experience, and they therefore felt suitable to teach sexuality education. Some came to teaching having studied LO from their block training and therefore were qualified candidates.

"I already had the experience and academic qualification to take on the task of teaching Life Orientation as I was teaching career guidance before the introduction of the LO teaching" (LO educator, school 1).

c. Responded to an advert of the position

Most of respondents indicated that they had responded to the advertisement when the sexuality education/ Life Orientation (LO) programme was phased in to the education system.

“The LO introduction post were advertised and therefore I responded to an advertisement” (school educator 4:2).

d. Role model

Other motivation for becoming an LO educator included a positive role model. LO educator (school 5) indicated that her role model was a nurse from a nearby clinic who used to visit the school dressed in a complete white uniform. The learners called her an angel and the educator would sit in the back and listen attentively as this nurse gave health education to the learners. They would listen so attentively and eventually ask question when given a chance to do so. But before doing so, one learner will thank the nurse for such wonderful empowering information, whilst other learners will sort of simulate what the nurse had taught them before and the educator then expand her information to the day related topic.

e. Friend's referral

One indicated that she was asked to fill in for another teacher and later decided to further her LO studies with a university degree. She mentioned that following an introduction to Life Orientation curriculum as a subject taught in schools, LO was introduced as one of the major subjects in Teachers' Training Colleges (TTCs). This gave the educators a choice to choose LO as one of their major training subjects. Below are some of the comments from the educators regarding the above motivations:

I was referred by a friend who mentioned the gap, as one LO educator where she was teaching had resigned. As I have studied LO in my block training, I took the chance and applied. “I was surprised to get this job because I had just graduated from my teacher training... but I was very grateful because it seemed to be a big step up” (LO educator, school 2). “The friend referral is what really made me want to become an LO educator. This made me realize that I will grow on my HIV skills knowledge. That and the fact that I always

wanted to come to expand my knowledge on HIV skills. My friend reminded me that HIV sickness is a global epidemic illness...The teaching salaries were comparable, but they would not cover your rent...wouldn't cover your roundtrip ticket...So, this seemed like a foot on the door that will open many chances even to go abroad...the chance I never thought of" (LO educator, school 2).

4.4.2 Theme 2: Training and preparation to teach LO

Three sub-themes emerged under this theme, namely a. DoE in-service training, b. Block training and c. mentored by other LO educators, each of which will be reviewed.

a. DoE in-service

The majority of the LO educators (schools 1, 2, 4.1, 5 & 6) confirmed having been trained through the Department of Education (DoE) in-service training program.

"I received the Departmental education (DoE) training both at the start of the programme and during three day courses every year" (LO educator, school 6).

b. Block training

An LO educator (school 3) had done LO as part of Block training after which she was orientated and mentored by other LO educators in the school. Most of these LO educators indicated that they had supplemented their LO teaching with the university degree in psychology.

"I had chosen LO module as one of my learning modules in my block training and therefore when I was asked to teach LO, I already had the qualification" (LO educator, school 3).

c. Mentoring by other LO educators

Some educators indicated that they were mentored by senior LO educators and supported by the principals.

“I was mentored by the senior educators in the school and that made me stronger even before I could go for departmental in-service training as I was next on the list” (LO educator, school 2).

Another educator at school 4 (school 4.2) mentioned that she received training from Department of Education, educators’ network, block education and the university

4.4.3 Theme 3: Introduction and phasing in of LO education

The LO educators mentioned that Sexuality education is embedded in the Health Promotion aspect of LO outcome. It is a complex intervention combining sex, gender and HIV/AIDS education used in South Africa schools in order to address the school children and youth in the fight against the STIs/HIV/AIDS epidemic.

The LO educators indicated that each school was responsible for developing their own curricula and programs regarding HIV Policy and their content therefore, varies widely.

The LO educators explained the content of LO curriculum briefly and how this was devised into learning outcomes (Annexure J). The researcher noted that very little detailed sexuality information came out during interviewing. Most LO educators emphasized that they are not sexuality educators, but that they teach sexuality education as part of LO Programme. The minority of LO educators explained the content further, and mentioned including discussions related to body development stages, sex and sexual health, abstaining from sex, discussions related to use of condoms, unwanted pregnancy, sexuality diseases and HIV/ AIDS. Shortage of time was noted as the big issue, as the LO educators indicated that so much has to be covered in a short period, and therefore at times they were forced to limit the discussion to what was set out in the guiding books in order to finish the syllabus in time. They clarified the phasing in of the LO programme and described a. The scarcity of sexuality component on LO programme and b. how it replaced the guidance counselling that was previously taught.

a. Scarcity of sexuality component on LO content

Few LO educators indicated that LO content is too scanty on sexuality information and that they themselves didn't know much until they learned more skills relating to STIs/ HIV disease.

"There are four learning outcomes in Life Orientation programme. Sexuality education is embedded in Health promotion or Personal well-being aspect of the curriculum. Health promotion covers sex and sexuality education, a brief explanation on HIV/ AIDS, teen pregnancy and Family planning" (LO educator, school 1).

b. Guidance replacement

The educators explained that career guidance and sports were the subjects that were regarded as shaping the learners skills to be able to face the future.

"I was a career guidance teacher and a sports organiser before LO programme. Now this has been integrated into LO learning outcomes" (LO educator, school 4:1).

4.4.4 Theme 4: LO educators' experiences when teaching LO

Four main themes were identified under this category, each with a number of subthemes. The four main themes were: 1. Adapting and finding purpose, 2. Differing expectations, and 3. Cost of the LO education experience, and 4. Bridging pedagogies. Each of these themes will be outlined:

1. Adapting and finding purpose

Positive experiences revolve around the community and classroom experience. The LO educators discussed their movement from the general teaching to becoming LO educators as a positive experience as follows:

a. Regarding fellow LO educators:

The LO educator at School 6 said *"I've enjoyed working with the other LO educators – meeting very interesting, talented educators and sharing the information on our sexuality education encounters."*

b. Regarding interaction with LO trainees:

The 2nd LO educator at school 4 tells: *“How amazing it is to be taught sexuality education/ LO! It is a very interesting subject. It reminds us of our youth days. Learning what educators really need to know and be able to transmit it– the realistic things educators’ need in the classroom – and being able to transmit this information to learners. Those are the things that I think I’m most proud of and really feel like they’re the best part of my job.” “To be on the receiving end of information (as in our LO training), It’s always been a constant challenge and push, and I like that...I’m always kept on my toes.”*

2. Differing expectations

The educators believed in collaborating LO educators and Health worker for health. These themes were:

c. Seeing experts in sexuality education

Some LO educators suggested that Instead of sexual health being taught by a teacher alone. *“ will like to see more health promotion experts like nurses coming in to talk about some topics e.g. teenage pregnancy, prevention of unwanted pregnancy, STIs/ HIV/ AIDS etc” (LO educator, school 6; school 1).*

d. Need for short skills courses e.g. HIV counselling

The educators believed that to be able to deal with HIV infected person, one need to be a trained on HIV counselling.

“...I thought about it and realized I was faced with a major situation. Then I thought to myself, how you can deal with something that you don’t understand. Worse, this girl had to also go for HIV testing. At that time people were not even talking about HIV, this was still new. “When the test came back, she was told she was HIV positive. This hit me so hard and I didn’t know what to do” (LO educator, school 6).

e. LO educators overwhelmed

The educators explained that it was overwhelming for them to learn the new content/ subject in a short period. Most of them had no physiology background and therefore this had to be understood before mastering sexuality content.

*“We were expected to learn the whole sexuality module in five days”
(LO educator, school 3).*

f. Time shortage

The educators argue that imparting these skills to other than as LO educators had been time consuming and therefore could imagine how much the learners were missing.

“Time given for sexual health education is short. One-shot deals show little or no change. Sexuality education needs to be taught and re-taught over and over” (LO educator, school 3).

In most of the chosen schools, in trying to help learners LO educators have embarked on placing learners in community service centres (especially grade 11 and 12) like Health centres, Police service, Social welfare, etc. The LO educators believe that this system teaches learners the reality of what is happening in the real world. The learners are required to spend 80hours to 120hours in such centres and give back feedback of what they learned and achieved in community service.

Some LO educators mentioned that they encouraged learners not only to be in community centres to learn and observe the caring that was provided, but to also use their initiatives and compile health packages containing all the necessary health material that can be used in emergencies (such as what should be added in the home first aid kit below). These are used in school premises when needed to provide first aid assistance arises. The LO educators indicated that these become handy during physical education and sports sessions.



Figure 4.1 a sample of first aid kit compiled by learners (school 6)

3. The cost of the LO educators experience

In defining this theme, the following subthemes were described:

g. Career advancement

The LO educators showed more commitment to the LO education field by going an extra mile of attaining higher education levels. Two LO educators are studying towards Masters Degrees.

