An investigation into the role of parents in HIV and AIDS education offered in schools in 2010 in the Directorate of Education, Oshana Region - Northern Namibia

by
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Declaration

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ABSTRACT

HIV/AIDS education has been accepted with mixed feelings mainly because of its close association with human sexuality. Notwithstanding the controversy, HIV/AIDS education is being taught in schools in Namibia for more than ten years. Programmes such as 'My Future is My Choice' programme, Window of Hope programme and the Life Skills subject all have one objective – to equip learners with information and skills to enable them to make decisions in the era of HIV/AIDS.

One of the most profound themes to emerge in recent years is that HIV/AIDS is more than a physical ailment. Its rate of transmission (or infection) is determined by the social context. The notion that once people have been informed about HIV prevention, they would use this information to make decisions that would protect them from infection has been proven a fallacy. It is now understood that the social context of people must be considered when they are being informed about HIV/AIDS to enable them to navigate through unfavorable and outdated cultural practices that accelerate the spread of the virus.

Learners come from different social contexts and this needs to be considered when educating them about HIV/AIDS. This research study investigated the role of parents in HIV/AIDS education offered in schools during 2010, in Oshana Education Directorate. Fourteen teachers from ten schools and twenty parents took part in the study. An implementation evaluation research design was chosen to investigate the roles parents played in complementing and supporting HIV/AIDS education

Findings of this study indicated that only 40% of the schools involved parents in the HIV/AIDS programmes. This was confirmed when it also emerged that only 70% of parents who took part in the study were aware of their children's involvement in HIV/AIDS

programmes. Thirty percent were not aware that their children participated in HIV/AIDS programmes at school. The study also revealed that all parents who took part in the study are in agreement with the school teaching learners about HIV/AIDS. However, only fifty percent (50%) of the parents in the study indicated that they were involved in the school's HIV/AIDS programmes.

One of the most notable roles mentioned by parents were that they emphasized at home on various topics that they were aware were being taught at schools, attending prize giving ceremonies at schools to witness the giving of awards after learners completed the programmes; some mentioned that they were also invited to give presentations on the topic of HIV/AIDS. Seventy percent of parents mentioned that they were asked permission for their children to take part in the programmes and some parents were specifically requested to talk to learners at home about HIV/AIDS.

Overall the research discovered that the practice of involving parents in HIV/AIDS education was not being practiced by all schools. Sixty percent of the schools did not involve parents in the HIV/AIDS programmes.

OPSOMMING

Daar kleef nog steeds ‘n stigma aan MIV/Vigs voorligting omdat dit aan seksualiteit verbind word. Ondanks hierdie kontroversie word MIV/Vigs-voorligting reeds die afgelope 10 jaar in Namibiese skole vir leerders aangebied. Die hoof doelwit van hierdie programme is om leerders beter toe te rus vir die eise wat deur die pandemie aan hulle gestel word.

Die doel van hierdie navorsing was ‘n ondersoek na die rol van die ouers van leerders wat MIV/Vigs voorligting aan skole kry. Vir die doel van die studie is 10 skole en 20 ouers van skole in die Oshana Onderwys Direktoraat in Namibië betrek.

Resultate dui daarop dat slegs 40% van die skole in die streek enigsins ouers van leerders by die MIV/Vigs-programme betrek terwyl slegs 70% van die ouers in die steekproef bewus daarvan was dat hulle kinders aan hierdie programme deelneem

Verdere resultate van die studie word bespreek en voorstelle ter verbetering van MIV/Vigs voorligting in die Oshana streek word gemaak.

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LIST OF ACRONYMS

ABC	Abstain, Be Faithful, Condomise
ART	Antiretroviral Treatment
ARV	Antiretroviral
AVERT	AIDS Education and Research Trust
HAMU	HIV and AIDS Management Unit
HIV and AIDS	Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome
MFMC	My Future is My Choice
MOE	Ministry of Education
MOHSS	Ministry of Health and Social Sciences
RACE	Regional AIDS Committee for Education
SRH	Sexual and Reproductive Health Education
STIs	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNESCO	United Nations Education, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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CHAPTER 1. INTRODUCTION.

1.1 Introduction

The study investigated the role that parents played in complementing HIV/AIDS education offered in schools in 2010. The HIV/AIDS education referred to 'My Future is My Choice' programme (MFMC), Window of Hope (WoH), and the Life Skills subject. The main objective of the study was to establish if parents play any role in the HIV/AIDS education and also examined how the schools involve parents in HIV/AIDS programmes and activities. This study focused on teachers from the 5 circuits in Oshana Education Directorate who were involved in HIV/AIDS education in 2010 as well as parents of learners who took part in HIV/AIDS programmes in 2010. The introductory chapter presents a brief background, the rationale and research questions and objectives of the study, as well as the chapter outlines.

1.2 Background to the study

Since its detection in Namibia in 1986, HIV/AIDS remains a social, economic and developmental problem (Ministry of Health and Social Services, 2008). Its impact is felt across all spheres of society and hence there is a need for comprehensive efforts to minimize its impact. The education sector in Namibia has been working hard to educate young people about the dangers of HIV/AIDS (Ministry of Education, 2007). Sexual and Reproductive Health (SRH) is one way Namibia combats HIV/AIDS. However, these well meaning efforts have proved to be controversial and at times are believed not to be yielding the desired outcome, which is a reduction in the spread of HIV/AIDS among the young generation (ATACMAG, 2011).

The debate on sex education in Namibia has been ongoing for over a decade (Mufune, 2008). The urgency to make it mandatory for all schools to teach sex education as in-

cluded in the Life Skills curriculum as well as implement extra-curricular programmes such as My Future is Choice and Window of Hope, is borne out of the need to address the HIV/AIDS crisis among school going children. The notion of formal HIV/AIDS education in school is well understood by academics and other service providers but their sentiments are not shared by all parents.

Without disregarding the need to educate young people on the dangers of HIV/AIDS, one needs to acknowledge that there are parents who oppose sex education, which now includes HIV/AIDS. Reasons range from their understanding that young people are being encouraged to have sex as long as they take precautions, condoms are being favoured over abstinence, and that young people are being exposed to too much information at a very early stage. Another reason cited by parents who oppose sexual health education (SRH) is that they are not given the option to either allow their children to be taught or not to be taught despite the differences in culture and religion among learners (Steinitz, 2011). On the other hand, a study conducted in Namibia by Mufune (2008), indicated that many teachers reported that as much as they would like active parental support, they have observed that many parents are suspicious of schools teaching SRH and do not have an idea of what to do.

Despite opposition by some parents, not all parents are against sex education. Sex education is viewed by some parents as a positive move to educate young people on the dangers of HIV/AIDS given the high number of HIV infected people and early experimentation of sex among adolescents (Chandan et al, 2008).

Regardless of the ongoing debate, sex education and HIV/AIDS education continues to be taught in schools. However, it has been noted that despite numerous successes achieved by the education system, a lot of challenges such as the continuing high rate of learner-pregnancy and alcohol abuse among young people have not been minimized

(Baker,2010). This can be attributed to the non-involvement of parents in school HIV/AIDS programmes; many of these challenges maybe overcome by asking parents to compliment efforts made in schools to educate young people on the dangers of HIV/AIDS.

A study by Mufune (2008) recommended for learners to be graded in sex education for them to value it more. A study conducted in 42 senior secondary schools in Namibia by Campbell and Lubben (2003) found that most schools were not implementing HIV/AIDS activities and only 7 schools had comprehensive health promoting environments. My Future is My Choice has also been criticized for not reaching all learners and for giving learners a choice to either participate or not since most learners who are more vulnerable may not choose to participate hence remaining vulnerable to HIV infection (Chandan et al., 2008).

1.3 Research problem and question

The main research question of this study is: What roles did parents play in complementing HIV/AIDS education offered in schools to learners in 2010? In order to find answers to the main question, the following sub-questions were formulated:

- What is the purpose of teaching HIV/AIDS to learners?
- What are learners' current attitudes towards HIV/AIDS?
- What is the impact of HIV/AIDS education on learners?
- What are parents' attitudes towards HIV/AIDS education taught at school?
- How does the school involve parents?
- What are the cultural practices and norms that prevent learners from implement what they are taught at school?

According to Tiffany and Young (2004) parents are expected to play the role of encouraging their children to enroll and actively participate in school activities. One can safely state that parents are also expected to know what information is being taught to their children in order to ensure that there is harmony between school teaching and home teaching as discrepancies can lead to the dissemination of ambiguous information on HIV/AIDS. Parents are also expected to help children practice what they are taught and to continue HIV/AIDS education at home.

For the purpose of this study, HIV/AIDS education referred to HIV/AIDS education offered in the voluntary extra curriculum programme 'My Future is My Choice' taught from grade 8 to 12 and the Life Skills subject which is taught from grade 4 to 12. The aims, objectives and contents of these programmes are outlined in the literature review. This is important in determining parents' awareness of what their children are being taught in school. The term, 'schools', referred to public or government schools. This study regarded parents as either the biological parents (father and mother or any one of the two), guardian or primary caregiver.

1.4 Significance of the study

Parental involvement in HIV/AIDS education is not formalized in Namibia. Apart from calls by education officers to parents to teach their children about HIV/AIDS, it is regarded as a task and duty of schools as delegated by the state (Ministry of education, 2007). The content of what is taught; when it is taught and the relevancy of what is being taught is decided by curriculum designers. The researcher is of the opinion that a call for parents to educate their children is well-meaning but not realistic if the factors that prevent parents from being involved in HIV/AIDS education are not known and addressed. Parents may not realize the need for their involvement and they may also not be informed about the content of HIV/AIDS education being taught in school per grade. Considering the different cultural practices and norms in Namibia regarding sexuality, par-

ents may also be confused as to how they can assist learners to practice what they are taught at school within their different cultural settings. The call may fall on deaf ears.

This research is significant because it highlighted the need and importance of parental involvement as complementing the efforts of the education ministry. The research also discovered roles that parents play together with the school and it includes recommendations that will help schools to consider ways of involving parents and establish platforms to discuss the content and objectives of teaching HIV/AIDS education at different age groups as well as cultural relevancy and practice of what is taught as a strategy to involve parents.

1.5 Aims and objectives

The aims of the research study was to identify the current practices of parental involvement in HIV/AIDS education in schools and make recommendations of incorporating a family-systems approach to education that would help to improve parenting capacity to respond to the increasing threats of HIV on young people.

The objectives of the study were as follows:

- To establish the level awareness among parents of HIV/AIDS education programmes in schools
- To find out how schools are involving parents in HIV/AIDS education in schools
- To identify roles parents can play in complementing and supporting HIV/AIDS education in schools.

1.6 Research design and methodology

Qualitative research design was used. A questionnaire was used a research instrument to gather data from parents and in-depth interview was used to collect data from teachers.

The questionnaire was translated into Oshiwambo, because most parents do not speak English. Teachers were interviewed and an interview guide with semi-structured questions was used as a research instrument.

The target population of this study was teachers and parents of learners who took part in HIV/AIDS education at school in 2010 from the 5 circuit (Ompundja, Eheke, Oluno, Onamutai and Oshakati) in the Directorate of Education, Oshana region. Two schools from each circuit participated in the study. Convenience sampling was used to select the schools and learners. Accordingly, 10 teachers and 20 parents from 10 schools took part in the study.

1.7 Outline of chapters

The assignment consists of five chapters. Chapter 1 introduces the study and presents the following topics: background and rationale for the study, research problem and questions, significance of the study, aims and objectives, Research design and methodology, chapter outlines. Chapter 2 comprises the literature review, while Chapter4 presents the methodology of the study, looking at aspects such as the research design, population and sampling, criteria for selection, the interview as a data collection method, organisation and analysis of data, ethical considerations, and the validity and reliability of the study. Chapter 5 contains the presentation of data and the analysis of information, while Chapter 6 presents the discussion on the findings and recommendations of the study.

1.8 Conclusion

The introductory chapter presented a brief background, the rationale and research questions and objectives of the study, as well as the chapter outlines. The study is an investigation into the roles of parents in HIV/AIDS education offered in schools in Oshana Ed-

ucation Directorate, Northern Namibia. The main objective is to establish the level of involvement of parents. It is the hope of the researcher's that this study will draw the attention of schools to the importance of involving parents in HIV/AIDS education and activities at school as a way of complementing their efforts.

CHAPTER 2. LITERATURE REVIEW.

2.1 Introduction

This chapter presents a review of the literature necessary to understand the significance of this study. A brief overview of themes, debates and research findings from around the world are discussed to set the context and give the reader a deeper appreciation of the topic of parental involvement in HIV/AIDS education. Finally, the literature will look at the drivers of the HIV/AIDS epidemic in Namibia followed by a description of the various HIV education programmes offered in school.

2.2 Sexual health education: themes, debates and research findings from around the world

Many literatures contain the word 'sexual and reproductive health education' but the Ministry of Education in Namibia rarely uses this term and instead the term 'Life Skill' is used. Walker and Milton (2006) explained that in the United Kingdom the cultural acceptability of using the word 'sexuality' in the context of school health education programme would be questionable given the taboos associated with it. Perhaps the same explanation is valid for the Namibian context. The term is suggestive of the intrinsic link between social expectations and education on sexuality: Cultural and social acceptance of sexuality education appears to depend on the openness and comfort levels of a society.

