Teach Them While They Are Young, They Will Live to Remember
The views of teachers and pupils on the teaching of HIV/AIDS in basic education: A case study of Zambia's Lusaka and Southern Provinces

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Introduction

According to UNAIDS and World Health Organization (UNAIDS, 2000) data, a total of 33.6 million adults and children are estimated to be living with HIV. Sub-Saharan Africa is the region with the highest number of these cases, estimated at 23.3 million. By the end of 1999, 16.3 million adults and children died due to HIV/AIDS. 13.7 million of those 16.3 million deaths occurred in Sub-Saharan Africa (USAIDS, 1999). Although unfathomable and difficult to express, perhaps the 1999 Association of Commonwealth Universities (ACU) Bulletin puts it best:

> The numbers seem too huge to grasp, the implications too terrifying to contemplate. The devastation of human life on such a scale is nothing less than a holocaust. Yet there is much that can be done to stem the tide of horror caused by the 'big disease with the little name' (p. 5).

The Bulletin further states that a global state of emergency was declared at the Commonwealth Heads of Government meetings in 1999. This declaration is a result of three facts. First, there is the lack of a near-term prospect of a vaccine. Second, existing drug therapies, though relatively effective, are too expensive for most poor countries. Third, interventions can be effective, and there is a tremendous need to start educating people at a younger age across the broader spectrum of the population. This paper limits itself to the efforts being made by the Ministry of Education (MOE) in Zambia on fighting the spread of the disease among school children and teachers.

The impact of HIV/AIDS on education in Zambia

In Zambia, as in many countries, a two-way relationship exists between health and education. Teaching and learning are affected by the personal health of school communities and by school activities. Obviously, all that is learned about health can have powerful effects on the health and well being of pupils. In addition, no amount of good school facilities, abundant materials and high quality teaching can result in the intended learning if children are too sick or weak to learn. This relationship between education and health is of great importance in Zambia where poverty related malnutrition, environmentally related malaria, life style related sexually transmitted diseases (including HIV and AIDS), and other health problems are widespread.

A 1999 Zambian Ministry of Health (MOH) Report summarizes the impact of HIV and AIDS on education by highlighting that there are decreasing numbers of trained teachers and education officers, increased teacher absenteeism, reduced public finance for schools, more orphans with less access to education, and fewer children able to afford, attend and/or complete school (p. 48).

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The MOH (1999) estimates that between 90,000 and 100,000 Zambians are said to develop full-blown AIDS each year. It also indicates that Zambia's cases stabilized at 600,000 in 1994 and 1998, but could rise to 19 percent by the end of the year 2000. Neighboring countries like Zimbabwe and Botswana have a prevalence rate close to 25 percent, while cases in Uganda have dropped to 10 percent. The MOH (1999) lists many social factors affecting the HIV/AIDS epidemic in Zambia including sexual behavior, cultural practices and poverty which gives rise to factors such as lack of disposable needles, gloves, sterilizers, autoclaving machines and laboratory reagents (p. 21). In response, the MOH is spearheading campaigns against HIV infections through their HIV/AIDS unit that falls under the AIDS/STD/TB and Leprosy program (NASTLP). The MOH's efforts are strengthened by those of the Ministries of Education, Information, Community and Social services, which are also working against the spread of HIV.

MOE policy interventions on the teaching of HIV/AIDS

The Zambian MOE regards HIV/AIDS as a cross cutting issue to be addressed in all subject areas. In 1993 it adopted an integrated approach to the teaching of HIV/AIDS. This followed along the heels of policy enacted in 1992 that encouraged the formation of Anti-AIDS Clubs in primary and secondary schools, teacher training colleges and other institutions of higher learning. Extra curricular activities including drama, cultural clubs and peer counseling were also expected to incorporate HIV/AIDS awareness messages and mandated to be offered in primary and secondary schools and teacher training colleges.

