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Teachers' attitudes towards adolescent sexuality and life skills education in rural South Africa

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Abstract

This study investigated the attitudes of 43 teachers and school administrators towards sex education, young people's sexuality and their communities in 19 secondary schools in rural KwaZulu-Natal, South Africa, and how these attitudes affect school-based HIV prevention and sex education. In interviews, teachers expressed judgemental attitudes towards young people's sexuality and pregnant students, and focused on girls' perceived irresponsible behaviour instead of strategies to minimise HIV risk. Despite general awareness of the HIV epidemic, few teachers perceived it as an immediate threat, and teachers' own HIV risk was infrequently acknowledged. Teachers perceived themselves to have higher personal standards and moral authority than members of the communities and schools they served. Male administrators' authority to determine school policies and teachers' attitudes towards sexuality fundamentally affect the content and delivery of school-based sexuality education and HIV prevention activities. Opportunities to create a supportive educational environment for students and for female teachers are frequently missed. Improving teachers' efficacy to deliver impartial, non-judgemental and accurate information about sex and HIV is essential, as are efforts to acknowledge and address their own HIV risks.

Keywords

teachers' attitudes; life skills education; sexuality; HIV/AIDS; South Africa

Introduction

The need for comprehensive and effective sex education for young people in South Africa is difficult to overstate. Young people are disproportionately affected by HIV, with approximately 16% of young women and 5% of young men between the ages of 15 and 24 already infected (Pettifor et al. 2005; Shisana et al. 2009). Young South African women are also at high risk for pregnancy: about one-third of 19-year-old women report having ever

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been pregnant (Pettifor et al. 2005). With a median age of sexual debut of 17 years for young men and women, the majority of young people become sexually active during their teen years (Department of Health, Republic of South Africa, Measure DHS, and ORC Macro 2004).

Because youth and adolescence are times of physical, emotional and psychological development when decisions about relationship formation and sexual debut occur, it is viewed as a particularly salient period in which to address issues of sexuality (Lloyd 2005). Schools in developing countries are regarded as appropriate settings in which to educate young people about sexuality and relationships, as school is a captive setting in which to reach a large audience of young people, often before they initiate sexual activity (Kirby 2002); WHO 2006). Also, evidence suggests that educational achievement and regular school attendance may be protective against risky behaviours (Kirby, Laris, and Rolleri 2007; Speizer, Magnani, and Colvin 2003).

While young people in other settings have lamented the irrelevance of the content of school-based sex education curricula (e.g. Allen 2008), the challenges of implementing sexuality education are especially acute in South African schools. As with other social institutions, government schools for black South Africans must contend with the legacy of apartheid, in which schools were segregated by race. Overall, while the national government has voiced its commitment to improving education in the post-apartheid era, decades of underfunding and the additional obstacles of poverty, violence and gender discrimination contribute to what has been called ‘elusive equity’ for students in predominantly black schools (Fiske and Ladd 2004). The history of gender-based violence and discrimination makes the school environment especially challenging for girls and young women, and is an issue of sufficient magnitude that even the national government has highlighted its seriousness. A 2000 handbook for educators, for example, included a message from the Minister of Education that urged male educators to stop the practice of ‘demanding sex’ from female teachers and students, noting that it ‘betrays the trust of the community’ and is illegal (Department of Education 2000).

Despite these myriad challenges and constraints, South Africa’s government mandated in 1996 that a national Life Skills programme be taught in all secondary schools (President’s Office, Republic of South Africa 1996). Life Skills was designed to provide students (known in South Africa as ‘learners’) with comprehensive information about the transmission and prevention of HIV and other sexually transmitted infections, as well as reproductive biology, contraception and pregnancy, domestic violence and sexual negotiation. The curriculum emphasises individual-level self-efficacy and behaviour change to promote outcomes such as delay of sexual debut and increased condom use. While the programme has a core set of topics, there is no single curriculum, meaning that schools can tailor the programme to meet learners’ needs (Visser 2005). Initially, a ‘cascade’ model of dissemination was employed, in which teachers trained in Life Skills were expected to instruct other teachers. The programme is now part of a broader curriculum, called Life Orientation, which also teaches about physical activity and nutrition, emotional and mental health, drug and alcohol use and vocational preparation.

