Theatre for a Change Primary School Project

Baseline Survey Report 2010/11

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Executive summary

Theatre for a Change (TfaC) is a registered Non-Governmental Organization in Malawi and Ghana and a registered charity in the UK. TfaC's goal is to reduce HIV infection among marginalized and vulnerable groups. To achieve this, TfaC uses participatory learning techniques that help young people:

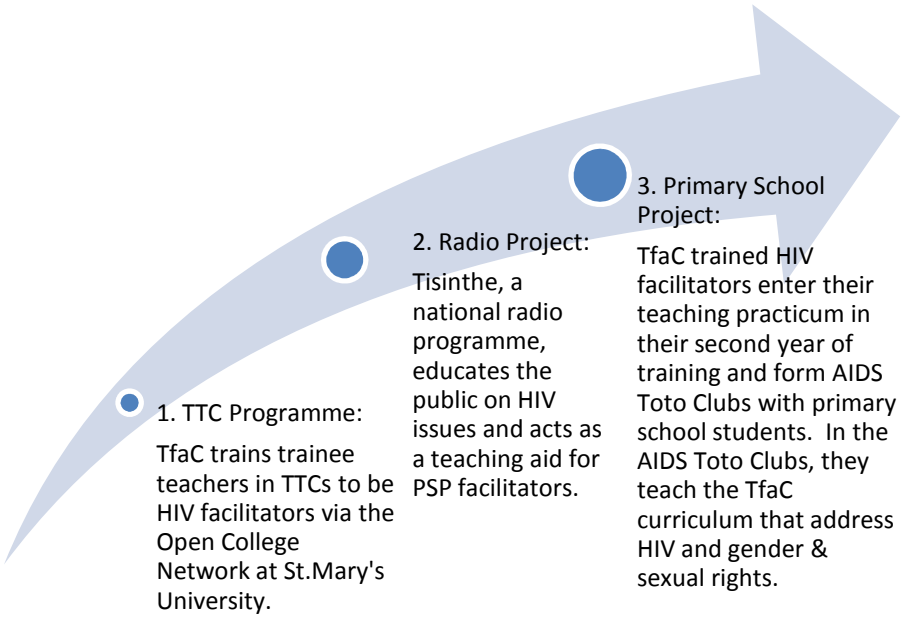
- Learn accurate information about HIV transmission, prevention methods and treatment
- Gain the confidence and communication skills that will protect them from HIV infection
- Discover and assert their right to relationships that are equal and free from abuse
- Become a catalyst for behaviour change in the lives of the people around them

In Malawi, the HIV prevalence rate is 12%. The majority of these infections (88%) result from unprotected heterosexual sex (National AIDS Commission, 2009). HIV prevalence among youth is especially high with 50% of all infections occurring in individuals aged 15 to 24 (UNGASS Country Report, 2009). Furthermore, the prevalence rates among women aged 15 – 24 exceed those of their male counterparts by 2 – 9 times. The National AIDS Commission of Malawi cites engagement in sexual activity with minimal consistent condom use as the main reason for the high prevalence rate among youth (2009). TfaC's Primary School Project is a preventative, behaviour change intervention that works with primary school learners nationwide to reduce the risk of HIV infection among youth in Malawi.

TfaC's Education Programme has three distinct components: The Teacher Training College (TTC) Programme, The Radio Project and The Primary School Project. For information on the TTC Programme and the Radio Project, please consult TfaC's website: www.tfacafrica.com.

The focus of this baseline report is the Primary School Project (PSP) which is the third component of TfaC's Education Programme. The PSP uses trainee teachers who have been trained as HIV facilitators in the first component of the Education Programme to start after-school AIDS Toto Clubs with primary school learners during their practicum (Figure 2). TfaC HIV facilitators use the TfaC curriculum and participatory learning techniques to address HIV, children's rights and gender and sexual rights. The PSP's first year of operation was the 2010 – 2011 school year. During this year, the PSP reached 4,100 students nationwide.

Figure 2: TfaC's Education Programme



TfaC contracted an independent consultant to coordinate the PSP baseline survey to provide baseline information before project implementation and benchmarks for project monitoring and evaluation towards impact assessment. The aim of this report is to provide baseline data to which the endline results can be compared in order to assess the impact of the Primary School Project.

The baseline survey took place in January 2011 in five main geographical areas defined according to the location of Teacher Training Colleges (TTC) where trainee teachers, who are also the primary school project's facilitators, received their training: Lilongwe, Blantyre, Dedza, Kasungu and Karonga. Specifically, the survey took place in Lilongwe, Mchinji, Dedza, Ntcheu, Kasungu, Blantyre and Karonga districts. Given the geographical spread of the survey, this baseline survey is truly national in scope. A mix method approach was used to collect data on the PSP's logframe indicators. The topics covered by the baseline survey included: students' knowledge, attitudes and practices, including perceptions and beliefs, relating to HIV and AIDS, gender and sexual rights, and children's rights.

To provide reliable data towards impact assessment, both the students about to take part in a TfaC after-school club, hereafter called treatment group, and the students not attending a TfaC after-school club, hereafter called control group, took part in the survey. Overall 1246 primary school learners completed the questionnaire: 636 treatment group students and 610 control group students. Approximately 200 students took part in focus group discussions.

Key findings:

- General knowledge on HIV and AIDS is high among Malawian primary school students, and increases as students advance in their education. However, comprehensive knowledge is rare, with almost all students making at least one mistake on knowledge of transmission and prevention mechanisms and condom use.

- Students in higher standards systematically showed greater knowledge of HIV transmission and prevention mechanisms and greater concern for people living with HIV and for gender rights. This suggests that the school plays an important role in teaching students about these issues and counterbalances knowledge and attitudes acquired as part of the early socialisation at home.

- Only a minority of students answered all the questions on gender norms without bias or prejudice. Students' answers showed that gender stereotypes rest firmly with primary school learners, particularly in the lower grades. There was evidence that girls have greater prejudices on gender-related issues. Girls were more likely to say that housework is women's work and less likely to say that it is OK for a woman to ask a man to use a condom. This suggests that attitudes to gender rights are acquired as part of the early socialisation in the household, and that early intervention at school is required to raise awareness on gender rights.

- Generally, a student's gender did not significantly affect respondents' knowledge of HIV and AIDS, nor their attitudes towards People Living with HIV (PLHIV).

- Students regarded issues of children's rights as a `taught concept', understanding that the correct answers were those given by teachers. It appears that the concept of children's rights has not yet been assimilated by students.

- The majority of students did not report any sexual activity. However, students' sexual activity clearly increased with age. Girls were significantly less likely to state being involved in sexual activities.

- The baseline survey identified a clear lack of communication between children and parents in the home on issues relating to HIV and AIDS, gender rights and children's rights. Students neither identified their parents as key sources of information, nor as interlocutor/confidante on the issue. Furthermore, during focus group discussions and

semi-structured interviews, students identified their own parents and members of their family as infringing on their rights, in particular the right to education.

- Focus groups and interviews also shed light on the absence of a supportive environment within the community for students' attitudinal and behavioural change. Students largely felt they had no say on what is happening within the community, which was associated with a feeling of disempowerment.

Recommendations

For programmatic purposes:

- The results show that knowledge on HIV and AIDS, attitudes to people living with HIV and gender rights strongly depend on students' school level (standard). Students demonstrate greater knowledge and more awareness of prejudices and gender stereotypes as they advance through their education. This has programmatic implications as a significant number of primary school learners drop out of primary school. There needs to be a higher number of early intervention programmes targeted at primary school children in lower classes.

- Students are very aware that blood can transmit HIV and that HIV can be transmitted through unprotected sex, but they do not seem to fully understand how HIV can actually be transmitted through unprotected sex. This highlights a fundamental lack of knowledge about sex. Focus group discussions showed that students fill in this knowledge gap by creating myths about HIV transmission. It is therefore important to go beyond general messages about HIV transmission and educate on how exactly HIV is transferred sexually.

- Results indicate that female respondents show greater gender prejudices than male respondents. Girls were more likely to say that housework is women's work and less likely to say that it is OK for a woman to ask a man to use a condom. There might be a need for specific targeting of girls at school to explore, in a supportive environment, gender-related issues.

- Youth prevention programmes are crucial to spreading knowledge. However, work

needs to be undertaken to include parents within such prevention programmes. The majority of learners did not consider their parents as either a source of information or people they feel confident talking about HIV and AIDS with. Furthermore, learners suggested in semi-structured interviews and focus group discussions that parents often infringed upon children's rights to education.

- Work also needs to be undertaken with the wider community to reduce the tension between school learning and community practices. This will ensure a more supportive environment to cement the students' behavioural change.

<u>For the design of the endline survey:</u>

- The endline survey should take place in exactly the same TfaC and non-TfaC schools. Care should be taken to ensure a similar distribution of standard between the two groups and for the sample to be well distributed across standards.

- It might be worth adding a question that was removed from the final version of the questionnaire relating to the body fluids in which the HIV virus can be found. Large numbers of students seem to think that the virus can only be found in blood.

- For the question 'where do you learn most about HIV?', the answer 'hospital' was not available for students to answer. However, approximately 15% indicated that they learnt about HIV and AIDS at the hospital in the 'other' section. This result would have been certainly higher if 'hospital' had been available as an answer. I would recommend including it in the endline.

- In order to complement current data on sexual behaviour, it is recommended that further data is collected on student pregnancy rates, both in control and treatment groups. This would be helpful since pregnancy rates are likely to be highly correlated with practices of unsafe sex.

- Given the significant impact of students' school level on their answer, it would be interesting to carry out standard-specific focus groups, for instance with Standard 4 students only or with Standard 8 students in order to assess the differences in knowledge, attitudes and practices.

Abbreviations

ARV	Antiretroviral [Drugs]
FGD	Focus Group Discussion
HIV and AIDS	Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome
HTC	HIV Testing and Counselling
PLA	Participatory Learning and Action
OCN	Open College Network
PLHIV	People living with HIV
PSP	Primary School Project
RA	Research Assistant
SSI	Semi-structured Interviews
TfaC	Theatre for a Change
TTC	Teacher Training College
UNAIDS	The Joint United Nations Programme on HIV and AIDS
USAID	US Agency for International Development

Glossary

Control group: Group of respondents that will not benefit from the intervention

Standard: Term used in Malawi to describe a school year at primary school level. For example, Standard 1 stands for Year 1 and Standard 2 for Year 2, etc.

Treatment group: Group of respondents that will benefit from the intervention between the baseline and the endline survey

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Introduction

Theatre for a Change (TfaC) is a registered Non-Governmental Organization in Malawi and Ghana and a registered charity in the UK. TfaC's goal is to reduce HIV infection among marginalized and vulnerable groups. To achieve this, TfaC uses participatory learning techniques that help young people:

- Learn accurate information about HIV transmission, prevention methods and treatment
- Gain the confidence and communication skills that will protect them from HIV infection
- Discover and assert their right to relationships that are equal and free from abuse
- Become a catalyst for behaviour change in the lives of the people around them

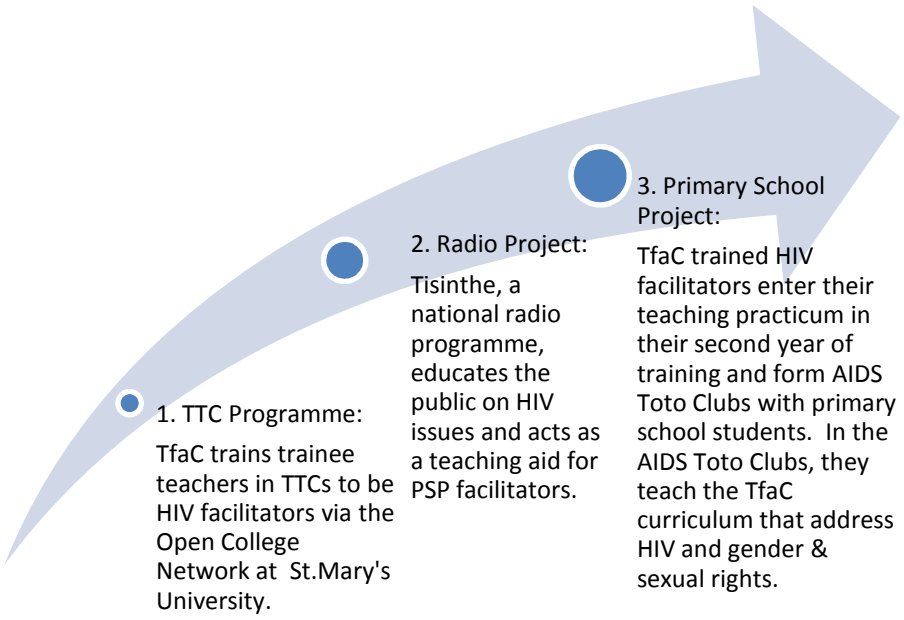
In Malawi, the HIV prevalence rate is 12% and is especially high among teachers and youth. Teachers have the third highest HIV prevalence rate by occupation in Malawi at 23%, almost double the national rate, and approximately 50% of all new infections occur in individuals aged 15 to 24 years (UNGASS Country Report 2009). Furthermore, UNICEF estimates that there are 100,000 children under the age of 15 are living with HIV (2008). The National AIDS Commission (2009) states that infection rates among male youths correlates with the age of sexual debut and the number of sexual partners. Among women, infection rates are associated with sexual behaviour related to seeking long-term relations than with casual sex with older males (NAC 2009). Young women aged 15 – 24, who are married or in a stable relationship (10.4%) have a much higher prevalence of HIV than those not involved in a stable union (4.8%).