As this study and others show, however, in general, Zambian teachers are either not aware of using extra-curricular activities to teach HIV/AIDS, or they do not see them as viable channels (Chiwela and Mwape, 1999, p. 22). This is because much as there is policy on the formation of Anti-AIDS clubs to supplement the teaching of HIV/AIDS, very few teachers and pupils are members and these clubs do not even exist in some schools.

As a result, the MOE, UNESCO, UNICEF, the World Bank's Basic Education Sub-Sector Investment Program (BESSIP), and other co-operating partners have concluded that Life Skills Programs in schools are the best way to address HIV/AIDS prevention. This program, slated to be integrated in all subjects and introduced in all schools by the end of the year 2000, will include comprehensive training for education managers, college lecturers, teachers, head teachers and student teachers. Emphasis will be placed on the basic subject content of HIV/AIDS and other health-related facts as well as on staff roles in attitude and behavior formation, and behavior change.

HIV/AIDS curricula already exist in Zambia's three teacher training colleges supported by the Danish Development agency (DANIDA). All students spend one semester on the subject, while those studying home economics, environmental science, literature and languages spend two extra weeks specifically covering HIV/AIDS. Syllabi are currently being piloted through the Zambian Teacher Education Reform Program (ZAREP).

Case Study

Between January and February 2000 a case study was conducted in Zambia's urban Lusaka Province and rural Southern Province to uncover and analyze the views of teachers and pupils on the teaching of HIV/AIDS in basic education. Data was collected with the help of a Zambian research assistant over a five-week period. These provinces were selected to facilitate quick access in light of the limited time available for data collection. The researcher sampled for information and not representativeness. The sample for this qualitative case study totaled thirty-eight pupils and sixteen teachers. Research techniques involved interviews, observations, and document review.

The main aim of this study was to examine the views of teachers and pupils on the teaching of HIV/AIDS in Basic Schools (i.e. schools that cover Grades 1 to 9 which include, primary and lower secondary schools also known as upper basic classes). This gave rise to several sub-questions including:

- How much training do teachers receive in the teaching of HIV/AIDS in schools?
- What school activities cover HIV/AIDS?
- What do pupils know about HIV/AIDS?
- What impact does the teaching of HIV/AIDS have on pupils?
- Are there any cultural conflicts that arise when discussing HIV/AIDS?
- How can the teaching of HIV/AIDS be improved?

This study was guided by early childhood development theories (Rosso and Malek, 1996; Colletta, Balachander & Liang, 1996; O'Flaherty, 1995), which state that there are benefits to starting the teaching of any subject at an early age and deciding the content according to the age of the children. Other influential theories included: (1) behaviorist theory, which emphasizes teaching for behavior change; (2) cognitive interactionist theories, which state that understanding and insights guide behavior; (3) Thorndike's theory of connectionism, and (4) Skinner's theory of operant conditioning, which states that reinforcement and repetition are important for teaching behavior change (Bigge & Shermis, 1992).

Five schools were selected from Lusaka Province. These included two government schools (Munali Basic and Chelston Basic), one Christian school (St. Mary's Primary, for Grades 5 and 7 samples and the Secondary School for Grade 9 samples), one private school (Rhodes Park Primary) and one Community school. A Community school has no age limits and is run by the community and or the church. Teachers tend to be volunteers paid by the community and/or the church. Pupils who do well in these schools eventually enter the formal school system. The Community school in Lusaka province caters to drop-outs, especially girls. Three schools were selected from Southern Province. They included two government schools (Magoye Basic and Monze East Basic schools) and one Christian school (St. Joseph's).

The choice of these schools not only allowed for a comparison of urban versus rural school systems, but for the comparison of data generated from schools being governed by different organizations. This is based on the assumption that even if the curriculum is centralized, its implementation can differ according to school management styles. Sixteen teachers were selected from the above-mentioned schools using non-random

sampling. The sample was therefore purposeful and comprised of those involved in the teaching of HIV/AIDS. One or two teachers were selected from each school from either Grades 5, 7 or 9, depending on the teachers' availability and presence on the day interviews were being conducted.

