International Journal of Humanities Social Sciences and Education (IJHSSE)
Volume 8, Issue 2, February 2021, PP 123-133
ISSN 2349-0373 (Print) & ISSN 2349-0381 (Online)
https://doi.org/10.20431/2349-0381.0802011
www.arcjournals.org

Integration of HIV and AIDS into Primary Curriculum: Teacher Training Curriculum

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Abstract: *This study examined existing nature and effectiveness of HIV instruction and existing curricula materials used in Teacher Training Institutions (TTIs) to prepare their pre-service and in-service teachers (PITs) to integrate Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) education into the mainstream curriculum teaching at Primary School level. The study showed that there was greatest variance between Content Area Experts (CAEs) and PITs on the appropriate setting to teach children about HIV and Acquired AIDS. The majority of CAEs (70.3 percent) stated the home setting while only 38.6 percent of TTI administrators choose home setting. While it was proposed by many respondents that it would be good to consider a separate, required, and examinable subject on HIV and AIDS in primary schools, 82% indicated that the best ways to teach about HIV topics is to integrate it into the core subjects for all primary schools . Findings indicate the important role a multiple-setting approach is by teaching children about HIV and AIDS in homes, schools, communities, and religious settings when considering reaching youths throughout the country and in helping to overcome the AIDS epidemic. From the study, it was clear that content experts need to arrange what should be taught in the curricula at different levels namely lower, middle and upper primary levels.*

Keywords: *curriculum, mainstreaming, curricula materials, content*

1. INTRODUCTION

HIV is not only an incurable disease but preventable one [1]. This prevention of HIV is only possible when all stakeholders at all levels are involved in the national response. In the absence of a cure, education is a social vaccine for HIV/AIDS [2; 3]. Synergistic partnerships between groups of stakeholders are essential as a way of enhancing an effective fight against HIV. The response to the global AIDS epidemic has increased dramatically since its first recognition over 30 years ago. Expansion of coverage services for prevention of mother-to-child HIV transmission (PMTCT) and antiretroviral therapy have played a large role in decreasing the annual number of new HIV infections on a global level [4].Neither words nor statistics can adequately capture the human tragedy of children grieving for dying or dead parents, stigmatized by society through association with AIDS, plunged into economic crisis and insecurity by their parents' death and struggling without services or support systems in impoverished communities.

Available information indicate that the age group mostly affected by the AIDS epidemic in Zambia, as also in most Sub-Saharan Africa, is within the range of 15-49 years [5]. The learners generally ranging from 7-25 years are within this most-at-risk age group. Surveillance data also indicates that 15-19 year old girls are six times more likely to be infected by HIV than their male peers [6].The population of learners in learning institutions is very high such that if the policies are formulated to target interventions in such settings, the fight against the spread of HIV can be significant.

Despite such a high number of enrolments at Grade one, there remains a high dropout rate as well in Zambia primary. So if those who drop out are taught about HIV and AIDS, then many can have the knowledge of protecting themselves. In 2012 alone, 411,506 dropped out of school due to various reasons. Among those who dropped out, 170,941 were males and 240, 565 were females [7]. Ministry

of General Education (MoE) enrolment data consistently shows that more females dropped out of school than males. Some of the causal factors leading to this include early marriages, pregnancies, and HIV/AIDS-related issues like or phanhood.

From the past three statistical bulletins released by the Ministry of Education, the numbers of the pregnancies have been high. Table 1 provides figures of pregnancies that occurred in schools at different levels in 2008, 2009, and 2012.

Table1. *Pregnancies in Schools, 2008, 2009, and 2012*

Level	**2008**	**2009**	**2012**
Basic Schools	12,370	13,634	12,753
High Schools	1,566	1,863	2,096
Total	**13,936**	**15,497**	**14,849**

The 2013 -2014 Zambia Demographic Health Survey [8] findings showed that teenage marriage (age 15-19) is more common among girls (17 percent) than boys (1 percent). The major causes to this might be many. Just think of the children who are vulnerable: children whose parents are alive but have HIV or AIDS; children in households where there is HIV, although the parents are healthy; children in a household where there are no adults; children in households where there are only elderly care-givers; children in households caring for other orphans; children in households no longer able to look to wealthier relatives for assistance in time of need; children who are exploited for their labor. "Children are a particularly vulnerable group where 9% of 10-19 year olds had reported having traded sex for food or money" [9].