“Working as an LO educator has been a great learning experience for my career advancement, I am now in my final year toward my psychology major (LO educator, school 1).”

An LO educator at school 6 furthered her short skills training and is now a HIV trained counsellor and attended a Rape Victim Workshop that taught her how to manage Rape Victims.

h. Frustrations

Some educators felt overwhelmed and burdened with extra work as they had to shift around other curriculums to accommodate the sexuality education/ LO programme.

“This curriculum burdens other curriculums. I think they wished we did way more in the schools when offering sexuality education/ LO. It would be great to have LO program R-12 inclusive so all children get excellent sexuality information; however, we are not well capacitated” (LO educator, school 3).

i. Need for more short skills courses e.g. HIV/ Rape counselling

The educators explained how they could not identify or tell when some learners were pregnant until these learners start showing of which by then some already had or their parents decided not to come back to school.

“Seven of the learners from two of the classes that I neither teach did not come back this term and there have been no news on five of them. Two parents came in reporting that their daughters are about to deliver and will only continue with school after at least one year of raising their babies” (LO educator, school 5).”

4. Bridging the pedagogies

The educators identified being involvement in youth development issues as bridging the pedagogy. This is outlined below:

j. Youth involvement

The LO educators mentioned that they always wanted to see changes in the youth behaviours. This was the better way to ensure that learners are empowered.

“I thought, in the grand scheme of things, it would be more productive to be working with the learners and the education system” (LO educator, school 2).

“I always needed to see how youth perceive sexuality education yet still practice unsafe sex. The idea of working with learners appealed to me. So I took this chance to get involved” (LO educator, school 3).

4.4.5 Theme 5. DoE's LO initiative labelled as an excellent move

The following themes emerged: a. vital programme, b. Need for mutual support and consultation in the planning phase, and c. need for expansion on sexuality education content. These are outlined below:

a. Vital programme

The LO educators felt happy and thought that this is a vital programme that needs to be taught in schools.

"This was a brilliant move by the DoE. If I had my way, this would have involved the LO educators and learners to discuss how to handle sexuality education/ LO in a way that can be suitable for both" (LO educator, school, 6). "This was an excellent move by the DoE. I would have done the same in their shoes" (LO educator, school, 1; also agreed by all educators).

b. Need for Mutual support and Consultation in the planning phase

Some LO educators wished that the DoE had given them a chance to have an input in the LO curriculum development as they believe that sometimes the information on sexuality content become so scanty in such that they have to seek help from the Health sector to bring us more related issues.

"This was a good move by the DoE; however, it would have been easier if we were consulted to make input into the planning of the Life Orientation/ Sexuality programme" (LO educator, school 3).

"Given a chance I would have gone out of my way to ensure that all the necessary information that pertains to a particular subject shows in each LO aspect e.g. getting all the necessary models to show the students on how to use condoms (LO educator, school 1). This teacher made it clear that He enjoys teaching, "I love teaching. Teaching is the only profession I would ever considered doing. It's what wakes me up in the morning. It's what puts me to bed peacefully at night. It gives me a sense of pride, a sense of self-respect. I love helping people. I love seeing that light bulb go off in my student's head when I know that they

understand a concept... There's nothing better than that in the world"
(LO educator, school 1).

c. Expansion on sexuality education content

A few LO educators indicated that LO content is too scanty on sexuality information. They believed that they themselves did not know much until they learned the new skills.

"It is not a good thing to have sexuality education embedded in LO outcome. It needs to be an outcome on its own. In that way more information can be given. There is so much that is missed out, it's like brushing it on and leaving" (LO educator, school 2).

4.4.6 Theme 6: identified support system

The following themes emerged: a. DoE guidelines, b. Health club and c. Educators' network. These are described as follows:

a. DoE guidelines

The DoE still plays a very important role in guiding how the educators transmit sexuality education to learners.

"We receive continuous updated guidelines from the Department" (LO educator, school 5; all LO educators in consensus).

b. Health club

Some LO educators mentioned started a Health Club consisting of various experts (a programme which is part of sexuality education) at which they discuss various topics including HIV/ AIDS. This is where the pupils involve their parents and seems helpful especially where there is no HIV counsellor on site. However, this need more support from the DoE and other departments.

"The school have embarked on opening a school Health Club."
However, this need more support from the DoE and other departments"
(LO educator, school 4:1).

c. Educators' network

The educators explained how they often meet with other LO educators from different schools and share their different experiences. This was usually arranged for at least twice a year but due to workload, it was difficult for some educators to be able to attend.

"We often meet with other LO educators in workshops and in different schools every year to support each other and share different experiences" (LO educator, school 2; all LO educators in consensus)

4.4.7 Theme 7: Identified barriers

Regarding the barriers they experienced, most LO educators indicated the following four issues: a. Cultural diversity, b. Poor teaching conditions, c. Poor capacity as well as Poor resources and a lack of privacy which affect the way in which sexuality education is perceived by pupils. These are outlined below:

a. Cultural diversity

The educators understood that they were teaching a multiracial group and therefore expected cultural diversity. However, this was noted as spiralling out of control.

When we teach sexuality education in schools, we are faced with comments like, "Don't talk about sex, I am not married yet, this is a taboo" or "Don't talk about sex, if my mother can hear me talking of sex, she will ban me from watching TV" (LO educator, school 1).

b. Poor teaching conditions

The educators mentioned dilapidated classrooms hinder the implementation. Learner-educator ratios, sharing of resources combined with poor physical conditions and inadequate facilities for teaching and learning affects the productivity of the programme.

"In my class, I cater for 42 learners with some sitting in threes in one desk since the class was equipped for 35 learners. They can become uncontrollable and wild during the session" (LO educator school 4).

c. Poor capacity

The LO educators also commented on the shortage of skills and capacity to accommodate the learners' individual needs. Some LO educators hinted that it will make a huge difference if the educators are trained on short courses like HIV counselling, Dealing with Rape victim, etc.

"introducing the courses on Training the Trainer, even if this is done afterhours to enhance educators' knowledge on how to deal with HIV infected individual learners will be a great help" (LO educator, school 6).

d. Poor resources and lack of privacy

Some educators Indicated poor knowledge of HIV skills and poor training, lack of supportive guidance, receiving guiding books late as being problematic. One educator mentioned that beside the principal, there is lack of administrative support from the DoE, which is why the Health Club seems to be a good source of support.

Among general issues, few LO educators mentioned gender discrimination and the lack of resources creating problems. Very few educators mentioned experiencing a language barrier. Some commented that some pupils are either ignorant, do not take on sexuality education seriously or are unable to express themselves in a mixed- gender class environment.

"Some learners fail to express themselves freely, fearing that may be the opposite gender will laugh at them" (LO educator, school 5).

4.5 SUMMARY

The participants' responses indicated a number of factors had resulted in their becoming LO educators, but that they had had similar experience with regard to its implementation, barriers and support factors. These findings will be discussed in the next chapter in relation to the studies presented in the literature.

CHAPTER 5

DISCUSSION OF RESULTS IN RELATION TO EMERGING THEMES

5.1 INTRODUCTION

The findings will be discussed with respect to the emerging themes as outlined in Chapter 4 to identify the educators' experiences in implementing sexuality education as disease prevention and a health promoting strategy at eThekweni-based secondary schools in KwaZulu-Natal. Each of these themes will be discussed with respect to the findings presented in Chapter 4.

5.2 DEMOGRAPHICS' DESCRIPTION

The gender distribution of two males and five females were in line with the gender demographics in the schools that participated, where there were more female than male teachers in general, not only in the area of LO teaching. The fact that most of the LO educators had been teaching LO for more than two years, with only one LO having taught it for less than two years indicated that they had had some teaching experience and were aware of the systems and challenges associated with working in government schools. The fact that some had studied further, taking either short courses in HIV counselling or in tertiary studies, indicated their interest and commitment to the field

5.3 DISCUSSION OF FINDINGS IN RELATION TO THE EMERGING THEMES

The findings will be discussed in respect of the emerging themes in order to address the two objectives. The replies to the eight questions were grouped into the following seven themes, each of which will be detailed below:

1. Becoming an LO Educator
2. Training and preparation to teach LO
3. Introduction and Phasing in of the sexuality education
4. LO educators' experiences when teaching LO
 - 4.1 Adapting and finding purpose
 - 4.2 Differing expectations

4.3 The cost of the LO education experience

4.4 Bridging pedagogies

5. DoE's LO initiative described as an excellent move
6. Identified Support system
7. Identified Barriers

5.3.1 Theme 1. Becoming an LO educators

It is evident from the study that the main attributes that were used as criteria for identifying and selection of LO educators were a. Guidance and sport experience, Academic qualification, responded to an advert of the position, Role model, and Friends' referral. These educators felt confident enough and ready to comprehend the DoE requirement of providing sexuality education/ LO. *"I had the qualities and skills with proven experience as I was the sports organiser of the school"* (LO educator, school 4:1).