Historically, families were regarded as the primary source of sexual and reproductive health education for children until the introduction of government mandated programmes. These also started the debate of who can best provide sex education, the state or the home and the debate has been ongoing ever since. Walker and Milton (2006) explained that for too long the debate has been centered around who is responsible for providing sexuality education rather than progressing towards securing pragmatic part-

nerships between schools, agencies and parents. Dyson (2010) noted that there has been a generalization over the years that parents are against sexual health education of any sort. The author explained that this generalization is mainly due to the fact that sexuality education has become a highly contested field and those who oppose it are mostly highly vocal and relentless in promoting their point of view thereby giving the impression that they represent a large portion of the community opinion. The author contends that research has continued to demonstrate that parents who oppose sexual health education are fewer compared to those who have indicated support.

In addition, it has been argued that the school teaches HIV/AIDS, a novel phenomenon, using outdated models. A paper by Frizelle published in 2005 argued that prevention programme need to move away from deficit models of youth development towards a view that the youth are capable of engaging meaningfully in decisions regarding their well being (Nguyeni et al, undated). Nguyeni et all reported that Frizelle reasoned that many HIV interventions aimed at the youth in South Africa have been criticized for not acknowledging the complex context in which identities and sexual behaviour are constantly negotiated. The author added that there is a need to encourage young people to view HIV/ AIDS as a 'novel and intriguing phenomenon of their time' and enable them to become critically aware of the way in which contextual factors impact on their sexual identities and hence promote a desire at an individual level to change the prevailing and outdated cultural practices. The author suggests a creation of platforms where young people can discuss and gain understanding that would equip them to negotiate their location within the context of HIV/AIDS.

The following is background information on the themes, debates and research findings on sexual health education offered in school. This presentation is not comprehensive and does not capture all the aspects but it is believed it will help the reader understand the significance of the research in the role of parents in HIV education. The most common debates in sexual health education in schools normally centres around the following

themes and questions: culture and sexual behaviour; knowledge and behaviour change; should sexual health education including HIV/AIDS be taught in school?; Who is the better teacher, parents or teachers?; The state versus the home; Acceptance by the school of parents as co-teachers; and the challenge to parents as co-teachers;

2.2.1 Culture and sexual behaviour

Social Comparison Theory postulates that people tend to conform to the attitudes and behaviour of others similar to themselves, partly because those others provide information about social reality, and partly because conformity may be socially rewarding (Goethals & Darley, 1977). Learners come from different social setups and hence consideration of the social environment in the effort to change sexual behaviour among young people cannot be stressed enough. Kelly (2000:35) explained that underlying cultural demands and expressions are contained in social pressures and cultural contradictions. Socially, they manifest themselves in the power of peer pressure and the group, and the need for young people to conform and belong. Cultural contradictions abound. Among them is the veneer of "respectable," approved sexual behavior encountered in society, while it is common knowledge that large numbers of adults are following a different sexual code. More overtly, different standards exist for different genders. As a result, social expectations condone in men and boys maybe condemned in women and girls, and vice versa. Kelly illustrates this practice by explaining that the usual socialization process teaches boys that they must be physically strong, emotionally robust, dominate women, and not worry about their health, or seek help when they face problems. For a girl, the socialization process teaches her that her principal role in life is to meet the physical, psychological, economic and sexual needs of a man, to be obedient to him and to show him unquestioning loyalty, to bear and rear his children, and to arrange for his comfort. An enormous mix of cultural values and counter-values send confusing messages to the rising generation. Kelly (2000) is of the opinion that this is embodied in the weakening and progressive demise of traditional cultural systems and the entertainment

industry's presentation of situations and role models which give prominence to temporary relationships and casual sex (Kelly 2000:35). Without assigning blame, traditional African interpretations of HIV/AIDS in terms of sorcery is also strengthened by the inability of western science to produce a cure resulting in skepticism about the existence of the virus (Kelly, 2002). The author explained that the deep-rooted belief that sorcery and witchcraft are the root causes of HIV/AIDS is not just among rural people, but also among urban dwellers, and the educated are not exempted.

Kelly is of the opinion that none of the HIV/AIDS educational programmes takes these cultural perspectives into account. Failure of many HIV/AIDS education programmes can be attributed to failure to contextualize messages about HIV/AIDS within the cultural discourse of traditional ideas and perceived traditions (Kelly, 2002). These programmes do not acknowledge and build on the understanding and beliefs of those they seek to influence but instead bring foreign concepts. Walker in Walker and Milton (2006) explained that research highlights the need for improving our understanding and knowledge of teachers' and parents' experiences. There is a need to acknowledge in practice the inherent link between HIV Education and the cultural context (Kelly, 2000).

2.2.2 Knowledge and behaviour change

According to Brown, Franklin, MacNell and Mill (2001) informing people about the existence of HIV, how it is transmitted and how to prevent HIV infection is not enough. The authors explained that the last two decades have demonstrated that HIV is more than just a 'behaviorally transmitted disease'.

Brown et al (2001) explained that it is now recognized that there are environment and contextual factors that may influence the effectiveness of HIV prevention efforts. The authors listed factors such as the social, cultural and economic environment and the context in which the behaviour takes place as having an impact on the decision an individual will take to protect him/herself when presented with the means and whether they will

execute that decision. Environmental and contextual factors influence an individual's level of vulnerability to HIV infection. The model developed by the authors encourages the use of preventive strategies that address risk and vulnerability. In other words, information about HIV/AIDS, past experiences, social pressures, risk perception, and personal concerns and motivations are all factors that should be included in the education. According to Setswe (2010) one of the stages in the behaviour change continuum is that a person becomes aware of the existence of the phenomenon HIV/AIDS, how it is transmitted and how to prevent infection using a condom as well as understanding the effectiveness of condoms as a prevention measure.

In acknowledging this fact, the Bureau for Africa (2003) explained that for many years, responses to the problem of high HIV prevalence among young people have focused on information, education, and communication (IEC) materials designed to impart knowledge on HIV prevention. In agreement, Kelly (2000) explained that the design of many HIV/AIDS education programmes may be faulty as a result. Programmes appear to have been developed from the top, with minimal participation of classroom teachers, parents, and young people themselves. Programme delivery is exclusively in the hands of the school, again with minimal involvement of parents and young people. This has led to the criticism that absorbing HIV/AIDS education into other curriculum areas render it irrelevant to reality outside the classroom. Thus, although the programmes provide young people with better factual information, this does not necessary lead to changes in behaviour. This approach to HIV prevention is based on an incorrect assumption that students will act accordingly in their own interest once they are informed of the risks of unprotected sex and the benefits of adapting behaviour to prevent infection, hence, bringing about positive attitudes and behaviour. Unfortunately the rising number of teenage pregnancy has proved this a fallacy. There has been little correlation between information and behaviour change.

This non-correlation between information on HIV and healthy sexual behaviour suggests that there is a need to search for strategies that go beyond prevention information as a way of influencing behaviour change in young people. In addition to basic facts about HIV/AIDS transmission, young people need practical skills to cope with peer pressure, solve problems, be assertive, negotiate safer sex practices, and develop life plans.

What is then an effective HIV/AIDS education programme? "Effective programmes are those that have had a positive influence on behaviour as regards sexuality, drug use and non-discrimination, and not those that simply increased knowledge and changed the attitudes of students" (UNESCO,2004:6).

2.2.3 Should sexual health education including HIV/AIDS education be taught in schools?

While there are parents pleading with teachers not to teach their children any 'sex education, there are also parents who are complaining that the teachers are not teaching enough sex education (Walker and Milton, 2006). The authors explained that there are myths surrounding Sexual and Reproductive Health Education in Australia and the United Kingdom, the most widespread and disproved is that it encourages young people to become sexaully active.

According to Walker and Milton (2006), research in Australia has found that the majority of parents are supportive of the school's role in sexuality education and it is very unusual for parents to withdraw pupils from these classes. In support of this fact, a study by Ogunjimi (2006) on the disposition of students and parents towards the inclusion of sex education in the school curriculum in Cross River State, Nigeria, found that the majority of the students (70%) and parents (93.89%) were in support of the inclusion of sex education in the school curriculum because they believed that the teaching of sex education would complement efforts being made towards the management of HIV/AIDS. Research in Australian also found that parents considered their involvement in school Sexual and

Reproductive Health Education important as they express their wish for their children to be more informed than they felt themselves as young people (Walker and Milton, 2006). In the United Kingdom, acknowledging parental involvement in their child's sex education as important and potentially having an impact on a child's future sexual health is also a new concept (Walker in Walker and Milton, 2006).

Not all parents support Sexuality and Reproductive Health education. A study in India by Mahajan and Sharma (2005) 'on the attitude of parents of adolescents towards imparting sex education' found that the 89% of the rural parents who took part in the study indicated that they do not see the necessity of imparting sex education to their children; 75% of the rural parents believed that 'not much' information should be imparted. Only 3% of parents were in favour of giving comprehensive sexual reproductive health information to their children.

The following is an extract of two set of arguments for and against sex education which now includes HIV/AIDS education in the United Kingdom but its argument maybe applicable elsewhere. The question posted was '**Should sex education be abolished in school?**' These examples of arguments are intended to familiarize the reader with the general reasoning pattern of those against and for sexual health education. The article is taken from the website http://www.debatepedia.org and is based on a *debatabase* written by Alex Deane. : Table 2.1: the debate, 'should sex education be abolished in school?

Yes: Sex education leads to experimentation and early intercourse, and indirectly encourages promiscuity. The most moral form of Sex Education says 'you shouldn't do this, but we know you are,' thus pushing children to consider their sexual existence before they need to or indeed should. Thus	**No:** Our children are sexually active. They are making decisions that can affect the rest of their lives. They should be able to choose responsibly and be well-informed about the likely outcomes. They should know about sources of free or cheap contraception, who to turn to when pregnant or

sex education's message is invariably confused – on the one hand, by saying 'here are the perils of teen sex – so don't do it,' and on the other hand, 'here is how to have teen sex safely.' Less moral forms start by saying, 'the best form of a relationship is a loving, constant relationship' and then say, here are the ways to use protection if you're not in such a relationship' – a logic which presumes children are in sexual relationships to begin with. The justification for this is that 'adolescents know all about sex' – an idea pushed in our permissive society so much it's almost a truism – but contrary to that bland generalization, many children don't do these things early, don't think about these things – they actually have childhoods, and these lessons stir up confusion, misplaced embarrassment or even shame at slower development. They also encourage children to view their peers in a sexualized context. The openness with which education tells students to treat sex encourages them to ask one another the most personal questions (have you lost your virginity? – how embarrassing, how un-cool, to have to say no), and to transgress personal boundaries – all with the	if they suspect they have a venereal disease, how to use contraception to avoid both, and, contrary to the impression of abolitionists, they should be told the benefits of abstinence. How can you tell people about that if you refuse to discuss sex? How can you imagine they will take you seriously if you turn a blind eye to something so many of their peers are doing? They need an external source of support to resist peer pressure, and have sex later rather than sooner: lamentably, it is presumed amongst many young people that having unprotected sex with many partners at an early age is the norm and they encourage others to do it (and attempt to humiliate those that don't). We need mechanisms to support those that want to resist that pressure: sex education is such a mechanism. Sex education is part of a package of provisions needed to help our teenagers avoid the terrible pitfalls of unwanted pregnancy and venereal disease. This problem is here – pretending that it isn't won't make it go away. How else do opponents of sex education propose to deal with the huge problems of STDs and teen pregnancy? Effective and widely supported

teacher's approval. Inhibitions are broken down not just by peer pressure, but by the classroom. As pro-sex education people love to point out, children develop in their own time – but that means that some are learning about this too early, as well as 'too late.' We in society are guilty of breaking the innocence of childhood, earlier and earlier – and these lessons are a weapon in the forefront of that awful attack on decent life.	sex education programmes can achieve real results. For example, in the Netherlands, amongst people having intercourse for the first time, 85% used contraception – compared to 50% in the UK.
Yes: Sex education informs children about sex, and then invites them to make a choice. But as demonstrated all the time, children are bad decision-makers; often choosing what is bad for them. That is why adult society often needs to decide for them – what they should eat, what they should watch on T.V., when they are mature enough to be able to choose whether or not to drink or smoke. Surely sex is just as important as those things – just as dangerous, just as potentially destructive. The abdication of our responsibility in the sexual arena is shameful; we should be unafraid to simply tell children this is something they cannot do, aren't mature enough to consent	**No:** That logic might sound impressive – but it's the same one that fails to control underage drinking, underage smoking, the watching of rated movies by those forbidden to do so, the eating of bad food – and underage sex. It's the same poor parental logic that has seen a generation of children grow up divorced from the society around them, children who die from drugs overdoses and whose parents say (honestly), 'I just had no idea.' It's time to talk to our young people about what they do – honestly, frankly, without frightening them into dishonesty and deception. To do otherwise perpetuates the cycle of ignorance about youth society, and perpetuates the status

to yet – a responsibility we seem to shrink from even though it is reflected by the stated aim of society enshrined in the law of the age of consent. Lessons implicitly lauding the pleasures of intercourse are entirely contrary to that aim.	quo of being able to do nothing to change it.