Research has shown that education about HIV and AIDS has the potential to reduce the number of young girls and boys involving themselves in early sex acts [10]. But sex education alone is not sufficient to reduce high-risk behavior, as other factors that include family and parental influence are often more influential [11].

The Importance of Beginning HIV Education at the Primary Level

All levels of education have the potential to reduce the risk of exposure to HIV. Research shows that participating in primary schooling is a critical factor in protecting young people, and especially girls, from HIV infection [1]. Life skills education programs that include specific skills to reduce risk to HIV (such as how to use a condom or how to refuse unwanted sex) and skills that reduce some of the underlying structural drivers of HIV (such as gender inequality or poverty) can address the socio-cultural dynamics that create situations where young people become vulnerable to infection[12].

Numerous research studies also show that sex education and HIV education delivered through curriculum-based programs can be effective in improving young people's knowledge, skills and behavioral intentions [13; 14; 2]. These programs can also delay the initiation of sex and decrease the number of sexual partners among the sexually active. Primary schools reach young people before they become sexually active and form fixed attitudes and thus provide an ideal opportunity for influencing learners' future behavior.

Undoubtedly, much energy has been spent on the curriculum and the integration of content relevant to the AIDS epidemic. But to what extent has this been little more than curriculum tinkering , the consideration of an almost infinite variety of models, but no real fundamental examination of the kind of education needed in a world with AIDS? The curriculum has not been addressing the core issues in the society. Somehow, the thrust seems to have been almost exclusively on integrating HIV into the curriculum, dealing with sexual and reproductive health, and promoting life skills. There has been less concern, however, with the whole purpose and rationale of a school curriculum and what the schools (and other channels for the provision of education) should be trying to achieve in the face of the AIDS epidemic. [15] added that education can generate hope because of its potential to work at the three levels where AIDS-related interventions are needed most: (1) while there is as yet no infection, (2) when infection has occurred, and (3) when AIDS has brought death. Each of these situations are realities for many thousands of learners in Zambian primary schools.

These young ones need support and skills to postpone having sex until they are prepared. Some suffer from sexual abuse and they need protection and care, particularly at this critical time period when there is a threat of death from AIDS. Some start sex before marriage and change sexual partners

several times before they marry. They need help to either abstain from sex or use condoms to prevent pregnancy and STIs. Life skills programs are among the information, education, and communication (IEC) skills that young people need to deal with these issues.

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2. METHODOLOGY

2.1. Participating Colleges of Education and Universities

Participating TTIs were systematically selected as representatives of the existing colleges of education and universities in five of the ten provinces of Zambia. A total of 11 TTIs in Zambia participated in this study. Two primary types of TTIs exist in Zambia: (1) universities, and (2) colleges of education or university colleges. TTIs were selected via a convenience sample from a list of all Zambia TTIs. TTI selection was stratified by (a) TTI category - university or other TTI, (b) geographic region, and (c) institution type - government and private (see Table 2).

Table2. *List of Sample TTIs in Zambia Geographic Region (Province) TTI Name Type*

Geographic Region (Province)	TTI Name	Type of Institution
Lusaka	Chalimbana University (formerly NISTCOL)	Government
	Chreso University	Private
	DMI – St. Eugene University	Private
	University of Zambia	Government
	Zambian Open University	Private
Central	Nkrumah University	Government
Eastern	Chipata College of Education	Government
Northern	Kasama College of Education	Government
	Northern College of Education	Private

Western	Mongu College of Education	Government
	Lyambai College of Education	Private

2.2. Participant Groups

Participant groups were drawn from the participating TTIs and CAEs. Once TTIs were selected, contact was made initially with the senior administrators of the respective institutions to introduce and explain the nature and purpose of the study. This initial meeting generally followed with a senior administrator signing letters of support for the study and afterwards she or he provided members of our research team with lists from which we randomly select faculty members, administrators, and pre- and in-service teachers from their respective institutions. In addition, we conducted in-depth ethnographic interviews with selected content area experts (CAEs)- policy makers and leaders of the community and other organizations associated with HIV education and teacher training at TTIs (e.g., employers of teachers, teacher supervisors, leaders of faith-based organizations, HIV focal persons of NGOs, bilateral, and multilateral development agencies).