Child abuse is also widespread in Malawi. It is estimated that over 50% of children have experienced abuse either at home, in their community or at school (USAID 2007). According to the Malawi Multiple Indicator Cluster Survey (2006), 28.8% of children between the ages of 5 – 14 are involved in child labour. Early marriages are also widespread with 10.6% of girls married before the age of 15 and 50.2% married before the age of 18. In addition, 32.1% of girls between the ages of 15 – 19 are currently married or in union resulting in an increase in teen pregnancy, STIs and HIV risk among this population. All the above mentioned facts therefore mean that youth in Malawi are highly vulnerable to HIV infection.

Theatre for a Change's Education Programme is a targeted behaviour change intervention that works with trainee primary school teachers and their learners to reduce the risk of HIV

infection among teachers and youth. The Education Programme has three distinct components: The Teacher Training College (TTC) Programme, The Radio Project and The Primary School Project (Figure 2). For information on the TTC Programme and the Radio Project, please consult TfaC's website: www.tfacafrica.com. The Primary School Project (PSP), the focus of this baseline report, is the third component of TfaC's Education Programme.

Figure 2: TfaC's Education Programme



Theatre for a Change's (TfaC) Primary School Project is an intervention that works with primary school learners from Standard 4 to Standard 8. Trainee teachers run AIDS Toto clubs for learners where issues regarding HIV and AIDS and children's rights are explored using physical and experiential approaches with the aim of increasing HIV prevention strategies among primary school learners. Trainee teachers help the learners gain comprehensive and accurate knowledge of HIV and an increase in safer gender and sexual practices, attitudes and behaviours. In addition, the Primary School Project aims to help make Primary schools safe places where children's gender and sexual rights are respected. The trainee teachers running the AIDS Toto Clubs have themselves benefited from TfaC's intervention during their first training year in a Teacher Training College (TTC). All of these trainee teachers attended a 10 months intervention programme and completed the first year of a behaviour-change facilitation course from the Open College Network (OCN) at St Mary's University in London.

The second year of the TTC programme is spent doing teaching practice in primary schools. It is during their year of teaching practice that trainee teachers run AIDS Toto Clubs, where they implement the HIV prevention training they received from TfaC in their TTC. Each club has approximately 20 learners. They follow a manual designed by TfaC that lays out the content and participatory methods to be used during workshops. They are mentored and monitored by specially appointed teachers who have received training from TfaC.

In addition to running the AIDS Toto clubs, the trainee teachers are also asked to use the participatory methods in their regular teaching and implement actions that promote HIV prevention and children's rights in their regular teaching.

Objectives and methodology

Objectives

The objective of this baseline survey was to gather and analyse data from primary school students on TfaC' Primary School Project indicators as expressed in the logframe.

The specific objectives of the survey are:

- To gather data on students' knowledge, attitudes and behaviour, including perceptions and beliefs, relating to HIV and AIDS and children's rights, according to the logframe's indicators (see Table 1 for a summary of these indicators)
- To provide baseline information before project implementation and benchmarks for project monitoring and evaluation towards impact assessment (see Table 2)
- To improve the quality and effectiveness of project implementation through a better understanding of students' knowledge, attitudes and behaviours

Table 1: Summary of Primary School Project's logframe's indicators

Indicators include the following (for all students taking part in AIDS Toto clubs)

- Percentage of learners who correctly identify ways of both HIV transmission and prevention
- Percent of learners who can effectively say 'no' to sex using voice, body and space
- Percent of learners who demonstrate a positive attitude towards PLHIV
- Percent of learners who confidently participate in discussions about HIV and AIDS
- Percent of learners who demonstrate a positive attitude to HIV prevention methods
- Percent of learners who are able to identify 3 examples of gender stereotypes and

provide explanation about why they are harmful

- Percent of learners who can correctly identify 3 examples of their gender and sexual rights
- Percent of learners who report increased self-efficacy
- Percent of learners able to identify situations or places that can expose them to risk of abuse

Table 2 outlines the Impact Assessment Framework for the survey. The intention is to return to the same set of schools after the programme has been in place for one to two years, and to measure changes in knowledge, attitudes and behaviour among a similar set of students.

Table 2: Impact Assessment Framework – Double difference

Survey round	TfaC AIDS Toto clubs' student group	Control group/non AIDS Toto clubs' students	Difference across groups
Follow up/Endline survey	**TfaC Students**: follow up survey	**Non TfaC Students**: follow up survey	**TfaC Students** follow up survey minus **Non TfaC Students** follow up survey
Baseline survey	**TfaC Students**: baseline survey	**Non TfaC Students**: baseline survey	**TfaC Students** baseline survey minus **Non TfaC Students** baseline survey
Difference across time	**TfaC Students**: follow up survey period minus **TfaC Students**: baseline survey period	**Non TfaC Students**: follow up survey period minus **Non TfaC Students**: baseline survey period	Double difference [(**TfaC students:** follow up survey)- (**TfaC students:** baseline survey)] – [(**Non- TfaC students** baseline **survey**)- (**Non-TfaC students** baseline survey)]

(based on Microloan Foundation 2008)

Methodology

Study site selection and sampling design

At the time the survey was planned, TfaC had identified 200 trainee teachers who were to run AIDS Toto clubs, aiming to reach a total population of 4,100 primary school learners from Standard 4 to Standard 8[1]. The determination of the sample size was largely guided by the need to obtain a size that would give statistically meaningful data.

For the purpose of sampling, AIDS Toto clubs[2] were first stratified by teachers' TTC of origin and were therefore divided into five main regions based on the location of the TTC of origin: Lilongwe, Dedza, Kasungu, Blantyre and Karonga.

Within these regions, AIDS Toto clubs were then stratified by size. TfaC AIDS Toto clubs range from 5 to 100 students for any one after-school club, and ranges differ considerably from one region to another. As a result, the ranges used to allocate AIDS Toto clubs to the different size categories differed from region to region. Based on the total number of AIDS Toto clubs per region, between 3 and 5 AIDS Toto clubs were randomly selected in each region.

A total of 19 TfaC AIDS Toto clubs were selected, totalling 636 students. All students participating or about to participate in a specific after-school club were asked to complete the survey. It was decided to sample students on a 'take-all' basis as it is less complicated than sub-sampling, which implies singling out students for inclusion or exclusion. In addition to excluding students from the study, sub-sampling would have entailed more planning, which would have made participation by some schools unfeasible. The inclusive approach was also considered more efficient since the required sample size could be achieved with fewer schools than if we had opted for the sub-sampling method (Tresta and Coleman 2006).

[1] At the time the survey was planned, it was decided that only students in Standard 4 to 7 would be ask to take part in the survey as we did not want to disturb Standard 8 students who were preparing for exams. However, a significant percentage of Standard 8 students still participated in the survey.

[2] It was decided to select AIDS Toto clubs as the sampling unit rather than individual schools as some schools run multiple TfaC AIDS Toto clubs.

Choosing the control group

19 control group schools were selected to act as counterfactual for the purpose of a difference-in-difference analysis. This approach contrasts changes in the treatment group with changes in a control group (see Table 2 for details). In this way, changes that occur in both groups are not erroneously ascribed to be an effect of the after school clubs. Selected TfaC schools were asked to name the school closest to them that did not run TfaC AIDS Toto clubs. Upon acceptance, all control group schools were asked to randomly select a group of students in Standard 4 to 8 based on pre-agreed gender quotas.

Sample size

A total of 38 schools, 19 TfaC schools, that is primary schools in which TfaC trainee teachers are running AIDS Toto clubs, and 19 control group schools, participated in the survey. A total of 1246 primary school learners completed the questionnaire. 636 of those learners (51%) were attending TfaC AIDS Toto clubs and 610 (49%) belonged to the control group. Of these respondents, 53.6% were girls (668 in total) and 46.4% were boys (578 in total). The five main geographical areas identified for the purpose of the baseline survey were based on trainee teachers' TTC of origin. Approximately a third of respondents (33%) came from the Lilongwe area (which includes Mchinji), 385 students in total. 175 students were surveyed in the Kasungu area, 158 in the Dedza area (which included areas close to Salima), 231 students in the Karonga area, and 297 students in the Blantyre area. As a result, this baseline survey is truly national in scope.

Table 3: Sample distribution by region and sex

			Gender		
			Boys	Girls	Total
Regions based on Teachers' TTC of origin	Lilongwe	Count	155	230	385
		%	40.3	59.7	100.0
	Dedza TTC	Count	78	80	158
		%	49.4	50.6	100.0
	Kasungu TTC	Count	99	76	175
		%	56.6	43.4	100.0
	Karonga TTC	Count	92_a	139_b	231
		%	39.8	60.2	100.0
	Blantyre TTC	Count	154_a	143_b	297
		%	51.9	48.1	100.0
Total		Count	578	668	1246
		%	46.4	53.6	100.0

Research Approach

The researcher adopted the following approach to the study:

- Literature Review
- Tool design
- Research Assistant (RA) training on research tools and techniques
- Pre-testing
- Tool refinement
- Collection of primary data
- Quantitative data coded, entered into and analysed through SPSS
- Qualitative data transcribed and analysed with Nvivo
- Quantitative and qualitative data analysis

The survey planning took place in several steps. First a random sampling took place to select 19 schools running or about to run TfaC AIDS Toto clubs. Mentors in each of these schools, that is teachers in charge of coordinating TfaC trainee teachers in schools, or TfaC facilitators, that is trainee teachers who have received TfaC training in TTCs, were called early on to explain the purpose of the survey and ascertain both availability and interest in taking part in the survey. All of the contacted schools – treatment and control – gave a preliminary agreement.

A second phone call was made nearer the time, once dates per region had been agreed upon, to reassert availability and interest. Parental consent forms (in Chichewa or Tumbuka) and head teachers' consent forms (in English) were sent to each individual school a week or two before students in a school were to complete the questionnaire. Together with consent forms was sent a copy of the questionnaire in order for head teachers to be kept informed of the survey content. At the same time, head teachers were reminded of the number of students and specific details to attend to (attending a specific TfaC after-school club for treatment group schools). Thus, prior to the survey, all head teachers were briefed about the survey set up and were well aware of both the activities and the content of the questionnaire upon research teams reaching schools. Head teachers and TfaC facilitators were asked to hand parental consent forms to children and to wait until forms were returned to discuss it with the group of learners.

A few days before the agreed date, schools were reminded of the survey and notified of the approximate time of the survey. Teachers were also asked to arrange a location if possible (a classroom or outside). They were also called on the day to inform head teacher and teachers about the precise arrival time. Upon arrival in school, a courtesy call was made by the research team to the head teacher to collect head teacher's consent forms and parental consent forms. Once the group of students had been gathered, assent was sought from children and young people following a clear and concise explanation on the nature of the survey, its purpose and implications. Each time, students were given the opportunity to opt out if they did not feel comfortable completing the questionnaire or taking part in FGD or SSI, but there was no refusal.

Data collection methods

Data was triangulated through three main data collection methods: questionnaires (read out loud by research assistants), focus-group discussions based on participatory methods and semi-structure interviews (SSIs). These different tools allowed for data on knowledge, attitudes and practices to be gathered, for contradictions to be probed and investigated, and for the data to be as representative as possible of the reality for primary school students.

Given the sensitivity of the issues raised as well as the potentially young age of respondents (the youngest respondents were seven years old), the twelve research assistants hired to carry out the survey received a specific four day training course on undertaking quantitative and qualitative research with children and young people.

Self-administered questionnaires

Self-completion questionnaires were selected for different reasons: first it is a "cost-effective method of collecting data from a large number of people in a standardised way" (Strange et al., 2003, p.337). It has also be demonstrated that self-administered questionnaires often allow respondents to express themselves on issues which they would not feel comfortable discussing face-to-face with an interviewer (Tourangeau and Smith, 1996, Tresta and Coleman, 2006). It was decided, however, to read each individual question and answer out loud in order not to leave any child with literacy issue or comprehension problem behind. When coming to more sensitive issues such as sexual questions, research assistants reiterated the confidential nature of the survey.

A conscious decision was taken to shorten the questionnaire commonly used for the TTC baseline/endline survey so as not to excessively tire students. Completion time varied between one hour with small groups and two hours with larger groups. This also included the reading of the consent form as well as some refreshments upon completion of the questionnaire.

The questionnaire, which was 10 pages long, included questions about students' knowledge, attitudes and practices in relation to HIV and AIDS, gender, sexual rights, children's rights, gender roles and stereotypes, own sexual behaviour and self-efficacy. More specifically, the questionnaire explored the knowledge, attitudes and practices of primary school learners on:

- HIV transmission and prevention
- Myths and facts about condoms
- Attitudes towards People living with HIV (PLHIV)
- Gender and sexual rights
- Children's rights
- Gender roles and stereotypes
- Sexual and risk behaviour
- Self-efficacy

Many questions required a yes/no answer, but multiple answer and grading system were also used to diversify the set of answers and prevent questionnaire 'fatigue'. In all schools, the questionnaire was completed in class groups. Questionnaire were labelled with a unique identifying code in order to both preserve anonymity, as students did not write their name on the questionnaire, and to simplify data entry/cleaning.

Research assistants were in charge of administering the questionnaire in a school setting. They were chosen over teachers as the aim was to differentiate the survey as much as possible from school tests in order to maximise reliability and honesty of answers. As mentioned earlier, before starting reading out loud questions, research assistants reminded students of the aim of the research, their right not to take part in research, and the confidential nature of the questionnaire. Also, research assistants demonstrated in advance how to fill in the questionnaire with some demonstration questions not included in the

questionnaire[3].In most instances, while one research assistant read questions out loud, another research assistant made sure to answer individual question, and spot students having difficulty keeping with the pace of the questionnaire in that case providing individual support.

Questionnaire completion was at times disrupted by extraneous events. The most common one was rain, as the baseline survey took place during the rainy season. As a result, in some cases, groups that were completing the questionnaire outside had to find refuge in a church building, a head teacher's office etc in order to continue with the survey.

