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# Teaching HIV/AIDS Curriculum to Primary Schoolchildren in the Republic of the Congo

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Teaching HIV/AIDS Curriculum to Primary Schoolchildren in the Republic of the Congo

By

Goma Mabika

A Thesis

Presented to the Graduate and Research Committee of Lehigh University in Candidacy for the  
Degree of Master of Arts

In Comparative and International Education

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## ***Abstract***

*2015 is the UN target year for countries round the world to halt, and then reverse the HIV/AIDS prevalence rate within their national boundaries. In most countries, education has been chosen as the cornerstone of prevention programs designed to meet that goal. Education is believed to impact young children's behaviors at an early age and equip them with life skills that will help them adopt healthy sexual behavior once they become sexually active. Today, three years ahead of the target year, studies reveal that the HIV/AIDS prevalence rate has neither been reversed nor halted and education in most parts of the world has not played a significant role in bringing young people to positively change their sexual behavior. Sub-Saharan Africa remains the most affected and the least effective part of the world in combating the pandemic. In most Sub-Saharan African countries, schools are failing to protect children from the pandemic threat and teachers are reported not to fully meet the goals set in the formal HIV/AIDS curriculum. The purpose of this study was to look at factors that prevent teachers from meeting the goals set in the formal curriculum. The study targeted grades 5 and 6 teachers in public primary schools in the Republic of Congo. It focused on, but was not limited to, factors such as teachers' religiosity, gender, in-service training to explain their attitudes toward sex education in primary schools. To achieve this, a semi-structured phone interview was conducted with teachers purposely selected. The study looked at these factors through the lens of the childhood innocence discourse (Beck et al, 1976) and the self-efficacy model, a component of the social learning theory (Irwin et al., 1994). An examination of the above mentioned cultural aspects of the teaching job through an ethnographic approach gave insight as to why teachers are not likely to meet the goal set in the formal HIV/AIDS curriculum in the three schools targeted in the Republic of Congo.*

## ***Introduction***

Twelve years after 189 countries around the world agreed to halt, and then reverse the HIV/AIDS prevalence rate by 2015, we can ask today what has been done so far and where countries stand in meeting that goal. Unexpectedly, recent statistics on HIV/AIDS show that infection rates and mortality due to HIV/AIDS continue to skyrocket specially in developing countries. In 2009, an estimated 33.3 million people lived with HIV, 33% higher than in 1999 (World Health Report, 2011). Just in the period from 2000 to 2004, there were 4 million new HIV infections and about 3 million died of HIV/AIDS around the world (UNAIDS, 2011). However, when we look at statistics at a regional level, it is clear that some regions of the world have made progress in reducing the spread of HIV/AIDS while others have failed. In South East Asia, for instance, the prevalence rate has been slightly reversed with 4.0 million people living with HIV/AIDS in 2000 and 3.8 million in 2008 (UNAIDS, 2010). That is quite the contrary to other areas of the developing world. In Sub-Saharan Africa, especially, 22.4 million people lived with HIV/AIDS in 2008 while they were 19.7 million eight years earlier (UNAIDS, 2010).

To halve the HIV/AIDS infection rate by 2015, most Sub-Saharan African governments adopted HIV/AIDS school-based intervention programs. Because education shapes the conscience of schoolchildren, it is believed to impact learners' behavioral change. And studies reveal that kids become aware of HIV/AIDS and risky behaviors when they are taught about sexuality issues early, before they become sexually active (Baxen, 2009; Coombe, 2000; Bhana, 2007). Every country adopted a formal HIV/AIDS curriculum with similarities: in almost all countries, HIV/AIDS curriculum is student-centered, has sections on human and children's rights and focuses on life skills and reproductive health education in early childhood education. In South Africa for instance, the National Policy on HIV/AIDS for Learners and Educators in

Public Schools (Department of Education, 1999) recognizes the duty of the state to ensure that schools and teachers provide adequate information and education on HIV/AIDS in the context of life-skills education (Bhana, 2009). In the Republic of Congo, the life-skills curriculum (PRESLADIS) was introduced in 2004. This HIV/AIDS program covers sex education from elementary school to high school to ready schoolchildren from an early age to face the challenge of the HIV spoiled adult world. This is still a challenge.

In 2000, the UN Economic Commission for Africa commissioned a case study for the African Development Forum that examined the impact of the HIV/AIDS education programs in combating HIV/AIDS (Coombe, 2000) in Sub-Saharan Africa. The Commission investigated specifically how to increase the capacities of education systems to change the behavior of learners and educators. The case investigation revealed that education has not yet played a significant role in fighting the disease. Apart from lack of funding, and weak political leadership, for most Sub-Saharan HIV/AIDS intervention programs, teachers in this region face cultural barriers and lack professional training to implement the HIV/AIDS curriculum in schools. Studies confirm that teachers in Sub-Saharan Africa not only lack adequate knowledge on the pandemic due to poor access to training, they also do not feel comfortable teaching HIV/AIDS and sex education in class, as set in the formal curriculum (Coombe, 2000; Bhana, 2007; Baxen, 2009; Epstein, 2000). For the most part, teachers think that schoolchildren, mainly in elementary schools are too young to learn about sexual issues. Teachers perceive schoolchildren as sexually innocent deserving protection against any sex-related information (Baxen, 2009).

In the beginning, when I was thinking investigating the impact of religion, gender and professional training on teachers' implementation of the HIV/AIDS curriculum in Sub-Saharan Africa, my first interest was to compare South Africa to the Republic of Congo. I chose South

Africa because of its higher rate of HIV seropositive persons and the Republic of Congo because the HIV infection rate has been reported to decrease over these years (CNLS, 2010). Soon, the existing literature gave me two opposite realities. First, much of what has been published on teachers' implementation of the HIV/AIDS concerns Eastern and Southern African countries. Second, no study has been published on the Republic of Congo that assesses the HIV curriculum even in a broader context. This gap in the existing literature brought me to shift my research interest uniquely on the Republic of Congo, my native country.

Notwithstanding the limitations, the existing literature has identified some factors affecting teachers' implementation of HIV/AIDS curriculum in the Southern Africa. These factors include religion, gender and in-service training. I chose to investigate the same factors in the context of the Republic of Congo, focusing on the implementation of the HIV/AIDS curriculum in grades 5 and 6 in primary schools in the Republic of Congo. In particular, the study focused on, but was not limited to, factors found from the literature review such as teachers' religiosity, gender, in-service training to explain their attitudes toward sex education in primary schools. Participants were teachers of grades 5 and 6 in the three following primary schools: Mayindou, Ngambio, La Poudriere in Brazzaville, the capital of the Republic of Congo.

To explore this phenomenon in its entire dimension, the research aimed at answering the following question: *What are the factors that facilitate or inhibit teachers' likelihood to implement the HIV/AIDS curriculum in public primary schools in the Republic of Congo?* More especially this study addressed the following questions: (a) what is the current background of the teachers in grades 5 and 6 in selected schools (age, gender, level of education attainment, work experience, religion)? (b) What is their personal experience with teaching the HIV/AIDS curriculum? (c) What is their training in relation to the teaching of the HIV/AIDS curriculum?

The first question investigated the influence of teachers' religion, age, gender and the level of education attainment on their teaching of the HIV/AIDS curriculum. For each demographic indicator, the researcher looked at convergent and divergent views among the participants regarding the implementation of HIV/AIDS curriculum. For instance, the study examined whether there was a difference in curriculum implementation between younger teachers and older ones, between teachers with higher level of education attainment and those with low level of education or between male and female teachers.

The second question focused on teachers' personal experience with the curriculum. This question looked at the number of years a teacher has been teaching the curriculum and to what extent teaching experience influenced curriculum implementation at the classroom level. It also highlighted the challenges faced by teachers in implementing the HIV/AIDS curriculum.

The last question examined whether and how the implementation of the HIV/AIDS curriculum is related to in-service training. The study looked at the difference between teachers who have received training to implement the HIV/AIDS curriculum and those who have not. For teachers who have received training, I looked at the duration of the training and the teachers' opinion about the perceived benefits of the training. For teachers who did not receive any training, I wanted to know whether it was their own decision and what were their expectations for in-service training more broadly.

Combined, the study aimed to capture the complexity of teacher experiences with the implementation of the HIV/AIDS curriculum, paying particular attention to teacher demographics (age, religion, and gender), teaching experience, and in-service training.

## ***Literature Review***

### *Overview*

Although my research focuses on primary schools in the Republic of the Congo, all studies included in this literature review were conducted in the Southern part of Africa, mostly from South Africa, Malawi, Zambia, Botswana and other southern African countries. As I said, no study has been done in the Republic of Congo to assess the HIV/AIDS curriculum since it was instituted in the primary education program in 2001. However, because most of the HIV curriculum in Sub-Saharan Africa follows the guidelines suggested by the World Health Organization, I believe findings that have assessed the curriculum in other countries of similar cultural context, even if non-generalizable, can inform and guide my research in the Republic of Congo. That is why I chose to review these studies, even if they do not talk directly about the country I am researching.