The implementation of the Life Skills programme – and more recently, Life Orientation – has varied widely across schools in terms of teacher training, curriculum, and available materials (Magnani et al. 2005). In schools where full implementation of the programme has occurred, Life Skills has been reasonably successful in increasing both knowledge about HIV and AIDS, and reported condom use (James et al. 2006). Yet until recently, few studies had systematically investigated the role of teachers themselves in promoting HIV prevention and sexuality education in schools (Morrell et al. 2009). A spate of new research points to

some common themes. Programmes that have relied on teachers to implement sexuality education generally find inadequate support from teachers at both the school and classroom levels (Ahmed et al. 2006; Mathews et al. 2006; Mukoma et al. 2009; Plummer et al. 2007). Often, this is not due to wilful disregard of the importance of the topic, but rather to discomfort with teaching about sexuality or because teachers' time is dedicated to administrative work, disciplining and controlling students, and filling in for absent teachers (Ahmed et al. 2006; Mukoma et al. 2009). Personal selfefficacy also plays a role in implementation, with some teachers expressing more confidence than others (Helleve et al. 2009b). For example, teachers who believe that abstinence is the most appropriate prevention strategy for young people have reported discomfort teaching comprehensive sexuality education, a finding also reported in other African settings (James et al. 2006; Oshi, Nakalema, and Oshi 2005; Plummer et al. 2007). Other teachers, however, express a high degree of confidence and self-efficacy with regard to teaching sexuality education, and think that personality, comfort with one's own sexuality, and life experience make some teachers better suited than others to teaching students about sex (Helleve et al. 2009b, 2011). Finally, the fact that teachers themselves are at high risk for HIV is an important – and relatively overlooked – reality, with implications for their willingness and ability to provide instruction about HIV and AIDS, sexuality and related topics. While accurate data are scarce, HIV prevalence among black South African teachers is estimated at 16% overall, and up to 24% among female teachers in their early thirties (Zungu-Dirwayi et al. 2007).

This paper reports qualitative findings from a study of secondary school teachers' and administrators' attitudes towards sexuality education, HIV/AIDS, adolescent sexuality and their communities, in a sample of rural South African government schools, and examines how their attitudes may affect the implementation of a government-mandated, school-based sexuality education programme.

Methods

Setting

This study was conducted in a rural sub-district in northern KwaZulu-Natal (KZN) province. KZN is South Africa's most populous province, and reports the highest overall HIV prevalence; among youth aged 15–24 years, HIV prevalence more than doubled from an estimated 7.2% in 2002 to 15.3% by 2008 (Shisana et al. 2009). Among educators in KZN, an estimated 21.8% were HIV positive in 2004 (Shisana et al. 2005). The subdistrict where the study took place has a population of over 200,000, and comprises primarily rural homesteads and small towns. Migrant labour remittances and state pensions provide most household income in the district, which averages US$1500 per capita (Statistics South Africa 2004). Most residents are ethnically Zulu. In this area, secondary school enrolment is high, but is characterised by high proportions of older students in the upper grades, with 36% of students aged 19 years or older (Harrison 2002. Economic determinants such as work obligations, labour migration, and lack of money for school fees, and health-related determinants including pregnancies explain the age distribution, which results in fluctuating enrolment and cyclical attendance over many years.

Data collection

As part of an ethnographic study of the social dynamics of sexual risk, carried out between 1999 and 2005, qualitative research was conducted with teachers and school administrators at the 19 secondary schools in the sub-district in 2000 and 2001 in order to gauge the extent to which teachers had received and implemented Life Skills training and other activities regarding sexuality education and HIV prevention. The study also served as formative research to develop a school-based sexuality education intervention that promoted 'dual

protection' to reduce both pregnancy and HIV risk among learners in grades 8–10 (Harrison 2002; Mantell et al. 2006). Teachers and school administrators interviewed for the current study did not have a formal role in the later intervention project. This study has been supplemented by further research with teachers in this area, reinforcing the continued relevance of these findings (Hoddinott et al. 2011; Mantell et al. 2006).