Focus Group Discussions (FGDs)

Participatory methods were used to elicit discussion within focus groups. The lead consultant designed different types of activities on five main areas:

- Knowledge of HIV and AIDS
- Stigma (relating in particular to PLHIV)
- Gender and Sexual Rights
- Children's Rights
- School Safety

Participatory Learning and Action (PLA) tools were used to collect data and served as the basis for in-depth discussions with students about the topics covered.

After initial introductions, the facilitator and the note-taker explained the purpose and nature of the focus group discussion, assured students that their anonymity and the confidentiality of their comments would be guaranteed, and outline the ground rules for the focus group discussion. Icebreakers were used at the beginning to create a rapport with the students and make them feel comfortable.

The participatory tools used included:

- Brainstorming exercise: students were to indicate on a diagram issues that relate to HIV and AIDS
- Mapping: students were asked to map their school and its surroundings and indicate where they feel safe and not safe.

[3] This decision was made to reduce the rate of errors. The questionnaire used during pre-testing was based on the method of ticking boxes, which was too complicated for many students. As a result, the ticking boxes method was abandoned in favour of a words circling method. Demonstration questions on flipcharts helped towards keeping completion errors at a very low rate.

- Problem tree: a problem tree is a type of diagram which enables participants to analyse the cause and effects of a problem. For the purpose of the survey, a problem tree exercise was used to investigate students' understanding of the causes and consequences of stigma.
- Role plays: Role plays were used to investigate students' views on both stigma and prevailing gender norms.

In each case, these participatory exercises were followed by an in-depth discussion on the issues raised by the exercises.

Semi-structured Interviews (SSI)

Semi-structured interviews (SSIs) were conducted with 11 students. In these interviews the interviewer steered the conversation towards some key monitoring areas: Gender and sexual rights, HIV, attitudes towards PLHIV, children's rights and responsibilities within the household and the school. These interviews ranged between 20 and 45 minutes. They probed some specific aspects raised in the questionnaire and in the focus groups to probe in depth students' personal views and feelings.

Fieldwork administration

Twelve Research Assistants (RAs) were recruited to carry out the fieldwork. A five-day training workshop was organised for the RA. The first two days focused on administering questionnaires for children and young people and the ethical issues of doing research with children. RAs were able to give feedback on the questionnaire in English and on its Chichewa translation. On the third day, all RAs were involved in pre-testing the questionnaire in three schools after which the questionnaire was further refined. The two other days were dedicated to focus groups and RAs were introduced to participatory methods, icebreakers and energizers to use during focus group discussion. They had multiple opportunities to facilitate and participate in mock focus groups.

Data management and analysis

Quantitative data

Quantitative data from the 1246 questionnaires were collected and entered into a Microsoft Excel database by a total of seven data entry clerks and one TfaC member of staff. After each session of data entry, a sample of questionnaires was checked for data entry errors

and the number of errors was recorded to provide an error rate estimate. The fidelity of data entry was found to vary between one and a maximum of six errors per questionnaire. This adds an approximately 1% margin of error additional to sampling error (statistical confidence intervals) to all conclusions from analyses of aggregate data. The data was then imported into IBM SPSS 19 for analysis. All analyses involved the comparison of the treatment and the control group.

It is common to disaggregate by gender. However, it was noted early on in the data analysis that one specific characteristic was differentiating the treatment group from the control group. Treatment group students were in higher grades than control group students, and more girls in the control group were in lower grades. As a result, disaggregating by gender would have made us run the risk of mistaking differences linked to standard for gender differences. Tables are disaggregated by gender only when gender has a statistically significant effect on results.

Qualitative data

The data from the 20 focus group discussions and 11 semi-structured interviews was transcribed and simultaneously translated into English from either Chichewa or Chitumbuka. These transcripts were analysed using Nvivo®, a qualitative data analysis software used to organise data into different themes and codes.

Ethics

Written consent was obtained from both head teachers and respondents' parents prior to commencement of data collection. Verbal assent was sought from children prior to questionnaire completion and participation in focus group discussions. Respondents' consent and assent was fully informed: a letter explained in details the purpose and nature of the survey, respondents were assured that their anonymity and the confidentiality of their comments would be respected. Students were informed that, if quoted, they would not be identifiable by name or by any other specific information.

Limitations to the survey

- Late start of the survey

The survey started in some schools two months after the first TfaC after-school club meeting had taken place. However, teachers assured TfaC management that none of the previous

sessions had been focusing on content. Indeed, there appears to be no difference between the treatment and the control group that might have resulted from this late start.

In the future, it is strongly advised to start the baseline as soon as possible after the beginning of the programme to gather pure baseline data.

- Reporting biases

Another limitation, but highly difficult to overcome, relates to students' desire to give the right answer, that is the one that they have learned at school. It appears very clearly throughout the analysis that students in higher standards, not necessarily older students, have much greater knowledge not only of HIV but also more open views on gender roles and people living with HIV. One reason for that might be that they learned more in lifeskills classes and therefore are more knowledgeable, but another might be that they have learned which answers are the expected answers.

- Difficulty of assessing sexual behaviours

Finally sexual behaviour is hard to measure accurately. In order to mitigate for inconsistencies in answers to sexual behaviour's questions, a set of different questions was asked to triangulate the results. It is therefore recommended that further data is collected on student pregnancy rates, both in control and treatment groups. This would be helpful since pregnancy rates are likely to be highly correlated with practices of unsafe sex.

Socio-demographic characteristics

The demographics between students in the treatment group and the control group are very similar.

Gender

The gender distribution of the two groups is very similar, as is shown in the table below:

Table 4: Gender in treatment and control group (in percent)

		Treatment group	Control group	Total
Gender	Boys	45.8	47.0	46.4
	Girls	54.2	53.0	53.6
Total		100.0	100.0	100.0

Age

The age distribution in both groups is also very similar, as shown in the table below:

Table 5: Age in treatment and control group (in percent)

		Treatment group	Control group	Total
Age	10 and below	9.6	13.1	11.2
	11-14	72.5	69.0	70.6
	15-20	17.5	18	17.7
Missing		0.3	0.7	0.5
Total		100.0	100.0	100.0

The highest number of students surveyed for both the treatment and the control group were in the age bracket 11 to 14, with 70.6 percent of the total interviewed (880 interviewees). The mean age of students in the treatment group is 12.83 years and that of students in the control group is 12.80 years. While there are no major differences in age distribution between the two groups, the standard distribution differs significantly between the two groups.

Standard

One key difference between students in the treatment and the control group related to the grade (standard) they were in at the time of the baseline. When planning the baseline, TfaC did not have information on the distribution of students attending TfaC after-school according to their standard. Knowledge was held on the fact that TfaC AIDS Toto clubs are targeting students in Standard 4 to 8. Thus, control group schools were informed to random select students in Standard 4 to 8 without specifying how many from each standard should be sampled.

The proportions of students attending Standards 4, 5, 6 and 8 differ significantly between the treatment and control group schools. As we shall see later on in the report, the difference in distribution of standards explains most of the differences in results between the treatment and the control group. Such strong differences in results according to students' standard were not, however, expected to such an extent. For more detail on the regression analysis relating to standard please consult Appendix 1.

Table 6: Standard in treatment and control groups (in percent)

		Treatment group	Control group	Total
Standard	4	4.4	17.5	10.8
	5	16.5	23.1	19.7
	6	34.4	22.3	28.5
	7	35.5	33.8	34.7
	8	9.1	3.3	6.3
Total		100.0	100.0	100.0

As the analysis will show, it is important to differentiate between students' age and the school year they are in as age and standard are far from being perfectly correlated. For instance, 17 percent of 11 year old respondents are in Standard 4 and 20 percent of the same age group are in Standard 7.

Family set up

The majority of students surveyed reported that they were living together with both parents (66.2 percent in total). Few students were living with their father only in both the treatment and the control group. A much larger proportion was living with their mother only (16 percent

in the treatment group and 14 percent in the control group) or with one of their grandparents (10.9 percent in total).

Table 7: Family set-up in treatment and control groups (in percent)

		Treatment group	Control group	Total
Family set up	Mother and Father	66.7	65.7	66.2
	Mother only	16.0	14.0	15.0
	Father only	1.1	3.0	2.0
	Grandparent(s)	11.2	10.5	10.9
	Other	5.0	6.8	5.9
Total		100.0	100.0	100.0

Findings

The goal of the primary school programme is to "increase HIV prevention strategies in targeted primary schools in Malawi". In particular it aims to ensure that "primary school learners demonstrate comprehensive and accurate knowledge of HIV and an increase in safer gender and sexual practices, attitudes and behaviours in line with outcome indicators". The objective was, therefore, to gather and analyse data from primary school students on indicators that TfaC is contributing towards through its AIDS Toto clubs run by TfaC facilitators (These TfaC facilitators were trained during their first year through the TTC Programme.).

Knowledge of HIV and AIDS

General knowledge of HIV and AIDS among primary school learners is almost universal, with 93.1 percent of respondents reporting that they have heard about HIV and AIDS.

Table 8: Knowledge of HIV and AIDS

	Percentage of respondents who gave the correct answer	
	Treatment group	Control group
Can you tell by looking at someone if he/she has HIV (Correct answer: disagree)	73.5	75.8
Is there a cure for AIDS? (Correct answer: disagree)	83.3	79.3
If you are fit and healthy, you won't get HIV (Correct answer: disagree)	63.5	61.9

Table 8 examines specific aspects of knowledge about HIV and AIDS. From the table, we can see that the majority of students answered each question correctly. However, there is still a significant percentage who answered incorrectly, suggesting that comprehensive HIV knowledge is far from universal. Furthermore, only 43.4 percent of all respondents managed to give the correct answers to all three questions, showing that the majority are mistaken on at least one of these issues and comprehensive knowledge is low. There are differences between the control and treatment group in the percentage of students having given correct answers. However, the regression results presented in the next section suggest that this is due to the fact that the control group contains a larger number of students in lower grades than in the treatment group.

The focus groups results relating to two of the HIV knowledge questions provide more insight into the reasons why students made mistakes.

Knowledge of appearance of people living with HIV

Focus group facilitators probed students about their opinion on how people living with HIV look. In these discussions, students were split as to the appearance of people living with HIV. The example below is typical of the divisions amongst groups:

> Facilitator: Can you tell that someone has HIV by how they look?
> Female respondent: We can know because he becomes thin.
> Male respondent: Yes, it is true because if he take a bath and apply lotion (mafuta) he shines in a different way.
> Female respondent: It is not true because we can know that a person has HIV unless he has gone for testing at the hospital and expose the result.
> Male respondent: It is not true because you cannot know the inside of someone's body
>
> Focus Group Discussion, Chitedze Primary School

Interestingly, when asked about symptoms and appearance of people living with HIV and AIDS, students also consistently referred to how a person's feelings regarding their status impact their appearance:

> Female respondent: If he has been told that he is HIV positive from the hospital, he becomes ashamed. If people are talking about HIV, he jumps up and down not to be in that group again.
> Female respondent: He becomes sorry for himself
> Female respondent: He can easily hang himself if not properly told
>
> Focus Group Discussion, Hangalawe Primary School
>
> Male respondent: It is true most of the time they are not happy
> Male respondent: If he has been told about the results, he feels sorry for himself
> Male respondent: And if he thinks like that he dies earlier
>
> Focus Group Discussion, Chilobwe Primary School

Knowledge of cure for AIDS

In terms of a cure for AIDS, the focus groups' results confirm students' questionnaire answers. Learners generally seem to be very aware that there is no cure for AIDS and that medicine (ARVs) are only used to prolong the life of PLHIV.

> Facilitator: Some people believe that HIV and AIDS has cure. What is your opinion?
> Male: It is false
> Facilitator: Why?
> Male: Nobody has ever taken medicine and got cured
> Facilitator: Isn't there cure?
> Male: There is medicine that just prolongs life
> Facilitator: What medicine is that?
> Male: ARVs
>
> Focus Group Discussion, Nankumba Primary School

In some cases, dissenting students argued that medicine sold on the market might be able to cure AIDS or also that praying might also cure AIDS. However, these minority views were quickly rebuked by the rest of the group.

Knowledge of HIV ***and*** *AIDS transmission and prevention*

UNAIDS has designed an indicator to assess the progress towards universal knowledge of the essential facts relating to HIV transmission and prevention. The indicator take a value of one if students answer all of the following questions correctly, and zero otherwise:

(1) A person can reduce their risk of getting HIV by using a condom every time they have sex (correct answer: True)
(2) A person can get HIV through witchcraft (correct answer: False)
(3) All people who have HIV look sick (correct answer: False)
(4) You can get HIV from a mosquito bite (correct answer: False)
(5) The risk of HIV transmission can be reduced by having sex with only one uninfected partner who has tested negative and who has no other partners (correct answer: True)

The following table considers the answers amongst the two groups to these questions:

Table 9: Questions and statements towards UNAIDS indicator

	Percentage of respondents who gave the correct answer	
	Treatment group	Control group
One can protect oneself from HIV and AIDS by always using a condom correctly (Correct answer: yes)	90.4	88.4
One can protect oneself from HIV and AIDS by being faithful to one uninfected partner (Correct answer: yes)	75.8	73.4
Can you tell by looking at someone if he/she has HIV? (Correct answer: no)	73.5	75.8
HIV can be transmitted through mosquito bites (Correct answer: no)	92.0	86.7
HIV can be transmitted through witchcraft (Correct answer: no)	97.8	94.4

The results show that general awareness of HIV transmission and prevention is high amongst young Malawians. However, comprehensive knowledge is still average. Only 46.6 percent of all primary school learners were able to both identify the correct ways to prevent the sexual transmission of HIV and to reject the major misconceptions prevalent in Malawi according to UNAIDS indicator. There is no significant difference in responses based on respondents' gender.