2.2.4 Who is the better educator, parents or teachers?

One of the major criticisms leveled against sexual health education is that it has replaced parental teaching and failed to include parents as partners (Dilworth, 2009). The author explained that this has proved to be a grave mistake because sexual health education holds multiple meanings and implications for parenting.

According to Hyde, Carney, Drennan, Butler, Lohan and Howlett (2009:28) evidence has shown that parents do not feature strongly as sources of information about sex for young people relative to other sources such as the school, peers and the media. The authors explained that there is data available suggesting that young people do not particularly want more sexual information from parents. Hyde et al (2009) cited a study by Rolston et al.'s (2005) conducted in Northern Irish, were respondents were asked to identify the sources from which they would like to learn more about sex and the first choice for 40.3% of the young people was the school. This is considerably a higher than the number of respondents who sought more information from parents (21.9% of all first-choice answers). Hyde et.al (2009) also referred to a study conducted in Australia by Rosenthal and Feldman's and published in 1999 that raised questions of young people's desire for parental input on sexual matters.

The authors reported that even though adolescents indicated that their parents did not deal with sexual issues, in most cases, they did not feel it was important for parents to address these issues (Hyde et al., 2009). The authors noted that these adolescents attached very little importance to parental input about private areas of sexuality. By contrast, parental communication about matters of sexual safety was accorded a more significant role by respondents (Hyde, 2009:28). The study concluded that most of the respondents reported that parents were not their preferred source of information or influence concerning sexuality, and as an outcome, most parents did not offer themselves in this regard, save (to a small extent) in areas where safety issues arose.

These contradicting research findings are perhaps an indication that every society must conduct research and find out from its rising generation where it prefers to get information on sexuality. This is an important step if education on sexuality is to be a success.

2.2.5 Why parental involvement in Sexuality and Reproductive Health Education?

According to Tiffany and Young (2004) parents are expected to play the role of encouraging their children to enroll and actively participate in school activities. One can safely state that parents are also expected to know what information is being taught to their children in order to ensure that there is harmony between school teaching and home teaching as discrepancies can lead to the dissemination of ambiguous information on HIV/AIDS. Parents are also expected to help children practice what they are taught and to continue HIV/AIDS education at home.

The argument for parental involvement is based on the following premises: The role of parents in Sexual and Reproductive Health Education (included HIV/AIDS education) needs to be acknowledged because parents influence the development of sexual attitudes, beliefs, and behaviors, especially in the years leading to early adolescence where interest in sexuality heightens. Parents shape their children's sexuality by encouraging religious beliefs and practices that influence morality and sexual behavior (Baptiste et al, 2009).

These beliefs and practices are not always healthy and preventive of HIV infection and hence the need for closer cooperation with the school.

It is widely accepted that general cooperation between parents and the school can enhance academic achievement of learners (Tiffany & Young, 2004). Collaboration on sexual health education is also perhaps a necessary ingredient to success. An important reason for this collaboration is that forming a partnership between the school and the child's home creates an opportunity to involve the family that is already busy shaping the child's understanding of sexuality. Apart from parents, siblings are also peer teachers. The authors explained that a research by Milton (2003) supported the idea of sibling involvement. The research revealed that teachers in Sydney, Australia, found that the eldest children are likely to know less than their peers who had older siblings. Similarly, another research by Walker (2001) concluded that sibling involvement could help clarify and reinforce sexual health messages from both parents and teachers. Other family members such as grandparents are also actively involved in shaping young people's perceptions of sexuality (Walker and Milton, 2006). The involvement of grandparents is evident among cultural groups where children are allowed to ask their grandparents sensitive questions of a sexual nature.

Baptiste et al (2009) cited a qualitative study of 14- to 18-year-olds in Jamaica, where females identified parents' "voices" in their heads and males indicated not wanting to 'disappoint' parents as important in deciding to delay sex. The authors also reported that another study in Trinidad and Tobago of 14- to 20-year-olds indicated that over 85% reported that views of parents and family members are important in sexual decisions.

Jack in Baptiste et al (2009) in agreement with Dilworth (2009) reasoned that parenting is a deep protective factor that can dull the effects of some of the negative messages about sexuality that young people are exposed to. The Baptiste et al (2009) concluded that collectivistic cultural values, prevalent in Caribbean islands, link individual decision-making to the norms and demands of family and other primary social groups (e.g.,

religious sect). Such traditions emphasize that children should accommodate the views of parents, submit to their positive socialization and consider how the family image might be flawed by their personal choices. The authors believe that this ascribed power and influence in families and especially in mother-child relationships can be used to help the youth to avoid HIV infection. In light of this, Baptiste et al (2009) highlights the following as some of the objectives of parental involvement:

- To respond to the need for parents to be aware of youngster's passage through puberty and to monitor sexual interests
- To promote value-clarifying discussions to combat growing pressure or expectancy to engage in sexual activities between the school, parents and learners
- To respond to adolescents need for sex and HIV/AIDS education
- To normalize talking about sex and HIV/AIDS in homes as it is in school
- To help parents modify their own risk behaviours to better serve as examples to young people as this will in turn lead to the promotion of healthy sexual behaviours in the community

2.2.6 Acceptance by the school of parents as co-teachers

A study by Dilworth (2009) analyzed empirically-validated curricula for the inclusion of parents as co-teachers in the sexuality education process. The goal of this analysis was to find out the extent to which parents and families are incorporated into the curriculum of 8 sexuality health school programmes in the United States of America. Content analyses were conducted closely examining each curriculum for the following:

- references to parents as sources of information and/or models of sexuality
- obtaining parental consent for children's participation
- pre-service meetings with parents to explain the purpose of the programme
- inclusion of parents in the design or pilot testing of programmes

- active involvement by parents in components of the programme
- Providing sexuality education to parents who serve as co-teachers in the programme.

Dilworth's study indicated that only one programme acknowledged that parents do influence adolescents' level of sexual knowledge as well as the development of beliefs and attitudes that guide sexual behaviour. All 8 programmes required some type of parental consent or notification to participate. Five programmes required the completion of parent-child homework, and only two programmes provide educational sessions for parents that go beyond simply informing them about the inclusion of their children in the programme and the content. The research also found that none of the programmes provided comprehensive sex education to the parents to enable them to serve as co-teachers to their children.

Walker and Milton (2006) suggested that roles of parents could range from parents involved through participation in the development of the school's sexuality education programme and policy to parents' involvement around learning activities of completing joint homework sessions with their children. A respondent in the research study made the following remarks: "It needs to be a partnership. The authors advised that Parents need to be aware of what the syllabus says, what is in the document and the reason to teach it to support hopefully what they are teaching at home" (Walker and Milton.2006). Parents play a vital role in socializing and passing down social and cultural norms and practices to young people (ministry of Education, 2009:7). If there is no harmony between what learners are taught at school and home, the less likely it will be for learners to internalize what they learn at school about HIV/AIDS. It will be ideal if parents were involved and become co-teachers to enforce what is taught to their children (Ministry of Education, 2009:7).

UNESCO (2008:24) suggested that one way to resolve this problem at school level and help to implement comprehensive HIV education, is for the school to conduct orientation sessions on life skills and HIV & AIDS for parents, as well as hold briefing sessions

on HIV and AIDS for PTAs and School Governing Boards (SGBs) on a routine basis. For example, Dyson (2010) cited a report of a three-year sexuality education intervention in 15 schools in South Australia that found that many parents were concerned about the content prior to the introduction of the programme. Parents' concerns were alleviated by attendance at public information sessions that were provided in all schools, which appeared to increase parents' understanding and acceptance of the programme.

In agreement with UNESCO, the National Institute for Education Development of Namibia (NIED) stated that is vital that parents, guardians and care-givers are involved in sexual health education so parents can support programmes in school (NIED, 2006:12). Nied further explained that involving parents will encourage them to support the work of the school in matters of sexual health, and will provide valuable information for them as well. NIED gives the following tips on how to involve parents:

- Organise a session to educate parents about sexual health.
- Hold a meeting to inform parents about what their children will be learning and explain that sexual health education in Namibian schools is called for by the Government's *National Policy on HIV/AIDS for the Education Sector* and the curriculum. In cases of learners who stay in the hostel, teachersare encouraged to send information home with children during the school holidays
- Assign homework in the form of interviews, brainstormers and comparing-opinion activities related to sexual health that children are encouraged to share with their parents.

2.2.7 The challenge to parents as teachers

While students acknowledge parents and teachers as the main sources of reproductive health information, they criticized them for not providing adequately detailed information and leaving students 'to fend for themselves'. Parents admitted that they found it

difficult to pass on sexuality and reproductive health information to their children reasoning that it is difficult because their parents did not do it (Carr-Hill, 2002:116).

Dilworth (2009) explained that one of the challenging factors parents face in educating their young is that they themselves lack knowledge of when and how to initiate discussions on sexuality with their children. The author explained that often the timing of the talk on sexual matters with their children is often best described as "too little, too late". Parents report feeling inadequately prepared to discuss sexuality in general and many hold the perception that because there is no evidence to suggest a teenager is sexually active, he or she does not need the information. The author concluded that as a result of this inadequacy, many parents appeared unwilling or incapable of taking on the task of being primary teachers of their adolescent children.

Parents need assistance on how to be more open and how to communicate about sexuality and HIV/AIDS. One study found that parents anticipated feeling uncomfortable discussing abortion, masturbation, and homosexuality and were less likely to talk to their children about these topics (Dilworth, 2009). In fact, Dilworth (2009) reported that although 47% of the 1,037 teenagers surveyed indicated that parents were most influential on their sexual decision-making, only 34% of parents believed that they were the most influential source of information. According to Dyson (2010), a study conducted by Lewis in Scotland with parents and their children to better understand the contexts of these interactions, found that in relation to the timing of the sex talk, families found it difficult to identify the right time, and had the idea that sexual matters would just 'come up' naturally. Dyson (2010) also noted that it appears as if some parents feel compelled to discuss sexuality with their children when the parent or child is not ready and this is often because of the sexualized content in the media and peer influence.

Dilworth (2009) noted that several factors are correlated with parents' level of comfort in sexuality communication with their children: Research suggests that a parent's years of education and occupation are associated with the probability of engaging in conversation

about sexuality with children, parents from managerial and professional backgrounds are more likely to engage in conversation about sexuality with their children compared to parents with skilled or unskilled jobs. Another study also indicated differences between urban and rural dwellers. The study in India by Mahajan and Sharma (2005) found that almost all the urban parents in the study were in favour of providing sexuality health education to their adolescent girls. 65% of the urban parents believe in verbal communication method while imparting sex knowledge, while 35% prefer to use different methods such as TV, magazines etc, for providing the related information. The majority of the urban sample considered all the components of sexual health education to be important but the rural sample made exemptions with regard to providing information on HIV/AIDS and Reproductive system and organs; 100% of the rural mothers and 10% of the urban mothers feel hesitant towards providing sex knowledge to their children. These parents explained that their girl children can get information through their friends and elder sisters.

Parents are also often not aware of the influence of many other sources of information on sexuality such as the mass media and peers, and sometimes these sources of information give conflicting, incorrect and inappropriate information. Dilworth (2009) hence advice that the school should guide parents in communicating to their children and help ensure that the information shared at school will be the same as information shared at home in order to reduce confusion on sexual matters. The author added that experts echo the sentiment that schools invite parents to attend the same programme intended for their children, provide information and collaborate with parents in the design, implementation and review of the programmes. Schools are encouraged to view parents as partners rather than detractors who are against the school teaching their children about sexuality.

2.2.8 The challenge of teachers as teachers of sexual and reproductive health

Kelly (2002) believes that teachers tasked with HIV/AIDS education have what he calls 'anxiety concerns' and 'resistance concerns'. The author defined 'anxiety concerns' as fears teachers have of violating taboos, giving offence to parents, being accused of encouraging promiscuity and loose moral practices in learners. 'Resistance concerns' refers to doubts teachers have whether sex education, the formation of appropriate sexual attitudes, and the transmission of very specific behavioural guidelines is legitimately the role of the school.

A study by Ogunjimi (2006) in Cross River State, Nigeria, found that the majority of parents and students who participated in the study were of the opinion that the teachers in schools are not trained or equipped to teach sexual health education. One of the commonalities between teachers and parents that are often ignored in debates of sex education is that most teachers are also parents. It must then be noted that teachers are members of society.

Despite the noted problems, parents suggested that teachers should take the lead in providing reproductive health education because they were more knowledgeable to provide correct information (Carr-Hill, 2002:116). I,n agreement, Avert (2010) explained that schools are the ideal place for learners to learn about HIV/AIDS because of its capacity to disseminate the correct information and its ability to shape the attitudes, opinions and behaviours of young people.

2.2.9 Content and age of teaching sexual health education

Whilst it is important to acknowledge the 'accepted' curriculum content that is actually covered in respect to the potentially broad scope of sexuality education, one Australian study found that even though no primary school formally addressed sexual orientation or identity in their sexuality education programme, teachers still report of learners' frequent questions on this issue (Walker and Milton, 2006).