The research team purposively selected teachers who could best provide information about the training and dissemination of the Life Skills curriculum. School biology and guidance teachers, who are usually charged with teaching Life Skills, were approached in each school unless another teacher was identified. Researchers also requested names of other teachers who taught Life Skills or conducted other HIV prevention activities (such as extracurricular clubs) with students. The team also requested an interview with the school's principal or other administrator, as they are responsible for setting school policies and overseeing curricular instruction.

The interviews focused on the following major areas of enquiry: school sexuality education, Life Skills, school policies regarding pregnant learners, awareness of HIV and AIDS and perceived problems facing learners. Interviewers used a research instrument that included a range of open-ended and close-ended questions, as well as follow-up questions or probes to elicit more details on the close-ended questions. The open-ended questions were designed to be neutrally worded and aimed at encouraging informants to express themselves more fully than in a traditional, close-ended survey (Ulin, Robinson, and Tolley 2005). A total of 43 interviews were conducted with teachers and administrators at the 19 schools. All informants gave verbal consent to participate, and there were no refusals. Verbal consent was deemed appropriate during ethical review, based on the use of anonymised data throughout the study process. Ethical approval was obtained from the Research Ethics Committee of the Faculty of Medicine, University of Natal (now Nelson Mandela School of Medicine at the University of KwaZulu-Natal), as part of a larger study on adolescent sexuality (Harrison 2002).

Each respondent was privately interviewed once in either isiZulu or English, depending on informant preference, by a member of the research team, a South African woman fluent in both languages. All interviews were audiotaped. Interviews were transcribed; those conducted in isiZulu were first translated by a member of the South African research team. Data analysis was conducted by the authors, using NVivo 7.0 qualitative analysis software (QSR International, Doncaster, Victoria, Australia). Responses to the close-ended questions were tabulated manually; schools were assigned a letter code (A–S) so that each school could be represented with a unique identifier during data analysis. A broad thematic analysis was conducted for the open-ended questions according to the following procedures. First, major themes that emerged from the data were listed, based on several initial 'close readings' of the transcripts. Through this process, the study's major themes of school-based instruction in sexuality education and HIV prevention and teachers' overall attitudes towards learners emerged. Second, using an iterative process, additional themes and sub-themes were then developed. Third, specific codes were developed, based on these emergent themes. Fourth, a complete content coding was then performed for all 43 interview transcripts.

To check for reliability and to ensure consistency in the data analysis, several coded transcripts of two independent data analysts were compared at different stages of the coding process. After completion of the coding, a fifth and final step in the data analysis was performed, in which data within the major themes and sub-themes were analysed to examine common patterns in the data, as well as exceptions to those patterns. This provided an analysis of the majority perspectives of the teachers, as well as key minority perspectives,

which were illustrated with representative quotes and the construction of individual narratives. Finally, to supplement this analysis, the data were examined across teacher characteristics, particularly looking at teachers' attitudes by sex and teacher type. Detailed demographic information about individual teachers was not collected.

Results

Study sample

All 43 informants were black South African secondary school teachers or administrators. The distribution of the sample is shown in Table 1. Notably, all but one of the school administrators were male, and most of the teachers were female.

Almost all informants reported having multiple teaching responsibilities, frequently across disciplines (e.g. a biology teacher who also teaches English). Informants represented all 19 secondary schools in the sub-district. More than one teacher or administrator was interviewed at 16 of the 19 schools in the sample. At three schools, only one interview was conducted due to teacher availability and time constraints.