2.3. Instruments

Four instruments were used in this study to survey responses from TTI administrators, teacher trainers, and pre- and in-service teachers in the 11 participating TTIs. The semi-structured questionnaires were developed by Jacobs [16] and adapted to the Zambian context to collect/gather both quantitative and qualitative data from the participants in the study. The instruments consisted of items that asked participant groups specific questions unique to each group (faculty members in TTIs, TTI administrators, and Pre- and in-service Teachers - PITs). The in-depth interview guide was first developed by Jacobs in 2002 and was used in this study [17]. Before they were administered, the surveys were reviewed by content area experts from TTIs (pre- and in-service teachers, faculty members, and administrators) for accuracy of the items and relevancy to the Zambian context. The instruments were pre-tested in the field as part of pilot study at multiple locations that were not included in our sample. Following this pilot study, revisions were made as necessary to the instruments.

3. Findings and Discussion

Participants in the questionnaires included pre-service students (N=72, 85.7 percent response rate), in-service teachers (N=32, 74.4 percent response rate), teacher trainers (N=15, 68.2 percent response rate), and TTI administrators (N=47, 85.5 percent response rate) randomly selected from the master enrollment and teacher and administrator roster lists at the sample TTIs (see Table 6).3 Desiring to compare gender differences among teacher participants, we stratified our PITs selection by gender.

Table3. *Demographic Characteristics of Survey Participants*

Demographic Characteristics of Survey Participants **PITs**			**Teacher Trainers**		**TTI Administrators**	
Frequency		Percentage	Frequency	Percentage	Frequency	Percentage
Gender Female	58	55.8	3	20.0	7	14.9
Male	46	44.2	12	80.0	40	85.1
Teaching Experience (in years) None	72	69.2	0	0.0	0	0.0
1-3	2	1.9	5	33.3	25	53.2
4-6	11	10.6	3	20.0	13	27.6
7-9	7	6.7	0	0.0	3	6.4
10-12	5	4.8	4	26.7	3	6.4
13-15	1	1.0	1	6.7	3	6.4
16 or more	4	3.9	2	13.3	0	0.0
Did not respond	2	1.9	0	0.0	0	0.0
HIV/AIDS Training Yes	38	36.5	10	66.7	24	51.0
No	64	61.5	5	33.3	21	44.7
Did not respond	2	1.9	0	0.0	2	4.3
TTI Governance Government	70	67.3	10	66.7	24	51.1

Private	34	32.7	5	33.3	23	48.9

3.1. How Does an Integrated Curriculum Approach Impact the Effectiveness of HIV Instruction?

There were mixed responses to this research question. Many CAEs felt that an integrated curriculum approach is essential to help prepare teachers at all levels, including at the early-grade levels in primary schools. Here are some responses that reflected many of the collective thoughts of CAEs on this question:

- An integrated curriculum approach is essential, because HIV is a cross-cutting theme that cuts across a number of subject areas. Even in such areas as mathematics, there is a need for HIV because teachers can use HIV statistics to help teach math.
- HIV should be integrated into every subject.
- It would be best if HIV and AIDS could be taught as a stand-alone subject, but if not, then HIV and AIDS should at least be integrated into the primary core subjects.

CAE responses varied substantially on the difference between what is currently being taught and what should be taught in the formal curriculum about HIV and AIDS. Some CAEs were very familiar with what is being taught and others simply did not know. For those who responded, they indicated that the following topics are being taught within the formal curriculum:

- Knowledge-based information, basic information, factual aspects regarding cause, transmission, prevention, treatment, and care.
- Understanding your body, safe sex practices, positive living (diet, hygiene, relationships, and choices), psychological aspects and life skills.
- Biological transitioning and establishing meaningful and positive relationships is essential for HIV prevention as well as treatment, care, and support of People Living with HIV and AIDS (PLHIV).

While life skills are advocated in the national curriculum, teaching strategies and teacher qualifications regarding HIV and AIDS vary substantially within the sample TTIs. In addition, the CAE interview findings show that in some TTIs, several aspects about HIV have not been included in the curriculum creating an educational gap for teachers graduating from such TTIs.