Experts in childrearing generally agree that sexuality education should start early, be age-appropriate, and be dealt with in an open way (Dyson, 2010). Experts in the field of sexuality education are of the opinion that HIV/AIDS education or as incorporated in Life Skills programmes should start early, because there is a growing trend among young people to experiment with sex early. Many young people are initiated into sex early, either voluntarily or forcibly. At present, Window of Hope in Namibia starts in the fourth year of primary school but even this has proven to be problematic. Currently Namibia enrolls learners in HIV/AIDS education according to grade. The practice of enrolling learners according to grade has been criticized (Kelly, 2002; UNESCO, 2004). In many countries it can be expected that at least half of those in primary school will have repeated at least one year, thereby extending the within-class age range. Children sometimes start school when they are older, repeat classes or do not attend school regularly, and do not have a linear schooling. This means that a class may contain pupils ranging from the sexually naive and innocent to the knowledgeable and experienced.

Asked about what the content of sexuality and reproductive health education should include, most parents (65%) in the United States of America believe that sexual health education should encourage young people to delay sexual activity but also encourage learners to use birth control and practice safe sex once they become or choose to be sexually active (Dailard, 2001). Teachers were also asked the same question. The author explained that although more than nine in ten teachers believed that learners should be

taught about contraception and half of these teachers believe that contraception should be taught in grade seven or earlier, one in four are instructed not to teach the topic. The majority of teachers in the study also believe that learners should be informed about where to get birth control something that is presently not agreed upon.

Dailard (2001) conclude that there is a growing body of research indicating that while politicians want to promote abstinence-only education, teachers, parents and learners want a far more comprehensive sexual health education that informs young people on how to avoid unintended pregnancy and sexually transmitted diseases.

In Namibia, The National Institute for Education Development (NIED) (2006:6) does not go into details about what sexuality and reproductive health education should comprise of but explained that learners need to have information about sexual health, HIV and AIDS preseented to them in a manner that is appropriate to their age and that will build a strong foundation for them to lead healthy lives in the future.

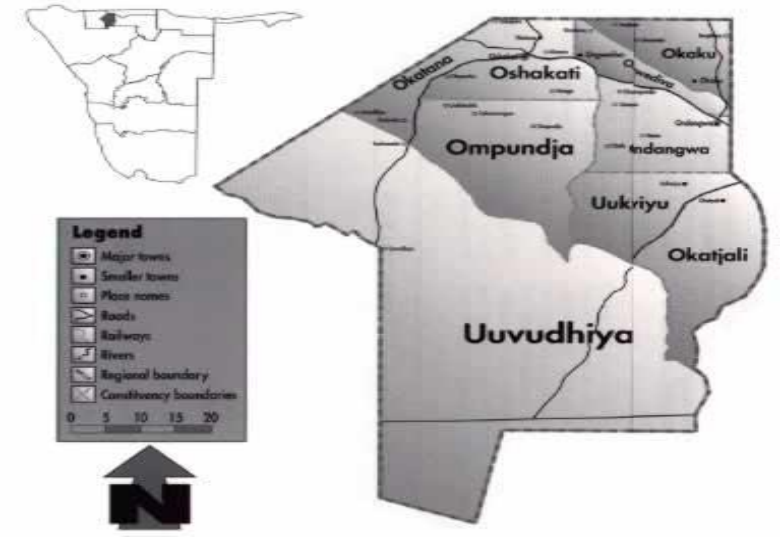
2.3 Namibia: situation analysis

2.3.1 Overview of Namibia and Oshana region

Namibia, officially, the Republic of Namibia is a country in Southern Africa, bordering South Africa to the south, Angola to the north, Botswana to the east and the Atlantic Ocean to the west (CIA, 2010). Namibia is the second least densely populated country in the world, after Mongolia (Wikipedia, 2010). According to the Ministry of Health and Social Services (2008) the 2001 population Census revealed that Namibia is estimated to have a population of about 2 million inhabitants with a growth rate of 2.6 % per year. Eighty-five per cent (85%) of its inhabitants live in rural and semi-urban areas and the country is classified as a middle income but also has one of the largest differentials between rich and poor in the world (CIA, 2010).

Namibia's economy is closely tied to the South African economy and used its currency, the Rand, until 1993 (CIA, 2010). The country now has its own currency, the Namibian dollar (or N$). The economy is heavily dependent on the mining industry which accounted for 12.4% of Gross Domestic Product (GDP) in 2007 (Wikipedia, 2010). Half of the population depends on subsistence agriculture for its livelihood (Bollinger & Stover 1999:90).

Namibia is divided into 13 regions. Oshana is one of the regions and is situated in the far northern part of the country. Oshana region is situated in the far northern part of the country bordering omusati, Oshikoto, ohangwena and Kunene Regions. It is peri- urban with two modern towns, Ondangwa and Oshakati, and has a population of 161,977 according to the 2001 census.



According to Wikipedia (2010) Oshana Region forms the second largest population concentration in Namibia after Windhoek. The population of Oshana Region is made up of mostly rural dwellers or communal farmers. The region has a high unemployment rate and as a result of many of the trained and educated youth leaving the region for better employment opportunities elsewhere in the country (Parliament of Namibia, 2010)..

Figure 2.1: Map of Namibia, with Oshana highlighted, courtesy of the Association of Regional Councils (2010, http://www.arc.org.na).

2.3.2 Oshana education directorate in the Republic of Namibia

The ministry of Education in the Republic of Namibia was established shortly after independence taking over the South West Africa Education Administration. The Ministry states its mission as follows: "We in partnership with our stakeholders are committed to providing all Namibian residents with equitable access to quality education programmes to develop the abilities of individuals to acquire the knowledge, understanding, skills, values and attitudes required throughout their lifetimes".

The Ministry of Education is divided into 13 directorates in line with the demarcation of regions. The Oshana Education Directorate office is located in Oshakati. There are 137 schools with 52318 learners, 1959 teachers and 358 non-teaching staff members (Human Resource Division, 2010). The schools are divided into 5 circuits each headed by an Inspector of Education.

2.3.3 HIV and AIDS in Namibia

The first HIV infection was reported in Namibia in 1986 (Ministry of Health and Social Services, 2008). In 1992 the prevalence rate was only 4.2% (LeBeau-Spencer, 2008). According to the 2008 HIV Sentinel Surveillance the overall HIV prevalence in Namibia was determined to have increased to 17.8 % with no difference between rural (17.8) and urban (17.8) areas (Ministry of Health and Social Services, 2008). This meant that 17.8% of the population (or 204 000 people) in Namibia were infected with HIV.

HIV prevalence is disproportionally distributed in Namibia. The Ministry of Health and Social Services (2008) noted that the Epidemic is centered on three geographic pockets where mobile populations are most likely to take temporal residence such as mining areas, commercial centre, tourist areas, and border entry and exit points. The Ministry of Health and Social Services (2008) also noted that HIV seems to be high in these areas: the southern part (Karasburg, Luderitz which is a fishing area), the northern part (Okahao, Tsandi, Oshakati, Oshikuku, Outapi, Onandjokwe, Engela which are near the border) and north western part of the country (Rundu, Nyangana and Katima Mulilo which are also near the borders).

2.3.4 Impact of HIV/AIDS

According to Phororo (2000:8) impacts of HIV/AIDS in Namibia have been felt at all levels – ministerial, private sector and non-profit making organisations. According to the IFC (2002) and Bollinger and Stover (1999) a study done in Namibia by UNAIDS and WHO in 1996 indicated that the total morbidity and mortality costs related to AIDS was about N$1billion, which was almost 8% of GDP and an estimated 20% of government expenditure. This study projected that the direct and indirect costs of AIDS in Namibia between 1996 and 2000 would be N$6 billion.

IFC stated that analysis by UNAIDS and WHO estimated that HIV/AIDS related expenditures would consume more than 20% of Namibia's annual budget leaving very little finance for other health related expenditures. In the absence of effective mitigation efforts, the IFC (2002) reported that the same study projected that the average direct medical costs of each AIDS patient would be N$3,600, the average financial support from the government to patients and their families would be N$2,429, and the average indirect cost which includes lost productivity would be N$125,318 for each AIDS patient. The total cost savings for the country for any HIV infection, including productivity gains, for any HIV infection prevented is N$131, 338 per patient (IFC, 2002).

It was estimated that the total costs of AIDS orphans to Namibia had reached almost N$51 million by the year 2000 (IFC, 2002). The Ministry of Education (2008:1) states that according to the 2001 census, there was an estimated 97000 orphaned children under the age of 15 years.

USAID (2007) reported that 62% of the population is under the age of 24 years of age. A joint study conducted by the Ministry of Education and UNICEF explained that this is because Namibia is undergoing a demographic transition, where the biggest proportion of the population is currently young people (UNICEF, 2008:9). The report further explained that this demographic transition presents both health and development opportunities as well as risks to the youth. According to the Ministry of Education (2008) people are now starting to have sex (sexual debut) at a very young age. In 2006, the Demographic Health Survey had indicated that by the age of 21 half of the population (50%) of young women in Namibia will have at least one child (Ministry of Health and Social Services, 2009).

According to UNAIDS (2003) it is estimated that life expectancy in Namibia has decreased by at least 10 years 1991. The current life expectancy is 42 years old. In 2000, AIDS was Namibia's leading cause of deaths and accounted for 28 percent of all deaths (IFC, 2002). 5,100 deaths in 2007 are due to AIDS related illnesses (Ministry of Health and Social Service, 2008:15). The Ministry reported that this has put an increasing demand on health service delivery.

2.3.5 Contextual factors driving the epidemic in Namibia

Studies have indicated that the spread of HIV/AIDS in Africa has been to a large extend aided by cultural practices of pre-marital sex, multiple sexual partnership, and a tendency for unprotected sex (Velayati, Bakayev, Bahadori, Tabatabaei, Alaei, Farahbood & Masjedi, 2007).

According to Nguyen, Klot, Philips and Pirkle (2003:4), in 1982 the World Conference on Cultural Policies as well as the UNESCO Universal Declaration on Cultural Diversity in 2001 defined culture as a 'set of distinctive spiritual, material, intellectual and emotional features of a society or social groups, which encompasses, in addition to arts and literature, lifestyle, ways of living together, value systems, traditions and beliefs". Cultural beliefs and practices have a clear influence on people's sexual behaviour and hence is a determinant of how vulnerable a certain group of people are to HIV infection. Cultural norms and beliefs that disregard the dangers posed by HIV infection make it difficult for people to make healthy sexual choices even when they know the facts about HIV/AIDS.

This cultural beliefs and practices promote the spread of the virus by favouring culture over health. Tobias revealed the following culture-specific themes: "cultural mores influence sexual behaviour; culturally sanctioned gender-based power differentials exist; religious & cultural taboos influence HIV/AIDS beliefs & behaviours; myths exist concerning condoms; intrapersonal/religious conflicts influence condom use; conflict exists between traditional & government health leaders; limited resources are available for condom purchase; & limited support systems are available for women" (Nguyeni et al, undated).

Literature has revealed that there are many norms and cultural practices that are contributing to the spread of HIV in Namibia and many people find it difficult to make healthy sexual decisions in the context of the prevailing cultural norms and practices. In 2003, the Ministry of Health and social services published a report titled 'HIV/AIDs in Namibia: Behavioral and Contextual Factors Driving the Epidemic'. According to the Ministry

of Health and Social Services (2009) the social and cultural factors causing the spread of HIV/AIDS are multiple and concurrent partnership, low and inconsistent condom use, inter-generational sex, transactional sex mostly due to poverty, HIV risk perceptions, low practice of male circumcision, alcohol abuse, mobility and migration patterns and norms regarding sexual partnerships. In addition, gender inequality is also cited as another factor that affects people's ability to make healthy choices about sexual behaviour (UNDP, 2009). The Ministry of Health and Social Services (2009:VIII) remarked that "When these inter-generational and multiple or concurrent partnerships occur in a context, such as Namibia, where condom use is inconsistent, circumcision rare, STIs under-diagnosed and under-treated, and approximately 1 in 7 adults is already infected with HIV, the results are a devastating epidemic". The following is an explanation of the contextual factors that drive the epidemic in Namibia:

2.3.5.1 Multiple and concurrent partnership

According to Velayati et al (2007) extensive spread of the virus in southern Africa has been facilitated by a practice of having multiple partners. The Ministry of Health and Social Services (2009) explained that having a lot of sexual partners and having concurrent partnerships or relationships that are overlapping in time seems to be a common practice in Namibia. The Ministry explained that this widely practiced type of relationship is risky because of the potential to infect many people at the same time thus accelerating the rate of infection in the general population. The Ministry further explained that "the mean number of total sexual partners for Namibian youths (aged 15-24) is 4.6 for young men and two for young women, with the mean number of sexual partners increasing with age. While male youth aged 15-19 have an average of 3.2 sexual partners, male youth aged 20-24 have an average of 5.6.".