The thirty-eight pupils were selected by stratified and simple random sampling methods using class registers. These included one pupil from each of the Grades 5 and 7 stratas and three or more pupils from some schools at the Grade 9 strata. Grade 9 pupils were selected to evaluate cumulative knowledge, as this is the grade when pupils move from lower to middle and upper basic classes respectively.

A total of eight focus group discussions were held with pupils, including four groups in government schools in Lusaka and Southern province (two in each province), three in the community school, and one with girls only at a Christian school in Southern province. Focus group discussions had an average of ten participants selected with the help of teachers who chose the children on the basis of their ability to communicate effectively in group discussions. The groups consisted of eight to twelve respondents of the same grade and sex, (intended to allow for free discussions) who sat together with the researchers in a circle to facilitate eye contact and group work.

Data collection started with informal discussions to create rapport between respondents and researchers and all discussions were tape recorded for future analysis. Separate non-standardized, open-ended interview guides were used and the sessions were conducted in both English and Zambian vernacular. Interviews lasted between 30 minutes to one hour. Data collection stopped when the sample became saturated.

Documents reviewed include the MOE policy on the implementation of the integration of HIV/AIDS teaching, a proposal on the integration of Psychosocial Life Skills, three textbooks used in the teaching of HIV/AIDS in schools (MacMillan and Longman Health Education Readers, Teaching AIDS and Kalulu). These documents gave insight into what was happening on the ground, while the pupil readers gave insight into what kind of curricula existed.

Findings

Training background on HIV/AIDS for teachers

Although the MOE has a clear policy on the integration of HIV/AIDS into basic school and college curricula it is not foolproof. As one MOE official saw it, there were two main problems. First, there were no teaching/learning materials provided. Second, teachers were not trained. In addition, the officer admitted that although the teacher training colleges had developed a training manual, it was not in use. There was no reason given for this. The MOE officer did explain that they will adopt some of the contents from the Life Skills Education Initiative used in Uganda under the School Health Education Project (SHEP). The teaching of Life Skills will specifically include the skills of knowing and living with oneself, the skills of knowing and living with others, and the skills of making effective decisions (Mabala, 1998, pp. 1-5). This Psychosocial Life Skills curricula would also be included in all subjects to address behavior change. The MOE officer was also optimistic that the involvement of the World Bank's BESSIP Program would improve material distribution and in-service training for teachers since BESSIP is

encouraging District Education Resource Centers to meet more often to discuss issues such as how to teach a HIV/AIDS curriculum more effectively.

Overall, teachers indicated that they received inadequate training in preparing them for teaching HIV/AIDS. The largest number of respondents (81 percent) cited either not receiving training at all or learning on their own. Many teachers reported that schools needed teaching and learning materials and that the subject needed to be given more class time. They cited shortage of time and rare opportunities to go into detail, adding that "very few teachers attend seminars and workshops on HIV/AIDS. (…) We only use our ability to educate the children."

Another teacher went into even greater detail explaining that "children need to be given the information so that they can share it among themselves, their families and communities. The teaching needs to start early so that they can grow up enlightened." In fact, both teachers and pupils viewed HIV/AIDS teaching as very important and something to be encouraged. Both also indicated that the teaching of HIV/AIDS had positive effects on the pupils' lives with some pupils promising that they would avoid infection. When asked how the teaching of HIV/AIDS could be improved, nine teachers or 66 percent said, "get all teachers more involved, train them and let it be part of the school syllabus," and "there must be a deliberate mention of HIV in every subject."

There is no need to spell out the connection between inadequate training and inaccurate information being passed on to pupils. It is important to note, however, that the pupils themselves were aware of the fact that their teachers were not doing enough in the teaching of HIV/AIDS. Perhaps even more importantly, they indicated that they would like to see their teachers getting more involved in the teaching of the subject. Pupils also wanted to see teachers more involved when teaching the subject, and to lead by example by practicing the sexual behavior changes they teach pupils, such as avoiding casual sex, sticking to one partner, and using condoms.