The study did not reveal any input from the class teachers on the inception sexuality/ LO programme planning which according to the literature would have been a valuable asset to the development of the curriculum. Some of the criteria that can relate to the educators motivation of becoming LO in this study is mature in years and attitude, and possess good communication skills which can relate to qualities and skills with proven experience in guidance and sports organisation. Also, the educators are already involved with youth activities in career guidance and sports activities and teaching sexuality could prove commitment to motivate learners to understand their own sexuality. None of the studied LO educators had a health background study, they all had to learn this when the programme was implemented. James- Traore et al. (2004) argued that knowledge of science subjects such as chemistry and biology may be helpful in teaching HIV/AIDS content, especially when it comes to having the confidence to answer medical questions. However, selecting teachers merely on the basis of subject of expertise limits the broader selection process. Those who do not teach science can learn basic information about HIV transmission and other technical issues (James-Traore et al., 2004).

As revealed in literature, James-Traore et al. (2004), suggested that teachers who provide education need to have capacity for "health literacy"- the capacity to obtain,

interpret, and understand basic health information and services and the competence to use this information to enhance the learning concepts and skills by students. Without this capacity and an ability to deal with the subject matter and with youth, teachers may be ineffective and lack confidence.

5.3.2 Theme 2. Training and preparation to teach LO

All LO educators that participated in the study had Life Orientation training either college trained or through DoE in-service training. It was clear from the interviews that there were a number of important benefits for LO educators from teaching Sexuality education. The benefits included increased knowledge on both sexual health and the Life Orientation curriculum, guidance on delivery and instilling teachers with the confidence to effectively deliver sexuality education.

Campbell & Daria (2004) argued that a lack of appropriately trained educators can obstruct the implementation of sexuality programmes. Fleish (2008) argue that teachers are at the core of the content that is taught and the pedagogy that carries that content, and also the key to successful reading.

The study revealed that when the sexuality education/ LO programme was introduced; a series of training the educators (tutor training) took place. Then using the cascade model, the selected educators to teach sexuality were sent to various camps for a five day course of training which was conducted. This was followed with a three day course in six month and a one day course review in a year. As the LO programme continued, LO education was introduce in Training Colleges, and is now a subject of choice. Whether this proves to be enough to ensure that educators are prepared and ready to deal with the challenges of teaching sexuality education remains a mystery depending on the content of education passed on to learners.

James-Traore et al. (2004) suggested that all school staff should receive at least an orientation to the new RH/HIV programme so that they have accurate information for themselves and their students. Those teaching the RH/HIV curriculum itself needed more extensive training. James-Traore et al. (2004) argued that training tutors (teachers of teachers), primary and secondary teachers, and to a lesser extent, other staff, principals, and administrators. Those who teach teachers -a critical, often

neglected group -should receive adequate training to prepare them for their roles. Their comfort and abilities will certainly influence new and impressionable teachers. Training primary school teachers offers an opportunity to reach young people before these youth become sexually active and to help those who are already active to protect themselves from pregnancy and disease. Introducing all teachers to RH/HIV content has value, especially where the content is infused throughout the school's overall curriculum. Exposing principals and administrators to the curriculum can help gain support for teachers in the classroom. Otherwise, some RH/HIV teachers may experience some of the stigma that HIV-infected people experience.

Literature revealed that James-Traore et al. (2004) argued that the duration and length of training appears to affect the effectiveness of teachers. Available evidence and anecdotal reports suggest a correlation between the duration of training and the degree of the content taught to students. Short term or one-time training courses are insufficient to affect teacher confidence and competence over the long-term. Teachers need periodic updates to reinforce learning, acquire new information, and satisfy ongoing needs. Teachers who receive initial training as part of both pre-service and in-service courses can be expected to benefit more.

The study proved that in-service by the DoE as well as educators' networks carried on despite of LO subject being introduced in TTCs. Therefore this ensures that educators are kept updated of the new developments on the program.

James- Traore et al. (2004) had suggested in literature that teacher training should cover RH/HIV content, teaching methodologies, teacher skills, personal attitudes, and teachers' HIV-risk behaviours. The content should address the medical and physiological aspects of RH/HIV as well as the social and cultural environment that shapes young people's development and sexual and other relationships. Teacher training should cover the policies, administrative practices, and cultural norms that will affect the teaching of RH/HIV information. Teacher training should include summaries of laws, policies, and structures that govern their teaching of RH/HIV content. Teachers should be knowledgeable about the customs and traditions of the youth and the communities in which they work (James-Traore et al., 2004). It did not become clear in the study as to what content was covered when training or

when teaching learners as most educators would concentrate on the guiding books to identify what they will teach the learners day by day.

5.3.3 Theme 3. Introduction and Phasing in of the Sexuality education

The school-based researchers argued that for some teachers, the content taught in sexuality education is new information and therefore, the educators are not able to go into more detail than is in textbook or manual (IPPF, 2006; Campbell & Daria, 2004; Waldman, 2004). It is this very issue that causes concern among some teachers when sexuality education programmes were proposed or when a particular topic within the content is discussed (Campbell & Daria, 2004).

The LO educator described some of the topics that they discuss in sexuality education sessions with learners. These included body changes through developmental stages; discussing reproductive system in details (including broad description of menstrual cycle and masturbation); how to prevent STIs/ HIV/ and unwanted pregnancy and describing how each outcome complement the other as in (Annexure J).

Literature described sexuality education primarily as a physical differences between boys and girls, body changes, reproduction and pregnancy, contraception and sexually transmitted infections (STIs), with only small reference to the personal and interpersonal components that might be expected in sexuality education (Schaalma et al, 2004).

In the study, sexuality education is spoken into LO education. LO educators described sexuality education/ LO as a very broad subject that covers four different aspects. Sexuality education is embedded in the Personal Well-being aspect of Learning Outcome 1

It also became evident that each and every school had been mandated by the DoE to develop their own HIV/ AIDS Policy which is in line with the National Education Policy Act 27 of 1996. In this way each school recognizes that STIs/ HIV/ AIDS are part of an epidemic that affects the school either directly or indirectly and therefore recognizes the need to minimize HIV epidemic through education. HIV/ AIDS is dealt

with in the LO lessons. The researcher noted that two LO educators from the six schools that were visited, were working both as LO educators and were also HIV trained lay counsellors. This proves some professional commitment and improvement on the educator's skills to ensure the best possible transmission of sexuality content to the learners.

5.3.4 LO educators' experiences when teaching LO

The LO educators unanimously felt that the content of sexuality education is inadequate to ensure that the learners obtain as much information as they need to empower them to make informed decisions on their sexual health . This caused a problem as many learners resorted to external sources such media and health facilities (which are limited to availability). Some educators sorted clarity and some visits health workers and this motivated them to start learning short skills course.

According to Mdutshane (2007), a clear picture of the desired outcomes is the starting point of curriculum instruction, planning and implementation, which must all be coherent (Mdutshane, 2007). Chisholm (2005) explains that in South Africa when the review of LO curriculum was introduced it had complex language that was difficult for teachers to understand.

The study revealed that educators had guiding principles and were therefore following these LO guidelines when teaching sexuality education. These guidelines differed for each grade and are explained further in (Annexure J).

James –Traore et al. (2004) suggested when developing and using teacher training curricula for any RH/HIV programme managers, curriculum developers, education officials, and others should be aware of four key aspects of the curriculum: goals and guiding principles, teacher-focused content, methodology and facilitation skills, and management and structure. These were discussed further in literature.

As educators encountered their own unique experiences in the introduction of LO programme, they indicated that for this program to be labelled as a success, the programme should show the following positive results:

- Reduction in STIs and HIV infections

- Reduction in teenage pregnancy
- Increased number of school leavers taking part in tertiary studies

The LO educators hinted that at the moment, pupils are just learning sexuality education because it is part of the LO content and do not comprehend the importance of taking sexuality education really seriously.

5.3.5 DoE LO initiative described as an excellent move

The majority of the LO educators were impressed by the DoE's initiative to teach LO in schools. They explained that before the LO was introduced, learners used to experience developmental changes such as menstruation or masturbation, without realising what was happening to their bodies. In most instances, teachers would assume that the parents have discussed these issues with their children, while the parents were hoping that teachers are covering these aspects in schools. Now that the LO programme has been incorporated into learning programmes, the learners are beginning to understand these changes in their body developments. The following themes emerged: a. vital programme, b. Need for mutual support and consultation in the planning phase, and c. need for expansion on sexuality education content. These were outlined in chapter 4. As happy as they were with the DoE's initiative, some educators felt burdened with work overload.

5.3.6 Theme 6. Identified supporting system

Training and adequate preparing of the educators and provide them with necessary resources is the key to function in a changed curriculum context. McLaughlin (2006), argued that implementation of sexuality education is more likely to succeed if support is provided in the form of finances, on condition that the support is substantial and continues over a period of time. The study revealed that the LO educators received series of training at the inception of the sexuality education/ LO programme and continuously received support from the DoE through the means of guidelines, schools forming health club as well as from the educators' network meetings.