2.3.5.2 Intergenerational and transactional sex

The Ministry of Health and Social Services (2009) reported that intergenerational sex or sex between people with 10 years or more age difference is common in Namibia. The ministry reported that a United Nations Children's Fund (UNICEF) study found that 1 in 4 adolescents 10 to 14 years in three towns in Namibia, namely, Okavango, Omaheke and Ohangwena reported that their first sexual encounter was with a person 10 or more years older. Three of the reasons given to explain the increase of intergeneration sex are that usually the young person is forced into the sexual act, and older people may be looking for an uninfected partner among the young generation. The Ministry explained that because HIV prevalence is highest amongst the age of 35 to 45, the risk of infection with a partner in this age category is high and hence the practice of looking for a younger sexual partner. Another reason given is that the young person may be looking for financial gain by engaging in sexual relationships with older people (Ministry of Health and Social Services, 2009). The Ministry of Health and Social Services (2009) has cited various studies that indicated that sex in exchange for food, sex, transportation, drinks, gifts, etc is commonly practiced in Namibia. These relationships are said to be either casual or long term. The ministry further explained that this may be due to widespread poverty and unequal distribution of wealth which makes 'sugar mummies' and 'sugar daddies' highly desirable to young men and women.

The practice of young people engaging in sexual intercourse with people from an older age group (intergeneration) in exchange for material gifts and favours (transactional) is known as sugar daddy and sugar mummy phenomenon. These coupled with the 'code of silence' on any sex related topics among the older generation makes it difficult for young people to engage in conversation with their parents and teachers a

2.3.5.3 HIV risk perceptions

Various researches conducted had demonstrated that even though people are aware of the existence of HIV/AIDS and know the modes of transmission, there will still be people who do not believe they can be HIV infected in spite of their high risk sexual behaviour (Ministry of Health and Social Services, 2009).

According to a study (Schwarz in 2003) Namibian Youths can be divided into two groups depending on perceived vulnerability to HIV infection. Those that do not perceive themselves at risk and those who hold a fatalist view of HIV. two-thirds of Namibian Youths believe they are not at risk of contracting HIV because they have adopted three of the safer sex practices; condom use, being faithful to one partner and abstinence. Schwarz explained that the other group holds a helpless view of their own vulnerability as indicated in a study done by UNICEF in 2002. These group of youth felt that they have little choice over whether they contract HIV or not because they have no control over their partners' fidelity, and also because of the abuse of alcohol which results in most cases in unsafe sex. Girls in this group are said to have indicated that they felt particularly vulnerable because they lack the ability to negotiate condom use.

"It is not so much denial of risk as it is resignation. There is a lingering sense among these individuals that there is nothing that can be done to prevent infection...some Namibians do not believe in the efficacy of condoms" (Ministry of Health and Social Services, 2009:29).

2.3.5.4 Low and inconsistent condom use

If a condom is perceived as anti-culture, anti-religion or condom use is perceived as a sign of weakness or promiscuity, this may influence people not to make use condoms (UNAIDS 2000).

Studies have indicated that marriage increases the frequency of sexual intercourse but decreases the use of condoms. Brown et al. (2001) explained that there are many societal norms and cultural beliefs that may influence an individual to refuse to use a condom. Firstly, there is a wide spread view among certain groups of people that condom use signifies infidelity and lack of trust for the other partner, hence no condom use is seen as a sign of commitment (PlusNews, 2010). Another reason why some people may refuse to use a condom is that it is considered a sign of character weakness and that it takes out some pleasure from sex (UNAIDS 2000). All this reasons may motivate a person to refuse to use a condom and thus increase vulnerability to HIV infection. In a society where multiple and concurrent partnership is practiced, refusal to use a condom is accelerating the rate of infection.

Studies have also confirmed that people in steady relationships do not consistently use condoms (UNAIDS, 2004). UNAIDS explained that low condom use in steady relationships is attributed to issues of trust, power inequalities in relationships and the need to have children. UNAIDS added that some individuals only use condoms when engaged in casual or commercial sex and there is a misperception that protection against sexually transmitted infections or HIV is not needed with regular sex partners. UNAIDS (2004)further explained that sometimes people do not carry condoms for fear of other people thinking that they engage in casual sex which can lead to stigmatization.

The Ministry of Health and Social Services (2009) reported that despite efforts to increase condom usage, many Namibians still report low and inconsistent use of condoms. The ministry stated that findings from studies indicated that the decision to use a condom depended not on having sex but the type of partnership; individuals who are married or cohabitating reported lower condom use.

2.3.5.5 Male circumcision

The Ministry of Health and Social Services (2009) reported that studies have indicated that regions (Omaheke, Kunene and Otjozondjupa) where circumcision is a cultural practice have low HIV prevalence compared to the northern regions where circumcision is not widely practiced. Low male circumcision is not driving the epidemic but when it is combined with low and inconsistent condom use and multiple and concurrent partnership, it is a contributor to the high HIV infection rate.

2.3.5.6 Alcohol abuse

The Ministry of Health and Social Services (2009) reports that studies have shown a correlation between alcohol abuse, sexually transmitted infections and multiple and concurrent partnership. The ministry reported that a study has indicated that 35% of Namibians consume alcohol. A study published by UNICEF in November 2006, revealed that more than 60% of 10-14 year old children were exposed to alcohol abuse and drunken behaviour displayed by adults (UNICEF, 2006). The study also indicated that one in three children interviewed were exposed to people using illegal drugs. The Ministry of Health and Social Services (2009:31) concludes that "alcohol may encourage multiple or concurrent partnership by clouding judgment, removing inhibitions, and reducing concerns about HIV infection".

2.3.5.7 Mobility and migration pattern

Increased mobility of people in southern Africa has contributed to the rapid rise of HIV/AIDS in the general population (Velayati et al, 2007). Population movement has been a driver of the epidemic for years (Ministry of Health and Social Services, 2009).

Migration greatly increases people's vulnerability to HIV infection, shapes the geographic distribution of the epidemic and increases the pace at which HIV spreads. Multi-

ple and concurrent partnership are fundamentally linked to high levels of population mobility (Ministry of Health and Social Services, 2009). According to the International Organization for Migration (LeBeau-Spencer, 2008) prior to independence of the Republic of Namibia in 1990, HIV infection rates were relatively low and this was mainly because of the internal travel restrictions imposed by the apartheid government of South Africa on black Africans. The LeBeau-Spencer explained that with independence these restrictions were removed. In 1994, four years after independence, the prevalence rate was 19.7% while in 1992 it was only 4.2%.

According to the Ministry the 2006 Namibia Demographics and Health Survey found that individuals who travelled away from home in the previous 12 months were more likely to report multiple partnerships during those 12 months than individual who did not travel (Ministry of Health and Social Services, 2008). It was thus concluded that population movement increases opportunities to engage in multiple and concurrent partnership. The study rationalized that "a combination of being away from home with greater access to new sexual partners encourages many migrants to take up relationships on the road or at their destination." Evidence has shown that mobile populations may bring HIV to areas of low prevalence and the reverse is also true: mobile populations are also vulnerable to being infected during transit and after arriving at their destination (LeBeau-Spencer, 2008). The ministry of Health and Social Services (2008) further noted that migrant labourers find it difficult to maintain a regular relationship because of frequent travelling and hence, they may opt to befriend sex workers or have several women in the places they travel to.

2.3.5.8 Norms regarding sexual partnership

The Ministry of Health and Social Services (2009) noted that there has been a notable decline of people entering into marriage over the past 20 years. The Ministry explains that cohabitating and adopting sex as a currency for acquiring goods and services has been on the increase. The decline in the number of people entering in marriage is easily notable because Namibia has a low rate of marriage compared to the rest of Africa, explains the ministry. The ministry also explained that low levels of marriage have implications for HIV because they are associated with multiple, concurrent or sequential partnership.

Sexual debut in Namibia occur at a very young age (IRINnews, 2010). This statement was supported in the 2006 Demographic Health Survey which indicated that half of the populations (50%) of young women in Namibia have at least one child by the age of 21 (Ministry of Health and Social Services, 2009). A study published by UNICEF in 2006 concluded that exposure of Namibian children to anti-social behaviour is disturbingly high and warrants interventions (UNICEF, 2006). Reported early sexual debut in Namibia is especially of great concern because of the practice of multiple sexual partnerships, low condom use, intergeneration sex, and sex in exchange for material and financial support, which in many cases translate into HIV infection (Ministry of Health and Social Services, 2009).

Research has linked continued involvement in risky sexual behaviour among young despite warnings of HIV/AIDS to deeply entrenched socio-cultural dynamics that prescribe the how and what of sexual and intimate relationships in any given society (Baptiste *et al*., 2009). The authors argued that adolescents follow behaviours modeled in adult relationships, behaviours of peers and the media's portrayal of sexual norms.

2.3.5.9 Gender inequality

The impact of HIV/AIDS on women in developing countries is particularly intensified because they are often economically, culturally and socially disadvantaged as they are seen as subordinates to men, which makes communication of sexual matters between men and women difficult (Pereira, 2004).

According to Haikuti et al (2003) there is a belief that a proper women must not 'talk too much'. It is believed that a good woman is one that is shy and does not question her partner's decisions irrespective of whether it is right or wrong. Haikuti el al. also explained that cultural beliefs that a woman must not ask her husband to use a condom and that doing so is a sign of accusing the partner of being unfaithful or a confession of infidelity further forces women not to demand healthier sexual relationships in the era of HIV/AIDS. On the other hand, there is a an expectation for men to know and be more experienced with sex and these has forced them to experiment with sex at a young age to prove their manhood but with little or no knowledge of safe sex. This puts them at risk of infection because these expectations prevent them from seeking information on issues pertaining to sex and admitting that that they lack information and knowledge about sex or safe sex.

Another demonstration of how gender inequality contributes to the spread of HIV is domestic violence. According to Haikuti et al (2003) domestic violence against women is one manifestation of gender inequality in Namibia as male partners enforce their will, including sexual desire, on women. The authors cited that 1 in 3 women around the world has been physically assaulted and coerced into sex. The authors cited that in Namibia, 86% of domestic violence victims are female compared to 14% male, and 93% of domestic violence are committed by men. Haikuti et al explains that the correlation between gender inequality and HIV/AIDS can best be described as: lack of education which increases poverty forces women to remain in high risk sexual relationships which are mostly violent which increases vulnerability to HIV infection.

According to Gupta (2000) the links between HIV/AIDS and gender based violence are becoming clear as indicated by studies conducted in the United States of America and Southern Africa. Findings indicated an increased risk of HIV/AIDS among female victims of gender based violence. In addition, the studies indicated that being HIV positive is a risk factor for violence against women. Dunkle, Jewkes, Brown, Gray, McIntyre, and Harlow (2004) explained that often when women reveal they are HIV positive to their partners, they face the possibilities of being abandoned and or violence due to their HIV status. Gupta (2000) also explained that the culture of silence on sex helps fuel the epidemic and puts women at risk of HIV infection. The culture of silence on sex dictates that a 'good' woman is one who is ignorant about sex and passive in sexual interactions. This makes it difficult for women to negotiate safer sex. Because of the culture of silence (Gupta, 2000) women find it extremely difficult to seek sexual health information and access treatment and care.

2.4 HIV/AIDS Education in Namibia

The expansion and improvement of HIV/AIDS education around the world is critical to preventing the spread of HIV as effective education on HIV can help prevent new infections and reduce stigmatization of those that are already infected (AVERT 2010).

The National Institute for Education Development (NIED) gave the following reasons why teachersin Namibia should teach learners about sexual helath, HIV and AIDS (NIED, 2006:4):

- Teachershave a unique opportunity to influence children's ideas about sex and relationships, even before they become sexually active.
- Teachers are well educated and therefore can understand the facts about HIV/AIDS and can help share correct information about the disease and its effects

- Because teachers provide emotionnal support for learners, they can help them cope with the impact of HIV/AIDS on their lives
- Teacherscan set an example of responsible sexual behaviour for learners

Although most people have and will have sex during their life time, not many people are willing or comfortable hearing or talking openly about sex. In fact most people have been taught by their culture that it is immoral and dirty to utter words such as 'penis', 'vagina' or sex (NIED, 2006:5). Some people go as far as say that these words sound better in English than in the local languages. Nied argues that culture cannot be an excuse for people not to discuss HIV/AIDS because cultural practices that shun discussions on HIV and AIDS emerged when HIV and AIDS did not exist. "Our whole Namibian way of life is now being directly challenged by HIV and AIDS, and we have to adapt the ways that we communicate and behave so that we can talk about sex and truly fight this terrible disease" (NIED, 2006:5). The Institution warns that if culture continues to be an excuse why HIV and AIDS can not be discussed openy, the disease will not only destroy society but also its culture.

In an effort to combat the spread of HIV infection and promote a culture of support and care of those already infected and affected, the government of Namibia has instituted HIV/AIDS education as part of the school curriculum (Ministry of Education, 2005). The Ministry explained that apart from mainstreaming HIV education across the curriculum (inclusion of HIV information in all subjects), the Ministry of Education is also implementing HIV/AIDS education programmes in primary and secondary schools. The secondary school programme is called 'My Future is My Choice' and the primary school programme is called 'Window of Hope'. In addition, the Life Skills subject which contains many topics on HIV is taught from grade 5 to 12.

A study conducted in 42 senior secondary schools in Namibia by Campbell and Lubben (2003) found that most schools were not implementing HIV/AIDS activities and only 7

schools had comprehensive health promoting environments. it has also been noted that despite numerous successes achieved by the education system, a lot of challenges such as the continuing high rate of learner-pregnancy and alcohol abuse among young people have not been minimized (Baker,2010).