It is evident that the responsibility to teach the subject of HIV/AIDS has added to societal pressure on how many teachers conduct their private lives. Some pupils said that teachers ought to discuss these issues openly and be role models: "teachers are shy, they are not open when discussing issues on sex." Chiwela and Mwape (1999) in their study justify teachers' shyness and lack of openness by indicating that teachers, just like any other adults, feel embarrassed to deal with matters related to sex with their pupils (p. ii). This is largely because in Zambian society, it is inappropriate to discuss sex with younger people. Chiwela and Mwape also established that some teachers were against the use of charts showing sex acts and demonstrations on how to put on a condom because teachers thought they bordered on being pornographic materials. Such beliefs, held by society for decades, can be removed by incorporating the use of more such charts so that people become more used to seeing them and may then be able to discuss sex with less reservations.

When asked during this study how the teaching of HIV/AIDS could be improved in schools, a combination of 20 of the pupils interviewed alone and in focus groups stated: "teachers should start teaching AIDS," "parents should ask teachers to start teaching AIDS in schools," and "teachers should feel free to discuss AIDS." One male teacher from

a rural government school however defended the teachers. He explained that teachers might be interested in teaching HIV/AIDS, but that they have neither the real support nor incentives to do so. He cited the absence of teaching and learning materials as a case in point. In a similar study, Chiwela and Siamwiza (1999) also found that nearly half of the school administrators in Zambia admitted that nothing was being done to enable teachers to teach these topics. These authors also noted that there was no system in place to monitor how teachers handled such issues in class (p. 15).

School activities covering topics on HIV/AIDS
The main activities cited by both teachers and pupils as covering HIV/AIDS were extra-curricular clubs where the technique of children teaching other children using 'child to child' messages tends to be employed. The most-often cited clubs were the Anti-AIDS and Red Cross Clubs, facilitated by teachers or health workers who are sometimes invited to give talks on HIV/AIDS to club members. A few pupils also mentioned singing clubs, debate clubs, biology and science clubs as options for learning about HIV/AIDS.

These findings have significant implications for the implementation of MOE policies. Although policy on the formation of extra-curricular clubs was adopted in the early 1990s, some schools still do not have such clubs. For example, out of the thirty-eight pupils interviewed in this study, only three were members of the Anti-AIDS Club at their school. Yet, at the same time, when pupils were asked how the teaching of HIV/AIDS could be improved in their schools, ten pupils, or 26 percent, responded by forming Anti-AIDS Clubs. It should also be noted that although these clubs are said to contribute to the teaching of HIV/AIDS participation by both teachers and pupils is voluntary.

What do pupils know about HIV/AIDS?
All 38 of the pupils interviewed in-depth, along with the 89 who participated in focus group discussions, knew of HIV/AIDS. There were a few who did say, "I don't know" (Grade 2 pupil) and "I am not sure" (Grade 9 pupil), but this was because they thought the researcher wanted them to define the letters HIV/AIDS. They were able to answer all subsequent questions competently. The findings from this study do indicate, however, that even if knowledge of HIV/AIDS is very high, there are still some pupils who are not sure what the difference between HIV and AIDS is. Consider the following response from a Grade 7 male pupil: "HIV is a disease you get after unsafe sex." When asked what AIDS was, he then answered, "HIV and AIDS are the same."

Interestingly, all seven Grade 5 pupils used the word disease in their answers. The pupils either said that HIV was a disease in itself or that "it is a disease you get before you get AIDS and AIDS is a disease without cure or disease that kills people who like sex. (…) It's a disease with more diseases." Consider that during one of the focus group discussions with Grade 7 pupils, a pupil caused laughter when he stated that "HIV is a disease that came from monkeys in America." He insisted that he was speaking from an informed point of view as he was certain he had read somewhere that HIV was first diagnosed in the United States of America associated with chimpanzees. These responses could be taken to reveal exactly what kind of information is emphasized to

pupils or they could be a reflection of what children conclude on their own after reading magazines and/or listening to television.