When the statement 'HIV can be transmitted through witchcraft' is replaced by the statement 'HIV can be transmitted through sharing a toothbrush with a person living with HIV', then only 18.2 percent of all primary school learners are able to both identify the correct ways to prevent the sexual transmission of HIV and to reject the major misconceptions prevalent in Malawi (17.7 percent of girls and 18.8 percent of boys). This shows that the belief that transmission can occur via toothbrushes is common even amongst those who are otherwise knowledgeable about transmission mechanisms.

Despite high rates of correct answers about HIV transmission, focus group discussions indicated that students are not completely clear about the specificities of HIV transmission, regarding in particular unprotected sex. Students repeatedly suggested that only specific sexual acts can transmit HIV. In particular, it became apparent that many students believe that it is only when people are bleeding during sex that HIV gets transmitted. Students are

unsure about what specifically happens during sexual intercourse with regard to bodily fluids exchanged and its potential impact on HIV transmission.

Facilitator: Somebody mentioned that if you have a cut or genital sores it's when you get the HIV. So if there is no cut or genital sores you cannot get the HIV?
Female respondent: Yes, you can get it because if people are doing sex friction is involved so there can be blood contact
Facilitator: I am trying to say if there is no cut or any other bruise, can you get the virus?
Male respondent: Okay, if there is no blood contact you cannot get the virus

Focus Group Discussion, Hangalawe Primary School

Male respondent: I hear that HIV infection can be prevented by being circumcised?
Facilitator: How does that work?
Male respondent: I do not know!
Female respondent: HIV can still be contracted because there is still a possibility of blood contact

Focus Group Discussion, Nankumba Primary School

Such responses indicate that students lack knowledge on what happens when a man and a woman are having sex. This suggests that youth prevention programmes should also explore in more depth what happens during sexual activities.

Knowledge of condoms

Students were asked a series of questions on condom use. The following table details students' answers relating to condoms:

Table 10: Questions and statements on condoms

	Percentage of respondents who gave the correct answer	
	Treatment group	Control group
Male condoms can be washed and reused (Correct answer: Disagree)	77.5	75.5
Your friend has bought a condom in 2002. He wants to use it with his partner in 2011. Will the condom still be ok to use? (Correct answer: Disagree)	67.5	72.6
You can use a female condom to avoid getting HIV (Correct answer: Agree)	61.0	55.9
Protected sex is not necessary when you know the person well (Correct answer: Disagree)	69.3	66.9

General awareness on condom use is average. In addition, knowledge is by no means comprehensive. Only 21.1 percent of all primary school learners managed to answer all the above mentioned questions on condom use correctly.

There is no significant difference between male and female respondents as to their knowledge of condom use. Age does not play a role either. Only students' year of study (standard or grade) has a significant impact on their answer. Results show that knowledge on condom use increases as students advance through their education. For instance, 18.5 percent of students in Standard 4 agree that male condoms can be washed and reused, when only 2.6 percent of students in Standard 8 agree with the same statement.

Likewise, students' knowledge of HIV and AIDS does not depend on their age, but on their school year. On average a 12 year old in Standard 7 will have greater knowledge of HIV and AIDS than a 16 year old in Standard 5. The significant impact of students' grades on their knowledge of HIV and AIDS suggests that the school plays an important role in teaching students about these issues.

General knowledge on HIV and AIDS is high among Malawian primary school students. However, comprehensive knowledge is rare, with almost all students making at least one mistake in the questionnaire. This rule also applied to knowledge of HIV transmission and prevention mechanisms and condom use. Focus-groups shed light on students' poor understanding of HIV transmission processes through unprotected sex. Students' school level had a significant impact on their answers on knowledge on HIV and AIDS: students in higher standards systematically showed greater knowledge of HIV transmission and prevention mechanisms. By contrast, age and gender did not play a significant role. These results indicate the need for early intervention within schools in order to target learners in early school years.

Attitudes towards people living with HIV (PLHIV)

Students were asked a series of questions to assess their attitude towards people living with HIV as a way to look into their potential stigmatising attitudes.

Table 11: Questions and statements on people living with HIV

	Percentage of respondents who gave the correct answer	
	Treatment group	Control group
Should people who have HIV and AIDS be shown the same amount of respect as everyone else? (Correct answer: Agree)	84.4	78.0
Would you buy vegetables from someone who has HIV and AIDS? (Correct answer: Agree)	77.2	70.2
Should a HIV positive student be allowed to continue studying at school? (Correct answer: Agree)	82.1	76.2
Should a HIV positive teacher be forced to stop teaching in the school?(Correct answer: Disagree)	69.3	66.9
If a member of your family got HIV, would you be willing to care for him or her in your home? (Correct answer: Agree)	92.4	90.7

All these different results suggest a high level of understanding of and concern for people living with HIV both in the treatment and the control groups. It is possible to identify differences in results between the treatment and the control groups. Students in the control group have a consistently lower rate of correct answers than students in the treatment group.

This is due to the fact that there are more students in lower grades in the control group. In their answers to questions on attitudes towards PLHIV, students in lower grades consistently show greater stigmatising attitudes towards PLHIV. This possibly suggests that schools do not address these issues in lower grades, but also that as a student progresses through their education the school provides a socialisation context that leads to attitudinal change.

Another question relating to stigmatisation was asked in the questionnaire, namely how students would feel if they knew there was a person living with HIV and AIDS in their class, as shown in Table 12:

Table 12: How would you feel if you knew there was a person living with HIV and AIDS in your class?

		Treatment group	Control group	Total
	Comfortable	70.7	60.5	65.8
	Frightened	7.6	11.9	9.7
	Worried	6.8	8.0	7.4
	I would want to change class	1.4	1.9	1.6
	I would want to sit far away from him/her	3.3	4.9	4.1
	I don't know what I would do	10.0	12.8	11.4
Total		100.0	100.0	100.0

The table shows that 65.8 percent of primary school learners would feel comfortable if they had a HIV positive pupil in their class. However, Table 13 below shows that this percentage is not nearly as high for students in lower standards.

Table 13: How would you feel if you knew there was a person living with HIV and AIDS in your class? (by standard)

		Person living with HIV in class						
		Comfortable	Frightened	Worried	I would want to change class	I would want to sit far away from him/her	I don't know what I would do	Total
Standard	4	54.2	19.2	7.5	4.2	3.3	11.7	100.0
	5	59.5	16.5	6.3	2.5	7.6	7.6	100.0
	6	61.1	9.7	7.4	1.4	6.3	14.0	100.0
	7	74.0	4.6	7.4	.7	1.4	11.8	100.0
	8	77.9	2.6	10.4	1.3	.0	7.8	100.0
Total		65.8	9.7	7.4	1.6	4.1	11.4	100.0

In Standard 4, only 54.2 percent of students would feel comfortable, as compared to 77.9 percent of students in Standard 8. 7.5 percent of Standard 4 students would want to either change class or sit far away from him/her. This confirms once again the extent to which students' attitudes towards people living with HIV depend on their school level.

Stigma was widely discussed in FGDs and during semi-structured interviews. Students in all groups were quick to explain what stigma or discrimination is and often referred to it either in relation to HIV and AIDS or to poverty, as shown by the following example:

Facilitator: Now we are going to discuss about stigma .Does anyone know about stigma?
Female respondent: If somebody has HIV and AIDS, some people don't want to sit close to him they run away.
Female respondent: Even they don't want to play with him
Facilitator: Apart from HIV and AIDS where else does this act happen?
Male respondent: If somebody is poor, people run away from him.

Focus Group Discussion, Chilobwe Primary school

Some of the students interviewed reported instances of discrimination relating to HIV and AIDS at school or in the community:

Interviewer: Is there anyone whom you think is HIV positive?
Respondent: Yes here at school there is one who has it and that I am the only who keeps this secret.
Interviewer: Did he tell you about his Sero-status?
Respondent: Yes he has told me.
Interviewer: Did he tell how he got it?
Respondent: Yes he has told me how he got it. He explained to me that got AIDS through parents and also that his are dead.
Interviewer: How do you feel about him?
Respondent: When I see him I do not feel okay. Sometimes when we are playing together since he is my friend, I see that he has a lot of problems. I feel sorry for him because he tells me that when he has gone out to play people laugh at him.

Male respondent, semi-structured interview, Uliwa Primary School

Such comments demonstrated that HIV and AIDS is a part of life for many learners. Many students strongly disagreed with such stigmatisation, as expressed by the following quote:

We should not stigmatize them by not sharing with the food on one plate, not giving them clothes. People talk nasty things by calling 'look at that one, he is HIV positive', they are not

taken as human being in the society, they are denied the food. People don't sit and chat with them, they are not given any authority at work places, they are laughed at and if still a child they drop out from school (Female respondent, Focus Group Discussion, Ukanga Primary School)

Interestingly, many students reported that they found it difficult to raise awareness against stigmatising issues. This is exemplified in the following quote:

The problem is even if we can tell the people that these facts are not true they cannot understand us they will just think that maybe we are one of the people who are HIV positive and our mission is to spread the virus in the society. (Male respondent in Ukanga Primary School)

Students were also asked what they thought they would do if they had HIV and AIDS, with results reported in the following table:

Table 14: What do you think you would do if you had HIV and AIDS?

	Percentage of respondents who answered yes to the following questions	
	Treatment group	Control group
I would talk to people I trust	70.1	67.7
I would go to a clinic to get treatment	87.4	86.4
I would kill myself	3.0	5.7
I would do nothing	11.5	17.2
I would hide it from people, including my family	7.7	8.5

The answers show that almost all students would go to a clinic to get treatment, and most would also talk to people they trust. When data is disaggregated by standard, one notices that students in lower standards are more likely to hide their status from people and less likely to go and get treatment, as shown in Table 15:

Table 15: What do you think you would do if you had HIV and AIDS? (per standard)

		Percentage of learners responding yes to the following statements:				
		If I had HIV and AIDS, I would talk to people I trust.	If I had HIV and AIDS, I would go to a clinic to get treatment	I would kill myself	I would do nothing	I would hide it from people, including my family
Standard	4	59.3	71.1	12.6	26.7	11.9
	5	67.8	86.9	8.2	25.3	16.3
	6	69	90.1	3.4	10.7	8.2
	7	70.8	88.2	0.7	8.6	2.8
	8	78.2	92.3	2.6	6.4	5.1
Total		68.9	86.9	4.3	14.3	8.1

Only students' school level has an impact on their answers. Age and gender did not play a role in influencing students' answers.

A different question asked students whether they had ever cared for a relative with HIV and AIDS, with results reported in the following table:

Table 16: Have you ever cared or are you now caring for a relative with HIV and AIDS?

		Treatment group	Control group	Total
Have you ever cared or are you now caring for a relative with HIV and AIDS? (in percent)	No	61.3	57.0	59.2
	Yes	32.5	36.7	34.6
	I don't know	6.2	6.3	6.3
Total		100.0	100.0	100.0

The table shows that those students who had cared for a relative were in the minority. This was nonetheless a large group, with over a third answering yes. These results show once more that HIV and AIDS is part of many students' life and affect them in many ways.

Overall, there appears to be a high level of understanding of and concern for people living with HIV both in the treatment and the control groups. Many students strongly disagreed with stigmatising attitudes towards the disease. Students in higher standards were typically more likely to answer questions `correctly', in that they expressed less negative attitudes to people living with HIV and AIDS than students in lower standards. Focus group discussion indicated that students might not feel fully empowered to raise awareness on people living with HIV and AIDS for fear of negative reactions within the community. This is further explored in the next sections.

Learning and talking about HIV and AIDS

Students were also asked a set of questions relating to learning and talking about HIV and AIDS. The following table details answers to the questions that assessed students comfort in talking about the issue:

Table 17: Comfort in talking about HIV AND AIDS

	Percent of students answering yes to the following questions		
	Treatment group	Control group	Total
Do you feel comfortable talking about HIV and AIDS in groups?	88.9	80.2	84.7
Would you feel confident talking about HIV counselling and testing with your boyfriend/girlfriend?	87.1	83.6	85.4
Would you feel confident educating your friends about HIV and AIDS?	93.9	90.1	92.0
Are primary school students too young to talk about HIV and AIDS?	20.1	24.1	22.1

Overall, Table 17 shows that students were generally comfortable with talking about HIV and AIDS. Students' confidence to talk about HIV andAIDS greatly improves as they advance in their education. Only 64.2 percent of students in Standard 4 feel confident talking about HIV and AIDS in groups, as compared to 93.5 percent in Standard 8. Similarly, 32.3 percent of students in Standard 4 reported that primary school students are too young to talk about HIV and AIDS, when only 5.2 percent of Standard 8 students answered positively to this question.

Students were also asked where they learnt about HIV and AIDS:

Table 18: Where do you learn about HIV and AIDS?

	Treatment group	Control group	Total
Lifeskills classes	86.5	82.3	84.4
AIDS Toto club	76.3	77.7	77
On the radio/TV	61.3	64.1	62.7
Community activities	58.2	53.9	56.1
Friends	40.9	42.3	41.6
Other classes at school	31	33.9	32.4
At home	29.7	34.2	31.9

Table 18 shows that students learned about HIV and AIDS from a variety of sources. School-based sources including Lifeskills classes and AIDS Toto clubs were most common, and a majority also reported learning from the radio/TV. Only a minority of students stated that they learned about HIV and AIDS at home, which suggests that students do not necessarily trust their parents and siblings as sources of information on HIV and AIDS. The answer 'hospital' was not available for students to answer. However, approximately 15% indicated that they learnt about HIV and AIDS at the hospital in the 'other' section. This result would have been certainly higher if 'hospital' had been available as an answer[4].