3.2. What Should be Taught?

The following themes emerged from CAE responses on what should be taught in the formal curriculum.

- What is HIV and how does it impact the education sector and the local and national economy?
- Modes of transmission and prevention strategies.
- HIV advocacy at all levels, including administrators, teachers, and students sharing messages with local communities throughout the country.
- Information on the nature of the disease, its short- and long-term effects, sexuality and safe sex practices.
- Cultural context, including how to deal with local taboos and traditional practices (e.g., use of razor blades and/or knives, etc.).
- Bodily fluids where HIV is transmitted.
- Emphasis on abstinence, being faithful to one's partner following marriage, and if people are unable to follow these two, use a condom every time they engage in sex.
- In agreement with the Cape Town Conference which was held in December 2013, where government ministers of education indicated that there was need for age appropriate materials to be taught from pre-grade or Grade 1 upwards. The content should include comprehensive sexuality education, life skills to deal with sexuality, and relationships. As indicated in the [18] report on education in the twenty-first century, HIV education should include the four areas of knowledge, life skills, how to preserve oneself, and learning to live together.

- Other topics should include self-awareness, male circumcision, unsafe sex, sexual harassment, interpersonal communications, adherence, and assertiveness.
- HIV education should other related issues and not limited HIV and AIDS alone, but also include diet needs, use of appropriate medicines and drugs, gender equality, and support areas such as protective devices and interaction with health personnel. In this respect MoE should involve closely with the Ministry of Health. This is because teachers deal with children living with HIV (CLHIV) on a daily basis in their classrooms, and health workers deal with PLHIV in the community at large.
- Teach appropriate Behavior Change Communication (BCC), including sound values, morals, and principles, and encourage children and parents to interact with each other, especially teaching parents to find time to be with and talk to their children about sexuality and HIV.

These responses from several participants demonstrated that there were many gaps in what is supposed to be taught in primary schools. These findings therefore show that there is a need for a comprehensive HIV integrated curriculum that goes beyond theory toward one that is implemented as part of all teacher training programs for PITs. In order to accomplish this it will be important to continue to receive government support from the MoE at the national, provincial, and district levels as well as from key stakeholders at all levels of the teacher training process. The support must be towards comprehensive curriculum development and training the trainers of trainers.

3.3. Effective implementation of an HIV integrated curriculum approach in real teaching settings.

Because there was such variance in what was being taught about HIV education at the participating teacher training institutions, it was difficult to fully answer this question. However, some general findings include:

- Most HIV education courses offered at the participating TTIs were electives and not required for pre-service and/or in-service teachers.
- For pre-service and in-service teachers who elected to enroll and take HIV education courses offered as part of their teaching degree/ certificate programs, they were able to receive quality instruction and examples on how to integrate HIV into their respective discipline areas.
- Teacher trainers are limited in what they can require to be taught on HIV in their respective subject areas, especially if the topics are not on the formal, examinable part of the curriculum.
- Teachers in Zambian primary schools are often limited in what HIV instruction they can offer, largely because of a lack of sufficient text book examples. More should be done to help provide integrated examples of HIV in core (if not all) subject areas.

3.4. What role does counseling about HIV and AIDS play in the early grade levels of primary education?

Most respondents felt that primary schools should employ and train Guidance and Counselling (G&C) Teachers. Most administrator (55.3%), teacher trainer (60.0%), pre-service teacher (73.6%), and in-service teacher (87.5%) respondents felt that teachers should have a certificate in HIV prevention and counseling to help their students better understand about HIV and to help them make good decisions related to the disease. But responses on how to certify teachers varied substantially by respondent groups, and included anything from a one-day or perhaps a one-week training program to one that is more comprehensive and is a stand-alone and required course-based (examinable) program of pre- and in-service teacher training programs.

Counseling plays a crucial role in the instruction of learners at all levels, including in the early-grade levels. The majority of CAE respondents felt that learners needed to be taught and counseled about HIV and AIDS as early as possible, and most definitely not to wait until when they reach puberty. Many CAEs cautioned that the HIV and sexuality instruction should be age-specific, but that HIV education should begin as early as Grades 1-4.