2.4.1 'My Future is My Choice' programme

'My Future is My Choice is a national, extra-curriculum peer HIV/AIDS education programme (Ministry of Education, 2009). The programme was first piloted in 1996 and augmented in 1998. In 2003, it became an official extra-curricular life skills programme of the Ministry of Education at secondary and combined schools. It is an official life skills programme with the overall aim of protecting young people from HIV infection, sexually transmitted diseases and unwanted pregnancies.

The Ministry explained that this is a peer education programme being implemented in all secondary (grade 8-12) schools and "... the goal is to promote the development of knowledge, attitudes, beliefs and skills that will enable young people to engage in healthy behaviour, reduce high risk sexual behaviour and improve youth reproductive and sexual health outcomes" (Ministry of Education, 2009:18). The programme is facilitated by same and near-age peers from similar backgrounds (Ministry of Education, 2009). The Ministry explained that this practice is based on the premises that young people are more likely to listen to their peers and engage in conversations about sexuality and reproductive health than to adults. The strategy of using peer educators has proved useful in the prevention and education of young people in HIV/AIDS matters. The ministry further explains that the programme inform young people of modes of HIV transmission, prevention strategies, voluntary testing and counseling, treatment and care services as well as other prevailing issues of HIV/AIDS. The programme enrolls a maximum of 66 learners per school. Various evaluation of the programme has been conducted and

findings have supported the continued implementation of the programme (Ministry of Education, 2009).

The programme is designed for people between the ages of 15-18 years (in-school) and not older than 25 years old for out of school youths. The responsibility of implementation lies with the sub-division Regional AIDS Committees for Education (RACE), which is tasked with routine oversight and periodic evaluation of the programme. Each region also has a MFMC Coordinator, a youth volunteer who reports directly to the RACE Coordinator and is responsible for routine administration of the programme and necessary documentation (i.e. course schedule, sign-up list, attendance records, evaluation of facilitators' forms, and course completion forms), the management and distribution of training materials, as well as liaising with principals and contact teachers at participating schools. The Responsibilities of the Principal is to provide leadership for the overall implementation of the programme and make sure that the MFMC programme and other HIV activities are part of the School year plan. The responsibilities of the contact teacher are to coordinate the process of signing up of MFMC participants at the school and to monitor the day-to-day implementation of the programme as well as monitor the performance of the facilitator (Ministry of Education, 2006).

The overall aim is to provide young people with the skills they need to enable them to can make informed decisions about their sexual health. The following is a table outlining topics covered in each of the 10 sessions for the education of learners and out of school youths (Ministry of Education, 2005):

Table 2.2: Content of My Future is My Choice

Session 1: Getting started -Getting to know each other	*Session 6: Choices and Consequences* -What is decision-making

-Ground rules -Physical and emotional development during adolescent	-influences on decision-making -Peer pressure in decision-making
Session 2: Reproductive health -Reproductive health -Teen pregnancy -Contraceptive	*Session 7: Communication* -Communication skills (verbal/body language, listening skills) -Assertiveness -Saying NO -Communicating with parents
Session 3: HIV/AIDS and other STIs -HIV/STD transmission (including mother-to child) -Safe and unsafe behavior -Myths on HIV/AIDS	*Session 8: Values and relationships* -Values -Values in relationships -Gender roles in relationships -Characteristics of good and bad
Session 4: Reducing the risk -Self-assessment on risk behavior -ABC and its problems -Delay/setting limits in showing physical affection -Condom practice	*Session 9: Alcohol and Drugs* -Health risks -Social consequences of substance abuse -Assessing risk behaviours regarding alcohol and drugs

-Negotiating condom use	
Session 5: Facing HIV/AIDS -What HIV does in the body -Stigma and discrimination -HIV testing and treatment	*Session 10: Our Future* -Review of expectations and objectives -pledges and planning outreach activities and post activities

The 15-16 year olds and the 17-18 year olds are separated into two different groups (Ministry of Education, 2006). The separation allows the facilitators to emphasize different HIV prevention messages because "it is likely that many more of the 17-18 year olds will be sexually active than the 15-16 year olds. Therefore the older group needs more emphasis on safer sex while the 15-16 year old will need more information that will help them delay sex".

The learners sign an attendance register and must complete no less than 9 of ten sessions within the given time frame before they can graduate (Ministry of Education, 2006). The certificates are handed over by the school principal during the graduation ceremony at the assembly or at another school gathering where other learners can also attend. The learners receive certificates of completion of the course and those that attend all ten sessions receive a t-shirt in addition at a graduation ceremony. The MFMC coordinator explained that 80% of the learners graduate. The 20% don't graduate mainly because they do not attend the required number of sessions. The learners are not examined or given any assessment. They just need to attend no less than nine sessions. The graduates are then encouraged to either form or join the school's AIDS Awareness Club and to incorporate HIV/AIDS related messages in other school activities like drama, choir and cultural clubs (Ministry of Education, 2006).

Chandan et al (2008) conducted a study on the effectiveness of My Future is My Choice and concluded that well designed and well implemented MFMC programmes are effective in positively improving knowledge, attitudes, and beliefs of young people with regard to HIV/AIDS. Participants in a study conducted by Chandan et al (2008) reported that MFMC is effective because it allows young people to be involved in a conversation about sex and other perceived taboo subjects without fear of being judged, reprimanded or suspicion of being sexually active. Participants in MFMC showed that they are knowledgeable about HIV/AIDS and methods of prevention. Chandan et al. also reported that most participants showed positive beliefs about sexuality and relationship. The study by Chandan et al. (2008) concluded that like other peer education interventions, there is a limit to what MFMC can achieve and it should be seen as an additional behavioral strategy that cannot be effective on its own but needs to be complimented by other interventions as part of a comprehensive HIV-prevention strategy for young people. My Future is My Choice has been criticized for not reaching all learners and for giving learners a choice to either participate or not since most learners who are more vulnerable may not choose to participate hence remaining vulnerable to HIV infection (Chandan et al., 2008).

2.4.2 Window of Hope

Window of Hope is an extra-curricular official programme of the Ministry of Education of Namibia, led by HIV/AIDS Management Unit (HAMU) and supported by UNICEF Namibia. It is implemented in all primary schools in Namibia and is facilitated by trained teachers and targeted children age 10- 14 (grades 4 to 7). Window of hope was developed to help reduce early transmission of HIV among children of early age. Research conducted found that Namibia is among the top country where HIV transmission prevalence is high and as a result many children are vulnerable hence there is a need for them to be educated at early age about the danger of HIV/AIDS. It was developed based on the experiences of My Future is My Choice.

Window of Hope was officially launched in June 2004 and is implemented from grade 4 to grade 7 in all primary schools and it enrolls a maximum of 30 learners per school per year (Ministry of Education, 2005:5). The aim of the programme is to start early with prevention education and building life skills and resilience in the face of effects of HIV/AIDS among children aged 10-14 years. The Ministry believes that children should be prepared to deal with the challenges posed by HIV/AIDS as well as the impacts of the epidemic on their lives. Another aim is to teach and inculcate healthy sexual behaviours early in children. It is believed that this will empower them to make healthy sexual decisions when they are older. The Ministry of Education explains that the third aim of the workshop is to make the process of learning about HIV fun for children. Often people become negative when they hear the word 'HIV/AIDS'.

The Ministry believes that when HIV/AIDS education is incorporated in child friendly activities such as singing, drama, games, drawing, dancing and storytelling this makes it easier for children to understand and internalize what they are being taught. Topics covered in Window of Hope are identifying and managing emotions, building self-esteem, communication skills, process of decision making, caring for infected and affected family members, learning to say no especially for girl children, coping with stigmatization, resisting peer pressure, protecting oneself against unwanted pregnancy and HIV infection, and promoting of relationships of respect and equality between girls and boys. With this holistic approach to HIV prevention, it is expected that this will help to drastically reduce future infections. A summary of the content is presented in the table below:

Table 2.3: Content of Window of Hope

JUNIOR WINDOW	**SENIOR WINDOW**
BLUE WINDOW: Yes/No Window • Good touch/bad touch (abuse	LIME WINDOW: Window of Love • New relationships

• Learning to say yes/no • Decision-making	• Dealing with sexuality • Gender equality in relationship
RED WINDOW: Power Window • HIV/AIDS: facts and myths • HIV prevention • Guarding against stigma • Caring for sick people	PURPLE WINDOW: I-We Window • Self-esteem/self-awareness • Sense of belonging /community awareness • Nurturing a culture of caring
YELLOW WINDOW: Window of Change • Dealing with physical and emotional changes • Understanding and respecting the opposite sex	ORANGE WINDOW: Double Power Window • Lerning about HIV and AIDS • Rights and responsibilities for protection • Dealing with loss and death
GREEN WINDOW: I-We Window • Self-esteem/self-awareness • Expressing and sharing good & bad feelings • Helping each other to feel better	TURQUOISE WINDOW: Double Yes/Double No Window • Seeing my future • Positive decision-making • Peer group/ peer pressure • Saying no to adults • Negotiation skills

Window of Hope makes learning about HIV fun by incorporating child-appropriate activities. Using activities such as information sharing, games, art, acting, stories, and the objectives of Window of Hope are:

- To equip learners with the self-esteem, knowledge and skills they need to protects themselves against HIV
- To cope in AIDS affected communities
- To develop the necessary life skills to empower them to face challenges
- To prepare them to care for others, to deal with sickness and to overcome the stigmatisation

According to UNICEF (2007) Window of Hope focuses on pre-sexually active children with the aim of molding positive sexual behaviour in children before they are sexually active.

2.4.3 Life skills Subject

Life Skills is defined by Edward de Bono as "those skills needed by an individual to operate effectively in society in an active and constructive way". Another definition is that Life Skills is "personal and Social Skills required for young people to function confidently and competently with themselves, with other people and the wider community" (Carr-Hill, 2002).

The Life Skills subject is offered in schools from grade 5 to 12. The themes covered are career guidance, daily living skills and personal social skills (National Institute for Education Development, 2007:1). Career guidance focuses on study skills, career research, work ethics and employment. Daily living skills focus on health care, family life and finances. Personal social skills focus on self-awareness, relationships and citizenship. The themes are the same for all grades (grade 5 to 12) but the content varies as it becomes more detailed with each progressive grade. HIV is taught under the theme daily living skills.

Life Skills is a school subject that is compulsory for all learners from grade 5 to grade 12. However, there have been reports that the subject is not being taught at most schools as it falls in the low priority list of subjects because it is not examinable (Mufune, 2008). A study by Mufune (2008) recommended for learners to be graded for them to value 'sex education'.

3. Conclusion

Regardless of the ongoing debate, sex education and HIV/AIDS education continue to be taught in schools. However, it has been noted that despite numerous successes achieved by the education system, a lot of challenges such as the continuing high rate of learner-pregnancy and alcohol abuse among young people have not been minimized. Cultural taboos have not been adequately acknowledged in HIV/AIDS Education to enable both adults and children, to appreciate diverse cultural values and identify myths that prevent understanding of HIV/AIDS and most importantly behaviour modification that enhance HIV prevention, care and treatment.

It has also emerged that it is important to consider forging of partnerships between schools and parents that would encourage parental involvement through a range of mechanisms. In order to effectively do this there is a need to create training opportunities for parents to be able to access appropriate resources and develop capacity and confidence to effectively deliver complementary HIV/AIDS education.

In Namibia HIV and AIDS education is offered in government schools in mainly three programmes namely My Future is My Choice, Window of Hope and Life Skills. The aims of the programmes are to create awareness of the pandemic, teach learners how to avoid infection and teach learners how to take care of people living with HIV/AIDS.

CHAPTER 3. RESEARCH METHODOLOGY

3.1 Introduction

This chapter provides an explanation of how the empirical investigation was carried out. The content includes the following topics: research design, population and sample, research tools, data collection, protection of human subjects, limitation of the study and data analysis.

3.2 Research design

The study employed a qualitative research methodology. Christensen et al (2011:506) defined qualitative research as "interpretive research approach relying on multiple types of subjective data and investigation of people in particular situations in their natural environment; the type of research relying on qualitative research data." The use of a qualitative research strategy was believed to be the most appropriate mechanism to ensure understanding of the subjective experiences and attitudes of teachers and parents.

An implementation evaluation research design was chosen for the study in order to investigate the role of parents in HIV/AIDS education in schools in Oshana Directorate of Education, in northern Namibia. This study used evaluation research as the investigation focused implementation process of involving parents in HIV/AIDS education as required by the National Institute for Educational Development (NIED) and specifically by programmes such as Window of Hope and My Future is My Choice. Werner (2010:1) explained that evaluation research refers to research that focuses on determining what is happening in the design, implementation, administration, operation, services and outcome of programmes. This study evaluated the level of involvement of parents in HIV/AIDS education.

Babbie and Mouton (2006:337) explained that evaluation researches are conducted in order to improve and refine a programme as well as to generate knowledge. In the case

of this study, it is hoped that shading light on the level of parental involvement in HIV and AIDS education would help schools to actively improve efforts involve parents and parents will have a better awareness of the roles they can play in complementing efforts by the school to improve HIV/AIDS education in schools.