The selection of the materials reviewed follows three criteria of high importance for my research: the date of publication, the setting and the themes. All materials reviewed are published after 1995 because, before that, the HIV/AIDS curriculum and the Life Skills programs were not implemented yet in most Sub-Saharan African countries. As far as the setting is concerned, I was more interested in Sub-Saharan Africa, and not Africa as a whole. I did not include the literature on North Africa. I believe there are more cultural differences between the Republic of Congo and countries in the Maghreb than between countries of Saharan Africa. However, I do not mean to say that all countries in Sub-Saharan Africa are culturally homogeneous. Three main themes came out of the literature review: teachers' religious involvement, gender and HIV/AIDS related in-service training.

### *Teachers' religious involvement*

Many systematic reviews of HIV/AIDS prevention programs have concluded that religion has an impact on teachers' decision to fully implement the HIV/AIDS curriculum in primary school in Sub-Saharan Africa (Baxen & Breidlid, 2005; Zou et. al., 2009; Trinitapoli, 2006; Nsubunga & Bonnet, 2009). However, before diving into the review of the literature related to teachers' religious involvement, let me make one remark. I notice that the existing literature on teachers' religiosity does not specifically talk about teachers as individuals, but as members of different religious communities. This shows the power religion has on individuals in general and on teachers in particular in the context of the Sub-Saharan Africa, where all the studies I am reviewing were conducted. In all the materials, teachers did not have their voice. The literature refers exclusively to the views of the religious leaders on HIV/AIDS and sex education. Also, the literature does not mention non-religious teachers as if in Sub-Saharan Africa, all teachers belonged to a religious organization, which I doubt to be true. It leaves me the feeling that teachers' religiosity is subordinate to the views of the religious communities they belong to. I found it important to point this out as I am going through the literature.

Three major themes come out of the literature on teachers' religiosity in Sub-Saharan Africa: the primary purpose of sex, condom use and monogamy, and language to be used when referring to sexual organs or sexual relationships.

The debate on the primary goal of sex is largely discussed in the literature. It explains how Christians, Muslims and Rastafarians conceptualize the purpose of the sexual act, ascertaining their views from their religious teachings. While Catholic, Protestants and Muslims share the same opinion on this issue, Rastafarians have different view. For Catholic, Protestants

or Muslims, the primary purpose of sex is procreation, not pleasure and is only appropriate within the marriage context (Baxen & Breidlid, 2005). Rastafarians do not believe in conventional marriage and are opposed to the Catholics', Protestants' or Muslims' views that non-married and pre-married individuals should abstain from having sex before marriage. If for the first group of religious leaders, married persons should remain faithful to their spouses, Rastafarians do not even think marriage is a symbol of love (Trinitapoli, 2006; Trinitapoli & Regnerus, 2006, Baxen & Breidlid, 2005).

The condom use issue is also differently approached by different religious organizations in Africa. This is obvious in the findings of three studies I found interesting to review. The first study was conducted by Zou and others on the influence of religious beliefs on HIV stigma and treatment attitudes in Tanzania. Responses to the question concerning participants' HIV knowledge, attitudes and use of all sexually active respondents, 55.5% responded that they never use condoms. While Pentecostals were likely to admit they never use condoms, Catholics were the least likely to say that (Zou et al., 2009). In Baxen's study South African primary schools, the findings on the vulnerability and risk of religious people toward the HIV pandemic are quite different. Here, Christians, Jewish and Muslims as a whole seem to agree on the non-condom use except Sangomas and Rastafarians, both traditional religions in South Africa whose faith is based on healing sicknesses from spiritual practices, prayer being the most common. Findings from this study report that Christians, Jews and Muslims believe HIV/AIDS is a punishment from GOD against those who deliberately choose to sin, pointing out extra-marital and same sex intercourses as the causes. Therefore, promoting condom use will encourage infidelity. Rastafarians and Sangomas have their own perspective on condom use. Not only they believe that HIV resulted from poverty people from developing countries live in, they also promote

condom use as a protection against the pandemic. The study by Trinitapoli draws a new line between Pentecostals and Catholics on the condom use issue. The findings report that Pentecostal pastors are more likely to relax prohibition on condom use than Catholic priests.

The language to use when discussing issues around sexuality matters in religion. Naming sexual organs, using body languages and motion to explain how to unfold and use a condom are “dirty words” for Christians, Catholic and Muslims. For instance, Simpson reports that, due to their Christian beliefs, Kenyan educated mothers learned to use “clean language” (Simpson, 2009). They were able to avoid talking about sexuality, sex education because they are dirty words. God does not want them to use such words as Christians. Referring to or even thinking of something that concerns private parts of the body like sexual organs is dirty. In Kenya for example, sex education is taught by biology teachers, using a bio-medical model of HIV/AIDS (Mbugua, 2004) but the language to use is censored by the community. How do religious views on sexuality inhibit teachers’ abilities to fully implement the HIV/AIDS curriculum?

Religion and education are two social forces that shape community and individual behaviors and attitudes (Baxen & Breidlid, 2005). Many teachers are part of the two social forces, religion and education. Therefore, they are affected by them. Consequently, teachers tend to reproduce their religious beliefs at school, and in class (Lesko et al, 2010). For instance, many teachers do not feel comfortable to teach sections of the curriculum that require them to talk about sex education (Coombe, 2000).

### *Teachers’ Gender*

Gender is a social construct. It shapes individuals' identities and personalities as social beings. Stereotypes around masculinity and femininity are present in all spheres of social life,

even at school. Its impact on the educational environment is undeniable (Mathews et al., 2006). The existing literature indicates the link between teachers' gender and their pedagogical choices (Chege, 2006; Nsubunga & Bonnet, 2009; Mathew et al., 2006). As far as the implementation of the HIV/AIDS curriculum is concerned, a number of studies that assess teachers' attitudes and perceptions on sex education for primary schoolchildren identify some differences in teaching outcomes between male and female teachers due to their gender. Unlike male, female teachers are more likely to implement the curriculum. They also are more likely to perceive the consensus among their colleagues about the importance of teaching HIV/AIDS education (Mathew et al., 2006). These findings are justified by two main factors: teachers' perceived identity and their ability to maintain discipline in class.

At school, descriptive norms and teachers' beliefs on the outcome of teaching the HIV/AIDS curriculum sometime follow the gender divide line (Helleve, 2001). In class, gender is a key element from which teachers negotiate their role as an adult. It is also through gender that many students construct their teachers' identity and personality. In the teaching of HIV/AIDS for instance, teachers' gender plays a significant role in inhibiting or facilitating the learning process (Weiss et al., 2000). A good example of this assertion is the students' portrayal of male teachers seeking to have sexual relations with female students as intimidating, violent and sexual bullies, an identity that contrasts to that of female teachers presented as caring and motherly (Chege, 2006). This portrait of male teachers problematizes their teachings on HIV/AIDS and sex education in many schools. Because male teachers, most of them married, wanted to have extramarital relationships with their female students, it is evident that their teachings on fidelity and abstinence as a preventive mode against HIV/AIDS pandemic will have limited influence on students' behavior change. Therefore, female teachers, constructed as

“caring”, not sexual to school boys, are believed to be able to fully implement the HIV/AIDS curriculum (Chege, 2006).

Maintaining discipline in class is teachers' major concern. Apart from many other strategies, teachers put gender into play to obtain students' attention during a lesson. The literature indicates that discipline is a very important aspect for teachers during the HIV/AIDS classes.. Class sessions on sexuality with young boys and girls can turn distractive if teachers do not have skills to maintain discipline in class. Students seem so enthusiastic about sex education topics that they can unconsciously disrupt the class. Teachers have to find a way to have a productive lesson on sexuality and obtain the expected outcome. Many teachers use their gender position to explain to the students why they teach them abstinence, condom use or fidelity for instance. Here a female teacher says: “I don’t depend on the manual only, I would even tell them my experience as a mother” (Helleve et al., 2001, p. 2). Like the female teacher, the male teacher also constructs his identity in teaching the HIV/AIDS education round his masculinity. From the quote above, gender seems to be a complicating factor for male teachers and a facilitator for female teachers.

#### *Teachers’ HIV/AIDS related in-service training*

Although teachers’ religion and gender impact on their teachings of the HIV/AIDS curriculum in primary schools in Sub-Saharan Africa, substantial research has demonstrated that teachers could fully implement the curriculum if they have received and continue to receive adequate training to do so (Bhana, 2000; Coombe, 2002; Mathews et al., 2006; Gallant & Maticka-Tyndale, 2003; Benell, 2001). The effect of teachers' religious involvement and gender could be reduced if teachers receive adequate training to implement the HIV/AIDS curriculum in

primary schools (Baxen & Breidlid, 2009). Training strengthens teachers' resilience against social norms that prevent them from fully meeting their professional goals (Mathews et al., 2006).