The knowledge students acquire must be gradual but incremental. Some suggested in terms of grades as starting from pre-school to Grade 3. Others added that children could be taught different messages

starting from Grade 1 to Grade 7. One participant emphasized this point stating, "Right from the time they enter school, for pupils..., whatever grade you are starting even Grade 1. Like I said earlier, it just has to be age appropriate, even Grade 1 students should be taught some information. And, then students continue to Grade 1 and build on from there. So as early as they start school they need the information about HIV prevention".

A few CAEs cited several reasons for starting as early as possible. Some said that the early ages were appropriate as the students were still developing and emphasized that it should become like a religion right from the early years of development. Others stated that at age 5, children are able to reason. Many suggested that certainly instruction should begin no later than ages 7 or 8. If instruction begins at ages 9, 10, or when many students engage in their sexual debut, it is often too late.

Other respondents suggested age-appropriate information teaching. Some suggested that children could be taught sexually transmitted infections from age 7 onwards, and about HIV as early as age 5. Some suggested that children could be taught according to age, depending on the degree of information starting with the basics. Some said that at age 10 or even 7, students could be taught basic information about HIV, from 10-11 years about modes of transmission and prevention strategies, and adolescents and young adults about how to deal with relationships as well as issues of AIDS stigma, discrimination, treatment, care, and support.

3.5. How Can Prepared Teachers Best Help Children in Early Grade?

What does it mean to be "a prepared teacher" when it comes to an ability to provide guidance, counselling, treatment, and support to those effected and affected by HIV?

- Regardless of what grade level they teach at, prepared teachers are those who have at least a basic knowledge and counselling skills; trained teachers are best able to meet the many differing needs of students and staff members in Zambian primary schools.
- The participating groups who performed highest on HIV knowledge were in-service teachers (where 31.3% received a high score), administrators (23.4%), pre-service teachers (15.3%), and teacher trainers (13.3%).
- Among pre-service teacher participants, there was a significant difference between male and female respondents, with males tending to have a higher HIV knowledge score than females.
- HIV and AIDS training proved significant for administrators, but not for other participant groups.

In response to what suggestions by CAEs on what teachers should know about HIV and AIDS, most of the respondents said that teachers needed to know the current trends in HIV. This knowledge includes basic information on what it is, how it is transmitted (various and potential modes of transmission), its effect, prevention, treatment, care, and the epidemics' impact on the economy and its workers.

Furthermore, most respondents said that teachers needed to have the knowledge about care, support, and how to avoid bullying and stigmatization of children in schools. In addition, the majority of respondents indicated that teachers needed to know how to share their knowledge with students, parents of students, and the communities in which they live. In the interviews, Most interviewees said that teachers needed knowledge about dealing with issues of saying "no," walking away, that one can't always tell who is HIV positive just by their appearance, treatment techniques and strategies that require basic literacy skills, and that PLHIV can live for many years with increased access and adherence to taking ARVs.

Many CAE respondents felt teachers should know and be prepared to teach about sexuality education in general and not only HIV and AIDS. Most respondents added that PITs need to remain current in their IEC and BCC strategies, including their psycho-social knowledge of how best to co-exist with PLHIV and CLHIV. While responses varied on a single most appropriate HIV prevention strategy, most agreed that teachers should generally show the merit of remaining abstinent before marriage and being faithful in their relationships following marriage by learners

Findings from the respondents also indicated that teachers need to be aware of how to identify and work with CLHIV in school settings so as to ensure that they help provide a positive and safe learning environment for all children. This includes ensuring that there is no bullying, stigma, discrimination

of any kind. It also means that teachers should learn about and help produce classrooms that are free of micro-aggression and macro-aggression discriminations [19]. This was one of the most important findings that came out of our in-depth oral interviews with CAEs, to help train teachers to befriend, support, and defend CLHIV in all school settings. Zambian schools should be what [20; 21] advocates as part of its global safe schools program. Schools are also an ideal platform to help train students on how to avoid AIDS stigma of all kinds and in all ways.

Therefore it was clear from the research findings that teachers need a wide knowledge and sufficient life skills to equip them so that they are able to teach learners from different backgrounds and situations, including CLHIV. Short HIV training seminars are generally not enough to impact them with the necessary and comprehensive skills and knowledge.