As McLaughlin (2006) indicated in literature that the climate within the school must be conducive to change. There must be a balance between pressure and support. Pressure is needed to concentrate attention on a specific innovation, but it must be

balanced by support in the form of expert assistance and finance. In particular, vague mandates and weak guidelines provide the perfect opportunity for dominant coalitions or competing issues to shape programme choices. Experience shows that delicate balance between pressure and support is essential. Pressure is required in most settings to focus attention on a reform objective while support is needed to enable implementation (McLaughlin, 2006).

This proved to be the support that the LO educators in the study felt they needed. The educators mentioned that through the help of the principals, and HoDs, they are able to get the required resources they require to provide the education however due to overcrowding and work overload in some schools, this seem to be difficult to achieve and therefore, only minimum resources are available. Due to the commitment from the leaders, the educators were able to make do with limited resources. Changes do occur if local leaders show commitment to the project and convey a sense of enthusiasm to the school staff. In part, questions of motivation and commitment reflect an implementer's assessment of the value of a policy or the appropriateness of the strategy. The educators mentioned that the HoDs and principals visit their classes often to see how they can improve on each programme. In this way, they are able to identify areas that need immediate attention. The educators also mentioned inviting experts to give talks on certain topics during the teaching period to enhance learners' understanding on sexuality issues.

According to Mdutshane (2007), the success of implementation lies in the establishment of effective ways of measuring how well or poorly a change is going on in the classrooms. Therefore, teachers need to be visited and supported by specialists in their classrooms to gain a clear picture of how they are coping with the delivery of the new curriculum (Mdutshane, 2007).

5.3.7 Identified barriers

The educators explained the few challenges hindering the provision of sexuality education. These included: a. Cultural diversity, b. poor teaching conditions, c. poor capacity and d. poor resources and lack of privacy, which will be detailed further.

a. Cultural diversity

The educators find themselves in a dilemma of not knowing whether the learners understood what they were taught or not as these were not reflected on the question responses that educators were asking on learner to review their understanding of the content. *When we teach sexuality education in schools, we are faced with comments like, “Don’t talk about sex, I am not married yet, this is a taboo” or “Don’t talk about sex, if my mother can hear me talking of sex, she will ban me from watching TV” (LO educator, school 1).* This seemed difficult to tackle unless the educator was on a similar culture with the learner facing the dilemma.

As Dube (2003) argued that we often find that when we talk about sex in public, we are faced with comments like, “Don’t talk about sex, we are Christians” or “Don’t talk about sex, we are Africans.”

b. Poor teaching conditions

James-Traore et al. (2004) Indicated poor knowledge and poor training, lack of supportive guidance, the lack of supplies, lack of administrative support, not enough monitoring of the teachers, and few refresher courses affects the introduction of the effectiveness of the programme negatively. Maphumulo (2010) argued that the (DoE, 2007) stated that the crowded and dilapidated classrooms hinder the implementation of the National Curriculum Statement (NCS). High learner-educator ratios, combined with poor physical conditions and inadequate facilities for teaching and learning, such as inadequate instructional support materials, make it more difficult to deliver quality education (Maphumulo, 2010).

c. Poor capacity

Number of LO educators noted when the researcher started the interviews revealed that each school chosen for the study had more than two LO educators. Initially, it was indicated that when the Life Orientation had been introduced, one or two teachers from each school had to be trained (National Department of Education and National Department of Health, 1999 {NSP 2000-2005}).

This showed an improvement in the LO educators development and gave them a greater chance of enriching as many learners as possible with LO education. Although every school in the study had more than two LO educators, they were rotating from one grade to the other. Some educator had 40+ learners in a class, and therefore could not easily maintain eye contact with all the learners. As mentioned by some educators, moving from one class to the other at times confused the content being taught. One educator mentioned that at one stage, this resulted in grade 10 sexuality content being taught in grade 8. At most times, this only realized when the period is almost half done of which by then, there is not enough time to change the content. This therefore confuses the teaching content which ideally is suppose to complementing content from grade 8 to grade 12.

Literature revealed that in 2006 there were 386 595 teachers employed by the DoE, of whom 19 407 (or 5%) were in independent schools. Of those in public institutions, 173 850 were in primary schools, 111 865 in secondary schools, and 53 988 in combined, intermediate or middle schools. In addition, there were 15954 Adult Basic Education and Training (ABET) educators, 7 392 teachers working in special schools and 7 363 in Early Childhood Development (ECD) centres. A total of 24 118 teachers in public schools (or 7%) were employed by school governing bodies (DoE, 2006:9 {KZN-NPF}).

Maphumulo (2010) argued that LO educators are not well capacitated to monitor how learners perceive what is being taught during LO classes. Teacher training development and support are therefore a necessary means of facilitating LO education (Maphumulo, 2010).

d. Poor resources and lack of privacy

As indicated in chapter 4, the schools visited were modern and equipped with basic resources. The educators mentioned uncontrollable resources like electricity (load shedding issues); water (burst pipe) and security issues were mentioned as having posed a few negative impacts on

learning health promotion in schools. Most schools as described in chapter 4., uses modern technology, therefore, educators felt that having to change back to paper work create delays and waste time. Some educators mentioned overcrowded classes some reaching 40 learners. Work overload was indicated as another barrier and few educators mentioned receiving guiding resources late and therefore seek help in health centres.

The researcher argued that the (DoE, 2007) stated that the crowded and dilapidated classrooms hinder the implementation of the National Curriculum Statement (NCS). High learner-educator ratios, combined with poor physical conditions and inadequate facilities for teaching and learning, such as inadequate instructional support materials, make it more difficult to deliver quality education (Maphumulo, 2010).

The study showed that most of LO educators were motivated and encouraged by the introduction of Sexuality education/ LO program. During the interview, LO educator 6 expressed both surprise and dismay at the STIs/ HIV and pregnancy statistic figures (AIDS 2008-XVII International AIDS), asserting that educators who were not passionate about service are detrimental to learners' development. LO educator, School 1 admitted that he became an LO educator in order to help empower learners' development on sexuality skills. In essence, all LO educators who were interviewed gave the same notion. It was clear that most LO educators' spotted a link on sexuality education and HIV right from the beginning. LO educators wanted to expand their knowledge on HIV skills, and all understood HIV to be a global epidemic.

Hans (2007) argued that currently, health promotion service delivery is the responsibility of the national, provincial and local governments, with provincial and local governments mainly implementing programmes, with the National Health Promotion Directorate offering support. There are also national NGOs (such as SOUL CITY, LOVE LIFE) and CBOs operating across the country providing health promotion services. The result is that there are numerous health promotion services with no single body coordinating their activities. There is, therefore, a need for a well coordinated monitoring and evaluation of health promotion services (Hans, 2007).

As the study has revealed, the DoE is doing the best to enlighten the youth to the reality of their sexuality. This cannot be achieved in one corner; a collaborated effort will ensure more productive results.

5.4 SUMMARY

The study has shown that the LO educators with the help from the DoE, are doing the best they can to empower school children with the necessary safety skills to safeguard themselves from sexuality challenges and its complications. The next chapter will describe the results in relation to the theoretical framework and give some recommendation for future studies.

CHAPTER 6

DISCUSSION OF FINDINGS IN RELATION TO THE THEORETICAL FRAMEWORK

6.1 INTRODUCTION

The findings will be discussed with respect to the structure-process-outcome model as outlined in Chapter 2 to identify the educators' experiences in implementing sexuality education as disease prevention and a health promoting strategy at eThekwini-based secondary schools in KZN. Each of the three components of the model will be discussed in respect of the Outcome criteria, the questions for which were outlined in chapter 2, in order to address the two objectives.

1. To explore educators' experience in providing sexuality education in eThekwini-based secondary schools.
2. To determine perceived barriers or support factors for educators when implementing sexuality education in schools.

The study limitations, recommendations and significance will also be presented

6.2 STRUCTURE - PROCESS - OUTCOME CRITERIA

Following the Donabedian evaluation framework, the developed framework (Figure 2.4) indicated that the Structures affects the Process, which in turn impacts on the Outcome criteria, and that for a programme to be effectively implemented, all three areas need to be evaluated. The results were described as set in the tables below

6.2.1 The structure criteria

As indicated in chapter 2, structural standards refer to the setting, the educational context and available resources, these being important because it will give an idea of whether the DoE requirement of providing LO education is fulfilled. This will prove health promotion strategy as a productive tool in schools and therefore enable effective LO education. Table 6.1 outlines a. the secondary schools that offers LO education, b. the educators' demographics and c. the availability of LO educators.