For instance, in a study published by Mathew and others that assessed the impact of teachers' training on their ability to implement the curriculum in South Africa, the variable for teachers who reported that they have been implementing the curriculum indicated a significant relationship with their training experience. In other words, teachers who reported having received previous training were more likely to implement the HIV/AIDS curriculum in South African primary schools than those who reported that they have not received adequate training (Mathews, 2006). The same results have been found in research that assessed "Life Skills Programs" in Namibia, Lesotho, and Swaziland. Teachers reported not having received enough training to implement the HIV/AIDS curriculum (Guchihi, 1999). The researcher concluded that teachers are facing self-efficacy in implementing the HIV/AIDS curriculum due to their lack of training.

Many teachers in Sub-Saharan Africa do not realize their susceptibility to be infected or expose schoolchildren to the risk of contamination by not teaching the HIV/AIDS curriculum. They are reported to lack the correct knowledge about the mode of contamination. Some teachers still believe that they can tell the HIV status of a person by the way he/she looks (Baxen, 2005). It is clear that those teachers do not feel the danger of being contaminated the same way others see it. They may happen to think that as long as schoolchildren can tell the HIV status by looking at the person's physical appearance, they will not feel the urgency of digging deep into issues around sexuality in class.

Training helps teachers acquire the accurate the right knowledge on HIV/AIDS. Because many teachers do not receive training prior teaching the HIV/AIDS curriculum, they consequently lack the right message to deliver to schoolchildren and the proper way to do it. They report feeling ashamed to starting teaching kids on an issue they lack correct knowledge themselves (Benell, 20001; Mathews, 2006; Debbie, 1999). Because of new technologies of information and communication, some students who have access to them from home are even reported to be more knowledgeable than their teachers on the issue of HIV/AIDS. Teachers feel embarrassed not only by this, but also by other students' questions they cannot correctly answer. They lack the self-efficacy the Health Belief Model (HBM) talks about. For some teachers, it is a humiliation that young children know more on these issues than they do (Verma, 1997). They decide not to teach some sections of the curriculum they do not have knowledge on rather than feel humiliated.

Talking to schoolchildren about their sexuality at their younger age is a new habit for adults in Sub-Saharan Africa in general, and for teachers in particular (Kinsman, 2002) and doing so without adequate skills can produce the opposite of the expected outcome. Traditionally, as stated earlier in the section about religious beliefs, adults do not talk about sexuality with children. That is how it has been for generations in Africa (Verma, 1997). Now that the devastation of the HIV/AIDS pandemic requires change of certain social norms that prevent government and community prevention programs from combating efficiently the pandemic, teachers' behavior change becomes investable. However, because teachers lack training on sexuality issues, talking about it to children may bring the opposite of the expected outcome. Teachers may end up using the opportunity of opening up class discussion on sexuality to sexually molest female students who may already be sexually active (Chege, 2006).

In summary, existing research highlights three major themes regarding the implementation of the HIV/AIDS education in primary schools in Sub-Saharan Africa, suggesting that teachers' religiosity, gender and the in-service training may impede or facilitate the learning process at the classroom level. Three observations are made from the literature. First, teachers with less religious involvement are more likely to implement the HIV/AIDS curriculum in comparison to those with more religious involvement. Second, female teachers are more likely to teach sex education in primary schools than male teachers. Third, teachers who receive in-service training related to the HIV/AIDS education are more likely to implement the curriculum than those who do not receive any in-service training. Two theories explain these observations: the Childhood Innocence Discourse and the Social Learning Theory.

### ***The Conceptual Framework***

I approached the study through the lenses of two social theories: the childhood innocence discourse and the social learning theory. While the Childhood Innocence Discourse helps understand the impact of religion and gender on teachers' attitudes toward schoolchildren, the social learning theory explains why a teacher with no training would choose to skip some sections of the HIV/AIDS curriculum. Combined, these two theoretical frameworks allow us to better understand the broader picture and the complexity of the implementation of HIV/AIDS in relation to teachers' religion, gender and in-service training.

The foundational work of the childhood innocence discourse is located in the work of Philippe Aries in 1962 whose historical research first underlined the socially constructed character of childhood (Beck et al, 1976). Childhood innocence discourse is that universal belief that children are weak human beings that need adults' protection to grow as responsible citizens.

According to theory it is adults' responsibility to shape children's personality through a protected childhood experience. In so doing, the discourse determines the kind of relationship an adult will have with a child (Coombe, 2000). Consequently, adults decide on children's lives without children's consent on issues perceived to be dangerous for their growth. Information children access must be censored by adults to prevent them from accessing knowledge that would spoil their innocent childhood. In sexuality for example, children are believed to be sexually innocent. So, adults have the moral responsibility of preventing children from accessing any kind of knowledge around sexuality (Epstein, 2000; Bhana, 2009) because children are too young to understand and responsibly use the knowledge of sexuality. Lessons they have at school and movies they watch at home must be under control of adults to make sure there is no message and images that dealt with sexuality (Kitzinger et al, 1998, Fine et al 2006; Epstein et al, 2000; Coombe, 2000).

This socially constructed discourse is present in all spheres of life including religion and gender. In religion, as the literature says, sexuality is reserved for adults. Protestants, Catholics and Muslims declare that the purpose of sex is for procreation and appropriate in the context of marriage only. Constructed in such a way, the discourse gives no excuse to young people to know about sexuality. They must wait until they become adults, get married and then experience sexuality. It can be inferred that according to the theory there is no need for young people to learn about sex education, a knowledge they will not use in their younger age. Perceived this way, teachers with more strong religious involvement may decide not to teach on sexuality in primary school.

This assertion applies to gender as a social construct but in different way. The literature reveals that female teachers are identified as caring and motherly (Chege, 2006; Nsubunga &

Bonnet, 2009; Mathew et al, 2006). This gendered identity constructed around female teachers changes the power relation in class between students and teachers. The identity of "mother" secures a dominant position to female teachers which they use to implement the curriculum in class.

The Childhood Innocence Discourse explains the impact of religion and gender in the HIV/AIDS education in Sub-Saharan Africa. Another aspect of the study concerns the teachers' capability to implement the new curriculum. This brings us to the Self-efficacy Model of the social learning theory that explains it.

The social learning theory was first introduced by a group of American social psychologists in 1950 to examine the failure of people to participate in health prevention programs (Irwin et. al., 1994). Inspired by Pavlov's Stimulus-Response theory of 1927 and Skinner's Reinforcement theory, the social learning theory examines individuals' motivations to adopt a positive health behavior. In other words, this theory tries to understand the factors that contribute to changing people health behaviors. In 1952, theorists of social learning conducted a study to determine what motivates people to have a voluntary TB test when many do not accept to do that (Irwin et. al., 1994). Findings from that research show that people accept to have a voluntary free TB test when they believe they are susceptible to be infected and when they perceive the benefit of doing such a test. Also, their perceived barriers in adopting a behavior may delay their decision to go for a free TB test. This theory takes into account components such as perceived susceptibility, perceived severity, perceived benefits, and self-efficacy (Irwin et al, 1994).

The Self-efficacy component of the theory says that individuals' decision to adopt new behaviors depends on their beliefs on whether or not they have abilities, skills to perform them. This theory applies to my study. Teaching the HIV/AIDS in primary schools became a requirement in primary schools in the Republic of Congo in 2004. Before 2004, teachers did not have to talk about issues of sexuality. Teaching on sexuality in primary schools is a new habit. It requires teachers to adopt a new teaching behavior. According to the self-efficacy model, teachers will fully implement the HIV/AIDS curriculum only if they believe that they have skills to do that. A number of studies reveal the importance of in-service training in improving teachers' beliefs on their self-efficacy to implement the HIV/AIDS curriculum (Bhana, 2000; Coombe, 2002; Mathews et al, 2006; Gallant & Maticka-Tyndale, 2003; Benell, 2001).

## ***Research Methodology***

### *Overview*

To better understand the influence of religion, gender and in-service training on teachers' implementation of the HIV/AIDS curriculum in primary schools in the Republic of Congo, I decided to conduct an exploratory study. An exploratory study does not aim to confirm or validate any hypothesis but explores in a more open lens a phenomenon being studied (Berman, 2001). Because my research did not have any pre-existing hypothesis, the exploratory approach helped look at any factors that facilitate or inhibit teachers in the Republic of Congo from teaching the HIV/AIDS curriculum including, but not limited to religion, gender and in-service training as suggested by the literature review. The study focused on grade 5 and 6 teachers. Officially in these grades, students are between 10 and 12 years old. At 10 to 12, some

schoolchildren may already be sexually active (Baxen, 2004; Coombe, 2000). This age is crucial to look at teachers attitudes during a HIV/AIDS class. Data collection was anonymous.