3.6. Practice of HIV Education

Some participants indicated that HIV education practices in Zambia were more focused on awareness than morality and religious-based teachings on sexuality education. For example several participants condemned the use and distribution of condoms to unmarried students. The rationale for this argument was that the promotion and distribution of condoms to students seemed to compromise the teaching on abstinence. Another area of dissatisfaction among several participants was concerning the policy on the teaching about male circumcision. While these participants recognized that circumcision reduces HIV transmission, it is not a 100 percent protection against the disease. Most participants advocated for HIV policies that would emphasize comprehensive sexuality education. Other prevention suggestions included the provision of sports activities, and behavior change communication (BCC) strategies to students, teachers and administrators via multiple media.

At primary school level, HIV education policy was implemented starting from Grade 1 . However, many participants mentioned that the primary schools lacked the appropriately trained teachers for the subject. In addition, most of the participants indicated that the policies did not cover the provision of HIV/AIDS education to pre-grade learners. The respondents stated that Early Childhood Training Colleges should also be trained in HIV education. Notably the policies were silent on issues of disclosure of status to pre-graders who may have been infected through mother to child transmission. This might be that disclosure might lead to discrimination of learners by teachers and fellow learners.

4. Conclusion And Recommendations

There is need to involve all stakeholders at all levels as is exemplified by the research. in collection of data. When survey respondents were asked “What are the best ways for teachers to learn about HIV prevention, treatment, care, and support?” the majority of participants indicated that they should have a solid foundation of basic information. This highlights the need to go a step beyond simply knowledge. Teachers should be able to share their knowledge with students, other teachers, parents of students, and the communities in which they reside. While some indicated that it would be good to have a separate, required, and examinable course on HIV and AIDS in the pre-service teacher curriculum at TTIs, most indicated that the best ways to teach about these foundational HIV topics is to integrate it into the core curriculum for all pre-service teachers. Others indicated that more books should be made available to teachers which contain accurate information on HIV.

Among the most important things is for the MoE to establish a guiding policy document on HIV education for all levels of education in Zambia (not just in the workplace) starting from pre-school to higher education and outside the classroom. A clear, sector wide policy document is necessary to help establish a foundation that other guiding documents can build upon. This National HIV and AIDS Policy Framework for the education sector should be in alignment with NAC’s National Strategic Framework. This subject area of HIV education must be properly professionalized, with the development of a corps of educators and teacher educators who are the specialized professionals in this field.

But over and above the policies, there must be a wholehearted effort to mainstream HIV and AIDS, sexual and reproductive health, and life skills education into the curriculum of every Zambian learning institution. The objective would be to empower participants to live sexually responsible and healthy lives. This type of education must start at the age of 7 years and it must be done well (is there a specific age that the author wants to mention? Early is too wide).The recently developed MoE curriculum notes that in all subjects at the primary school level teachers will teach about HIV and

AIDS as it is part of the curriculum introduction saying that the new syllabus integrates life skills as a solution to cross-cutting issues and themes such as HIV and AIDS, gender, human rights, reproductive health, corruption, good governance, environmental education, and water sanitation across the syllabus to ensure holistic development of the learner [7].

The emphasis on HIV and AIDS in the introduction section of the MoE Curriculum document is encouraging; and it is also noted in each subject area; there is an overall emphasis on the integration of HIV and AIDS in the formal curriculum. The gap is that in some of the actual subjects' syllabi, there is no mention of how HIV and AIDS shall be taught. Two examples are presented here as follows; firstly, in Home Economics where topics on Health Education and on Food and Needle Work, where there is no mention related to issues of HIV and AIDS. Secondly in Integrated Science, where one component includes a brief mention of HIV and AIDS, and some direction from the syllabus is given on how the teacher may expand on this as needed (see Appendix 1 for the current Integrated Science syllabus). These examples show that much more need to be added to the syllabus to include basic HIV and AIDS information in other subjects like Civic Education, Geography, Chemistry, and all other subjects in one way or another.

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Citation: *Harrison Daka, et.al. "Integration of HIV and AIDS into Primary Curriculum: Teacher Training Curriculum" International Journal of Humanities Social Sciences and Education (IJHSSE), vol 8, no. 2, 2021, pp. 123-133. doi: https://doi.org/10.20431/2349-0381.0802011.*