Life Skills programme – training and dissemination

Given that the Life Skills programme is a national mandate, informants were asked whether there was a teacher at their school who attended formal Life Skills training, and if so, whether and how that teacher had shared what was learned with students, teachers and school administrators. At most of the schools, informants reported that usually a female teacher had attended some type of formal Life Skills training, usually an intensive week-long programme. However, the Life Skills/Guidance teacher only provided a formal report of the training to administrators and other staff at a few schools. At two schools, teachers reported that they had shared training information only with female staff and students; at two other schools, information was only shared with learners. In most schools, dissemination was extremely informal, for example, two teachers said that they shared Life Skills information by leaving pamphlets and handouts in their schools' common areas.

More than one-third of all respondents cited time constraints and heavy teaching workloads as the reason why information was not more formally disseminated. In addition, because there was no dedicated time in the school schedule for the Life Skills curriculum, several teachers reported that they had to focus on teaching those subjects for which students took formal examinations; as one teacher noted, 'We are always rushing to finish the syllabus'. One administrator suggested that he discouraged his Life Skills/Guidance teacher from spending too much time on that curriculum, because Life Skills is 'not the only thing she does. She is a teacher too and is supposed to teach'.

Other school-based sexuality education

Some interviewees discussed other types of school-based sexuality education. Teachers' descriptions revealed considerable differences in their comfort with teaching these topics. One administrator described the coded language that he used to teach learners about intercourse and condom use:

> I have special names and learners know those names. If I say 'write' they know that is a sexual intercourse. This [is] not a problem to say it or to say it as vague language … If you 'write' you will get an STD [sexually transmitted disease], if you 'write' you must wear a 'coat' to prevent STD. Learners know. (Mr Silongo, Principal, school S)

Another administrator suggested that students who understood the basics of human reproduction should not become pregnant:

> The other day I was in grade 11 [biology class] and discovered that the topic was about the reproduction … So I even added in their talk … telling them that there is no need of a student to be found pregnant because they know now how does the pregnancy occur. (Mr Mabena, Principal, school A)

Conversely, biology teachers seemed somewhat more comfortable instructing students in these topics. One male biology teacher noted that he incorporated lessons about sexually transmitted diseases into his classes because 'I have seen that they need awareness to these things', a sentiment echoed by a female biology teacher at another school. Several biology teachers also noted that learners seemed particularly engaged in learning the curriculum related to human reproduction. Several teachers described the processes of menstruation, fertilisation and gestation at length, suggesting that the school's efforts in sexuality education were largely focused on teaching human reproduction.

Teachers' suggestions and needs for sexuality education

Teachers were emphatic in articulating their schools' needs for additional sexuality education and HIV prevention. Nearly all informants offered specific suggestions as to how to improve school-based awareness and prevention efforts aimed at learners. Several explicitly articulated their views that Life Skills should have dedicated time in the school day. One Life Skills/Guidance teacher suggested, 'If we can be provided with a period where we talk about HIV/AIDS, [it] can be of a great value to our learners'. In a similar vein, teachers mentioned needing additional teachers in the schools to help reduce overall teacher workload; as one biology teacher noted, 'Our problem is that we are understaffed'. Importantly, some teachers also highlighted a need for more HIV prevention among fellow teachers as well, with one male administrator noting, 'teachers have the same problem. Many have died'.

Many teachers spontaneously suggested that persons and programmes from 'outside' the school be brought in to provide instruction and interventions in sex education and HIV prevention. At some schools, this was already occurring, as teachers reported that the Department of Health, the Department of Education and non-governmental organisations sometimes supplemented school-based instruction in HIV prevention and sexuality education through occasional assemblies and performances. Reasons for this suggestion included perceived student fatigue with teachers' instruction on these topics, lack of teacher expertise regarding accurate information about HIV and Life Skills, and lack of teacher time and school support to implement the Life Skills curriculum:

> If we can get people who [are] coming from outside to address learners I think learners can pay more attention … They are tired of me, they will not pay attention. (Mrs Shabangu, Biology teacher, School H)