A related question asked students who they felt comfortable talking with about HIV and AIDS, with results given in the following table:

Table 19: With whom do you feel comfortable talking about HIV and AIDS? (in percent)

	Treatment group	Control group	Total
TfaC teacher	92.5	81.5	87.1
Medical practitioner	82.1	77.7	79.9
AIDS Toto club teacher	76.3	77.7	77
Friends	62.6	66.2	64.4
Mother	59.3	57.9	58.6
Siblings	55.7	56.4	56.0
Other teachers	53.0	48.7	50.9
Father	48.6	50.0	49.3

[4] It is recommended to include the option 'hospital' in the list of answers.

The table suggests that students generally feel comfortable talking to medical practitioners, friends, and teachers in AIDS Toto clubs. Mothers are also common interlocutors; however the majority of students stated that they did not feel comfortable talking about HIV with their father. Based on students' answers on their sources of information and confidantes, two thirds of students reported that they neither learnt about HIV at home, nor were comfortable talking about HIV at home. Such lack of communication with parents should be addressed and it would be worth looking into avenues to enable better communication between parents and children.

In terms of learning about HIV and AIDS, school-based sources including Lifeskills classes and AIDS Toto clubs were most commonly mentioned, and a majority also reported learning from the radio/TV. Students generally reported feeling comfortable talking to medical practitioners, friends, siblings and teachers in AIDS Toto clubs. Results on students' sources of information and confidantes suggest that discussion between students and their parents on HIV and AIDS is not free flowing. These results point to the need to improve communication between students and parents, which would certainly result in greater prevention strategies for the entire family.

Attitudes to gender and sexual rights

Students were asked a series of questions to assess their attitudes towards prevailing gender norms in Malawi. The following table presents the answers to one of these questions:

Table 20: Taking care of housework is women's work, not men's work

		Treatment group	Control group	Total
Taking care of housework is women's work, not men's work	Yes	10.6	22.2	16.2
	No	76.0	81.9	87.6
	I don't know	1.9	1.8	1.8
Total		100.0	100.0	100.0

Based on their questionnaire results, students in both the treatment group and the control group strongly oppose the idea that housework is women's work only. The difference in results between the two groups is statistically significant. As shown in Table 20, students in

the control group more readily answer that housework is women's work. The regression analysis show that it is due to the fact that there are more students in lower grades in the control group. In their answers to questions on gender rights, students in lower grades consistently show more stigmatising attitudes towards women, as shown in Table 21:

Table 21: Taking care of housework is women's work, not men's work (by standard)

		Taking care of housework is women's work, not men's work			
		Yes	No	I don't know	Total
Standard	4	38.5	55.6	5.9	100.0
	5	27.3	70.2	2.4	100.0
	6	13.5	85.1	1.4	100.0
	7	7.4	91.9	.7	100.0
	8	3.9	94.8	1.3	100.0
Total		16.2	81.9	1.8	100.0

As shown by the table, 38.5 percent of students in Standard 4 consider that housework is women's work, when only 3.9 percent of students in Standard 8 think the same. This suggests once more that the socialisation context provided by the school might contribute to attitudinal change.

FGDs provide interesting complementary information on students' views on prevailing gender norms within the household, as the following role play and discussion highlights:

ROLE PLAY

Husband: The house looks dirty

Wife: I went for a choir practice

Husband: What about water?

Wife: I did not fetch

Husband: Water too!?

Wife: Yes

Husband: And there is no nsima!

Wife: I will now cook for you

Facilitator: What would you do as a husband who comes home and finds that the wife did not cook any food neither did she do any household chore?
Male respondent: I would divorce her
Facilitator: That is his views. What else?
Male respondent: I would tell her to cook right away
Facilitator: What else?
Male respondent: I would tell her never to do that again
Facilitator: Any other thought?
Female respondent: Divorce her
Facilitator: What else?
Female respondent: Would tell her to clean the place and cook
Facilitator: What else?
Male respondent: Beat her up

Focus Group Discussion, Chilindaukwe School

Facilitator: Have you ever seen a wife and husband having conflict just because she hasn't cleaned the house or cooked?
RESP: Yes (In a chorus)
Male: Especially if the woman has not cooked nsima
Female: And also if she doesn't take care of the house
Facilitator: If it can happen to you, what can you do?
Female: I can just apologize to my husband and do the cleaning
Male: I can tell my wife that the marriage is over because she is unhygienic (mukazuzi)
Facilitator: What else can you do?
Male: I can tell her never to do this again because this behaviour can bring us cholera.

Focus Group Discussion, Hangalawe Primary School

DISCUSSION OF ROLE PLAY

If we are to believe that students provide answers that they feel are the 'expected' answers, male and female students' contributions to the discussion on housework show that they have no doubt about the fact that it is a wife's duty to do the cleaning and the cooking.

The following table presents the results of a range of questions on students' attitudes to gender:

Table 22: Attitudes on gender related issues

	Percent of students providing the `correct' answer		
	Treatment group	Control group	Total
A woman has not cleaned up the house. Her husband is annoyed and beats her up. Is this OK? (Correct answer: disagree)	86.9	85.7	86.3
A man is 40 years old. He wants to marry a girl in your village, who is 15. But she wants to study. Does the girl have the right to refuse to marry him? (Correct answer: agree)	90.4	88.0	89.2
Boys are more intelligent than girls (Correct answer: disagree)	71.5 (don't know: 18.4)	70.3 (don't know: 18.0)	71.0 (don't know: 18.2)
It's OK if a boy touches a girl's bum or breasts (Correct answer: disagree)	91.5	92.6	92.0
Is it OK for a woman to ask a man to use a condom? (Correct answer: agree)	84.5	77.1	80.9

The table shows that the large majority of students answered the questions in a way that did not suggest gender bias or prejudice. However, only 37.9 percent of students were able to answer all of the questions relating to gender norms in the way which would be considered as `correct', confirming that there is much work still to be done on this issue.

On gender related attitudes, both students' school level and students' gender had a significant impact on their answers.

Let's first consider the impact of students' school level on their answers. The following table on the question 'is it OK for a woman to ask a man to use a condom?' again shows a strong relationship between standard and answers on gender issues:

Table 23: Is it OK for a woman to ask a man to use a condom?

Is it OK for a woman to ask a man to use a condom? (in percent)				
		No	Yes	Total
Standard	4	41.8	58.2	100.0
	5	25.5	74.5	100.0
	6	18.0	82.0	100.0
	7	11.2	88.8	100.0
	8	9.1	90.9	100.0
	Total	19.1	80.9	100.0

These results show that gender stereotypes rest firmly with students in lower grades. Students in lower grades have been less confronted with school programmes and their early socialisation at home seems to influence their attitude on gender norms. This has programmatic implications as a significant number of primary school learners, especially in rural areas, drop out of primary school during lower standards, therefore only partly benefiting from awareness-raising programmes. If gender stereotypes are to be reduced, there needs to be a higher number of early interventions targeted at primary school children in lower standards.

This issue of gender rights is the only one where gender had a significant impact on students' answers. There was a clear pattern in female respondents' answers that suggest that their gender had a determining effect on their answer, as shown in Table 24.

Table 24: Attitudes on gender related issues (by gender)

	Percent of students answering yes to the following statements		
	Boys	Girls	Total
Taking care of housework is women's work, not men's work	13.2	18.9	16.2
A woman has not cleaned up the house. Her husband is annoyed and beats her up. Is this OK? (Correct answer: disagree)	5.6	8.3	7.0
A man is 40 years old. He wants to marry a girl in your village, who is 15. But she wants to study. Does the girl have the right to refuse to marry him? (Correct answer: agree)	90.4	88.1	89.2
Boys are more intelligent than girls	15.2	7.1	10.8
Is it OK for a woman to ask a man to use a condom? (Correct answer: agree)	84.0	78.2	80.9

Girls are less likely to say that boys are more intelligent than girls, but more likely to say that housework is women's work. They are also much less likely to say that it is okay for a woman to ask a man to use a condom. This result suggests that female respondents actually have greater gender biases than male respondents. This might be due to their early socialisation at home, where the mother is in charge of housework and the father takes the decision on many issues, including on sexual activity. Some FGDs confirmed that learners view the man as the one taking initiative as far as sexual intercourse is concerned:

> Facilitator: Once again I just want to remind you that whatever we are discussing here is confidential. Who decides when to make love?
>
> Male respondent: There is nobody
>
> Female respondent: The male decides
>
> Male respondent: The male person
>
> Female respondent: It's a the male
>
> Focus group discussion, Hangalawe Primary School

A further set of questions attempted to establish the extent to which teachers may also discriminate between boys and girls. The following table gives the answers relating to a question over who was generally assigned school chores:

Table 25: Who helps more in carrying out school chores?

		Treatment group	Control group	Total
Who helps more in carrying out school chores?	Boys	1.7	3.8	2.7
	Girls	15.6	25.7	20.5
	Boys and girls	80.6	68.2	74.5
	I don't know	2.1	2.3	2.2
Total		100.0	100.0	100.0

From the table, we can see that the majority of students said that both boys and girls were assigned school chores. However, 20.5 percent of the students suggested that chores were assigned to girls, when only 2.7 suggested that boys help in carrying out school chores. This suggests the existence of some difference in treatment. There was no significant difference in results according to students' gender or age.

The following two tables detail questions that explored whether teachers make a difference between male and female students in class:

Table 26: Who receives more negative comments and insults from teachers?

		Treatment group	Control group	Total
Who receives more negative comments and insults from teachers? (in percent)	Boys	15.0	20.8	17.8
	Girls	9.4	10.5	9.9
	Boys and girls	53.7	42.4	48.1
	I don't know	22.0	26.4	24.1
Total		100.0	100.0	100.0

Table 27: Who receives more positive comments and praise from teachers?

		Treatment group	Control group	Total
Who receives more positive comments and praise from teachers?	Boys	9.5	11.3	10.4
	Girls	13.7	16.6	15.1
	Boys and girls	68.7	61.1	65.0
	I don't know	8.1	11.0	9.5
Total		100.0	100.0	100.0

From the tables, we again see that most students do not feel that teachers are differentiating between boys and girls. When students did report a difference in treatment, they reported boys being given less favourable treatment. Observations in classrooms would be necessary to assess whether such difference in treatment is due to discrimination on the teachers' behalf or to students' perceptions.

It is worth noting that in many of the questions above there is a significant difference between the treatment and control group. Such difference is principally due to the presence in greater numbers of students in lower classes within the control group. However, the sex of the respondents also influences their answers for some of the questions, as shown in the following tables:

Table 28: Who helps more in carrying out school chores?

		Boys	Girls	Total
Who helps more in carrying out school chores?	Boys	3.8	1.8	2.7
	Girls	16.2	24.2	20.5
	Boys and girls	78.2	71.4	74.5
	I don't know	1.7	2.6	2.2
Total		100.0	100.0	100.0

Boys are more likely than girls to suggest that boys and girls carry out school chores to a similar extent. 24.2 percent of girls answer that girls help more with carrying out school chores, whereas only 16.2 percent of boys give a similar answer.

Table 29 explores students' participation in the classroom:

Table 29: Who participates more in class activities

		Boys	Girls	Total
Who participates more in class activities	Boys	12.3	6.3	9.1
	Girls	8.6	17.6	13.5
	Boys and girls	74.0	69.6	71.6
	I don't know	5.1	6.5	5.8
Total		100.0	100.0	100.0

Both boys and girls overwhelmingly argue that boys and girls participate equally in class activities. However, boys are more likely than girls to say that they participate more in class. Similarly, girls are more likely to say that girls participate more in class than boys.

Only a minority of students answered all the questions on gender norms without bias or prejudice. Students' answered showed that gender stereotypes rest firmly with primary school learners, in particular in the lower grades. There was also some evidence that girls were more attached than boys to such stereotypes. It seems that girls' socialisation at home, in particular what they learn about their role and responsibilities, sticks with them whatever their age or school level. This suggests that it might be necessary to target girls specifically to explore with them and work on their attitudes to gender rights.

Attitudes to children's rights

Students were asked which three children's rights were most important for them. The aggregated ranking is as follows:

1. Right to education (90.5 percent)
2. Right to be safe from harm (77.3 percent)
3. Right to protection from sexual abuse (57.5 percent)
4. Right to protection from dangerous work (29 percent)
5. Right to be listened to by adults (27.6 percent)
6. Right to family life (21.1 percent)

The major differences between the treatment and the control group relate to the right to be listened to by adults, right to protection from sexual abuse and right to family life. The regression results in the following section suggest these are the result of the different standard distribution in the two groups.

Focus groups and semi-structured interviews provide interesting insights into students' understandings of children's rights. Students' awareness of their rights as children is by no mean a 'given', but rather a 'taught' concept that students have not yet fully interiorised, as shown by the following examples:

Interviewer: So for you which one is the most important right of a child?
Respondent: The right to go to school, to eat, to bath and to look good so that you can tell that you are being raised in a home
Interviewer: Why are these important?
Respondent: Because we learn and are taught by the teacher which ones are important

Female Student, semi-structured interview, Chiphaso Girls School

Interviewer: So what are your rights as a child?
Respondent: That I should work hard in school
Interviewer: Any other right?
Respondent: I can't remember

Male Student, semi-structured interview, Chilobwe School

Interviewer: So have you ever heard of children's rights.
Respondent: Children's rights? Is it about AIDS?