Table 6.1 Structure criteria

Model criteria	How measured
a. The Secondary school that offers the Sexuality/ LO program	<p><i>Establishing if all selected Schools do provide sexuality education/ LO programme:</i></p> <p>All the schools where LO educators participated provided LO education. This is in line with requirement of Life Skills Strategy plan where the DoE mandated the implementation of a comprehensive life skills education programme in all secondary schools by 2005 (Magnani et al., 2005).</p>
b. The Educators' demographics	<p>Obtaining educators ages, gender and qualifications</p> <p><i>Ages: 22-51years.</i></p> <p>Included young teachers of similar age to students as well as mature teachers with more life skills experience. As indicated in literature, the age most affected by the HIV/AIDS epidemic are those of child bearing age 15-49 years (UNAIDS, 2008; ASSA, 2008). Having educators of a similar age group who can relate to similar sexuality experiences will help enlighten the school learners who are affected by the programme or who are already sexual active.</p> <p><i>Gender: 5 female, 2 male.</i></p> <p>Gender did not appear to affect teaching experience. Having more female as LO educators empowers young females with assertiveness skills because they are otherwise unable to influence the sexual behaviour of men even if they have the intention to engage in safer sexual practices. In this way the government is addressing STI preventative strategies for women.</p> <p><i>Qualifications:</i></p> <p>Most educators who were selected to attend these courses were either involved in sports development or career guidance teaching. They had been providing LO teaching area for more than two years had both a diploma and a degree. This proved experience and ability to deal with the challenges that come out when teaching LO. As commented by Waldman (2004), the youth deserve the best-qualified sexual health educators that can be found.</p> <p><i>Establishing if all the schools do have LO educators and determining if these educators do receive continuous training in-service.</i></p> <p>The no of LO educators varied according to the number of learners available in each school with one school (no.5) having 6 LO educators. This showed great developments in terms of the availability of LO educators since the introduction of Life Skills Program in 1999. Long & Zimmerman (2008) emphasized the importance of a teacher in the implementation of a new curriculum. The DoE has done a tremendous job in ensuring that each school has means of developing and training their own LO educators keep abreast with new information.</p>
c. The Availability of LO educators	

The results of this study indicated that all six schools met the structural criteria required to enable effective LO education to occur.

6.2.2 The process criteria

In this criterion, the focus will be on implementation, and facilitation of learning and assessment of achievements. This will describe the following: d. the LO education programmes planning, e. delivery methods and f. communication methods.

Table 6.2 Process criteria

Model criteria	How measured
d. LO education programme planning	<p><i>Identification of the LO educator:</i></p> <p>The identified characteristics were sports and career guidance, role model, qualities and skills with proven experience. This is in line with requirements as identified by most school-based researchers (Campbell & Daria, 2004; Barber, 2004; Smith et al., 2003; James-Traore et al., 2004). This proves that the DoE is following defined criteria when identifying and selecting LO educators.</p>
e. Delivery methods	<p><i>Introduction and phasing in of the LO education:</i></p> <p>This included brief discussions to actual role playing the message to be transmitted using the senior students with the little help from health service sector. This proved accessibility of sexuality education in all schools provided in a coordinated effort among educators, learners, parents and health service centres. Fostering sexuality education content to learners requires transformation of the LO content. This transformation of content occurs as educators critically reflect on and interpret content and determine appropriate examples and instructional representations (Darling-Hammond et al., 2005).</p> <p><i>Views of LO educators on DoE offering the LO programme:</i></p> <p>The LO educators unanimously confirmed that an introduction of LO education programme within the education system was a very good move by DoE. Most children go to school to learn at one stage in their life. Even if these children leave the school before completing all the grades, that child has had an exposure to LO education somehow. In this way such a child will be able to identify wrong from right at one stage in their life since this is the skill that is fostered on the children minds to ensure that they grow old wiser and ready for life challenges.</p>
f. Communication methods	<p><i>Educators' training development</i></p> <p>The study proved that when LO was introduced in schools, DoE embarked on training LO educators using the cascade model. The training was then incorporated into Teachers' Training Colleges. This makes the LO education easily accessible as now educators can choose it as one of their major subjects.</p>

The LO educators indicated that they wanted to be involved in the development and implementation of the program. Although there were widespread consultation within the National Department of Education concerning the introduction of LO in schools, regarding the content of sex and relationship education, no consultation with educators or learners were considered or done. The failure to consult with LO educators was even more pronounced when some LO educators and learners find themselves being confronted with their morals and values because of their conservative nature. Some LO educators clearly found it difficult to balance the need to foster the rationale of LO education whilst at the same time taking the DoE's requirement into account.

The social justice principle relevant to this assumption is participation. This is meant to include perspectives of all stakeholders. It is a major challenge to this principle that HoDs and educators are rarely included in the development of the LO education programs at their school. Even more confronting though, is how to include learners- the most important stakeholder of all- to ensure that programs actually address their needs.

6.2.3 The Outcome criteria

The Outcome criteria will be discussed with respect to the two objectives:

- a. To explore educators' experience in providing sexuality education in eThekwini-based secondary schools.
- b. To determine perceived barriers or support factors for educators when implementing sexuality education in schools.

Objective 1: To explore educators' experience in providing sexuality education in eThekwini-based secondary schools. This objective describes the following: the educators' commitment to the profession and the resources both physical and technologically as shown in (Table 6.3).

Table 6.3: The exploration of educators' experience in providing LO education in eThekweni-based secondary schools.

How measured

Commitment to profession and program

McLaughlin (2006) argued that changes do occur if local leaders show commitment to the project and convey a sense of enthusiasm to the school staff. In part, questions of motivation and commitment reflect an implementer's assessment of the value of a policy or the appropriateness of the strategy.

Attempt to further education:

The educators proved their commitment to the program by attending the necessary training workshops regularly as was provided by the DoE. The study revealed some commitment on the part of some educators voluntarily went for short skill courses on their own accord.

Specialization:

Some LO educators mentioned having enrolled in universities to advance their knowledge and specialize on certain subjects including LO and psychology.

Professional consultation:

It is noted that during the early days of LO introduction only the DoE was training the educators and later the training institution gradually started. For such reasons, it was easier for educators to seek clarity on certain issues from health workers.

Resources

1) Physical

Classrooms:

These were not adequate to accommodate the capacity of learners. The classrooms were capacitated with 40 learners with two schools having 42 learners in each class. This goes beyond the national requirement of 35 learners per teacher. Maphumulo (2010) argued that the crowded and dilapidated classrooms hinder the implementation of the National Curriculum Statement (NCS). High learner-educator ratios, combined with poor physical conditions and inadequate facilities for teaching and learning, such as inadequate instructional support materials, make it more difficult to deliver quality education (Maphumulo, 2010).

Staff rooms/ and library or conference room:

These schools had a library Where the learners can meet and briefly discuss some material in the DoE guideline. All the instructional and teaching guidelines were provided by the DoE and kept safely in school libraries. This is where in some schools, learners practiced and role played some of the teaching content that the educators intended to impart to learners. The resources are the core requisite for any program to be a success.

2) Technological

IT services such as Computers:

Not every school had access to computers. However, where available, this proved to be of valuable help to those educators who were HIV trained to be able to access latest statistics on HIV/ AIDS.

Objective 2: To determine perceived barriers or support factors for educators when implementing sexuality education in schools. This objective describes the support factors and the barriers that hinders the delivery of LO education as shown in (Table 6.4. 1 and 6.4.2).

Table 6.4.1 Determination of support factors for educators when implementing sexuality education in schools: support factors

How measured

Support factors

1) Internal (within the school and department)

Supporting teachers is the key to the successful delivery of sex and relationship education. As Campbell and Daria (2004) suggested that to ensure that LO education programmes are effective, school administrators have to provide continuous staff development sessions for teachers and provide them with current resources.

Establishing availability of support:

LO education is guided by the DoE Policies. A variety of strategies, including refresher courses, mentoring, and supportive supervision, can help ensure long-term impact from training. Because teachers may see this as an additional responsibility when they are overworked and underpaid and may be apprehensive about the subject, incentives need to be given, such as certificates, public recognition, continuing education credits, or opportunities to speak to their colleagues about their work. The study revealed that the LO educators receive updated LO guidelines every year and have continuous one to five days update yearly. However, coordination these activities lacks guidance as some educators reported not having gone to any in-service training due to the shortage of staff as one of their LO educator colleague had taken maternity leave and was not replaced in time.

Inclusion in college training:

The LO training has now been incorporated into Teachers Training college. This gives educators a choice of incorporating LO as one of their major subjects. This lessens the burden on DoE of having to organise trainings often. Now, the DoE can focus the attention on ensuring that LO educators are kept updated with new information.

2) External (interdepartmental)

Teachers will also benefit from being part of an integrated team delivering school based sex and relationships education which receives clear policy direction regarding roles and responsibilities and whose work complements that of parents and health care workers.