3.3 Population and sample

According to De Vos (2002:197) a sample is the elements of the population for actual inclusion in the study. The population is the total number of learners and teachers who took part in the either Window of Hope programme, My Future is My Choice programme or taught Life Skills subject as part of the HIV/AIDS education in 2010 at the selected schools In Namibia HIV/AIDS is mainstreamed in academic subjects but this subjects are not considered in this study because there is no evidence (attendance register) to indicate if HIV/AIDS was indeed taught as prescribed by the syllabus along with other subject matters.

The initial plan of selecting a sample was to use random sampling to select parents and learners to ensure equal chance of being included in the study. Unfortunately, the researcher discovered that some of the learners and teachers who were involved in HIV/AIDS education in 2010 had left the school and in many instances the town/village/region. In some cases the schools only had one teacher responsible for HIV/AIDS education. In light of these facts, convenience sampling was used.

Christensen (2011:354) explained that convenience sampling is a non-probability sampling method and makes use of people who are readily available, volunteer, or are easily recruited for inclusion in the sample. Teachers were very instrumental in helping to identify learners who took part in the HIV/AIDS education in 2010 and who were still at the school. Their parents were then selected to be included in the study. This was a necessary step as parents were selected based on their children's involvement in HIV/AIDS education.

In the Namibian education system, schools are divided into phases and distinguished as follows: grades 1-4 (lower primary), grades 5-7 (upper primary), grades 8-10 (junior secondary) and grades 11-12 (senior secondary). Combined schools refer to schools that have two phases, primary and junior secondary grades.

The target population of this study was teachers and parents of learners who took part in HIV/AIDS education at school in 2010 from the 5 circuit (Ompundja, Eheke, Oluno, Onamutai and Oshakati) in the Directorate of Education, Oshana region. Two schools from each circuit participated in the study. Convenience sampling was used to select the schools and learners. The principal helped identify available teachers who took part in the HIV/AIDS education in 2010. In most schools teachers had left the school and as a result only one teacher was interviewed. In total 14 teachers were interviewed from the 10 schools selected.

To determine which 2 schools per circuit will be taking part in the study the researcher chose a lower grade school and an upper grade school that were located within 5 kilometers of the circuit office to allow the researcher easy access. The researcher worked together with the circuit offices to identify these schools. The names were provided, see table below

Table 3: list of schools that involved in the study

Circuit	**Upper grade school within 5km of the circuit office**	**Lower grade school within 5km of the circuit office**
Oshakati Circuit	Mwadina gwa Nembenge Senior Secondary School	Oshakati Primary School
Ompundja Circuit	Ondjora Combined school	Ompundja Junior Primary School

Oluno	Nangolo Senior Secondary School	Oluno Primary School
Onamutai	Onamutai Senior Secondary School	Onamutai Primary School
Eheke	Kapembe Combined Secondary School	Eheke Primary School

3.4 Research tools

Christensen et al (2011:53) explained that one of the components of qualitative research is the use of various methods to collect data. The use of various methods is called triangulation as it provides a better understanding of the phenomenon under study. For this research a questionnaire was used a research instrument to gather data from parents and in-depth interview was used to collect data from teachers.

The questionnaire was translated into Oshiwambo to enable most parents to understand and answer questions appropriately. Questions for the questionnaire as well as questions for the in-depth interviews were translated into the Oshiwambo language by the researcher. Two Oshiwambo language teachers were consulted to validate the accuracy of the translation. An English teacher edited the questionnaire.

Parents therefore had a choice to use the English or Oshiwambo questionnaire. Two parents used the English questionnaire and 18 used the questionnaire in Oshiwambo.

3.4.1 In-depth interview

An interview is a situation where the interviewer asks the interviewee a series of questions (Christensen et. al, 2011:56). It is carried out in a face-to-face situation or over the telephone. For the purpose and practicality of this research the interview of teachers was carried out face-to-face.

According to Boyce and Neale (2006:3) in-depth interviewing is a qualitative research technique that involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, programme or situation. In-depth interviews are appropriate when detailed information about person's thoughts and behaviour are needed. Teachers were interviewed using an interview protocol with semi-structured questions. Interviews were seen as the best tool to gather data from teachers because allowed the interviewer to probe for more detail and to ensure that the informants were interpreting questions the way they were intended to be understood.

An interview protocol was set up. An interview guide or protocol (Boyce and Neale, 2006:5) is a set of rules or instructions that guided the administration and implementation of the interviews to ensure consistency between interviews and thus increase the reliability of the findings. The interview protocols included the following:

- Interviews were set up with respondents. The purpose of the interview, why the respondents were chosen and the expected duration of the interview.
- Informing interviewees that the interview is voluntary and is to be audio taped
- Ensured confidentiality when setting up the interviews and obtaining written consent Informed respondents of the use of a tape recorder.
- Conduct the interview.
- Thanking interviewees in concluding the interview

An interview guide was used. An interview guide is a list of the questions or issues to be explored during the interview. The rule of thumb was that there should be no more than 15 main questions to guide the interview and it included probes where necessary (. The questions were closed ended.

3.4.2 Questionnaire

For the purpose of this study, questionnaires were used as data collection instruments. According to De Vos (2002:172) a questionnaire is set of questions in a form which is completed by respondents in respect of a research project.

The questionnaire contained both closed-ended items (where respondents selected from the responses given by the researcher) and open-ended items (where respondents provided answers in their own words). Questionnaires were handed to the respondents who completed them on their own.

3.5 Data collection

Data was collected during the month of November and December 2011. The researcher was granted written permission by the Permanent Secretary of the Ministry of Education and as advised, contacted the school principals before talking to teachers. Schools were provided with a copy of the letter granting permission. The purpose of the research project, techniques and procedures to be followed were explained to both the school authorities and participants. Participants received an information sheet, which outlined the study, what participation would entail for them, the voluntary nature of participation, how anonymity would be ensured, how the data would be treated and how to contact the Research Director for further queries.

Qualitative data was collected through questionnaires as well as individual in-depth interviews using audiotape recording after permission was granted. Field notes were taken

and were used in conjunction with the audio tapes. Due to the sensitivity of the topic all respondents were informed of the availability of a counselor but none of the respondents used this service. Parents answered the questionnaire at home and it was collected after a day. 30 questionnaires were distributed to parents and 25 were returned, a return rate of 83%. Five were questionnaires were discarded since half of the questions were not completed. The total number of qualified questionnaires was 20.

3.6 Protection of human subjects

Prior to data collection, the researcher asked for written permission from the Ministry of Education as well as contacted the school principals before talking to participants. After the explanation of the research project's objectives, procedures, confidentiality, benefits and possible risks, all participants were requested to give written consent.

It was emphasized that participants could withdraw from the study at any time or refused to answer questions. Participants were also informed and invited to make use of the counselor should they feel negatively affected by the process. None of the participants used this service. Privacy and confidentiality were protected throughout the process. Teachers were instructed not to mention their names as well as the name of their school to ensure that no information could be linked to them or the school. Teachers were interviewed at the school premises using a private office. Parents were also instructed not to write their names or their children's names on the questionnaires.

3.7 Data analysis

Descriptive statistic was used to illustrate the demographic characteristics of the samples. Quotes from respondents are frequently used as it gave credibility to the information. Data is presented in tables, boxes and figures.

Data from in-depth interviews was analyzed using the following process:

- Transcribed data from audiotape
- Analyze data by looking for patterns or themes among the respondents.
- When a variety of themes are identified, they are then grouped together
- Review data to ensure accurate interpretation

For the purpose of this study, qualitative descriptors were mostly used rather than quantified data. This is largely because the sample size is not sufficient for generalization. In-depth interviews are not to be generalized using numbers and percentages as it gives the impression that the results can be projected to a population something that in-depth interviewing cannot do (Boyce & Neale, 2006:8).

3.8 Validity

According to de Vos (2002:166) validity refers to whether a measuring instrument actually measures the concept under study and whether the concept is accurately measured. Simply said, validity asks the question (Baker 1998:109) asks the question "Am I measuring what I think I'm measuring?"

Before commencement of the study, the researcher carried out a pilot study. According to De Vos (2002:211) the pre-testing of a measuring instrument, in this case a questionnaire, consist of trying a small number of persons having the same characteristics similar to those of the target group of respondents. For this research study, the questionnaire was piloted on five parents and terms that were not clear were revised according to their suggestions. The pre-test was done in order to rule out any error before the commencement of the large-scale data collection. A pre-test was carried out on five respondents from the population and it was discovered that there were errors in the questionnaire and these were rectified.

The design of the interview guide was carefully discussed and tested by interviewing three teachers who taught HIV/AIDS education in the past before implementation. To ensure reliability in the quality of data, the researcher used the same interview guide for all the interviews. Using the interview protocol ensured that the researcher gave the same introduction to the respondents.

3.9 Limitation of the study

The researcher discovered shortcomings that threatened to derail the data collection phase. The most serious aspect was illiteracy which was reflected in poorly answered and incomplete answered questionnaires, which were discarded.

3.10 Conclusion

This was a qualitative research employing implementation evaluation research design. This design was chosen for the study in order to investigate the role of parents in HIV/AIDS education in schools in Oshana Directorate of Education, in northern Namibia. This study used evaluation research as the investigation focused implementation process of involving parents.

The target population was teachers and parents of learners who took part in HIV/AIDS programmes (Window of Hope, My Future is My Choice or Life Skills subject) in 2010. The sampling method used was Convenience Sampling as this made it easy to identify teachers and learners as most had relocated to other schools and regions. Respondents were assured anonymity. The research instrument used is the questionnaire and interview protocol.

Data analysis was done and is presented in tables, boxes and figures to illustrate findings. Validity and reliability was determined through the pre-testing of the questionnaire and

interview protocol. Barriers that would have otherwise impeded the research were overcome through the different means employed.

The research methodology used for this research is based on those prescribed by various authors as cited in the reference section and therefore the methodology used is reliable to qualify this research as authentic and scientific.

CHAPTER 4. PRESENTATION OF THE FINDINGS.

4.1 Introduction

This chapter presents findings of the study. The study was conducted at ten schools in the Oshana Education Directorate in Namibia from 29 November to 08 December 2010; an ideal time after learners completed the examinations. This study was undertaken to find out what roles parents play in HIV education offered at school. This is important as it will help to establish the level of involvement of parents in HIV/AIDS education and make recommendations to incorporate a family-systems approach to HIV prevention that would help improve parenting capacity to respond to the threats of HIV on learners.

The study looked at the attitudes of both teachers and parents towards HIV/AIDS education as well as the inclusion of parents in the HIV/AIDS education process. The presentation of data is hence divided into two parts. Part A is the findings of the in-depth interview conducted with teachers and part B is the findings of questionnaire conducted with parents.

The schools at which the study was conducted were: Onamutai Combined School, Onamutai Primary School, Nangolo Senior Secondary School, Oluno Primary School, Eheke Primary School, Kapembe Combined School, Ondjora Combined School, Ompundja Combined School, Oshakati Primary School and Mwadhina gwaNembenge Senior Secondary School. The names of the teachers who were interviewed and the names of the parents who completed the questionnaires are withheld for purposes of confidentiality. Because only one teacher was interviewed at most schools the school names are not used as reference.

4.2 Part one: in-depth interview with teachers

4.2.1 Demographic information of the respondents

Fourteen teachers from ten schools were interviewed: three teachers from three combined schools, two teachers from two secondary schools and five teachers from three primary schools from Oshana Directorate of Education in northern Namibia were interviewed. The profile of the teachers who were respondents in the study is presented in Table 4.1 below:

Table 4.1 Profile respondents (Teachers)

GENDER	**PHASE OF SCHOOL**		**TOTAL**
	PRIMRY SCHOOL	COMBINED/SECONDARY SCHOOL	
Male	2	2	4(29%)
Female	5	5	10 (71%)

In total 14 teachers from 10 schools took part in the study. Twenty-nine (29%) of the respondents were male teachers and 71% were female teachers. This presents a high level of female teachers who took part in the study compared to male teachers. Although the gender was not considered in the sampling method, there were an equal number of male teachers and also female teachers from the primary schools and the combined or secondary phases.

4.2.2 The aim of teaching HIV/AIDS education to learners at school and values to be learned

In order to find out if schools shared the same understanding of why HIV/AIDS is being taught at the schools, the following questions were posed: (1) what is the aim of teaching HIV/AIDS to learners? (2) What values or behaviour changes do you want learners to learn from the HIV/AIDS education programmes? With regard to the first question, respondents gave their opinions as to why HIV/AIDS is being taught in school. The key words in the responses is *'creating awareness', 'educating', 'protection', 'introduce HIV', 'teach' and 'caring for those infected'*. In summary the respondents all agreed that the reason for teaching HIV/AIDS to learners is to create awareness about the existence of HIV, educate them on how to protect themselves from infection and how to take care people infected with the virus.

One of the respondent indicated that *"it is to make them aware of the epidemic in our country so that they can behave well and not get infected. Teach them how to live with HIV positive people."*. This was supported by another respondent who stated that "*the purpose is to create awareness among learners. To know how to take care of themselves if they are HIV positive"*.