### *Research Design*

I used qualitative methods to explore factors that impact on teachers' attitudes in teaching the HIV/AIDS curriculum in primary schools. The literature review has given some guidelines on the influence of religious involvement; gender and HIV related in-service training on the teachers' implementation of the HIV/AIDS curriculum in some countries in Sub-Saharan Africa. However, there is no evidence to claim that teachers in the Republic of Congo are impacted by the same factors as those in other countries in Sub-Saharan Africa. Therefore, while particular attention was given to factors such as religion, gender and HIV/AIDS related in-service training, the study aims to explore beyond that scope. Aspect such as age, academic background and work experience were also explored. The design followed the ethnographic guidelines.

My choice on this perspective derives from the goal of the study itself, the setting and the theoretical framework. The Childhood Innocence Discourse and the Social Learning Theory support ethnographic research, because both theories focus on human behavior, which is a very significant component of ethnography. Ethnographic research was also the most appropriate because my research focused on cultural aspects of teaching the HIV/AIDS curriculum including religion, gender or in-service training. As Patton (2000) says, the primary goal of an ethnographic study is to look at the culture of a particular group of people. In fact, an ethnographer not only studies other people's culture, he may also study his own culture, being himself part of that culture.

Being a teacher from the Republic of Congo, I have observed teachers implementing the HIV/AIDS curriculum at the school level. Although this experience adds the necessary understanding of the contextual background of the HIV/AIDS education in the Republic of Congo, the ethnographic approach recommends the investigator to be physically present in cultural community he/she is investigating to observe attitudes and behaviors of the people being studied. From the perspective of traditional ethnography, the fact that I did not personally observe research participants in the 3 selected schools in the Republic of Congo during data collection hinders my legitimacy as an ethnographer. However, as Ruhleder (cited in Patton, 2000) indicates, nonphysical presence of the ethnographer in the cultural community being studied is no longer a handicap due to the availability of increasingly sophisticated information technologies. In particular, a researcher is now able to conduct an ethnographic study via phone, Skype, Facebook and many other social networks. From a distance, they can observe their study participants' behavior. Using Ruhleder's approach to ethnography, and because of my limitations in time and funding to travel back home to collect data and observe teachers attitudes, I chose to conduct interviews by phone without necessarily being physically present in the study setting.

### *Participants sampling*

In this study, participants were teachers of grade 5 and 6 in three primary schools: Mayindou, Ngambio, and La Poudriere. I intended to have 12 participants but due to teachers' unavailability, a sample of 9 participants, aged between 23 and 60 was purposely selected from these 3 schools – 3 participants from each school. The goal was to have a representative and diverse sample. Therefore, the selection took into account the participant's work experience,

level of education attainment, the number of years in teaching the HIV/AIDS curriculum, age, gender, religion and their HIV/AIDS related in-service training. In other words, I intended to have a sample with a proportionate number of male and female, young and old, experienced and less experienced religiously involved and not religiously involved teachers. In cases where schools had more than 3 teachers who wanted to participate in the interview, the teacher who volunteered to help me, in collaboration with the school board, used the administrative list of teachers in each school. From the general list, he rewrote the names of all teachers who wanted to participate on a piece of paper. To select the actual participants, he put all the piece of papers with teachers name on in a hat, and asked a teacher to pull 3 names out of the hat. The names of the 3 teachers pulled out were the names of the participants of the school. Fortunately, this happened only in one school where four teachers wanted to participate, two females and two males. The final selection gave two female teachers and one male.

In the Republic of Congo, there is no obligation to school administrators to produce written documents that give permission to teachers to participate in a study for public good. But the contact person talked to the Directors of the three schools sampled to make sure the teachers who consent to participate have first talked to the school administration and obtain the school support before they do so. The directors of the schools gave written permission to teachers who were selected to participate.

I did not foresee any major risks for participating in this study except some breach of confidentiality. Giving personal opinion on the HIV/AIDS curriculum in primary, or declaring not to teach all sections of the curriculum may not be free of risk for teachers. They may face disciplinary sanctions from the school administrators, or the Ministry of Education. To reduce the risks and guarantee the anonymity of the participants, no names of the participants were

taken during the interview. No name of the school where the teacher is from was attached to the background information provided. Findings are discussed in more general terms with no reference to any schools where participants teach.

### *Data collection*

In order to assess factors that impact teachers' ability to implement or not the HIV/AIDS curriculum in primary schools in the Republic of Congo, including religion, gender and HIV/AIDS related in-service training, I conducted semi-structured interviews in French with the use of an interview protocol. Conversations were recorded. The interview protocol included the participant background with no name attached to it. To collect maximum details on factors being explored, each participant had a 30-45 minute interview (maximum) using open ended and follow up questions. Before conducting the interviews, participants received consent forms. The teacher who volunteered helped me communicate with each participant on the convenient date and setting of the interview. He also helped with administrative procedures required in schools in the Republic of Congo, which include talking to the school board of the benefit of their school to participate in the study and get their support to encourage teachers to do so.

### *Data analysis*

The data analysis considered any factors the teachers think facilitate or inhibit their ability to implement the curriculum. Drawn from the literature review, factors such as religious involvement, gender and in-service training were given particular attention. The data analysis also explored the issue of the adaptability of the curriculum, as a new theme that emerged from the interviews.

I transcribed each recorded interview and then translated it into English. In transcribing them, I made comments in the margin about what I was going to do with the different parts of the data. This constituted the first step in organizing the data into factors around the impact of teachers' religious involvement, gender and in-service training on their implementation of the HIV/AIDS curriculum in primary schools in the Republic of Congo. Once a relevant passage was identified, a shorthand code was directly written in the margin with a tab attached on the page. I used colored highlighting pens to keep track of the source of a quote when cutting and pasting different quotes into a theme. I used convergence and divergence in coding and classifying major themes (Patton, 2002). This means for each factor or emerging theme, I identified a code and classified convergent and divergent views of the findings. According to Patton (2002), convergence deals with "recurring regularities in the data" (p. 465). To sort convergent views, I began by looking at themes that had similarities and fit together. For each question, I highlighted in red those teacher views and opinions, which conveyed similar ideas and separated those views and opinions, which differed in a meaningful way from other respondents. I looked whether these themes are redundant or complementary. In case of redundancy, I chose to analyze the views that appeared to be the most pertinent and discarded the less significant one. At the end, I had a set of convergent views in each theme that I found pertinent to discuss.

After sorting out convergent views, I highlighted in yellow divergent views. A view was categorized divergent when it did not fit the dominant view. So, views that brought out unique perspectives were categorized as divergent. I looked at how many divergent views I had from each set of answers and chose the ones that highlighted those perspectives, which differed from the dominant views.

### *Data management*

For the sake of confidentiality, all identifying data were removed when the interviews were being transcribed so that the identity of the research participants and schools remain unknown. Throughout the research process, all audio-recorded data and notes were locked in my home office. No identifying data were shared with anyone other than my dissertation committee members, and then only on an as-needed basis. After I finished transcribing the interviews, the audio-recorded data and notes were destroyed.

## **Findings**

### *Overview*

The study looked at the impact of religion, gender and in-service training on teachers' implementation of the HIV/AIDS curriculum in primary schools in the Republic of Congo. Because the study did not have any pre-existing hypothesis, I used convergence and divergence in coding and classifying themes. This implies that the researcher attention was focused on recurrent themes, either because they were convergent or because they contradicted one another. As a consequence, certain themes did not appear as major in the finding sections even if they were part of the goal of the study simply because most of participants did not see them as major issues. As such, though the impact of gender on teachers' implementation of the HIV/AIDS curriculum was part of the study goal, most teachers I interviewed thought that it was not such a big issue. Therefore, gender did not come out as a main finding in this study.

There are several factors that may have influenced this finding. The first factor is the respondent themselves. They could have said things that they believed were positive to their own reputation. The fact that all interviews were conducted over the phone made it more difficult for

me to “read” the participants and their reaction to the questions. Another factor could be the sample. The sample was not representative in term of gender. I intended to proportionate the number of male and female teachers, all of them from different age group; however, I was unable to secure such a sample. Instead of dismissing the impact of gender in teaching the HIV/AIDS curriculum, I suggest investigating the same issue with well elaborated instruments and a more representative sample combined with field observation in the future.

Although gender did not emerge as a significant theme in this study, three major themes emerged from the conversations with teachers: (1) teachers' religious involvement, (2) in-service training, and (3) the inadequacy of the HIV/AIDS curriculum.

### **Teachers' religious involvement**

The goal was to assess the impact of religion on teachers' implementation of the HIV/AIDS curriculum. Two main questions with some follow up questions were asked. The first question investigated whether the participants were involved in religious activities in the community they live. The second question asked the participant's opinion on whether he/she would choose not to teach on a section of the HIV/AIDS curriculum that he/she thinks is contrary to his/her religious beliefs.