HIV and AIDS knowledge

Many informants revealed their knowledge and awareness of HIV and AIDS indirectly, through responses to other questions. Overall, teachers reported high levels of knowledge regarding the transmission and prevention of HIV, although they were sometimes misinformed about testing and treatment. One female Life Skills/Guidance teacher asked whether a blood test would confirm HIV infection, and one teacher, after stating that 'in order to know that the person is HIV positive you need to test his blood', commented later in his interview:

> Like the traditional healers they must be given permission to treat people with this disease … You know it is funny that doctors do accept to work with traditional healers in other conditions but with this AIDS they do not want to. (Mr Thusi, Biology teacher, School M)

Several respondents cited statistics about HIV prevalence in the province and mentioned various popular media reports on HIV and AIDS, suggesting that awareness of the scope of the epidemic was widespread. Several other teachers also mentioned circular patterns of migration as a reason behind increased rates of HIV, and asked questions regarding programme interventions and successes in other settings.

Perceptions regarding HIV and AIDS in the community and schools

Respondents were asked how HIV and AIDS affected their communities and learners at their schools. Several mentioned that they knew people in the community or elsewhere who were affected by AIDS mortality, but none reported with certainty that anyone at their schools was infected with HIV. Overall, teachers reported that the majority of learners appeared to be healthy, although they were aware that students' appearance was not indicative of their HIV status. As one male administrator remarked:

> I can say just now is not a big problem but we cannot run away from the fact that there are symptoms. (Mr Ndebele, Deputy Principal, School R)

Teachers seemed more likely to view HIV as a significant *future* threat rather than as an immediate danger, with another male administrator predicting, 'it is possible that the big number of learners will become affected one day'.

However, teachers did relate accounts of seriously ill students. Several teachers mentioned tuberculosis as the main cause of poor health among learners at their schools, and one administrator highlighted the difficulty in attributing serious illness to a particular infectious disease:

> Here in this school pupils are sick with different sickness and they were sick even before HIV/AIDS existed. The presence of AIDS did not bring about any change. The symptoms of AIDS are similar to those of pulmonary tuberculosis and we end up not having a clear picture of [what] AIDS is and what is the difference between AIDS and other sickness. (Mr Mabuza, Deputy Principal, School I)

Another male principal suggested that perhaps the stigma associated with HIV led learners to claim that they had tuberculosis, noting: 'The learners hide if they are sick. Everybody says she/he is suffering from TB, so it is not easy to see that a learner is suffering from AIDS'. Only a few teachers expressed concern about their own and their colleagues' HIV risk. As one female Life Skills/Guidance teacher admitted, 'I do not know whether I am infected or not. They are afraid to check themselves and I am afraid to check myself'.

Policies and attitudes towards pregnant learners and young people's sexuality

The South African government mandated in 1996 that pregnant learners should be allowed to remain in school as long as they are able, or be provided with instruction outside of school if their health prevents them from attending classes. Teachers frequently commented that while they could no longer 'chase' pregnant learners out of school, they pressured these students to leave. As one male administrator said, 'We do not suspend a learner at school, but we negotiate with parents'.

All informants reported that pregnant students regularly left school. Several teachers reported that they discouraged the attendance of pregnant students because pregnancy was shameful or an affront to the community's values. Still others expressed concerns about

alleged health risks or the potential distractions of having pregnant students (or new mothers) in class. Male school administrators were particularly likely to articulate concerns about potential problems associated with having pregnant learners in school, and many expressed frustration over the national mandate. One principal noted:

> I think the [school's] governing body is more effective than [the national] government to this situation, to our cultures and to our environment. (Mr Dlomo, School B)

Sexuality and romantic relationships

Young people's sexual behaviour and romantic relationships were discouraged and even stigmatised. A majority explicitly characterised learners' – particularly girls' – romantic relationships and sexual activity as problematic, often stating that their 'love affairs' undermined learning and classroom instruction. Their statements about adolescent sexuality frequently reinforced prevailing gender norms, often equating young women's sexual and romantic activity with immorality or rebellion, and underscoring expectations about appropriate behaviour:

> I have told them you are bad, you like to involve yourselves in love affairs. (Mrs Phoshoko, Biology teacher, School B)

> I would like female students to be taught how to behave as young people. A girl has a certain way of how to talk to elders, how to stand and even how to walk … Girls are keys of AIDS and STDs, if they can lock everything we won't have so much people with AIDS.