Determining the relationship with other departments:

Availability of catalogues, handbooks and determining Health Talk Visits as often as it happens. This ensures continuity of caring for the learners even after school hours. The study revealed that some LO educators seek help from health personnel when challenged with problems that they cannot handle on their own. This shows lack of coordination of service with health department. As Coulson (2000) argued, have a critical role to play in health promotion. The role of the health system includes providing leadership and strategy, and ensuring that there is adequate research and training capacity in the country.

Table 6.4.2 Determination of perceived barriers by educators
when implementing sexuality education in schools: Barriers

How measured

Barriers

1) Communication challenges

Chisholm (2005) contended that in South Africa when the review of curriculum was introduced it had complex language that was difficult for teachers to understand.

Language barrier:

The LO educators indicated that the sensitive issue of the content in LO education created misunderstanding and misinterpretation and this made it difficult for the educators to freely transmit the message behind the content whilst at the same time making it difficult for the learners to comprehend the content. As this was a sensitive topic, some teachers avoided using appropriate wording such as describing sex so they could avoid giggling and many question from the class.

2) Cultural influence

Values, taboo, Cultural diversity and Religious deviation:

This is in line with what the literature revealed. The researcher argued that the flipside of the coin is that culture has fostered the conspiracy of silence (Dube, 2003).

One teacher from the six schools represented gave the impression that there was a positive and productive relationship between classroom teachers and the HPE teacher in terms of achieving health education outcomes. Few LO educators mentioned cultural diversity having a negative effect in LO education especial on Africans, as this leads to misinterpretation and misunderstanding.

Kluge (2006) argued that LO education should take the form of a comprehensive approach that provides knowledge, encourages the development of positive attitudes and self-esteem and provides skills to cope with negative social and cultural norms.

3) Resource challenges

Inadequate Availability of resources:

As described in the first outcome objective above, poor availability of resources created some difficulties when educators were teaching LO. This included inability to keep in check that all learners understood the LO content due to overcrowding. LO education requires time and attention to detail. This together with other subjects taught in schools, deprives learners that individual attention especially when the circumstances requires that special attention.

4) External influences

External influence (i.e. Media; parental; community):

The great fuel comes externally. By the time the educators come into teaching learners, most learners have already been exposed into some form of sex education, primarily at home, by peers in the community or through media. This requires that the educators be more prepared to be able to deal with such influences.

Summary of the Short-term outcome

It is evident from the study that LO educators had different experiences with regard to LO education, as some had only been providing instruction for a short period. The educators, who had guidance teaching experience, as well as those with sports background, had no difficulties during this transition. When introducing the LO education, many of the LO educators had to understand their own sexuality to be able to transmit LO knowledge to learners. This gave rise to many questions, such as morals, culture, values, etc.

As commented by the LO educator, School 6 in Chapter.4, when one is faced by devastating situation, one goes beyond her power and knowledge to seek the appropriate help for each individual. If that is the stance of all health promoters approach when faced with any dilemma, such promoters should play a huge role on identifying and soliciting innovation ideas. Giving adequate support to ensure that such ideas prosper is imperative. This is challenging all the departmental sectors to play a role in ensuring that LO educators have all the help they need (physical and emotional) to assist in growing future healthy adults.

It is evident from the study that LO education is taught in collaboration with other subjects. Some educators indicated that concentrating on LO education burdens other curriculums. The educators argued that as much as they would like to cover and equip as much learners as possibly, the educators felt not properly capacitated.

6.3 RECOMMENDATIONS FOR THE LO EDUCATION

Currently, health promotion service delivery is the responsibility of the national, provincial and local governments with provincial and local governments mainly implementing and the National Health Promotion Directorate offering support. There are also national NGOs (such as SOUL CITY, LOVE LIFE) and CBOs operating across the country providing health promotion services. The result is that health promotion services are grossly proliferated with no single body coordinating activities. There is, therefore, a need for a well coordinated monitoring and evaluation of health promotion services.

6.3.1 The LO educators' recommendations to service and practice

Exploring the notion of having LO educators trained on most short skills courses like HIV counselling and dealing with rape to improve educators' confidence when challenged with such situations in a classroom need further research. In this way the DoE can benefit both from not contracting external service specialist whilst ensuring enhancement of skills development on both the educators and learners.

6.3.2 Recommendations to Department of Education

Introducing alternative teaching methods like inviting speakers for sessions from other departments as well as parents/ guardians to reinforce LO education will play a vital role. This will help educators understand the cultural diversity and view LO education not merely as a subject, but more of a necessity to prevent problems resulting from not talking freely about sex. Working in collaboration with other departments will ensure continuity of youth care even after school hours.

6.3.3 Recommendations for further research

Further investigation needs to be done to check the advantages of having health promoters taking a part in teaching the learners LO education parallel with and collaborating with the LO educators. This could be in combination with the educator or by taking a particular topic in the learning outcome to emphasize what the LO educators are teaching.

6.4 LIMITATIONS

This was an explorative study limited to Life Orientation Educators at eThekweni-Based Secondary schools and who are currently teaching the Life Orientation Programme. While the findings may be relevant to institutions under similar administrative authority, they cannot be assumed to be generalisable for areas with access to fewer resources or throughout the whole country.

6.5 CONCLUSION

It is clear from the study that LO education goal as mandated by the DoE is achieved in all schools. The findings of this study indicate that to have an effective LO

education, there are a number of issues that need to be reviewed. These include policy changes and implications, planning and implementation, human resources and skills development, expertise, system improvements, monitoring and evaluation, and health promotion collaboration with various departments which is described below:

Policy changes and implications

The implementation of health promotion as defined by the Ottawa Charter (1986) should be empowering, participatory, holistic, intersectoral, equitable, sustainable, and multi-strategy

Planning and implementation

The study revealed that educators wanted to be consulted and involved in the planning phase of the LO education. Therefore, the adoption of participatory approach provides meaningful opportunities for involvement by all those with direct interest in health promotion initiatives. They should have the opportunity to participate in all stages of its planning and evaluation. Direct, hands-on health promotion experiences, will enable educators to make valuable contributions to the LO education.

Adequate resources

The study revealed that educators felt inadequately capacitated as well having limited resources. Both these have a negative impact on what the learners absorb and understand. Therefore adequate resources need to be devoted to health promotion initiatives.

Expertise

Expertise supports the establishment of a training and education infrastructure to develop expertise in the evaluation of health promotion initiatives. The study revealed that this is done through educators' networks and through DoE workshops. Thus expertise needs to be developed and sustained as this creates and promotes opportunities for sharing information.

System improvements

Health care personnel can function parallel with educators to ensure continuity of health promotion both during and after school hours. Health workers can also have a discussion with local committees in order to gain understanding of customs and traditions which will help equip them formulate appropriate messages in short stories or songs.

Curriculum development

Effective health promotion depends on a broad information base and with the help of new technology, librarians are responding to this challenge. The DoE need to ensure that curriculum keeps updated with new information.

Monitoring and evaluation

Literature revealed that evaluation tends to focus on learners as recipients of the service, looking at their change in behaviour, leaving the providers out. Health promotion initiatives should be evaluated in terms of their processes and outcomes.

Health promotion collaboration

What is obvious nowadays is that health promotion programs that were once limited to hospitals settings have now moved into the community settings such as clinics, schools, churches, businesses and industry. Health promotion is a process directed towards enabling people to take action. Thus, health promotion is not something that is done on or to people; it is done by, with and for people either as individuals or as groups. The purpose of this activity is to strengthen the skills and capabilities of individuals to take action and the capacity of groups or communities to act collectively to exert control over the determinants of health and achieve positive change.

Health education is an instrument for the prevention of disease and the promotion of health. It forms foundation of primary health care and is an important method of transmitting messages about the modification of health behaviours, as well as prevention of diseases to as many people as possibly.

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INTERVIEW SCHEDULE

Date of interview: _____

Demographics:

Type of school

Private		Public		Other	
---------	--	--------	--	-------	--

Policy framework that guides the program (Explain briefly):

Age in years (Optional) _____

Gender _____

Number of years in the teaching profession _____

Number of years as a Sexual Education Educator _____

Educational qualifications

Diploma _____

Degree _____

Additional
qualifications _____

1. How did you get involved in teaching this program? (How were you identified?)
2. How were you selected? (Did they specify which attributes were required? what?)
3. What training did you receive to offer the program?
4. Can you explain briefly how the sexuality program is implemented? (What does the curriculum cover?)
5. Can you share your experiences in teaching sexuality education so far?
6. What is your view on having educators offering this program?
7. What kind of support are you receiving as an educator involved in this program?
(From whom? In what way?)
8. What barriers if any, have you experienced when offering the program?