Findings from the first question reveal convergent views among the participants. All participants claimed to be involved in religious activities in their community at their spare time. All are Christians. None claimed to be Muslim or any other religious organizations. I had a sample of three Catholics (male and female), two Protestants from the Evangelical Church of Congo (EEC), two fellows from the Gospel of the Church of Living God also known as followers of Brother William M. Branham, one follower of Louzolo Amour, a religious

organization that believes in traditional healing of human spirits and one teacher from Nehemie (Nehemiah), a revival church in Congo. Each of them was interviewed at a different time and place. This homogenous Christian sample does not surprise me because in the process of identifying schools, I wanted to have teachers from schools known to be under different religious influence. Apart from Christians, I wanted to have teachers from Islamic schools in Brazzaville. Unfortunately I could not due to the unavailability of teachers. This fairly reflects the religious demography of the Republic of Congo. According to US Department of State, only 2% of the population in the Republic of Congo is Muslim, the rest being either Christians or Traditional believers (retrieved from <http://www.state.gov/j/drl/rls/irf/2006/71296.htm>).

On the question of whether a teacher would choose not to teach the HIV/AIDS curriculum in case the teaching is contrary to his/her religious beliefs, all participants said no. They said they would not skip to teach a section of the curriculum based on religious preferences. Some participants reported skipping some parts of the curriculum for reasons other than religion. One teacher said that religion and professional obligations should not interfere with the teaching of the school curriculum. He added that he would teach any section of the curriculum, even if the message it conveys is contrary to his religious beliefs. When I asked a female teacher whether she chooses to teach something she does not believe to avoid professional sanctions from the school board or the school district, she pointed out ethics. She said it was ethical to teach the prescribed curriculum without distorting it. She also pointed out her respect to the class diversity as she said:

*School is not a homogeneous entity. You will find in a classroom, children from different religious background. You will even find those who do not believe in any God. So I cannot decide to teach what conforms to my beliefs. What about the*

*other students? I teach what the curriculum requires me to teach, not what I think I should teach.*

As a matter of fact, no participant reported having skipped any section of the curriculum for religious reasons.

This convergence of views on the question about skipping any section of the curriculum for religious reasons could be the results of two factors. Despite the fact that the consent form gave assurance about teachers' privacy and the protection of rights, some teachers could still be reserved to talk to me. Giving professional opinions over the phone to an unacquainted person could be associated with a lot of risks. I suspect that some teachers could have said things they believed I wanted to hear. This poses the issue of the validity of the data. Field observation could have minimized this threat if I travelled to collect data in person.

Interestingly, however, the follow up question on what teachers think about the education on sexuality in relation to their religious beliefs showed divergent views. Seven out of nine participants thought that teaching sex education, condom use and issues around sexuality was not contrary to their religious beliefs. Among the 7 participants, many reported having participated in HIV/AIDS prevention programs at their church, similar to the program they teach at school. One teacher said he is also a facilitator at the Sunday school for children between 7 and 15 years old at his church. Every Sunday morning, for 45 minutes, he and other facilitators conduct morning services at church for youth. They talk about many themes of youth life including but not limited to sexuality and HIV/AIDS education. He emphasizes the interdependent relationship between school and church:

*At school and at church, I teach HIV/AIDS. It is not against my religion. GOD gave us spirit to know what is good and what is not good for our life but he also gave intelligence to doctors to help us prevent diseases. Yes, the Bible says, men should be faithful to their wives but teaching children to use condom does not mean we are teaching them how to become unfaithful once they are married.*

He insisted on the fact that condoms are not uniquely made to be used with a different person, other than the usual partner. He said:

*What if you marry a HIV/AIDS seropositive partner and both agree that you should always use condom to prevent the other partner to get infected? Isn't that a good use of condom? I do not see anything against GOD's will in this case.*

Unlike these 7 participants, two other participants, one female and one male, think that sex education or teaching children about how to use condom is against their religion. They said they teach the section about that because they have no other choice. The female teacher said she does not feel comfortable in doing that and explained it clearly:

*Condoms are used when a partner wants to cheat on his/her usual partner. Why would someone faithful to his/her partner want to use condom? By teaching kids to use condom or even talking about sex education, we are sending them out to go and do it. Remember, sex is for reproductive purposes only.*

She argued that if she is given the possibility to talk to the school district board or people who work at INRAP, the National Institute for Educational Research, she would suggest removing the section on sex education and condom use from the curriculum.

## **In-service training**

Four questions assessed the impact of in-service training on teachers' capability to implement the HIV/AIDS curriculum in 5th and 6th grades. All the four questions investigated the teachers' views on the importance of in-service training. The two first questions aimed at finding out whether the participant has received any in-service training related to the teaching of the HIV/AIDS. Follow up questions investigated the duration and the benefits of the training when the participant has received one. For participants who did not receive any in-service training, the researcher investigated the value participants place on training and any possible challenge they face in teaching the curriculum due to the lack of training. The two last questions talked about actual teachings practices in class. The questions investigated teachers' attitudes in class; whether they choose to skip some parts of the curriculum when they think it difficult to implement, whether they feel comfortable to name sexual organs, to draw them of the board, or to use images that illustrate organs when teaching on condom use, for example.

Findings from the two first questions show that only 2 out of the 9 participants have received in-service training for a period between 1 and 15 years. Seven participants reported that they have never received any in-service training related to the teaching of the HIV/AIDS curriculum for the class they teach. The two participants said they have received in-service training related to the teaching of the HIV/AIDS pandemic only once. The male said he attended one seminar on HIV/AIDS education for a week in 2008. Since then, he has not been offered any other training opportunity. He has been teaching the HIV/AIDS curriculum for the past 11 years. The female attended a workshop on HIV/AIDS led by the school district for three days, four hours each day. She has been teaching the curriculum for 7 years now.

All participants, even those who have not received any training yet, believe that training has an impact on teachers' implementation of the HIV/AIDS. The two teachers who have been trained think they have improved their practices in class. They report having corrected many mistakes they were making in class before they receive training. For instance, the female teacher acknowledged that she did not know the difference between HIV and AIDS in her first three years of teaching the curriculum. She said the curriculum did have a component that defined HIV and AIDS but she could not explain it well to students. Thanks to the workshop on HIV/AIDS she attended, now she can teach that lesson well. The other teacher also pointed out the fact that the seminar he attended for a week gave him a very deep understanding of the HIV/AIDS education. He realized that HIV/AIDS education did not only mean showing schoolchildren how they could protect against the pandemic, but something beyond:

*Teachers' training is the key to HIV/AIDS education success. Many of us have good teaching skills but we do not have all the information we need to teach about HIV/AIDS. In fact, what can a teacher do when he/she doesn't even know what is HIV/AIDS? The most important thing I learned from the training is that HIV/AIDS and poverty go together. So I teach my students how to prevent HIV but also how to fight against poverty. That's something I did not know before I received the training.*

Another participant who has never received any in-service training believes she could do better if she received training to teach the HIV/AIDS curriculum. She describes the HIV/AIDS pandemic as new disease that has been ignored for long:

*Teachers did not teach even know about that in the past. They are learning at the same time with the students they teach. It is hard if you do not know. Some students have*

*access to internet from home while many teachers like me do not. No newspapers. The teacher's guide book does not explain the pandemic in detail. Only training can help teachers do better. Unfortunately, I only use books.*

The two last questions about teachers' attitudes and practices in class in relation to their HIV/AIDS related in-service training revealed two main differences between participants who have received training and those who have not. The first attitude is that participants who have received training do not report having skipped some sections of the curriculum because they do not know how to teach it, while most of those who reported having received no training at all also reported having skipped at least one chapter of a section for reasons related to their lack of training. One teacher said he could not teach the section of the HIV/AIDS entitled "HIV/AIDS: two vectors, destroying the immune system, exposure to opportune diseases" (HIV/AIDS Curriculum, Congo). He said he did not understand some wording like vectors, immune system or opportune disease. Because he did not have knowledge of what the section required to teach, he chose not to teach:

*I skipped it. I chose not to tell lies to my students. When the inspector came to inspect my class, he asked me why I did not teach this or that. I told him "Mr. Inspector, you cannot inspect me on something you did not teach me how to do before. You should first teach me how to do it and come back to see whether I have respected your instructions or not.*

The above quote shows that even teachers who did not receive any training believe it is a good thing.

The second attitude that differentiates teachers with training and those without training is their comfort or discomfort in naming sexual organs in front of children. Teachers who have

received training report that they name sexual organs all the time when teaching condom use for example. By contrast, a higher number of those who have not received any training said they do not feel comfortable naming sexual organs by their usual names in front of children. One teacher said that it was not appropriate to children. Some used expressions such as "the body of the man" to describe the male sexual organs or the "body of the woman" to describe the female sexual organs. A teacher who has received training said:

*I use the name that we use every day to describe sexual organs of males and females. At the seminar, the instructor emphasized on the fact that children need to learn things on the language they know and understand better. At the beginning my students thought I was using inappropriate words but they realized they understand better. The class I have this year got higher grades in a HIV/AIDS knowledge test contest at the school district because I teach them without hiding things.*

Also, none of the teachers who have received no training said they used teaching materials such as samples of a male and a female condom to show to children how to use it. They did not use photos or cartoons to show what they were talking about in class. One of the two teachers who received training said she did that and it was successful.