Transmission of HIV

When asked how a person becomes infected with HIV, the majority responded that HIV is transmitted through sex. More than half of the respondents (53 percent) were able to qualify their answer by saying, "you can get AIDS by having sex with the infected partner." This could mean that half of the pupils believe that having sex causes HIV. It could also mean that they just forgot to qualify their answers. The same goes for the eleven pupils or 29 percent of respondents who stated that HIV is caused: "by having sex without a condom," "by having unprotected sex," or "by having sex with many sexual partners."

These responses assume that even if people are HIV negative, they can get HIV after having 'unprotected sex' (sex without a condom). The pupils did not indicate understanding of the need for one of the persons to be HIV positive for the disease to be transmitted during any type of sexual intercourse. However, 14 pupils or 36 percent did say a person can get HIV through blood transfusions or from using un-sterile utensils like razor blades, needles and/or sharp objects. It should be noted, however, that only four out of that fourteen (29 percent) mentioned that the transfusion involved HIV infected blood, or that the un-sterile utensils, etc. must be contaminated with HIV infected fluids.

The cure for AIDS

When asked what the cure for AIDS was 63 percent of the pupils answered that there was no cure; 23 percent said that the cure was abstinence from sex - or, as one Grade 9 male student put it, "you just have to control yourself when you get sexual feelings." To some degree this may not be considered an answer since many may consider sex a basic physiological need. One pupil responded that a cure for AIDS was "to not sleep around." The pupil actually meant that reducing sexual partners would be a cure for AIDS. This is probably because Zambian National Television carries messages about sticking to one faithful partner. The pupils did not realize that a person could have one HIV infected sexual partner who could transmit the infection. Another pupil from a Christian school responded, "God can heal, if you have faith." This response indicates a belief that God can cure HIV and AIDS. Most of the pupils also mentioned contraceptives, stating that you can protect yourself "when having sex, if you use condoms each time" -- a statement that also sounds like it may come from a television commercial.

The prevention of HIV/AIDS

When asked how a person could prevent becoming infected with HIV almost all the pupils (84 percent) responded by using a condom. This response was expected due to the many advertisements on National Television that talk about using condoms. In fact, many of the pupils' responses were in line with the MOH's descriptions of prevention as safer sexual practice, mutual fidelity, non-penetrative sex, partner reduction, condom use and avoidance of risk-conducive situations. One respondent was however quick to add that "using condoms, is not 100 percent safe." Like nine others, this pupil advocated abstaining from sex as a sure way of HIV prevention. Interestingly many pupils talked about abstinence but very few added that they should abstain until marriage, then

marry a partner after they have proof that the partner is HIV negative. Other pupils used phrases like "by not sleeping around," "avoid sex," "no sex," "being faithful," "stick to one faithful partner." Other respondents who talked about the use of un-sterile utensils as a possible way of contracting HIV, also talked about using sterile needles, razor blades and other sharp objects as a way of preventing the HIV infection. Yet only once, during this study as part of a focus group discussion with seven boys in an urban government school, did a pupil who had earlier talked about blood transfusion as a possible transmitter of HIV respond that it was important to "test blood for HIV." Overall these responses indicate that there are still gaps in information given or retained by pupils.

The source of pupils' knowledge of HIV/AIDS

This study established that the main source of the pupils' information on HIV/AIDS was television and radio (66 percent). It also revealed that many pupils who learned about HIV/AIDS in schools tended to be taught in Anti-AIDS Clubs by teachers and Health Workers. It is interesting to note that the Community school in the Lusaka Province taught HIV/AIDS through sports related activities instead of in class while one Christian school in the Southern Province taught it through the Zambia Young Christian Society (ZYCS). The ZYCS is actually in the process of developing a syllabus for the teaching of HIV/AIDS and another Christian school in Lusaka Province that does not currently teach HIV/AIDS is also developing a syllabus. Reading through the proposed subject contents, however, it is clear that the approach is purely fact-driven and does not address behavior changes or life skills.