Male Student, semi-structured interview, Chimvite School

Children's rights were also explored in relation to teachers/pupils' relationship in the questionnaire, focus group discussions and semi-structured interviews. A set of questions in the questionnaire aimed to identify students' views on teachers' role, rights and responsibilities.
First, students were asked to agree or disagree with the statement 'Teachers have the right to hit you if you have done something bad'

- 72.3 percent of all students agree that teachers have the right to hit students if they have done something bad – with no statistically significant difference between the treatment and the control group

Questions relating to sexual relationships between teachers and students yielded partially contradictory results. On the one hand:

- Only 1.8 percent of primary school learners agree that male teachers have the right to demand sex from school children
- To the question 'What should happen to a teacher caught having sex with a primary school student?' (one answer only)
    - 46.1 percent report that the teacher should be dismissed
    - 44.8 percent report that the teacher should go to jail

On the other hand, when asked who is to blame in situations where a student and a teacher have sex, students did not prove to be as clear about imparting blame. In situations where the student was presented as being morally ambivalent, dressing provocatively or making the advance, respondents were prone to impart blame to the student:

- 42.3 percent of respondents suggest that the student is at fault if dressing provocatively
- 26.7 percent of respondents suggest that the student is at fault if making the advance
- 22.8 percent of respondents suggest that the student is at fault if exchanging favours for sex
- It is only when the teacher was presented as making the advance that the majority of students (55.8 percent) imparted blame to the teacher

Using a regression analysis, controlling for age, gender and standard, we can see that students that stated that housework was women's work (previous section) were more likely to attribute blame to students in a relationship with a teacher.

In the questionnaire, children's rights were principally explored in relation to teachers or strangers potentially infringing on students' rights. Focus group discussions and interviews, however, shed light on the fact that the family – parents or grandparents – might in numerous instances be responsible for breaching children's rights. Students complained in particular about being asked to work during school:

Interviewer: Who do you feel mostly disrespects children's rights?
Respondent: Sometimes it's parents
Interviewer: Why do you say that parents disrespect children's rights?
Respondent: It is because sometimes when they don't have other means of meeting certain needs, they make you do things at the expense of maybe you school or other things. For example if there is no money in the home, they will make you go sell things that will bring some money in the home, even if it means you not going to school

Female Student, SSI, Lunzu Catholic Primary School

Interviewer: Have there been times when your rights were disrespected?
Respondent: Yes, I was told not to come to school but to go apply fertilizer at our maize field, so I came to school and reported to my teacher and then he went and discussed with my grandma and I was permitted to come to school
Interviewer: Who do you feel disrespects children's rights most of the times?
Respondent: Parents
Interviewer: In what way do they disrespect the rights of children?
Respondent: They force children to do things that they don't want
Interviewer: Such as?
Respondent: Forcing them the quit school or be absent from school so that they go sell stuff or go to the farm
Interviewer: Does this happen in most homes or is it something that just happened at your house?
Respondent: I know of others that have faced this, it does happen
Interviewer: Does it happen a lot?
Respondent: Yes it does, but at least now things are changing; it's not happening as it used to before because of different organizations that are helping

Male Student, SSI, Chilobwe School

Such answers suggest that there is a need for greater parental inclusion in awareness raising programmes on children's rights, in particular children's right to education.

Students regarded issues of children's rights as a `taught concept', understanding that the correct answers were those given by teachers. Parents and other family members were felt to be those most likely to impinge upon children's' rights. A large majority of students were against sexual relationships between teachers and pupils. However, few apportioned blame to the teacher in instances of a relationship between a pupil and a teacher. Those most likely to apportion blame to the student were those with the greatest gender biases.

Attitudes and behaviour on 'Saying No to Sex'

Students' ability to 'Say no to sex' was probed in the questionnaire, focus-group discussions through role plays and semi-structured interviews. In the questionnaire, students were asked questions in relation to both 'Saying no' to a boyfriend/girlfriend wanting to have sex and 'Saying no' to an adult wanting to have sex. The table below summarises students' responses to the first question:

Table 30: A girl and a boy your age are girlfriend and boyfriend. He wants to have sex but she doesn't want. What should she do?

A girl and a boy your age are girlfriend and boyfriend. He wants to have sex but she doesn't want. What should she do? (in percent)		Treatment group	Control group	Total
	Leave him	40.6	44.4	42.4
	Say yes	1.0	1.4	1.2
	Say no	24.3	23.8	24.1
	Ask him to wait until she is ready	28.9	27.1	28.0
	Let him touch her without having sex	5.2	3.3	4.3
Total		100.0	100.0	100.0

Table 30 shows that the great majority of respondents suggest ways to say no, either by leaving the person, asking the person to wait or by saying simply no. Disaggregating by gender shows that boys and girls answer this question differently:

Table 31: A girl and a boy your age are girlfriend and boyfriend. He wants to have sex but she doesn't want to. What should she do? (by gender)

A girl and a boy your age are girlfriend and boyfriend. He wants to have sex but she doesn't want. What should she do? (in percent)		Boys	Girls	Total
	Leave him	33.9	49.8	42.4
	Say yes	1.4	.9	1.2
	Say no	21.4	26.3	24.1
	Ask him to wait until she is ready	37.0	20.3	28.0
	Let him touch her without having sex	6.3	2.6	4.3
Total		100.0	100.0	100.0

As shown in Table 31, both boys and girls quasi-unanimously rejected the idea of the girl saying yes against her will. However, boys were much more likely than girls to suggest that the girl should ask her partner to wait until she is ready or let him touch her without having sex. By contrast, the majority of girls suggested that the girl should leave the boy, followed by 'say no'.

Saying No to Sex was also discussed during FGDs:

ROLE PLAY

Male: We have been in love for a long time so for only today we should at jungle

Female: For me I don't want stupid things

Male: We are just like a married couple these days, it's a long time we started loving each other.

Female: I have already told you I don't want silly things

Male: You should just accept it there is no need to talk much

Female: I have already said

END OF ROLE PLAY

Facilitator: Now everybody should come close, have you ever heard about the boy insisting sex from a girl?

Respondents: Yes we have heard about it (In a chorus)

Facilitator: Where have you heard about it?

Respondents: In the villages

Facilitator: Has it happened to you?

Respondents: YES

Facilitator: What did you do?

Male respondent: I refused

Facilitator: What about to the side of the girls

Female respondent: It has never happened to me

Facilitator: So what can you do if it can happen to you?

Female respondent: I can just end the relationship

Male respondent: For me if I spent something on her I can say gives me back.(followed by laughter)

Female respondent: Some of the people can beat her up if you are not allowing it because they will say why you accepted my love

The response of the last female respondent suggests that girls might have reasons not to dare saying no to boys for fear of repercussions, including the use of violence. However, such concern was not raised during many focus group discussions.

Furthermore, during focus groups discussions, large numbers of students linked the decision to have sex with their partner's agreement to go and get tested:

Male respondent: If I were a girl I would force the boy to go for HTC and map the way forward

Facilitator: What would you do Mercy?

Female respondent: I would refuse

Facilitator: How? What would you do to convince him?

Male respondent: I would go for a test and have sex after the results

Facilitator: What do others think?

Female respondent: It all depends on the results

Facilitator: What would you do if one of you were found to be positive?

Female respondent: Abstain

Facilitator: If the results showed that you are negative?

Female respondent: We would do it

Facilitator: That is her view. Other views?

Female respondent: I would go for a test and have sex later

Focus Group Discussion, Chilindauwke Primary School

Such responses suggest, however, that students' decision to have sex might only depend on their partner's sero-status. It is, however, highly possible that young people might simply not feel ready to have sex and therefore refuse to have sex. As a matter of fact, only 2.3 percent of the girls surveyed reported feeling ready to have sex. It is important, therefore, to

emphasise during programme implementation that one should not feel forced to agree to sex just because one's partner has agreed to be tested and/or tested negative.

Table 32 reports the answers in the case where students were hypothetically asked what they would do if they were asked to have sex by an adult:

Table 32: If an adult asked you to have sex, what would you do?

(more than one answer possible)

	Percent of students who answered yes to the following questions		
	Treatment group	Control group	Total
I would report it to the Police	93.1	94.1	93.6
I would tell my parents	93.1	92.1	92.6
I would say no	87.7	88.5	88.1
I would go and see a teacher	70.4	63.0	66.8
I would talk to a friend	42.1	41.6	41.9
I would say yes	3.6	5.1	4.3
I would do nothing	2.7	5.7	4.2

It is interesting to see that teachers only come in third position in terms of whom students would go and see if asked to have sex by an adult, far behind the Police and students' parents. One potential explanation for such result might be that teachers might be at times those asking students to have sex. Such situations have been reported by some students in FGDs and SSIs:

> Male Respondent: It can't happen for a student to have an intimate relationship with a teacher.
> Female Respondent: It does happen like here at the school.
> Female Interviewer: Some teachers have intimate relationships with students at the school?
> Female Respondents: Yes. Even one of the students got pregnant.
>
> Focus Group Discussion, Kapiri School
>
> Interviewer: Does it happen that a teacher gets into a relationship with a student?

Respondent: It once happened here, a standard 8 teacher was dating a pupil
Interviewer: So what happened?
Respondent: The matter was discussed among the teachers but I don't know what happened. Both the teacher and the pupil are still here

Female student, semi-structured interview, Chipaluka School

Semi-structured interviews proved to be a more appropriate tool than focus groups to discuss female students' views on sex and marriage, as exemplified by the following discussion:

Interviewer: What are the things that do not make you happy at home?
Respondent: I do not become happy when people talk to me about getting married.
Interviewer: Who says this? Is it your mother or father or other people?
Respondent: They say that I cannot get educated we have already passed through this school thing. Just get married.
[...]
Interviewer: Have you ever being in a situation whereby you have been forced to do a thing that is against your will?
Respondent: Yes.
Interviewer: Can you tell me what happened?
Respondent: Yes I can explain. When at home people told me that a stranger wanted me and that I should just accept him. When I did not do that, they told me that I was not their child anymore and I should leave their home.
Interviewer: Who said this?
Respondent: People at home.
Interviewer: What did you do?
Respondent: I refused.
Interviewer: What did they do after you refused?
Respondent: I refused. During night time they started beating me and I left home the same night, sought shelter at my uncle's place.
Interviewer: What was the end result?
Respondent: I refused that and said I do not want to go to Mr. X and in the end they understood me.

Female student, semi-structured interview, Ukanga Primary School

This suggests once more that a conflict exists in some families between students and their parents on the opportunity to access education versus getting married. This reinforces the need for greater parental inclusion in awareness-raising programmes.

Both boys and girls clearly believed that it was reasonable to say no in case they were to be propositioned into sex. However, comments during focus groups and interviews suggested that there might be some barriers to girls, in particular, saying no to sex.

Attitudes towards school safety

There has been growing concern about pupils' safety in Malawian schools, and projects have been designed to tackle this issue. For instance, a five-year project funded by USAID entitled 'Safe schools program' was designed to create 'safe environments for both girls and boys that promote gender-equitable relationships and reduce school-related gender-based violence' (USAID, 2008, p vi). An impact assessment was made of that project, using questionnaires and focus-group discussions. Some of the questions used in the 'safe schools' questionnaire (USAID 2007), relating to both gender rights and school safety, were included in the PSP baseline questionnaire. Students were first asked if they felt unsafe at school and 94.3 percent reported feeling safe at school

Students were then asked a series of more specific questions on feeling safe at school.

Table 33: Safety questions

	Students having answered yes to the following questions		
	Treatment group	Control group	Total
Do you feel unsafe at school?	4.7	5.0	4.8
Do you feel unsafe when you walk to and from school?	9.9	8.3	9.1
Have you ever been teased or had sexual remarks made at you at school?	24.2	17.7	21.0
Have you ever been teased or had sexual remarks made at you when walking to and back from school?	14.8	13.6	14.2
Are you sometimes afraid to go to the toilet alone at school?	12.8	10.9	11.8
Do you know where to go at school if you have a problem or if you want to talk about something personal?	77.3	72.9	75.1

The majority of students reported feeling safe when walking to and from school, even though a little more than 9 percent of students reported feeling unsafe when walking to and from school. 14.2 percent of students reported having been teased on the way to school. A higher proportion of students reported having been teased or had sexual remarks made at them at school.

FGDs and mapping exercises shed more light on students' feeling of safety on the way to and at school. Few of students' comments actually related to Gender and Sex-Based Violence. In most instances, learners' perception of danger related to the presence of "vicious dogs" (Hangalawe School), "ghosts in the graveyard" (Chitedze Primary School), or "snakes in maize fields" (Uliwa Primary School). At school, students were mainly scared of going to the headteacher's office for fear of being told off.

There were no major gender differences in relation to school safety, neither in the questionnaire, nor in FGDs.

Pupils generally felt safe in and around school. In the minority of cases where students did not feel safe, this appeared to be due to other factors besides gender and sex-based violence.

Sexual and 'risky' behaviour

Students were asked a series of questions on their sexual behaviour, with results reported in the following table:

Table 34: Sexual awareness and risky behaviour

	Students having answered yes to the following questions		
	Treatment group	Control group	Total
Have you ever drunk alcohol?	12.8	6.1	9.5
Do you drink alcohol regularly?	1.7	1.0	1.4
Have you ever smoked chamba?	1.8	1.0	1.4
Do you smoke chamba regularly?	1.6	0.7	1.1
Do you have a boyfriend/girlfriend?	13.1	7.9	10.5
Do you feel ready to have sex with a boy/girl?	5.4	4.1	4.8
Would you have sex with someone who promises to buy you a cellphone?	4.1	2.8	3.5

The table makes clear that only a small minority reported to be engaging in what might be considered `risky' behaviour. This may signify a reluctance to report such behaviour in a questionnaire. Older people were more likely to acknowledge being in a relationship or feeling ready to have sex.

The sex of the respondents significantly influenced their answers solely on their readiness to have sex, as shown in the following table:

Table 35: Do you feel ready to have sex with a boy/girl?

		Gender		
		Boys	Girls	Total
Do you feel ready to have sex with a boy/girl?	No	92.3	97.7	95.2
	Yes	7.7	2.3	4.8
Total		100.0	100.0	100.0

While the majority of students, both boys and girls, answered that they did not feel ready to have sex, boys were more than three times more likely to say that they felt ready to have sex.

Students were also asked whether they worry about getting HIV and AIDS, with results as follows:

Table 36: Do you worry about getting HIV and AIDS?