I cannot claim from the above findings that these attitudes are shaped by training only. Culture and tradition may play a significant role, too. But I am convinced that it not a simple coincidence that a higher number of teachers who have not received any training in the three schools are likely to report the same teaching practices. Same classroom practices were reported for those who have received training. Future research will tell more about this.

## **The inadequacy of the curriculum**

It is important to clarify some particularities of the HIV/AIDS curriculum in primary schools in the Republic of Congo. Unlike in many Western and Southern African countries, there is no particular curriculum for HIV/AIDS education for primary schoolchildren in the Republic of the Congo. The HIV/AIDS education in grades 5 and 6 is part of Reproductive Health curriculum. It is the last section of the curriculum with few subsections. Also, unlike many HIV/AIDS prevention programs in other parts of the world, the curriculum in Congo does not give enough room to life skills promotion. Schoolchildren do not learn a lot about social and economic issues around the HIV/AIDS pandemic. The curriculum does not even cover issues such as how to make good friends, good decisions etc. These two aspects are important for understanding the themes below that emerged from the interviews.

From this particularity emerged a new theme: the inadequacy of the curriculum. Three aspects of the curriculum popped up in most of participants' interviews as inadequate, therefore having a negative impact on their teaching of the HIV/AIDS education.

First, teachers pointed out the unsuitability of the curriculum to the context of the daily life in the Republic of Congo. The HIV/AIDS curriculum in the two grades, in the reproductive health section talks about safety tips children must know and use in case they are sexually assaulted. Among the safety tips, the curriculum recommends schoolchildren to use the alarm to alert the police if they think someone in their surroundings is behaving as if he/she is likely to sexually assault them. However, teachers think this is inadequate to the lifestyle of people in the Congo. The alarm system does not exist in public places in the Congo. And there is even no toll free number to reach the police in case of emergency. Here a teacher says:

*I cannot tell my student "ok, use the alarm when you are in physical danger to alert the police" because I know there is no alarm here. What is the benefit of teaching something they cannot use in their daily lives? I always tell them 'don't wait to be in danger to care about your safety'. I teach them how to make good friends. I also tell them places they do want to go because they are not safe. The curriculum should be readapted to the needs of the children here. Alarm is good in other countries, not here.*

Second, there are problems with curriculum adaptability. Many teachers said that the curriculum fails to link HIV/AIDS to poverty. Teachers think the curriculum does a great job in providing schoolchildren with the necessary knowledge they need to fight against the pandemic and avoid its threat but it does not prepare them to fight against poverty which is one of the cause of the failure of many prevention programs. One teacher repeatedly argued that children may have knowledge about the HIV/AIDS prevention but this does not mean they are prevented from contracting the disease if they do not have a place to live or enough to eat, for example. Another teacher went further in pointing out how the curriculum should address this issue. He said:

*I understand that 5th grade students are too young to impact the family income and poverty level. But this should not be a reason not to teach them about poverty, the relation between poverty and HIV/AIDS. Poverty is mental before it becomes material. Female students for instance should know that having multiple sexual partners for money will not positively impact their family income. Poverty is a cycle.*

The quote above clearly shows the negative impact that some sections of the curriculum have on teachers' practices in class. Most teachers in the three schools think what they are teaching to their students on HIV/AIDS prevention will not work unless the curriculum

addresses the poverty issue at the same time. They suggest including sections in the curriculum that talk about poverty, what it is, what causes it and how to prepare young people to combat it. It seemed from the teachers' interviews that combating HIV/AIDS through the biomedical model will protect young people from the threat of the pandemic unless they are equipped with skills they need to overcome poverty. Poverty is a non-negligible factor of "HIV/AIDS" rapid spread in developing countries.

The third issue with the curriculum is the gap between the message it conveys and the population it targets. Officially, grades 5 and 6 receive schoolchildren between 10 and 12 years old. However, due to higher retention rates in schools in the Republic of Congo, it is common to find in 5 and 6 grades, young people who are beyond that age frame. Some teachers reported having students who are 14 or 15 years old in grade 6. However, because the official age of students is 10 to 12 and due to the fact that children at this age are believed to be sexually inactive, the curriculum, according to some participants, fails to reach the other group of student who is beyond that age and possibly sexually active already. Most teachers reported having some students in their classes whom they think are sexually active at their young age. The age of students believed to be sexually active ranges between 12 and 15 in the two grades, most 15 years old students being in grade 6. One teacher said that he has already had within the 6 past years of his teaching two girls of his class who got pregnant. Another teacher said that he saw one of her 14 years students in his last year class coming out from a hotel late at night with a boy much older than her. He remarked that "*many of the students in grade 6 are already sexually active. Because the curriculum only targets students that are believed to be sexually inactive, the message in class does not reach those who are already engaged in sex*". Another teacher declared that one day, during an HIV/AIDS class, after explaining how to use condom, a male

student took off his shorts and showed his male sexual organ to his female classmate who was sitting next to him. The teacher put it:

*I was a bit shocked that it happened in class. After class, I took few minutes to talk to the student. I asked him why he did that in class. He said that he does that with other girls out of school. I understood that he is sexually active already. I told him, 'it is not good to do it in class; you should apologize to your classmates.*

From teachers' testimonies, it is obvious that the curriculum itself is a problem as is its implementation. I cannot claim that this is applicable to all teachers in the Republic of Congo but this is a good start for large scale research on this particular issue of the HIV/AIDS curriculum in the Republic of Congo.

## **Discussion**

Nine teachers out of thousands shared their stories and experience on teaching the HIV/AIDS curriculum in primary schools in the Republic of Congo. I intended to have a sample that represents all the teachers of the Republic of Congo but time and financial capacities limited my goals. I know many other teachers would have shared their experiences but I did not reach them. Because I only reached few teachers and because all of them came from one city, I hesitate to generalize these findings from the sample. Findings could have been different if I had a larger participant sample. However, these findings have raised some important questions, highlighting the diversity of the teacher perceptions about HIV/AIDS curriculum implementation and revealing the complexity of teaching HIV/AIDS in the Republic of Congo.

The findings reveal that religion has an impact on teachers' attitudes towards the teaching of the HIV/AIDS and sex education. In particular, the two teachers who said it was not good to

teach children about condom use or issues around sexuality go to the same church: The Church of the Gospel of the Living God also known as the Church of Brother William M. Branham. Although this could have been a coincidence due to the limitations of the study sample, the role of the Branham Church could be further investigated in a confirmatory study. In addition to religion, I looked at other demographic indicators such as the level of education attainment, work experience, age and sex to see if the two teachers have other demographic traits in common that could explain their views on HIV/AIDS and sex education. In particular, I was interested in finding out whether teachers from the same age group, with the same teaching experience, and the same level of education attainment would have the same opinion in the same issues. Surprisingly, for this specific case, the two teachers did not share any other demographic indicator apart from religion. One is a 45-year-old male teacher with a bachelor's degree in geology. He has been teaching for 7 years. The other is a 24 year old female teacher with a high diploma. She has been teaching only for 4 only months. This caught my attention. Having lived with my cousin who is a Pastor of one of the congregations of that church, I do understand the viewpoints of the two teachers. The church of Brother Branham is a reformist religious organization that was founded in the USA a hundred years ago. In Congo, this church has a particularity: the dress code. Female believers from that religious organization do not wear pants, trousers, earrings. They also do not make up their skin. It is believed that women seduce men when they wear pants, trousers or earrings or when they make up their skin. They believe such adornment would cause men to fall into temptation. In sum, believers from this particular religious organization claim that they are the only religious entity that obeys the commandment of GOD. Some teachings from this religion even recommend followers not to obey any rule that does not honor their GOD. Though neither of the teachers said they would choose not to teach on

a section of the curriculum that is contrary to their religious beliefs, I wonder whether I could have the same findings if I observed each of the teachers in their classrooms. For this reason, ethnographers do not only interview their study participants but they also observe them in their daily lives to balance between what they say and what they do (Patton, 2002). The fact that I did not observe participants' behavior inside and outside the classroom poses a threat in the validity of the results obtained. I relied only on behavior and practices reported by teachers. For further research, I intend to observe teachers inside and outside the classroom to minimize this results validity threat.

The other interesting observation is the fact that the teachers who reported not having received any in-service training related to the teaching of the HIV/AIDS are also the same who skipped some sections of the curriculum for training reasons. Of seven teachers who have never received any training, five said that they skipped at least one section of the curriculum. The two teachers who said they have received training did not report having skipped any sections of the curriculum due to lack of teaching skills. Again, the 5 participants who skipped some sections of the curriculum come from different education backgrounds, are from diverse age range and have different teaching experiences. The most common trait they have is the lack of training. Here the group of teachers who skipped some parts of the curriculum is larger than the group of teachers who never skip any part of the curriculum. However, future research in the three schools will confirm whether teachers who have never received in-service training on HIV/AIDS and sex education are more likely to skip lessons they do not know how to teach.