Two pupils also cited church as a source of information on HIV/AIDS and eight said they got information from their parents. One boy, from a Grade 9 class said, "my mother told me, but she was shy." On average, however, student interviews revealed that some parents appreciated the teaching of HIV/AIDS and had also started discussing the subject with their children. It was encouraging to find that some parents are now discussing sexual issues with children, but it is a pity that parents feel shy or embarrassed to discuss an issue that can determine their child's future.

Effects of HIV/AIDS lessons on pupils

To determine the effects of HIV/AIDS teaching on pupils, both teachers and pupils were asked how the information has changed the lives of pupils and how they would use this information in future. Most teachers responded that children are now more aware of the dangers of HIV/AIDS, that they keep away from these dangers, and that they also teach others about HIV/AIDS. One teacher who responded that it has increased pupils' knowledge of the disease also said: "Kids are now aware of the seriousness of the disease, they promise to keep away from dangerous sexual activities. (…) Male pupils always move with condoms in their pockets."

Other teachers who saw positive behavior changes added that "it has reduced indulgence in immoral behavior, they practice safe sex and say no to sex," and "it has contributed to the prevention of AIDS in that pupils now know how AIDS is spread and that it brings low production." Teachers also mentioned the issue of AIDS orphans, and that both those who have lost their relatives as well as those who have not "would not want to make the same mistake." Although most teachers recognized that only a few

pupils had probably actually changed their behavior, they tended to credit awareness and any behavior change to the in-school teaching.

It should be noted however that change in behavior is also directly related to many television and radio campaigns organized by NGOs targeting adolescents in and out of school. Together, these combined efforts, in and out of school, may have led to the reduction in the number of new infections in the 15 to 19 age group in 1999 (MOH 1999, p. 9).

Consider that about half of the pupils (47 percent) responded that the HIV/AIDS information has made them more aware of the dangers of the disease and therefore will be more careful about their lives. Several pupils said: "it has helped me to be careful with my life and not to sleep around so that I will not die young," and "it has helped me not to have sex until I am married and to think more about my future life and success."

The extent to which pupils will put into practice what they learn remains uncertain. For example, one pupil who did not think that the information on HIV/AIDS changed his life in any way, said: "It hasn't really changed my life but at least I know what AIDS is and in future I know how to take care of myself. I will always keep the information in my mind and teach others about AIDS." Eleven pupils (29 percent) responded that they would abstain from sex until marriage while others said they would use condoms whenever they had sex. It was interesting to find that some girls used the information to prevent pregnancy, with one girl even saying that it had helped her not to get pregnant and thereby helping her finish her education. Two teachers from two different schools in the rural Southern Province reported that they had witnessed a reduction in the number of pregnancies at their respective schools in the past two or three years and that they actually had no pregnancies in 1999. The teachers attributed the reduction to the increase in the number of pupils using condoms. Last but not least, 82 percent of those interviewed and most of the pupils who participated in all focus group discussions, said their greatest wish was to teach their children, friends, families and community members about HIV/AIDS.

How the teaching of HIV/AIDS could be improved in schools

62 percent of the teachers responded that there was a need for more teaching materials especially for the lower grades (i.e., Grades 1 to 5). Teachers, as well as four pupils (11 percent) said that schools needed more books, videotapes, charts, magazines and teachers' guides and manuals on HIV/AIDS. Some teachers said: "A subject based on HIV/AIDS notions should be introduced. All teachers should be involved in teaching the dangers of the scourge and it should be given a 40-minute period each week." The fact that teachers responded in this manner was interesting because they often complain of an overloaded curriculum. This is an indication of just how aware teachers are of the importance of the subject.