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02 February 2010

Ms. B K R Khathi
Faculty of Health Sciences
School of Nursing
HOWARD COLLEGE CAMPUS

Dear Ms. Khathi

PROTOCOL: "An exploration of Educators' experiences in implementing Sexuality Education in selected eThekweni-based Secondary Schools"
ETHICAL APPROVAL NUMBER: HSS/QQ49/10M

In response to your application dated 27 January 2010, Student Number: **206517942** the Humanities & Social Sciences Ethics Committee has considered the abovementioned application and the protocol has been given **FULL APPROVAL**

PLEASE NOTE: Research data should be securely stored in the school/ department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.
Yours faithfully

Professor Steve Collings (Chair)
HUMANITIES & SOCIAL SCIENCES ETHICS COMMITTEE

cc: Supervisor (Dr. G Mchunu)
cc: Ms, C Dhanraj



kzn education
Department:
Education
KWAZULU-NATAL

MS B KHATHI
UNIVERSITY OF HEALTH SCIENCES
SCHOOL OF NURSING

Enquiries: Sibusiso Alwar
Date: 09/03/2010
Reference: 0026/2010

RESEARCH PROPOSAL: AN EXPLORATION OF EDUCATORS' EXPERIENCES IN IMPLEMENTING SEXUALITY EDUCATION IN SELECTED ETHEKWINI-BASED SECONDARY SCHOOLS

Your application to conduct the above-mentioned research in schools in the attached list has been approved subject to the following conditions:

1. Principals, educators and learners are under no obligation to assist you in your investigation.
2. Principals, educators, learners and schools should not be identifiable in any way from the results of the investigation.
3. You make all the arrangements concerning your investigation.
4. Educator programmes are not to be interrupted.
5. The investigation is to be conducted from 08 March 2010 to 08 March 2011.
6. Should you wish to extend the period of your survey at the school(s) please contact Mr Sibusiso Alwar at the contact numbers above.
7. A photocopy of this letter is submitted to the principal of the school where the intended research is to be conducted.
8. Your research will be limited to the schools submitted.
9. A brief summary of the content, findings and recommendations is provided to the Director: Resource Planning.

...dedicated to service and performance
beyond the call of duty.

KWAZULU-NATAL DEPARTMENT OF EDUCATION

POSTAL: Private Bag X9137, Pietermaritzburg, 3200, KwaZulu-Natal, Republic of South Africa
PHYSICAL: Office G25, 188 Pietermaritz Street, Metropolitan Building, PIETERMARITZBURG 3201
TEL: Tel: +27 33 341 8610/8611 | Fax: +27 33 341 8612 | E-mail:



kzn education
Department:
Education
KWAZULU-NATAL

10. The Department receives a copy of the completed report/dissertation/thesis addressed to:

The Director: Resource Planning
Private Bag X9137
Pietermaritzburg
3200

We wish you success in your research.

Kind regards

R. Cassius Lubisi (PhD)
Superintendent-General

...dedicated to service and performance
beyond the call of duty.

KWAZULU-NATAL DEPARTMENT OF EDUCATION

POSTAL: Private Bag X9137, Pietermaritzburg, 3200, KwaZulu-Natal, Republic of South Africa
PHYSICAL: Office G25, 188 Pietermaritz Street, Metropolitan Building, PIETERMARITZBURG 3201
TEL: Tel: +27 33 341 8610/8611 | Fax: +27 33 341 8612 | E-mail:



kzn education
Department:
Education
KWAZULU-NATAL

MS B KHATHI
UNIVERSITY OF HEALTH SCIENCES
SCHOOL OF NURSING

Enquiries: Sibusiso Alwar
Date: 08/03/2010
Reference: 0026/2010

PERMISSION TO INTERVIEW LEARNERS AND EDUCATORS

The above matter refers.

Permission is hereby granted to interview Departmental Officials, learners and educators in selected schools of the Province of KwaZulu-Natal subject to the following conditions:

1. You make all the arrangements concerning your interviews.
2. Educators' programmes are not interrupted.
3. Interviews are not conducted during the time of writing examinations in schools.
4. Learners, educators and schools are not identifiable in any way from the results of the interviews.
5. Your interviews are limited only to targeted schools.
6. A brief summary of the interview content, findings and recommendations is provided to my office.
7. A copy of this letter is submitted to District Managers and principals of schools where the intended interviews are to be conducted.

The KZN Department of education fully supports your commitment to research: **An exploration of educators' experiences in implementing sexuality education in selected eThekweni-based secondary schools**

It is hoped that you will find the above in order.

Best Wishes


R Cassius Lubisi, (PhD)
Superintendent-General

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Information sheet

Title

An Exploration of Educators' Experiences in implementing Sexuality Education Program as Disease Prevention and a Health Promotion Strategy in Selected eThekweni-based Secondary Schools

Background

Health promotion interventions have been identified as one of the strategies that can empower people with skills that will assist them in making informed choices regarding their own health. In line with this strategy, the South African Government has identified the school as the most important setting for health promotion programs through their health promoting schools initiative (Coulson, 1999: 297). Literature reveals that HIV/ AIDS education forms the central part of sex education or sexuality education (Avert, 2005; Kluge, 2006; WHO, 2004). In HIV/ AIDS education, the process involves developing young people's skills so that they make informed choices about their behaviour and feel confident and competent about acting on their choice (Avert, 2005:67). Kluge argued that in promoting sexual health in adolescents, it is not adequate to only provide sex education, but young people should be empowered to determine their own healthy sexual behaviour (Kluge, 2006).

According to the Provincial MEC for education in KwaZulu-Natal (KZN), the department has adopted a number of measures in a bid to remedy the issue of teenage pregnancy (Daily News, 2006:2). These measures include programmes

such as life skill orientation and sexuality education. There is however still some concerns that in spite of these programmes being in place; a number of new HIV infection and teenage pregnancy in school are on the increase (Daily News, 2006:2).

Despite, these initiatives by the government, statistics still show that there is an increase in the number of school pupils in KZN that are running a risk of being infected with the dreaded HIV and AIDS scourge owing to the alarmingly high rate of teenage pregnancy in schools (Daily News on August 25, 2006:2). According to the report sent to DoE, a total of **5 349** school pupils fell pregnant in year 2005, while in 2004, **5 358** cases of teenage pregnancy were recorded by the department (Daily News on August 25, 2006:2).

What is the purpose of the study?

In the South African context, studies relating to sexuality education in schools have mainly focused on learners as the recipients of service. In essence, there has been no study that focuses on evaluating the process of implementing sexuality education by South African educators. Such an evaluation can provide baseline information with regards to effectiveness of educational approach in providing sexuality education in schools.

The purpose of the study is therefore to explore the process involved in implementing sexuality education in Durban-based secondary schools, in KZN, with the main focus on educators' experiences.

Why have I been chosen?

Since school nurse's service have been reduced from providing health promotion service in schools, life skills orientation component is now a responsibility of the educators. In KZN, the process of implementing such programmes has up to this far not been evaluated. Furthermore, it is unclear how the educators are experiencing this new role and how it affects their productivity. There is therefore a need for a study that will evaluate teachers' experiences in providing sexuality education in schools.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will be involved if we agree to take part in the study?

This is a voluntary study to discuss the educators' experiences during implementation of sexuality education. An individual interview with each participant will be conducted by the researcher. It is anticipated that the expected duration of the participant's involvement will take more or less one hour (about \pm 1hr).

Can I withdraw at any time?

Yes, everyone is free to change their minds. A participant is free at any time to withdraw consent to further involvement in the research, without having to face any unfair negative consequence or disadvantage.

When and where will the interview take place?

With the permission of the Principal(s)/ HOD(s) and if the participants are comfortable, the researcher plans to have the interviews conducted within the school premises. The researcher aims to begin interviews from the 1st April to early August 2010.

What other information will be collected in the study?

Demographic related question e.g. age; gender; etc. In all cases confidentiality will be maintained, responses will be kept anonymous, and researcher will respect the decisions of participants as to the extent of their involvement in the study. This will help if there is a need to verify certain responses during data analysis.

Will this influence my opportunity to teach in future?

No, however, the researcher hopes that the findings of the study can be used as the baseline for evaluation of the existing school based sexuality education/ Life skills

Orientation program. Moreover, the findings of this study can contribute in designing capacity building programs for educators and as well, looking into a collective approach, including utilising parents and other government departments to participate in this project of curbing STIs/ HIV in schools.



Faculty of Health Sciences

School of Nursing

An Exploration of Educators' Experiences in implementing Sexuality Education as Disease Prevention and a Health Promotion Strategy in Selected eThekweni-based Secondary Schools

Nursing (Community Health)

Postnet suite 33
Private bag
x9005
Pietermaritzburg
3200

Dear Principal/ HOD

RE: PERMISSION REQUEST TO CONDUCT RESEARCH STUDY

I kindly request your permission to conduct my research study in your school. I am currently studying masters nursing in Community Health at UKZN- Howard College and in order to fulfill the requirements for a coursework masters in Nursing (Community Health), I need to conduct a research study. I have chosen the above named study. Please find enclosed the approval by the UKZN Ethics Review committee; the approval by the KZN DoE and the Information sheet.