> *Interviewer*: What do you mean they are keys?

> I mean if they can change their behaviour and learn to say no to boys I think even the high rate of rape would decrease. (Mrs Radebe, Female Life Skills/Guidance teacher, School I)

Six teachers and administrators stated that it was important for girls to 'empower' or 'respect' themselves by abstaining from relationships and sex. In addition, 10 teachers and administrators also espoused more conservative and/or traditional practices relating to adolescent sexuality, including virginity testing for girls, abstinence-only education and reading the Bible. One teacher advocated for virginity testing even as her own statement contradicted that it works:

> I think this is good idea although we have had other learners had got a certificate for virginity. Those virgins are no longer with us here at school they have dropout due to pregnancy … this disappointed us because we were very proud of them … I think if we can go back to our culture of virginal testing maybe this can minimise the rate of pregnancies. (Mrs Sisulu, Biology teacher, School E)

General attitudes towards learners and the community

Teachers' attitudes towards learners more generally, as well as towards the community, were also often notable in their complexities. When asked about problems facing learners at their schools, teachers most frequently cited a lack of motivation or responsibility for education among learners:

> What I can say is that they have lost the direction, they do not know why learning is important … they do not have an enthusiasm to go to school. (Mrs Nhlapo, Female Life Skills/Guidance teacher, School D)

> Another problem [is that] we have no culture of learning, it is just gone away. (Mr Tshabalala, Biology teacher, school A)

These attitudes were sometimes attributed to a lack of exposure to formal schooling and living in an impoverished rural area that privileged Zulu traditions such as early marriage over secondary education. Interestingly, while several teachers endorsed traditional cultural practices such as virginity testing, as mentioned above, others highlighted the cultural and socioeconomic differences between themselves and the communities they served:

> This environment has a habit of *ukuveza* (all people should know that a girl has fallen in love) … It's because we come from different societies, other people fail to adjust themselves to this community and I have noticed that thing. We as teachers, we fail to communicate with learners, we fail to understand that children from this environment cannot copy with [emulate] the children from urban areas. (Mrs Mathebula, Female Life Skills/Guidance teacher, School B)

Along these lines, teachers largely characterised parents and the community as poor, illiterate, and ignorant of the value of schooling, and frequently blamed parents for their children's perceived failings. Teachers frequently implied that parents' attitudes and behaviour were in conflict with the values of the school, or that parents were incapable of acting as positive influences on their children's lives:

> I think the community members or some of the parents accept certain behaviours that we do not accept at all to our learners. Parents encourage the female learners to have boyfriends. (Miss Kaleni, Female Life Skills/Guidance teacher, School L)

> No one encourage[s] them … another problem [is that] parents are illiterate. (Mr Hlanganani, Principal, School E)

Discussion

Teachers' and administrators' strong opinions and sense of moral authority regarding young people's sexuality dominate both the formal and informal discourses about sexuality within the schools in our study, and may impede delivery of school-based sexuality education and HIV prevention curricula. Teachers' attitudes towards sexuality tend to be judgemental, especially for girls. These attitudes are not related specifically to HIV and AIDS, which is regarded as a 'recent' problem, but instead reflect deeply rooted and highly gendered beliefs and values among educators and reinforce a more general view of adolescents that sees them as 'problems' for adults (Aggleton and Campbell 2000). Informants' attitudes towards pregnant learners were particularly critical, as were frequent comments equating girls' sexual behaviour with immorality. Despite the fact that teenage pregnancy is so common that every informant in the study reported that female learners dropped out, teachers spoke of adolescent pregnancy as something that was an affront to their sensibilities and shameful behaviour on the part of the young women. Such comments contribute to stigma against young women who are already sexually active and who often lack the power to negotiate safer sex behaviours.