Another suggestion from both teachers and pupils was to start teaching the subject early in schools. This proved slightly controversial as one teacher commented: "I think HIV/AIDS teaching should be introduced at an early stage so that pupils can know about the killer disease (AIDS) even as they grow they can be able to teach others about it." Yet others disagreed stating, "it is unfair to teach the Grade 1 to 4 pupils because they

don't understand." One female pupil from a private school echoed this view, but what neither the teachers nor the pupil seem to realize is that understanding is contingent on teaching according to the level of understanding of pupils, which is practiced in all subjects. Subjects, which continue from Grade 1 until the last grade (Grade 12), are built on content as a child advances in school. The same could be done with topics related to HIV/AIDS.

Teachers and pupils also suggested the formation of Anti-AIDS Clubs, Red Cross, Drama Clubs and ZYCS clubs, to compliment the efforts of class teaching of HIV/AIDS. These clubs could then perform for the whole school or give organized talks to other pupils in order to reach pupils who are not club members. Pupils also suggested that more teaching needs to be intake place in rural communities. This was particularly true as radio and television messages target the urban population who have access to the media.

HIV/AIDS discussions in Zambian culture

Both pupils and teachers were asked whether there were any cultural conflicts in the teaching of HIV/AIDS. Nine out of 16 teachers (56 percent) said "yes". They responded that parents were not happy with schools discussing sexual issues with children who were still young because early teaching of sexual issues brings about promiscuity at an early age for the children. In Zambia, the word "sex" has been considered culturally taboo. The same goes for names used to describe sexual activity. As a result other words such as "sleeping" and "playing" had to be used when describing sexual acts.

Chiwela and Siamwiza (1999) found that teachers also hold the same belief that exposing young people to sexual information and related images, stimulates them to practice what they see or hear (p. 11). In this study one teacher said: "Parents have accused us of teaching children to have sex and use condoms." There is a strong belief among some parents and adults in Zambia that children try out what they learn. This argument has been discussed even on national television where women think that sexual discussions given to young girls during initiation ceremonies, make them curious and therefore they start practicing sex earlier than those who have had no exposure to sexual education. This assertion may have some truth to it but children can learn about sex from television and friends. Moreover, there has been no change in the average age of first having sex despite an increase in sex education. The good thing about teaching safer sex practices is that children are informed. They would then finally make their own informed choices before they have sex.

Some teachers added that even though the community believes that they teach promiscuity because they teach children how to use condoms, they are happy about the AIDS awareness among their children. As one teacher put it: "Yes, those days it was not culturally accepted although nowadays, parents and teachers are open to discuss AIDS with children, to some extent the language used, but now society is slowly accepting these facts. (…) It is also discussed during initiation ceremonies."

When asked whether they discussed HIV/AIDS with their friends, more than half of the pupils said that they did. This indicates that at least children have started talking to each other about the disease. Consider the following: "We discuss it with friends to help each

other, we also discuss with parents because they want us to know more about it," and "I discuss it only with my mother, I do not feel comfortable to discuss it with my dad." Similar responses were also given by a group of twelve girls attending Grade 7 classes at the Community school during focus group discussions. About a quarter of the girls said that they have discussed HIV/AIDS with their mothers but not fathers at least once. Some pupils responded that their age could be why their parents had not discussed this topic with them. Many of them said they thought their parents thought they were still too young. As one 12-year-old, Grade 7 male pupil said: "I don't know why I do not discuss HIV/AIDS with my parents, but now my mother told me that one day we will sit down and discuss. Maybe my parents think it is too early for me to know such things until I grow a bit older."