The KwaZulu-Natal Department of Education has granted me permission to conduct this study at eThekweni-based Secondary Schools, Umgeni North Branch. This will be facilitated by allowing the educators some time which will be +_ one hour (1hr) to participate in interviews that I will be conducting. Furthermore, I ask permission to

use the school Boardroom/ conference room when conducting these interviews in order to take as less time as possible.

Please kindly respond by placing a mark below:

Permission granted yes no

Name of the Principal/ HOD-----

Principal / HOD's signature-----

School stamp-----

Date-----

This can easily be returned by fax, email or call me to collect it at once. I will also be calling back in seven days (7 days), to verify if completed for collection.

Student NO: 206517942

031 3686527 (H)

031 5641211 (W)

0865788433 (fax)

0832281149 (C)

busisiwemakhathak@yahoo.com

Thanking you in anticipation

Yours gratefully

Busisiwe Khathi (Miss)

Signed and dated-----

Supervisor:

Dr Gugu Mchunu

Academic Coordinator: Bachelor of Nursing Advanced Practice (BN-AP)

University of KwaZulu Natal

School of Nursing

Desmond Clarence Building, Rm 04-014

Durban

4041

Email: mchunug@ukzn.ac.za

Tel: +27 31 2601075

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You are invited to participate in individual interview that is part of a study entitled:

'An Exploration of Educators' Experiences in implementing Sexuality Education as Disease Prevention and a Health Promotion Strategy in selected eThekweni-based Secondary Schools'

Please read the information Sheet carefully, and feel free to ask questions you might have.

Researcher(s):

Busisiwe Khathi, Principal Investigator

UKZN Student: 206517942

Faculty of Health Science

Masters in Community Health Nursing

University of KwaZulu-Natal: Howard College

Telephone numbers: 031 3686527 (H); 031 5641211 (W); 0832281149 (C).

Email address: busisiwemakhathak@yahoo.com

Zanele Tembe, research assistant

X UKZN Community Nursing Student

Registered Nurse

Redhill Clinic

Telephone numbers: 031 564 5938 (H); 031 5641211 (W); 0842613928(C).

Email address tembezanele@yahoo.com

SUPERVISOR (S):

<u>Former</u>	<u>Latter</u>
Dr Gugu Mchunu Academic Coordinator: Bachelor of Nursing Advanced Practice (BN-AP) University of KwaZulu-Natal School of Nursing Desmond Clarence Building Room 04- 014 Durban 4041 Email: mchunug@ukzn.ac.za Tel: +27 31 2601075 Fax: +27 31 2601543	Professor Busisiwe Ncama Head of Department – School of Nursing University of KwaZulu-Natal Email: Ncamab@ukzn.ac.za Tel: +27 31 2602270 Fax: +27 31 2601543

Description

There are no known risks from participating in the individual interviews. We will be audio taping the interviews, and have the tapes transcribed. Tapes and transcripts will be kept in locked storage at the University of KwaZulu-Natal for five years, until at least (2015). The consent forms signed by participants will be kept separate from the tapes and transcripts.

You will not be identified by name anywhere in the transcripts. We will also send a brief summary of the interviews, and invite you to comment on the issues raised. We will not disclose the identity of anyone providing these comments.

We will be presenting the results of our research in the research thesis, and may use direct quotations. However, we will not use a quotation when doing so that might identify the person speaking.

If you have any questions concerning the study, please feel free to ask at any point; you are also free to contact the researchers at the numbers provided above if you have questions at a later time. This study has been approved on ethical grounds by the University of KwaZulu-Natal

Behavioural Sciences Research Ethics Board on (02 Feb 2010). Any questions regarding your rights as a participant may be addressed to that committee through the Office of Research Services at (031 260 1075).

Consent to Participate: *I have read and understood the description provided above; I have been provided with an opportunity to ask questions and my questions have been answered satisfactorily. I consent to participate in the study described above and I understand that I may withdraw this consent at any time. A copy of this consent form has been given to me for my records.*

(Signature of Participant)

(Date)

(Signature of Researcher)

ADDITIONAL SKILLS

The researcher discovered that out of the seven interviewed LO educators, two of these LO educators had been trained as HIV counsellors and one of the two was also trained on how to counsel rape victims. This educator described the circumstances that led her into training for HIV counselling and how she ended up in a Rape Victim Management workshop.

“Long before this whole guidance, this whole LO Programme was implemented, a little girl named Putty (not real name), she came to me and explained some of her symptoms to me, “I really didn’t know what to do.” So I took her to the hospital. It turned out she had STIs. But the word that she used to describe it was new to me and I really did not understand what it meant. I thought about it and realized I was faced with a major situation. Then I thought to myself, how can one deal with something that one doesn’t understand. Worse, this girl had to also go for HIV testing. At that time people were not even talking about HIV, this was still new. When the test came back, she was told she was HIV positive. This hit me hard, it disturbed me so much, and I didn’t know what to do or how to help her. There was this conflict in my head, thinking about religion, morals, and everything. I gave her a whole pack of condoms. I then phoned City Health and asked for help. That’s when I enrolled for the two weeks HIV counselling course. I knew nothing about it, it was all new. At that time we as teachers thought that sexuality should be taught by parents at home and we as teachers should supplement what the parents have already done. So we thought the parents were doing it and the parents thought we were doing it. Now that this programme has been implemented, some parents are happy that we are teaching LO while others complain that we are giving the learners too much information, so much that they go outside and experiment it., so it causes conflicts” (LO educator, school 6).

This LO educator explained that she further went for a Rape Victim Management workshop, but it was expensive. She paid R400 for this course.

Annexure I

A SAMPLE OF TRANSCRIPT OF ORAL INTERVIEW

LO educator teaching LO (Grade 9-12)

1. How did the educators get involved in teaching the sexuality/ LO programme? (How were they identified?)

There was a position advertise, LO educator in 2001. I enjoy teaching sports, and sports involve teaching LO. That's how basically I became interested and therefore, I responded to the advertisement.

2. How were the educators selected? (Did they specify which attributes were required? If so, what were these attributes?)

It was not specifically for sexuality education, it was LO post and they were looking more for somebody with a sport background and with the ability to organize the programme. In terms of guidance and skills, one definitely needed an experience in a sport background.

3. What training did the educator(s) receive prior to teaching sexuality education/ LO programme?

Every year the DoE have workshop on LO. This covers different aspects of LO. Three of these workshops were a five day course and were quite extensive.

4. Can the educators explain briefly how the sexuality programme is implemented? (What does it cover?)

LO did not come easily, it was phased in gradual. LO covers four different aspects sports and recreation, career education, personal well being. Sexuality will fall under Personal wellbeing. We address various personal developments. Grade 8 and nine is basically an introduction. It is structured in such a way that it is a major part in grade 10. What is done is explaining the body structure changes, as most of learners are already maturing at this time. This is where we go in-depth in discussing sexual reproduction and its challenges. The aspect discusses sexual behaviour as a whole, explaining menstrual cycle and masturbation, having sex, falling pregnant, sexually

transmitted diseases and HIV/ AIDS. The text book covers this section extensively. In grade 11 and 12, the emphasis is more careers orientated.

5. How have the educators experienced teaching sexuality education/ LO so far?

Children need lot of guidance. Lot of children comes from homes where there is no proper guidance undertaken. They don't have people teaching them personal hygiene and body changes.

Working with the kids that are already sexual active is a challenge. Teaching sexuality is one thing, but trying to persuade these kids to change their behaviour is more challenging. Very seldom, these kids will come forth for help. What we have done, is that every year we set up a Health Club in conjunction with the LO. We invite various experts including parents to take part in this club. However, this year, this did not get off the ground because of the pressure of workload from other curriculums.

Some kids do not take LO seriously and still fool around the subjects. We have then started placing them in community centres to do certain hours.

6. What is the educator(s) view on having educators offering this programme?

It burdens other curriculum. However, it is important that educators teach this curriculum at school. It is very important that the kids have this explained to them so that they do not learn by experiencing sex in their own. The educators have the opportunity to get these kids at school and in this way all the learners are exposed to this programme.

7. What kind of support are the educators receiving as an educator involved in this programme? (From whom? In what way?)

The DOE provides us with guidelines; we also have textbooks that we use. We have departments and regional meetings where we share information on handling the task in a more positive way.

8. What barriers, if any, have the educators experienced when offering the programme?

Nothing necessarily needs to be removed. However, most of the learners are shy and feel uncomfortable expressing themselves in front of the others. This curriculum need restructuring in such a way that girls have a separate class from boys, i.e. have a female LO educator responsible for teaching girls and a male educator for boys. This will facilitate the kids to express themselves freely without fearing negative remarks from the opposite gender, which in most cases they see each other as their boy/ girl friends already.