		Treatment group	Control group	Total
Do you worry about getting HIV and AIDS?	No	36.9	47.8	42.2
	Yes	63.1	52.2	57.8
Total		100.0	100.0	100.0

Table 36 shows that a majority of students were worried about getting HIV and AIDS. Differences between the treatment and control groups were again a result of standard distribution, which the following table shows has an important effect:

Table 37: Do you worry about getting HIV and AIDS? (by standard)

		Do you worry about getting HIV and AIDS?		
		No	Yes	Total
Standard	4	53.0	47.0	100.0
	5	43.4	56.6	100.0
	6	42.7	57.3	100.0
	7	41.5	58.5	100.0
	8	22.1	77.9	100.0
Total		42.2	57.8	100.0

Students in higher standards were considerably more likely to worry about getting HIV and AIDS. This might be due to them being more aware of the risks of getting HIV as a result of having been taught more about it.

Towards the end of the questionnaire, students were asked a series of questions about their sexual behaviour. It is known in research that students' answers on their sexual behaviour are to be assessed with care, as students tend to be reluctant to admit having had sex. To mitigate such limitations, multiple questions were asked on the same issue, as previous research has shown that a single question on 'have you ever had sex' does not give reliable data. The question 'have you ever had sex?' suggested that 16 percent of students in the treatment group and 10.3 percent in the control group had ever had sex:

Table 38: Have you ever had sex?

		Treatment group	Control group	Total
Have you ever had sex?	No	84.0	89.7	86.8
	Yes	16.0	10.3	13.2
Total		100.0	100.0	100.0

Students' likelihood to admit having had sex increased with age and depended on their gender. 23.1 percent of male respondents stated having had sex, when only 4.7 percent of female respondents admitted to the same fact. As far as age is concerned, all students

under the age of 10 stated never having had sex, when the percentage of students having had sex increased with age.

Table 39: Have you ever had sex? (by age)

Have you ever had sex?		No	Yes	Total
Age	7	100.0		100.0
	8	100.0		100.0
	9	100.0		100.0
	10	93.3	6.7	100.0
	11	93.2	6.8	100.0
	12	91.0	9.0	100.0
	13	85.7	14.3	100.0
	14	85.1	14.9	100.0
	15	78.0	22.0	100.0
	16	72.3	27.7	100.0
	17	77.3	22.7	100.0
	18	83.3	16.7	100.0
	19	42.9	57.1	100.0
	20		100.0	100.0
Total		86.8	13.2	100.0

To the question ‘how many times have you had sex?’, students more readily reported having had sex than when answering the direct question ‘have you ever had sex?’:

Table 40: How many times have you had sex?

		Treatment group	Control group	Total
How many times have you had sex?	Once	10.3	10.1	10.2
	Two to four times	6.3	4.0	5.2
	Five times or more	3.3	2.6	3.0
	I have never had sex	80.1	83.3	81.6
Total		100.0	100.0	100.0

According to students' answers, 19.9 percent of students in the treatment group and 16.7 percent of students in the control group had had sex one time or more at the time of completing the questionnaire.

Reporting of risky behaviour was very low, whilst a majority of students worried about contracting HIV. Concern over contracting HIV was greater for students in higher standards. There was variation in students' reports of sexual behaviour that was dependent on the questioning style, possibly suggesting reluctance to answer such questions. Girls were systematically less likely to report feeling ready to have sex and to report having had sex before, notwithstanding their age or school level.

Self-efficacy

A set of questions relating to students' sense of self-efficacy were also included within the questionnaire. The following two tables present the results of questions asking students their ability to make friends:

Table 41: Ability to make friends with boys

		Treatment group	Control group	Total
Ability to make friends with boys	Never	30.7	45.0	37.7
	A little	7.0	7.3	7.1
	Sometimes	8.9	9.0	8.9
	Always	53.5	38.7	46.3
Total		100.0	100.0	100.0

Table 42: Ability to make friends with girls

		Treatment group	Control group	Total
Ability to make friends with girls	Never	22.1	30.8	26.3
	A little	6.7	7.8	7.2
	Sometimes	8.1	6.5	7.3
	Always	63.2	54.8	59.1
Total		100.0	100.0	100.0

From these tables, we can see that many students reported difficulty in making friends, both with boys and girls. The sex of respondents clearly influenced their answers on their ability to make friends. 49.1 percent of the female students surveyed responded that they are never able to make friends with boys. By contrast, 24.6 percent of boys stated that they can never make friends with girls. More than 61 percent of girls and of boys stated always being able to make friends with students of the same gender as theirs. These results suggest that girls have great difficulty making friends with boys.

The following tables report the results of other questions relating to self-efficacy, disaggregated by gender:

Table 43: Ability to express opinions during a disagreement (by gender)

		Boys	Girls	Total
Ability to express opinions during a disagreement	Never	25.2	30.6	28.1
	A little	6.7	7.7	7.2
	Sometimes	10.4	12.1	11.3
	Always	57.7	49.5	53.3
Total		100.0	100.0	100.0

The above results indicate that boys are less likely to say that they are never able to express opinions and more likely to say that they are always able to express their opinion during a disagreement.

Table 44: Ability to tell someone when they have made me angry (by gender)

		Boys	Girls	Total
Ability to tell someone when they have made me angry	Never	17.1	21.2	19.3
	A little	4.0	6.1	5.1
	Sometimes	11.2	8.3	9.7
	Always	67.7	64.4	65.9
Total		100.0	100.0	100.0

The above results indicate that girls are more likely to say that they are never able to tell someone when they have made them angry, while boys are more likely to say always or sometimes.

The table shows that for each question a majority of students answer in the way which suggests most self-efficacy. However, significant proportions admit not being able to express their opinions during a disagreement and/or cannot tell someone when they have made them angry.

Students' attitudes on the opposition between school knowledge and community practices

During focus group discussions, students repeatedly raised the tension between what they learn at school on HIV and AIDS, which they adhere to, and community attitudes, beliefs and practices such as *fisi* and *chokolo*, which they see as directly contradicting such learning. Students' criticisms were addressed most particularly at the elders in the community.

Male respondent: Some people also say that if you are HIV positive and you have sex with an albino you get cured from HIV, but it is not true

[...]

Male respondent: It is not true and we Malawians we should not take part in these beliefs of the old people.

Focus group discussion, Chitipi Primary School, Lilongwe

Male respondent: I just want to add that we can protect ourselves from getting HIV by avoiding some of our culture like kulowakufa.

Comment by a focus group participant in Chizite Primary School, Lilongwe

Female respondent: It is more spoken in the villages especially the aged people (wachekulu/nkhalamba) they talk a lot of things that are not true.

Facilitator: If the aged are in the forefront of talking about these things, so what action do you take?

Male respondent: They just lack knowledge instead of telling the children real way of how you can get HIV they tell you lies which is not good

Focus Group discussion, Ukanga Primary School in Karonga

Overall, students see a divide between their desire to prevent the spread of HIV and community practices that directly contradicts such students' endeavour. This suggests that primary school learners themselves feel they need a supportive environment within the home and the community for behaviour change. Such results provide further evidence that awareness raising projects need to target not only children and young people, but more widely parents, teachers and community leaders in order to facilitate awareness-raising work.

Conclusions

This nationwide baseline survey set to collect and analyse data related to primary school learners' knowledge, attitudes and behaviour on issues relating to HIV and AIDS, gender and children's rights. Overall 1246 primary school learners – 636 treatment group students and 610 control group students – completed the questionnaire and approximately 200 students took part in focus group discussions. This wide-ranging survey has yielded interesting results for both impact assessment and programmatic purposes.

Key findings:

- General knowledge on HIV and AIDS is high among Malawian primary school students, and increases as students advance in their education. However, comprehensive knowledge is rare, with almost all students making at least one mistake. This rule applied for knowledge of transmission and prevention mechanisms and condom use.

- Students in higher standards systematically showed greater knowledge of HIV transmission and prevention mechanisms and greater concern for people living with HIV and for gender rights. This suggests that the school plays an important role in teaching students about these issues and counterbalances knowledge and attitudes acquired as part of the early socialisation at home.

- Only a minority of students answered all the questions on gender norms without bias or prejudice. Students' answers showed that gender stereotypes rest firmly with primary school learners, particularly in the lower grades. There was evidence that girls have greater prejudices on gender-related issues. Girls were more likely to say that housework is women's work and less likely to say that it is OK for a woman to ask a man to use a condom. This suggests that attitudes to gender rights are acquired as part of the early socialisation in the household, and that early intervention at school is required to raise awareness on gender rights.

- Generally, a student's gender did not significantly affect respondents' knowledge of HIV and AIDS, nor their attitudes towards People Living with HIV (PLHIV).

- Students regarded issues of children's rights as a `taught concept', understanding that the correct answers were those given by teachers. It appears that the concept of children's rights has not yet been assimilated by students.

- The majority of students did not report any sexual activity. However, students' sexual activity clearly increased with age. Girls were significantly less likely to state being involved in sexual activities.

- The baseline survey identified a clear lack of communication between children and parents in the home on issues relating to HIV and AIDS, gender rights and children's rights. Students neither identified their parents as key sources of information, nor as interlocutor/confidante on the issue. Furthermore, during focus group discussions and semi-structured interviews, students identified their own parents and members of their family as infringing on their rights, in particular the right to education.

- Focus groups and interviews also shed light on the absence of a supportive environment within the community for students' attitudinal and behavioural change. Students largely felt they had no say on what is happening within the community, which was associated with a feeling of disempowerment.

Recommendations

<u>For programmatic purposes:</u>

- The results show that knowledge on HIV and AIDS, attitudes to people living with HIV and gender rights strongly depend on students' school level (standard). Students demonstrate greater knowledge and more awareness of prejudices and gender stereotypes as they advance through their education. This has programmatic implications as a significant number of primary school learners drop out of primary school. There needs to be a higher number of early intervention programmes targeted at primary school children in lower classes.

- Students are very aware that blood can transmit HIV and that HIV can be transmitted through unprotected sex, but they do not seem to fully understand how HIV can actually be transmitted through unprotected sex. This highlights a fundamental lack

of knowledge about sex. Focus group discussions showed that students fill in this knowledge gap by creating myths about HIV transmission. It is therefore important to go beyond general messages about HIV transmission and educate on how exactly HIV is transferred sexually.

- Results indicate that female respondents show greater gender prejudices than male respondents. Girls were more likely to say that housework is women's work and less likely to say that it is OK for a woman to ask a man to use a condom. There might be a need for specific targeting of girls at school to explore, in a supportive environment, gender-related issues.

- Youth prevention programmes are crucial to spreading knowledge. However, work needs to be undertaken to include parents within such prevention programmes. The majority of learners did not consider their parents as either a source of information or people they feel confident talking about HIV and AIDS with. Furthermore, learners suggested in semi-structured interviews and focus group discussions that parents often infringed upon children's rights to education.

- Work also needs to be undertaken with the wider community to reduce the tension between school learning and community practices. This will ensure a more supportive environment to cement the students' behavioural change.

<u>For the design of the endline survey:</u>

- The endline survey should take place in exactly the same TfaC and non-TfaC schools. Care should be taken to ensure a similar distribution of standard between the two groups and for the sample to be well distributed across standards.

- It might be worth adding a question that was removed from the final version of the questionnaire relating to the body fluids in which the HIV virus can be found. Large numbers of students seem to think that the virus can only be found in blood.

- For the question 'where do you learn most about HIV?', the answer 'hospital' was not available for students to answer. However, approximately 15% indicated that they learnt about HIV and AIDS at the hospital in the 'other' section. This result would

have been certainly higher if ‘hospital’ had been available as an answer. I would recommend including it in the endline.

- In order to complement current data on sexual behaviour, it is recommended that further data is collected on student pregnancy rates, both in control and treatment groups. This would be helpful since pregnancy rates are likely to be highly correlated with practices of unsafe sex.

- Given the significant impact of students’ school level on their answer, it would be interesting to carry out standard-specific focus groups, for instance with Standard 4 students only or with Standard 8 students in order to assess the differences in knowledge, attitudes and practices.

Appendix 1

Regression analysis

Methodology

In this section, we use a regression approach to analyse the impact of the independent variables (that is, variables which will not be affected by the TfaC club sessions) on the dependent variables (all those variables which we feel the TfaC club sessions might have an effect on). In particular, we regressed the variables measuring knowledge, attitudes and behaviour on age, standard, gender and the treatment/control variable.

The basic idea behind using a regression approach is to understand how the typical value of the dependent variable changes when any one of the independent variables is varied, while the other independent variables are held fixed. Using a regression approach in this way gives us two key advantages:

First, a regression approach allows us to analyse whether there is a significant difference in the way students answer questions depending on whether they are in the treatment and control group. This is important partly because, as was shown above, we have seen that the distribution of standards is significantly different between the two groups. Hence, when it appeared that the treatment group gave significantly different answers to the control group for a large number of questions, it was not clear what it might be due to. Therefore, there was a need to determine the cause for the differences in answers between treatment and control group.

Second, we can explore the effect of age, standard and gender on the various questions that have been posed. A regression approach is more suitable to do this than splitting the sample, since we know that some of the independent variables are highly correlated. For instance, students of a higher age are more likely to be in a higher standard. If we simply split the sample by age and compared the answers to the questions, then we would be unable to know whether differences are due to differences in age or differences in standard.

In order to keep the approach simple, we will only analyse questions that have a yes/no answer.[5] The regression analysis works by looking at the data and working out the relationship that fits it best. For each question, the software estimates the following equation:

$$q_i = \beta_1 T_i + \beta_2 s_i + \beta_3 g_i + \beta_4 a_i + \grave{o}_i$$

where q_i is the answer of student i to the question, taking a value of 0 if the student answered no and a value of 1 if the student answered yes. On the right hand side, T_i is a variable taking the value 1 if student i is in the treatment group, and 0 otherwise. s_i and a_i are the student's standard and age respectively, whilst g_i is their gender, taking a value of 1 if the student is a boy and 2 if the student is a girl. $\grave{o}_i$ is then the error term. The coefficients β_1, β_2, β_3 and β_4 are then those estimated by the regression process. We estimate this equation using a probit regression, which essentially assumes the probability of answering yes to the question is normally distributed around some mean.