In addition, the stigma surrounding acknowledgement of HIV infection in the broader community is implicit in these interviews. Notably, no teachers attributed school dropouts to HIV, despite the fact that these interviews were conducted in the South African province with the highest prevalence of HIV. This is a similar finding as in more recent qualitative work byHelleve et al. (2009a), in which Life Orientation teachers were not aware of any HIV-infected students at their schools. While some informants mentioned their own risk of HIV or that of their learners, teachers' attitudes focused more on learners' poor choices and irresponsible behaviour, rather than on strategies to minimise risk of HIV infection. In

addition, the suggestion by some teachers that learners and community members were affected by tuberculosis – but not HIV and AIDS – offers further evidence of how circumscribed the acknowledgement of HIV status and the accuracy of perceptions about the HIV epidemic were at the time of this study, even among those tasked with instructing young people in those very topics (Chao et al. 2007). The Life Skills teacher's statement that she was afraid to be tested for HIV underscores how stigma may unwittingly be perpetuated even as teachers are supposed to promote awareness and prevention. The implications for teachers themselves are also substantial: their own risk for HIV is significant, and denial and fear of HIV may not only indicate their own lack of awareness and limited self-efficacy to teach sexuality education, but mask their own HIV risks as well.

Furthermore, male administrators' authority has important implications for school-based sexuality education programmes, as well as whether the school climate is supportive of both learners and fellow teachers. In spite of national education policies intended to keep pregnant girls in school, male administrators frequently set informal school-level policies that discouraged their attendance, compounding young women's problems in a gender-unequal school environment. Lack of time in the curriculum was also a major reason why the Life Skills programme was not more broadly implemented. This suggests that male administrators have considerable, perhaps uncontested, power in determining school agendas and policies that may be in conflict with national mandates for both school curricula and attendance. Female teachers, in particular, likely have difficulty challenging this authority. Human Rights Watch has documented the threats of physical and sexual violence that both female students and teachers in South Africa face in South African school settings (Human Rights Watch 2001), and more recent work on gender relationships in schools underscores that little has changed (Morrell et al. 2009). Indeed, in a qualitative study of Life Orientation teachers,Helleve et al. (2011) found that many teachers had heard of intimate and sexual relationships between male teachers and female students at their schools, which female teachers in the study viewed as inappropriate and unequal in gendered power dynamics.

In addition, teachers' inability to provide more thorough sexuality education and HIV prevention may reflect their own limited self-efficacy to teach on sensitive topics, but also reveals much about their own personal beliefs as members of the communities they serve. Our interviews with educators reflected the widespread self-perception that teachers are outsiders in (and more 'modern' than) the rural Zulu communities where they teach. Yet teachers are, of course, adult residents of those same communities, and likely to share many of their community's value systems even as they expound on the community's perceived ignorance (Gallant and Maticka-Tyndale 2004; Mantell et al. 2006). Occupying this liminal role, teachers reinforce a specific set of local values and norms around adolescents' sexual behaviour and sexuality education, but also position themselves as having a superior set of values and knowledge, despite evidence that they are often misinformed themselves. This stance clearly limits their effectiveness with regard to delivering sexuality education, and more broadly, with regard to creating a supportive educational environment.

There are several limitations to our study. One is the age of the data, as the change to the more broadly focused Life Orientation programme occurred soon after this study's implementation. As our study was at only one point in time, we do not know how the implementation of Life Skills may have changed in the schools in our sample due to resources or the evolution of the curriculum. For this study, the informants were selected intentionally, represented schools in only one rural sub-district and did not include uniform sampling of the number of teachers and teacher types at each school. Also, while the interviews covered many of the same topics, not all gathered the same data due to the study's open-ended investigative approach; therefore, our findings are limited in their scope.