Though almost all teachers interviewed believe that some sections of the curriculum are not adapted to the needs of the students and do not match the daily lives of students in the Republic of Congo, findings from this theme cannot be generalized to all teachers from the three

schools because of the limitations of the sample. Future research is needed to confirm or infirm this finding.

Generally, the findings from this study corroborate the findings from other existing studies. In particular, findings on the impact of teachers' religious involvement and in-service training on their implementation of the HIV/AIDS curriculum match the findings from previous studies on HIV/AIDS curriculum in primary schools in Africa. For example, many systematic reviews of HIV/AIDS prevention programs concluded that religion has negative impact on teachers' decision to fully implement the HIV/AIDS curriculum in primary school in Sub-Saharan Africa (Baxen & Breidlid, 2005; Zou et al., 2009; Trinitapoli, 2006; Nsubunga & Bonnet, 2009). Similarly, findings of this research reveal that the two teachers from Brother Branham church think teaching condom use to primary schoolchildren breaks their religious principles. This is quite similar to what Zou et al., (2009), Trinitapoli (2006), and Baxen and Breidlid, 2005) found out in their studies in the Southern part of Africa. In Baxen and Breidlid's (2005) study in South African primary schools, for instance, the findings on the vulnerability and risk of religious people toward the HIV pandemic are quite different. Here, Christians, Jews and Muslims as a whole seem to agree on the non-condom use, with the exception of Sangomas and Rastafarians (both traditional religions in South Africa whose faith is based on healing illnesses from spiritual practices, prayer being the most common).

Like previous research, this study has raised questions regarding the impact of in-service on teachers. In particular, substantial studies have demonstrated that teachers could fully implement the curriculum if they have received and continue to receive adequate training to do so (Bhana, 2000; Coombe, 2002; Mathews et al., 2006; Gallant & Maticka-Tyndale, 2003; Benell, 2001). For instance, in a study that assessed the impact of teachers' training on their

ability to implement the curriculum in South Africa, the variable for teachers who reported that they have been implementing the curriculum indicated a significant relationship (Mathew et., 2006). In my research teachers who have received in-service training report having implemented all sections of the curriculum while those who have not received any training reported have skipped some sections of the curriculum.

This research also identifies areas of divergence with the existing literature. In particular, the existing literature indicates that there is a link between teachers' gender and their pedagogic choices (Chege, 2006; Nsubunga & Bonnet, 2009; Mathews et al., 2006). In the area of HIV/AIDS education, a number of studies assessing teachers' attitudes and perceptions on sex education for primary schoolchildren conclude that there are some differences in teaching outcomes between male and female teachers due to their gender. Unlike male teachers, female teachers are more likely to implement the curriculum. They also are more likely to perceive the consensus among their colleagues about the importance of teaching HIV/AIDS education (Mathews et al., 2006). My interviews with teachers reveal that gender's has no impact on their implementation of the HIV/AIDS curriculum. All participants said that gender had no influence on their choice of lessons or on the success or the failure of their class activities. For this reason, gender impact on teachers' implementation of the HIV/AIDS curriculum does not appear as a major finding in this research.

Furthermore, this research has also brought up new concerns about the curriculum adaptability, a new knowledge in the existing literature. Before this study, I did not come across any research identifying teachers' concerns about whether the HIV/AIDS curriculum was adapted or not to the real needs of the learners. I have read articles that linked poverty to HIV/AIDS vulnerability but in a broader sense. The existing literature does not emphasize the

failure of the HIV/AIDS curriculum to address the poverty issue through education in primary schools. Also, the literature does not mention the actual impact of teaching HIV/AIDS safety measures that are not applicable in the environment schoolchildren live. This is the new knowledge the present study adds to the existing one.

Combined, this study constitutes a good starting point for large scale studies at the national level that could have an impact on policy reforms on HIV/AIDS prevention programs in the Republic of Congo.

## **Conclusion**

According to the UN Millennium Development Goals, 2015 is the deadline for countries round the world to be able to halt and reverse the ever growing HIV/AIDS infection rates through prevention. To meet these goals, education was made a top priority. Subsequently, education became the cornerstone of most prevention programs around the world. Today, three years before the deadline, researchers want to know whether education has contributed to meeting that goal. Though some statistics already reveal that in most countries education is failing to prepare schoolchildren to live out the HIV/AIDS threat, some countries are doing better than the others. Therefore, it is only through research that one will know which country is doing better and why. That is why I chose to research the impact of religion, gender and in-service training on teachers' implementations of the HIV/AIDS curriculum in primary schools in the Republic of Congo.

I chose the Republic of Congo because no research was conducted to assess teachers' capabilities to implement the HIV/AIDS curriculum. And the primary school is where teachers face more challenges due to both the sensitivity of the issue and the sage of students. Nine

teachers from three schools participated to the interviews. I approached the topic following the guidelines of an ethnographic study. I chose my questions for interviews based on the findings from the existing literature. I conducted the interviews in French, transcribed and translated them into English. I analyzed findings from their interviews through the lenses of two theories: the childhood innocence discourse and the social learning theory. This research raised three issues

First, the 2 teachers who are religiously involved in the Church of the Gospel of the Living God stated that teaching condom use to children or even talking about sexuality in class is against God's prescriptions. Whereas the 7 teachers who claim to be Protestants, Catholics, and followers from Louzolo Amour and Nehemiah religious organizations stated that it is God's recommendation to save the lives of people. Therefore, teaching schoolchildren how to use condom, or how to engage in safe sex activity at their debut is part of God's mission to save their lives. The most frequent argument for teachers who do not want children to learn about sexuality is that God said that sexuality is appropriate for married people, not for children. Using the childhood innocence discourse, it is established that some teachers consider children as sexually innocent.

Second, teachers who reported that they have never received in-service training related to the teaching of the HIV/AIDS curriculum also skipped some parts of the curriculum due to the lack of skills to do so. By contrast, those who said they have received in-service training said they implement all the sections of the curriculum. This finding applies to the theory of social learning, on its self-efficacy section. The theory says that individuals are likely to adopt new habits when they believe they have ability, skills to successfully perform new habit without putting themselves into troubles.

Third, almost all teachers believe the curriculum is not adapted to students' need and their lives in the community they live. As revealed in the findings section, teachers believe that the HIV/AIDS curriculum is failing to meet the needs of learners. Not only does the curriculum fail to teach schoolchildren how to cope with HIV/AIDS and families' low incomes, but it also does not connect children to their environment. This study argues that children may know all about HIV/AIDS and its prevention but they are not ready to overcome the pandemic threat yet. Girls, for instance, need skills from school that will help them resist turning to prostitution because of hunger and a lack of basic needs. For boys, it would be helpful to learn skills to help them understand that drug addiction is not the right response to hunger or lack of basic needs. They need to know that drug addicted persons are among the most cited HIV/AIDS vulnerable population.

Like previous studies conducted by Baxen & Breidlid (2009), Coombe (2002), Mathews et al., (2006), Gallant & Maticka-Tyndale (2003), and Benell (2001), this study produced almost the same results. Regarding religion, for instance, teachers from more conservative religious organizations are more likely to believe that HIV/AIDS education is adults' domain than teachers from less conservative religious organizations. As far as in-service training is concerned, teachers who received training related to the teaching of HIV/AIDS curriculum said they meet the goal set in the curriculum. Those who did not receive any training reported having skipped some sections of the curriculum

These questions raised are quite understandable if we look at them through the lens of the Childhood Innocence Discourse and the Social Learning Theory, which explain that certain teachers may not feel comfortable to talk about condom use or issues around sex to children under 18 years old because they believe sexuality is for adults (Beck et al., 1976). And if we look

at teachers' in-service training through the lenses of the Social Learning Theory, there is no surprise that teachers who have received in-service HIV/AIDS related training perform better in implementing the curriculum than those with no training. The social learning theory examines individuals' motivations to adopt a positive health behavior. The theory focuses on components such as perceived susceptibility, perceived severity, perceived benefits and self-efficacy (Irwin et al., 1994). The self-efficacy component of the theory says that individuals' decision to adopt new behaviors depends on their beliefs on whether or not they have abilities and skills to perform them. Teaching the HIV/AIDS became a requirement in primary schools in the Republic of Congo in 2004. Before, teachers did not have to talk about issues on sexuality. For teachers, this is perceived as a new habit. To meet the goals set in the curriculum, teachers need to adopt new teaching habits. The self-efficacy model of the social learning theory explains this. According to the model, teachers would fully implement the HIV/AIDS curriculum only if they believe they have skills to do that. And a number of studies reveal the importance of in-service training in improving teachers' beliefs on their self-efficacy to implement the HIV/AIDS curriculum (Bhana, 2000; Coombe, 2002; Mathews et al., 2006; Gallant & Maticka-Tyndale, 2003; Benell, 2001).