Another 13-year-old, Grade 7 male pupil from a private school responded that "my family members do not have time to discuss AIDS, I also think I am still too young, that is why my parents do not want to discuss this issue with me." A 14-year-old, grade 9 female pupil from an urban Christian school responded, "I think my parents still stick to principles of their time, for example, some parents believe that it does not show respect to discuss issues relating to sex and sexuality with children." A 12-year-old, Grade 5 male pupil from an urban government school said, "It is not good to discuss sexual issues. I am scared to discuss with my parents because my parents get embarrassed and annoyed when you talk about sex." Lastly, one 14-year-old, Grade 9 female pupil from a rural urban government school, had this to say, "my parents think I learn about most of the things at school." Other pupils added that their family members might think that "each and every family member discovers about such things like AIDS from other people" or because "everyone in our home knows about it, so they express less concern about discussing it."

These responses indicate that overall parents are not doing much to discuss the issues of HIV/AIDS with their children. During a focus group discussion with ten boys at a private urban school, one pupil said that the parents could be infected themselves and would find it difficult to advise children on how to avoid infection. At the moment, due to the stigma associating HIV/AIDS with promiscuity or unfaithfulness, parents who are infected might be more effective in teaching their children to avoid infection so that the children do not end up like them. These findings agree with Siamwiza (1999) who indicated that far too many people, including teachers, find themselves in a situation where they are embarrassed to teach about HIV/AIDS because of their own HIV status or vulnerable situation (p. 32). However, some orphaned children are believed to have made positive decisions about their sex lives due to experiences they have had with their parents before they died.

Lastly, during focus group discussions some pupils responded that discussions on HIV/AIDS were more open in urban areas compared to rural areas where people are still very conservative. One adult during an informal discussion made the important point that that Zambian culture teaches young people to respect elders. Similarly girls are asked to respect older women and men. How then can young girls be expected to say 'no' to sexual advances from older men including teachers?

Conclusion

Although the HIV/AIDS subject has been integrated into Science, Social Studies, Environmental Sciences, English, Home Economics, Religious and Moral Education, Geography, Physical Education and the proposed Psychosocial Life Skills, it has been given less emphasis because it appears as a topic in passing. Pupils had high knowledge levels on HIV and AIDS, especially on the sexually related prevention methods of HIV infection. Most of the pupils also knew that there was no cure for HIV/AIDS although many cited use of condoms. Overall, however, the knowledge displayed by pupils lacked detail. For example, most pupils did not associate HIV/AIDS infection with an infected person or infected blood and infected razor blades, needles and other sharp objects. Lack of school discussions could have led to the lack of factual details about the disease. Teachers and pupils were, in general, not satisfied with the extent to which HIV/AIDS is taught in schools. Pupils and teachers would also like to see an increase in the supply of teaching/learning materials in schools including audio-visual materials. Pupils also pointed out that they would like to see teachers improve their approach and involvement in the teaching of HIV and AIDS in schools.

In general, the pupils were very enthusiastic about being part of the HIV/AIDS awareness campaign group. Most pupils were very interested in teaching their children, families, parents and the community about the disease. They said that they would avoid getting infected and think about their future. Both pupils and teachers felt that the teaching of HIV/AIDS was a very good and important subject that needed to be allocated more class time than what is currently in practice. Pupils talked about doing everything possible to prevent infection and not die at an early age.

The culture of sex education in Zambia has changed slightly with a few parents reported as having discussed HIV and AIDS with their children. Few other family members seem to discuss the topic with children. More still needs to be done to change the attitudes of majority of parents who think that children are too young to discuss sex and children who feel they cannot discuss sex with parents.

More programs are needed to address parents' problems in facing the reality of inevitable discussions on HIV and AIDS, for the current increasing trend of infection to be reduced. It is time that the older generations in Zambia realized that children have the right to information, to enable them to make informed choices. This therefore calls for change in the sexual behavior patterns of adults as well as children in the society these children are expected to live in as independent adults.

Lastly, although this study sampled for information over representation and/or generalization, its findings do depict a similar picture to that of the larger study done by Chiwela, Siamwiza and Mwape (1999 that was generalized to Zambia as a whole.

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