However, contemporary work in this area specifically (Hoddinott et al. 2011), as well as elsewhere in South Africa, suggests the continued salience of the issues raised by the respondents in this study. The similarities between our findings and other well-documented barriers to Life Skills and Life Orientation implementation over the past decade lend reliability to this study (e.g. Ahmed et al. 2006; Helleve et al. 2009a, 2009b). Indeed, given the lack of generalisability of many studies of teachers' attitudes and behaviours in the context of sexuality education, our data lend important support to the broader picture of teachers' and administrators' perspectives on sexuality education, and provide evidence from a particularly remote and HIV-affected area of South Africa. Therefore, we believe that this study contributes to knowledge about why school-based sexuality education may not be delivered as intended, and raises important questions about the efficacy of the Life Skills approach in a context where frank discussion of sexuality and HIV risk remains both relatively proscribed and influenced by gendered power dynamics, despite the magnitude of the HIV/AIDS epidemic.

The future

With respect to the future, interventions aimed at training teachers in sexuality education should assess teachers' attitudes regarding adolescent sexuality and measure their actual knowledge about HIV/AIDS. Such interventions should recognise the complexities of teachers' lives and the school environment (Morrell et al. 2009). After all, teachers are adults of authority in the school setting, but are also men and especially women whose values may both oppose and reflect social norms in a setting characterised by poverty, gender discrimination and violence, and limited resources. In particular, female teachers may feel that they are not adequately empowered or supported by male administrators to impart sexuality education. Enhancing their professional capacity and self-efficacy to deliver high-quality teaching on these topics, through investments in education infrastructure, expanded teacher training, human resources and dedicated time for sexuality education is urgently needed if school-based programmes are to be successful in this challenging context.

School-based programmes must also address the varied life experiences and sexuality of adolescents and young people, and should focus not only on the negative potential consequences of sex, but also on healthy sexuality as a normal part of the life course (Aggleton and Campbell 2000). A 'one-size-fits-all' model of sexuality education is inappropriate for learners who have already had significant life experiences including pregnancy, parenthood and labour migration. Students often leave school to begin families or to work, then re-enter school in a transitional position between adolescence and adulthood, facing 'real life' responsibilities but still expected to defer to teachers' authority in the classroom (Grant and Hallman 2006).

In such a context, sexuality education that privileges abstinence education and tells young women that they must 'behave' chastely has little relevance for a 23-year-old learner, for example, who is trying to balance motherhood with completing her secondary education, and may in fact hinder her efforts to negotiate safer sexual practices in the future. As Allen (2007) suggested, young people who are taught to see themselves as sexual beings are often better able to engage in healthy and protective sexual behaviours, such as buying and using condoms. One study in Zimbabwe suggested that appropriate strategies to reduce pregnancy and HIV risk among young people will promote safer sex and abstinence as 'complementary alternatives', will minimise 'moralising statements' regarding sexual behaviour and will present young people with real and supportive knowledge and choices for sexual decision making (Marindo, Pearson, and Casterline 2003).

School-based sexuality education and HIV prevention is an area of enormous potential for South Africa, but must provide information that is non-judgemental, accurate and that

promotes strategies to empower young people to make responsible decisions regarding their sexual and reproductive health. Equally, teachers' personal and professional needs must be considered as part of such strategies. As in similar settings throughout sub-Saharan Africa, teachers' own circumstances have continued to worsen as a group severely affected by the HIV/AIDS epidemic (Zungu-Dirwayi et al. 2007), indicating the need for more sweeping changes both in sexuality education and in the resources and support provided to them (Chao et al. 2007; Morrell et al. 2009). Programmes that seek to integrate and unite the disparate elements of the school community, through mobilisation of key stakeholders and other participatory strategies, are most likely to have a sustained impact on improving both health and educational outcomes.

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Table 1

Characteristics of the study sample.

	Male (*n* = 22)	**Female (*n* = 21)**
School administrators	15	1
Biology teachers	5	10
Life skills/Guidance teachers	1	10
Biology–Life skills teacher	1	