This research indicates areas in which new knowledge can be added to the existing literature on teaching HIV/AIDS curriculum in primary schools. Most of the literature I reviewed did talk about the interdependent relationship between poverty and HIV/AIDS spread but in a broader sense. The literature did not give the teachers' perspective on how the curriculum is failing to connect children in class to the real world they live in. Here we learn, at least in the three schools sampled, that the unsuitability of the curriculum impacts teachers' expectations on the outcome of such teachings. The impact of the lack of adaptation on teachers' expected outcome of their teachings is the new knowledge that comes out of this study.

Despite interesting findings, this research does have some limitations. They are many but two are worth explaining. The first limitation goes with the purpose of the study itself. It is an exploratory study. This implies that it could not prove or validate any pre-existing hypothesis. Findings were only be used to draw inferences. The second limitation goes with the size of the sample. Only selected among schools in Brazzaville, the sample of participants is not representative of all teachers in the Republic of Congo. So findings from this study could not be generalized to the whole population of teachers in the Republic of Congo.

Nevertheless, this study adds important insights to the existing literature and creates a foundation for further empirical research. Though the sample is not representative, findings from this study open doors to large scale studies on the national level to see if other teachers, in other places in the Republic of Congo. It is too early to conclude that education has failed to prepare schoolchildren to fight against the HIV/AIDS pandemic in the Republic of the Congo. However, because the three schools that participated to the study are publicly funded, it is possible that many other schools will show the same findings mainly in training teachers.

I decided to explore this topic in the Republic of Congo for professional and academic purposes. As I plan to further my education for a PhD, this is a topic I will investigate more in depth through a confirmatory study. And beyond the PhD goal, the teaching of the HIV/AIDS curriculum in Sub-Saharan Africa is one of my areas of interests.

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## **Annexes**

### **Interview Protocol on HIV/AIDS School Curriculum in Grades 5 and 6 in the Republic of Congo**

This interview is being conducted under the auspices of Lehigh University, Bethlehem, Pennsylvania, USA. The goal is to learn more about how the HIV/AIDS school curriculum is being taught in grades 5 and 6 in the Republic of the Congo. The researcher responsible for this study is Monsieur Goma Mabika who is a candidate for the Master of Science degree in Comparative and International Education at Lehigh University.

All interview participants will remain anonymous. No names will be taken or associated with any answers. You may decline to answer any question.

#### **Interview Items**

Please tell me a little about yourself.

1. What gender (sex) are you? Male or Female
2. What is your age (how old are you)?
3. How many years have you been teaching?
4. What is your highest level of educational attainment (highest academic degree)?
5. What grade level do you currently teach? 5th or 6th
6. When the HIV/AIDS curriculum was first introduced at your school?
7. Do you think it is very important for students in the 5th and 6th grade to know about sexual issues and sexual practices?

Please explain your answer:

8-Tell me about your experience in teaching the HIV/AIDS curriculum. What are the challenges in teaching the curriculum and how do you overcome them?

9. Are you a member of any religious organization? Yes or No

If Yes, what is the religious organization you belong to?

10. Do you hold, or have you held any position of responsibility at your religious organization? Yes or No

If Yes, what are you (or were you) responsible for at your religious organization?

11. Do you believe that teaching about sex education or condom use to students is contrary to the principles of your religious organizations? Yes or No

If Yes, will you choose not to teach sex education on the basis of your religious beliefs?

12. Have you received any in-service training related to the HIV/AIDS education? Yes or No

If Yes, when?

How many days of in-service training did you receive? What did you find most useful about the in-service training?

Have you changed anything about the way you teach sex education as a result of in-service training? For example, do you teach more sections of the curriculum or teach them differently?

13. The HIV/AIDS curriculum for 5th and 6th grade students has different components such as reproductive health and sex education. Do you teach all components of the curriculum?

If no, which components do you teach and which do you skip?

Please explain your reasons for including or skipping particular components?

14. On the sections that require you to talk about issues of sexuality such as condom use, negotiating a safe sex relationship, do you engage your class in an open discussion on those issues? Yes or No

If Yes, how do you do that?

If No, why not?

15. In teaching a lesson on condom use for instance, do you name sexual organs by their formal names (i.e., penis and vagina) or do you use other words to name them?

I use the formal names

I use other (less formal) names

If you use other names, what are they?

Please explain why you do or do not use the formal names:

THANK YOU FOR TIME AND CONSIDERATION. The survey is now finished. If you have any questions or comments, you may address them to M. Goma Mabika at [gom210@lehigh.edu](mailto:gom210@lehigh.edu)



### CONSENT FORM

Experiences in teaching the HIV/AIDS curriculum to primary schoolchildren in the Republic of the Congo

You are invited to be in a research study about your experience in teaching the HIV/AIDS curriculum in primary schools in the Republic of Congo. You were selected as a possible participant because of your teaching background. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by:

Goma Mabika, College of Education (Lehigh University), Iveta Silova (Education, Lehigh University), Janet Laible (Political Science, Lehigh University), Bruce Whitehouse ( Anthropology, Lehigh University)

**WHAT IS THE PURPOSE OF THIS STUDY?**

The purpose of this study is to investigate to what extent religion, gender and the lack of training impact on teachers' ability to fully meet the goals set in the HIV/AIDS curriculum for primary schoolchildren in the Republic of Congo. In other words the study intends to explore the association that exists between teachers' level of religious involvement, gender, and in-service training and the way they teach the HIV/AIDS curriculum in public primary schools

**WHAT ARE THE PROCEDURES?**

You are asked to participate in a 30-45 minutes interview. The interview will be audio recorded.

**IS THIS STUDY CONFIDENTIAL?**

Yes. The information you provide in this study will be kept confidential. Your name will not be stored alongside any of the information you provide. Your name or identifying features will never be used in any reports or publications of this study's results. To protect your confidentiality, we will keep data for this study only on secure computer systems in locked offices

**WHAT ARE THE RISKS AND BENEFITS ASSOCIATED WITH PARTICIPATION?**

We do not foresee any risks to you other than a possible breach of confidentiality. As outlined above, however, we take a series of precautions to protect against that risk. Benefits include a chance to use your teaching experience to inform decision makers on the necessity to take into consideration in future policy reforms the impact of teachers' level of religious involvement, gender and in-service training in fighting against the HIV/AIDS through education.

**IS THIS STUDY VOLUNTARY?**

Yes. Participation in this study is voluntary:

Your decision whether or not to participate will not affect your current or future relations with me and/or with Lehigh University. If you decide to participate, you are free during the interview to not answer any question that you do not feel comfortable with or to withdraw at any time without affecting those relationships.

**IF I HAVE QUESTIONS, WHO CAN I CONTACT?**

The researchers conducting this study are:

Goma Mabika. You may ask any questions you have now. If you have questions later, you are encouraged to contact him at Lehigh University, 716-289-5957, gom210@lehigh.edu. You may also contact Mabika's thesis committee, Iveta Silova at 610-758-5750, ism207@lehigh.edu. If you would like to talk to someone other than the researcher(s), you are encouraged to contact to Susan Disidore or Troy Boni at (610) 758-3021 (email: inors@lehigh.edu) of Lehigh University's Office of Research and Sponsored Programs.

You will be given a copy of this information to keep for your records.

**Statement of Consent**

I have read the above information. I have had the opportunity to ask questions and have my questions answered. I consent to participate in the study.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Investigator: \_\_\_\_\_ Date: \_\_\_\_\_

### **Vita**

Goma Mabika was born on August, 21st 1979 at Kinkengue, Republic of Congo to N'zolani Joel and Milandou Bernadine. He got his bachelor's in Modern Languages at Universite Marien Ngouabi in 2001 and his Masters in Teaching English as a Second Language at Ecole Normale Superieure of Brazzaville in 2004. Like many others, Mabika did not get the government job he is constitutionally entitled to as a graduate from a State Teachers' College in the Republic of Congo. He set out to change things with the support of thousands of teachers. He became president of a teachers' union and fought for paid jobs throughout the Congo. Because of his courage and integrity, teachers got their jobs after two years of struggle. He was assigned by the Ministry of Education at Lycee de la Reconciliation as a high school teacher in 2008. In 2010, he got a job leave to pursue another Masters at Lehigh University in the USA as a Fulbright grantee. At Lehigh, Mabika pursued a Masters of Arts in Comparative and International Education with a concentration in International Relations and Political Science from 2010 to 2012. As part of the Lehigh University United Nations Partnership, he interned with the United Nations. At the time he was graduating at Lehigh University in 2012, he got another fellowship to pursue a doctoral program in Educational Leadership and Policy Studies at the University of Vermont in the USA. Mabika continues his education so he can work for more change and more schools in the Congo.