Results

Table 44 shows the results for the regression analysis for each of the binary questions. The numbers in the columns are the estimated coefficients β_1, β_2, β_3 and β_4. Positive numbers therefore represent a positive association – that is, holding the other variables constant, students answer yes to the question more frequently when the variable corresponding to the coefficient is larger. For example, if $\beta_1 > 0$, this means students in the treatment group more frequently answer yes to the question than students in the control group, once we control for the other dependent variables.

After each numeric column, there is a column that contains a number of stars between 0 and 3. These stars represent the `significance' of the coefficient. They represent the probability that the `true' parameter might be zero – that is, there is no fundamental correlation between the variable and the question.[6] When there are no stars present, this means that there is a

[5] One potential weakness of such an approach is that we simply ignore students that have given no answer (or answered `don't know'). However, the previous section did not find large differences in the proportion that answered the question between the treatment and control group.

[6] More precisely, they represent whether zero is in the respective confidence interval of the estimated parameter.

greater than 10% chance that the parameter being estimated is zero. One star means that the probability is between 10% and 5%, two stars represent between 5% and 1% and three stars mean there is a less than 1% chance that the true parameter is zero. For example, in the first row of Table 44, there are no stars in the `Gender' column, meaning that it is likely there is no relationship between a student's gender and their answer to the question `Have you heard about HIV and AIDS?'. On the other hand, the three stars in the `Standard' column indicate that there is very likely to be a relationship between a student's standard and their response to this question.

When interpreting these results, it is important to bear in mind that almost 400 coefficients have been estimated (4 coefficients for each of almost 100 questions). Therefore, even if all of the true coefficients were zero, we would expect to see around 40 coefficients marked as significant (that is, with stars next to them). When analysing the results therefore, we look for patterns such as when a particular independent variable appears to be significantly correlated with a set of similar questions. We proceed by considering the coefficients relating to each of our independent variables in turn.

An explanation for the impact of each of the independent variables follows after the table.

Table 45: Results of Regression Estimation

	Treatment group		Standard		Gender		Age	
Heard about HIV and AIDS	-0.46	**	0.34	***	-0.13		0.01	
Can you tell by looking at someone if he/she has HIV	-0.07		0.01		-0.13		-0.03	
Is there a cure for AIDS?	0.3	**	-0.16	**	0.36	***	0.03	
If you are fit and healthy, you won't get HIV	0.24	*	-0.35	***	0.06		-0.03	
HIV passed through mosquito bites	0.14		-0.32	***	0		-0.03	
HIV passed through unprotected sex with a HIV positive person	-0.16		0.4	***	0.04		0.04	
HIV passed from mother to baby	-0.3	***	0.09	*	0.03		0.03	
HIV passed from sharing a toothbrush with a HIV positive person	0.14		-0.07		-0.01		-0.03	
HIV passed through witchcraft	0.1		-0.54	***	-0.05		0.08	
HIV passed by receiving a blood transfusion	0.08		0.17	***	-0.05		0.01	
HIV passed through kissing	0.13		-0.21	***	0.3	**	-0.03	
HIV passed through handshakes	0.36		-0.41	***	0.11		-0.07	
Preventing HIV through abstinence	0.02		0.23	***	-0.08		0.02	
Preventing HIV by praying	0.05		-0.37	***	0.18		0.02	
Preventing HIV by always using a condom correctly	-0.03		0.12	*	-0.23	*	0.03	
Preventing HIV by always being faithful to one partner	-0.04		0.04		-0.17	*	0	
Preventing HIV by avoiding kissing a HIV positive person	0.21	**	-0.18	***	0.24	**	-0.04	
You cannot do anything to prevent HIV	0.12		-0.42	***	0.27	*	0.05	
Male condoms can be washed and reused	0.22		-0.42	***	0.22		0.04	
Condoms' best before date	0.04		-0.06		0		0	
Female condoms	-0.17		-0.06		-0.2	*	0.06	*
Use of condoms	0.18	*	-0.14	**	-0.03		-0.01	
Respect for PLHA	-0.22	*	0.27	***	-0.13		-0.03	
Buying vegetables from PLHA	-0.15		0.29	***	-0.2	*	0.02	
Student living with HIV	-0.03		0.34	***	-0.17		-0.01	
Teacher living with HIV	-0.04		-0.41	***	0.07		0.02	

	Treatment group		Standard		Gender		Age	
Willingness to care for relatives living with HIV	-0.01		0.27	***	-0.13		-0.03	
Experience of caring for relatives living with HIV	0.02		-0.22	***	0.06		0.01	
If I had HIV, I would talk to people I trust	-0.04		0.09	*	-0.08		0.02	
If I had HIV, I would go to a clinic to get treatment	0.07		0.15	***	0.05		0.01	
If I had HIV, I would kill myself	0.12		-0.36	***	0		0.01	
If I had HIV, I would do nothing	0.15		-0.31	***	0.25	**	0.03	
If I had HIV, I would hide it from people	-0.04		-0.26	***	0.02		0	
Confidence to talk in group about HIV	-0.34	***	0.25	***	-0.15		0.05	
Confidence to talk about HTC with boyfriend/girlfriend	-0.13		0.24	***	-0.16		0	
Confidence to educate friends about HIV	-0.12		0.31	***	-0.26		0.02	
Primary School learners too young to talk about HIV	-0.02		-0.33	***	-0.1		0	
Learn about HIV at home	0.09		-0.08	*	0.02		0	
Learn about HIV in lifeskills classes	-0.13		0.06		-0.2	*	0.04	
Learn about HIV in other classes	0.03		-0.08	*	0.15		0.01	
Learn about HIV from friends	0.06		0.06		-0.09		-0.01	
Learn about HIV on the radio/TV	0.11		0.11	**	-0.2	**	-0.01	
Learn about HIV in an AIDS Toto club	0.18	*	0.28	***	-0.09		-0.03	
Learn about HIV in a TfaC after-school club	-0.38	***	0.3	***	-0.05		-0.06	*
Learn about HIV from community activities on HIV	-0.07		0.1	*	-0.15	*	0.01	
Nowhere	0.21		-0.32	***	0.16		-0.01	
Friends	0.08		-0.02		0.01		0.04	
Teachers	-0.16	*	-0.08	*	-0.1		-0.01	
AIDS Toto club teacher	0.15		0.15	***	-0.25	**	0	
Siblings	0		-0.02		-0.01		0	
Mother	-0.05		-0.06		0.21	**	-0.02	
Medical Practitioner (doctor, nurse)	-0.12		0.05		-0.1		0	
Religious leader	-0.1		-0.25	***	-0.11		0.05	
Housework is women's work	0.31	**	-0.46	***	0.39	***	0.06	*

	Treatment group		Standard		Gender		Age	
Young girl's right to refuse to marry older man	-0.04		0.31	***	-0.18		-0.06	
Boys are more intelligent than girls	0		-0.26	***	-0.41	***	0.1	**
Domestic violence for lack of cleaning	0.03		-0.12	*	0.24	*	0	
Boys' touching girls	0		-0.21	**	-0.35	**	0.1	**
Boys and girls should be treated equally	-0.2		0.1		-0.08		-0.06	
Right to be safe is important	-0.02		0.05		-0.13		0.01	
Right to be listened to by adults is important	0.18	*	-0.36	***	0.13		0	
Right to education and learning is important	0.06		0.31	***	-0.1		-0.05	
Right to protection from dangerous work is important	-0.1		-0.11	**	0.04		0.02	
Right to protection from sexual abuse is important	-0.08		0.29	***	0.02		0.02	
Right to family life is important	0.13		-0.12	**	0.02		-0.03	
If an adult asked me to have sex, I would tell my parents	-0.04		0.07		-0.18		0	
If an adult asked me to have sex, I would talk to a friend	-0.02		-0.01		0.23	**	0.02	
If an adult asked me to have sex, I would say no	0.03		0.03		-0.19	*	-0.02	
If an adult asked me to have sex, I would say yes	-0.01		-0.23	***	-0.04		-0.02	
If an adult asked me to have sex, I would report it to the Police	0.24	*	0.21	***	-0.18		-0.03	
If an adult asked me to have sex, I would go and see the teacher	-0.2	**	0.01		0		-0.01	
If an adult asked me to have sex, I would do nothing	0.18		-0.45	***	0.07		-0.01	
Teachers have the right to hit you if you have done something bad	0		-0.17	***	-0.03		-0.01	
Do you feel that the teachers listen to the students in your school?	0.2	*	0.1	*	-0.34	***	0.02	
Male teachers have the right to demand sex from school children	-0.06		-0.19	*	-0.28		-0.07	
Female teachers have the right to demand sex from school children	-0.39	*	-0.16		0		-0.02	
Do you like your school?	-0.13		0.02		0.49	*	0.14	*
Do you feel unsafe at school?	-0.05		-0.18	**	0.09		0.04	
Do you feel unsafe when you walk to and from school?	-0.16		-0.1		-0.08		0.05	
Have you ever been teased or had sexual remarks made to you at school?	-0.22	**	0		-0.07		0.05	
Have you ever been teased or had sexual remarks made to you when walking to and from school	-0.1		-0.08		0.08		0.08	**

	Treatment group		Standard		Gender		Age	
Are you sometimes afraid to go to the toilet alone at school?	-0.05		0.07		0.11		-0.09	**
Do you know where to go at school if you have a problem or if you want to talk	0.06		0.32	***	-0.03		-0.06	*
Have you ever drunk alcohol?	-0.45	***	0.05		-0.46	***	0.06	
Do you drink alcohol regularly?	-0.3		-0.16		0.04		0.05	
Have you ever smoked chamba?	-0.21		0.03		-0.49	*	0.03	
Do you smoke chamba regularly?	-0.46		-0.09		0.14		0.07	
Do you have a boyfriend/girlfriend?	-0.31	**	0.05		-0.12		0.19	***
Do you feel ready to have sex with a boy/girl?	-0.2		-0.07		-0.53	***	0.13	***
Is it OK for a woman to ask a man to use a condom?	-0.11		0.34	***	-0.31	***	-0.06	*
Do you worry about getting HIV and AIDS?	-0.26	***	0.05		-0.17	*	0.05	*
Would you have sex with someone who promises to buy you a cellphone?	-0.3	*	-0.18	*	-0.23		0.05	
Have you ever had sex?	-0.32	**	0.02		-0.93	***	0.13	***

Treatment group: From Table 44, we can see that there are several questions where the coefficient on the treatment group variable is significantly different from zero. However, within each set of questions, the coefficient is insignificant for the large majority of questions. This suggests that there is no fundamental difference between the treatment and control groups once we control for the other independent variables. Given the design of the sampling, this is as expected.

Standard: From Table 44, we can instantly see that standard appears to be highly correlated with several sets of questions. Students in a higher standard appear to have better knowledge of issues relating to HIV and AIDS. For example, they are significantly more likely to say that you can receive HIV from a blood transfusion, and significantly less likely to say that you can receive it through mosquito bites. Moreover, their attitude to people living with HIV and AIDS is more positive, with them showing higher levels of respect and willingness to interact with such people. They also report that they would undertake more sensible actions were they to test HIV positive, and appear more confident to talk about the issue. Standard does not appear to be related to where students learnt about HIV and AIDS, though students in higher standards appear more likely to assign responsibility to a TOTO after school club, and less likely to listen to a religious leader. Attitudes to gender are also more positive among students in higher standards: they are less likely to think boys are more intelligent and that housework is women's work. In terms of children's rights, the relationship with standard is more nuanced. Students in higher standards are less concerned with the right to be heard by adults, to be protected from dangerous work and the right to family life, but more concerned about the right to education and to be protected from sexual abuse. In terms of behaviour, higher standard students appear to be less likely to say yes to sex (instead, they would report them to the police), but otherwise there appears to be no major correlation.

Overall the main conclusion we can draw is that what standard a student is in has a significant effect on the way they answer most of the questions in the survey, particularly in terms of knowledge and attitudes. Of course, there are many potential explanations for this link, and we do not have sufficient information to distinguish between them. Perhaps the most positive explanation is that the relationship represents a direct effect of one's standard – that by progressing through the school system, students improve their knowledge and attitudes towards both gender and HIV and AIDS.

Gender: Generally, a student's gender does not appear to significantly affect the way they answer the questions once we control for the other variables. There does not appear to be a

systematic difference in their knowledge of HIV and AIDS, nor in their attitudes towards the illness and people living with it. In terms of attitudes to gender rights, the pattern is interesting. Girls are less likely to say that boys are more intelligent than girls, but more likely to say that housework is women's work. They are also much less likely to say that it is okay for a woman to ask a man to use a condom. In response to being asked to have sex, they are less likely to say no than boys and more likely to talk about it with a friend. Finally, in terms of behaviour, they are much less likely to report having drunk alcohol. They are also much less likely to report having had sex, and in general feel less ready to have sex than boys.

Age: Interestingly, age appears to have no systematic effect on HIV and AIDS knowledge. This suggests that learning about HIV and AIDS generally comes from school, or at least does not appear to increase with time if one does not progress through the school system. Similarly, age does not appear to have an effect on students' attitudes towards HIV and AIDS as well as on attitudes on gender rights. Age appears to have an effect on a relatively few answers, generally ones that one would expect: for instance, older children are more likely to have been teased on the way to school, presumably because they have walked to school for longer. Older children also feel less afraid of going to the toilet at school and more ready to have sex. Not surprisingly, they are also more likely to have a boyfriend/girlfriend and more likely to state that they have had sex.

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