With regard to the second question (What values or behaviour changes do you want learners to learn from the HIV/AIDS education programmes?), respondents gave various answers that include accepting and treating HIV infected people with respect, abandoning cultural practices that increase risk of infection, abstinence and self respect. All respondents mentioned safe sexual behaviour that acknowledges the existence of HIV as one of the values they would like learners to learn. Seven of the respondents' answers are presented in the box below:

Table 4.2: Values teachers want learners to learn

NO.	Respondent's answer
1	*"To accept infected people that they are also human beings"*
2	*"Learners must get rid of some cultural practices that prevent people from practicing what they are taughts regarding HIV. They need to change the perception of HIV people are bad and its dangerouns to be around them"* .
3	*"The first one is self respect; Secondly they need to be aware of how peer pressure can put them at risk".*
4	*"Actually the learners have to understand that people have to change when it comes to sexual behaviour and they have to understand that by changing you also save your life".*
5	*"To empower them and for them to be responsible. To abstain , to make wise decisions on their future, avoid infections".*
6	*"Our children come from different backgrounds. Sometimes parents will feel free to talk to their children about HIV but some parents are not free and in this case children recieving or attending the programme at school, its good if they learn that they need to take care of themselves because in the programme they are taught that they should protect themselves. They are been given the differences between myths and facts so i would like to see change in what they believe".*
7	*"It can depend based on the cultural values that we have in our houses. Let's say our grandfathers have two wives or so, than the child will have an open mind to say 'I will only have one partner in order to protect myself'.*

These answers indicate that HIV/AIDS education offered in school aims to increase awareness and help decrease learners' vulnerability to HIV infection.

4.2.3 Learners current attitude towards HIV

The respondents were asked about their opinion with regard to the current attitude of learners towards HIV/AIDS. Learners' attitudes towards HIV as observed by teachers can be categorised in three ways:

- The seemingly not bothered. One respondent remarked *"most of them still dont understand. This year we have 8 cases of pregnant girls in grade 9 alone".*
- The seemingly bothered. One teacher had these to say about this category of learners, *"most of the learners, when i look at them they really want to know more about the programme on HIV. they need a lot of support"*
- The seemingly bothered but shy and easily pressured by others not to take part. A teacher described this group of learners as follows, *"some of them are open to learn but there are some who are still shy whenever people talk about Aids"*

Seventy-eight percent (78%) Eleven of the teachers reported that most learners want to learn about HIV while three respondents are of the opinion that many learners do not want to learn about HIV. Ninety percent (90%) of the teachers who think learners do not want to learn about HIV are from combined and secondary schools while only 10% are from primary schools.

4.2.4 The School's involvement of parents in HIV/AIDS education

To establish the roles that parents play in HIV/AIDS education the schools were asked if they involved parents in HIV/AIDS education during 2010 academic year. Of the ten schools that took part in the study, forty percent reported that they involved parents in the school's HIV/AIDS programmes. Sixty percent (60%) of the schools report that they did not involve parents in the HIV/AIDS programmes.

The respondents were then asked how the schools involved parents. All the respondents from the schools which involved parents mentioned that the first involvement was asking parents for their permission to allow learners to take part in HIV programmes. One respondent remarked *"we informed parents of the HIV programme at school during the parent-teacher meetings when discussing about planned school activities for the academic year and HIV is included. Parents are explained what the programme will teach. Parents who did not show up for the meeting were sent letters explaining what the programme is about and asking them permission to allow the child to stay behind after school to attend the sessions"*.

In addition to asking permission, two schools invited parents to perform in the cultural dance, storytelling and drama plays together with the learners. Another school invited parents to witness the giving of certificates to learners after completion of the programme. A committee consisting of parents was also set up in another school to organize HIV/AIDS education activities for the learners.

4.2.5 The reasons for involving parents in HIV/AIDS programmes at school

The respondents from the four schools that involved parents in HIV/AIDS education were also asked why the schools involved parents. It is particularly interesting to find out why some schools involved parents and others did not. A respondent from one of these schools is of the opinion that parents should help educate their children about HIV and the dangers of falling pregnant at a young age and contracting HIV. Another school stated that parental involvement *"is necessary because even though learners learn at school when they get home, parents need to be able to talk to their children". His colleague added saying that "We want parents to add to what the kids are taught. They must open up and do their part at home".* Even more profound is the observation made by one of the respondents that *"most of them are not well educated about HIV so they are happy to know that their kids are being taught".*

4.2.6 Reasons for not involving parents in the school's HIV/AIDS programmes at school

Respondents from the schools that indicated that they did not involve parents in the HIV/AIDS programme explained why they did not involve parents. Two schools indicated that it just did not do it but promised to do it in the next year. One combined school was supposed to have the programme My Future is My Choice but said the facilitator never turned up. The school had HIV activities organized by the school's AIDS club instead and there were no programmes that 'required' parents to be involved. Three schools apologetically explained that it did not follow the right procedures by omitting to invite parents.

4.2.7 Parents' attitudes towards HIV/AIDS education in schools

Parents' attitudes towards HIV/AIDS education is an important theme because parents' attitudes will influence the role they play in support the school. According to the respondents most parents are supportive of the school teaching HIV/AIDS to learners but there are few parents who do not approve of the school teaching about HIV/AIDS to learners.

Of the ten schools, three schools reported that most parents of learners at their school are not happy that they are being taught about HIV/AIDS. One respondent said the following *"Many parents are happy. Some parents are not happy. The parents, the older people,think the school is teaching the learners big things. They dont refuse their children to attend but they are not happy. The parents talk at meetings that they dont want their children taught HIV but we explain to them HIV is real and this way we are helping them".*

Three schools reported that parents approve the HIV/AIDS education. One respondent happily remarked that *"thier attitude as parents are quite encouraging because i dont have. I did not meet any parent that was against it. So everybody agreed and i believe they undersant the importance of health education for their children".* Another respondent stated that "*up to now we didnt have problems. They know that there is a need of teaching the learners on HIV".*

In addition one of the respondents from the schools where parents have shown support for HIV/AIDS programmes explained that sometimes parents are willing to let their children attend the programmes but because the sessions are conducted in the afternoon, it is difficult to arrange for transport to pick up children late in the afternoon and therefore parents refused.

One school reported that it managed to work with parents and over the years has seen a change in attitude of parents from utter disapproval to overwhelming support for the HIV programme. The teacher explained that *"they are not really against it but at the beginning they were like 'wow, they are teaching our kids big stuff'. But now they know AIDS is real. They are happy with it"*. Another respondent from the same school remarked that *"from previous meetiings we inform them about the different programmes of HIV/AIDS. We have seen parents supporting us. They feel it's a good idea and after meetings when the programme starts we see a lot of kids turning up. And are eager to attend".*

Another school reported that it does not know if parents approve or disapprove the school teaching HIV/AIDS because it has never involved parents in HIV/AIDS education.

4.2.8 Parents role in HIV/AIDS education offered at school according to teachers

All 14 respondents from ten schools agreed that parents can and should play a role in HIV/AIDS education offered in school. The following are roles that parents are expected to fulfill in order to complement efforts made by the school to provide sexual health education which includes HIV/AIDS education.

Schools expect parents to ask learners to be involved in taking care of sick relatives. One respondent explained that this will help learners realize that the disease exists. In agreement, another respondent stated that *"i think the role of parent is to enforce what learners have learnt if they understood everything then they will now be able to make sure that the children are guided in direct correct way by parents not by teacherrs because we teachers are only with children for some time but most of the time the cchildren are with their parents. So if the parents understand and they can probably positively involve themselves in these programmes for education".*

Parents are also expected to act as role models for their children by avoiding practices that increase risk of HIV infection because this will enforce the lessons learnt at school. Furthermore, parents are also advised to avail themselves when asked to participate in school HIV/AIDS activities and programmes and to educate learners more about HIV/AIDS. In explaining this, a responded noted that *"a parent can strengthen what the child learns from school and to give clarity and direction that when you are dealing with things or when you kids are being taught this it doesnt mean you should go practice this things but rather the information you are given is to make you aware. Children listen to their parents. Tell the kids that they are being taught to prevent future infections".*

In addition to this parents are also expected to encourage learners to take part in HIV/AIDS activities. Twenty-nine (29%) of the respondents explained there is peer pressure among learners not to participate in HIV/AIDS activities and parents can play a role to counteract it. The respondent remarked as follows: *"Some attend because of friends. If one bullies the others saying that 'you just attend that HIV programme as if you already dont know what HIV is', than this bullied learner will stop attending".* Another respondent also explained peer pressure among learners by stating that *"a child might learn something about HIV from school wheather MY Future is My Choice or Window of Hope but when she or he is with friends she does not want to be different from her peers so she goes in the opposite direction and not do what she was taught."* Another respondent explained that "*the other thing is that they bully each other. When one is attending HIV or is a member of an HIV Club some learners bully others saying 'what are you telling us. You always talk about HIV, HIV. We all know what it is". "Some learners don't care. Our people are ignorant even when you talk people are just having the attitude of 'what is she saying'? AIDS has become a peom"* remarked another teacher. Teachers explained that parents can play a role in encouraging and ensuring that learners participate in HIV/AIDS programmes even if they are voluntary.

4.2.9 Should the school provide HIV/AIDS education to parents?

Since many teachers cited that parents are in need of information to effectively educate learners, we asked them if the school should be educating parents; 26% felt that the school can be tasked to provide parents with education on sexual health and HIV/AIDS. The respondents motivated their decision saying that many parents especially the older generation and rural dwellers don't know much about HIV/AIDS. One respondent reasoned that *"it is vey important for all parents to understand the importance of sexual education for them to be able to help someone also to understand this things".* Another answered "*Yes because if parents are aware they will contribute more".* The third respondent explained that some learners live with grandparents and there is a need to educate them about the importance of teaching learners about and human sexuality. The concept of discussing sex related topics is a foreign concept to them and they need to be made to understand that it is for the good of the learners. This respondent remarked that "*the problem we are facing is that children live with granny's and granny cant read or write". Another parent is said to have remarked to a teacher "in the olden days we were not taught this things and we turned out fine".*

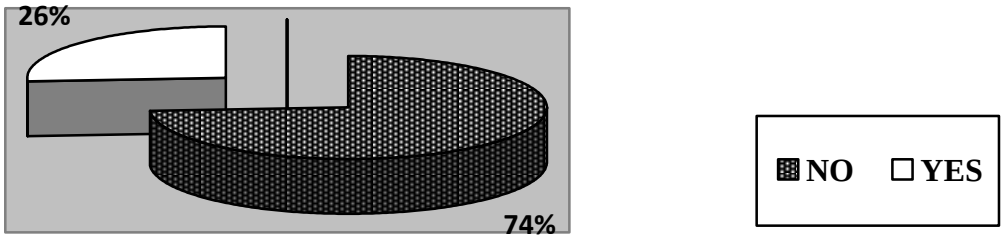


Figure 4.1: should the school be tasked to provide HIV/AIDS education to parents?

Seventy-four percent (74%) felt that the school should not be tasked to provide sexual health and HIV/AIDS education (see figure above). Fifty-seven percent (57%) out of the 74% felt that parents need the education but it cannot be expected of schools to also educate parents in addition to learners. the other 17% felt that parents should get the information from the programmes taking place in the community. One respondent recalled what happened years ago when they tried to give sexual health education to parents; *"i remember suggesting the idea to one parent and the parent said 'you want to teach us about sex?' No! and she refused so we dont. There was a time our school topped the list of teenage pregnancy and i informed the parents to talk to their children and that we can offer them training but majority refused".*

4.2.10 Cultural norms and practices that prevent learners from implementing what they are taught

To better understand factors that would hinder parents from fully supporting the school's HIV/AIDS programmes, the researcher turned to culture. The respondents were asked to mention any cultural norms or practices that would thwart efforts made by the school to educate learners about HIV. 43% of the respondents identified 'the culture of silence' or not talking about sex and sex related matters as the main cultural norm and practice that prevent learners from fully implementing what they are taught at school about HIV/AIDS. Twenty-two percent (22%) mentioned intergeneration sex as another factor.

Seven percent blamed called ''tjiramue' or encouraging children to have sex with their cousins as another cultural practice counteracting efforts made by the education system to prevent the further spread of HIV among learners. One respondent explained how this practice affects learners by stating that "From my area we have 'tjiramue' where children are encouraged to have sex with their cousins and refusing is seen as going against cul-

ture. So, children do it sometime against their will. Infections can be transmitted because many people don't use condoms. Another practice that is identified by 7% of the teachers as a threat to the progress of HIV/AIDS education in schools is the apathetic attitude of learners towards HIV. A responded described it by simply stating that it is *"Ignorance. Some learners dont care".* Another reason stated by 7% of the respondents is that there are some learners who dont believe condoms can protect from HIV infection. Another 7% mentioned the wide spread belief that a man can have more than one girlfriend at a time as an obstacle to effectice HIV/AIDS education.

Seven percent (7) of the respondents also indicated the lack of understanding by some parents who take learners to traditional doctors do not take their own blades to use during rituals is also worrisome.

4.3 Part two: questionnaire for parents

4.3.1 Demographic data

To determine the age of children, parents were asked to state the year in which their child was born. Table 4.3 illustrates the demographic information of learners as indicated by parents.

Table 4.3.: Demographic data:

Year of birth	**Age in 2010**	**Number of learners**
1992	18	1
1993	17	2
1994	16	3

1995	15	1
1996	14	6
1997	13	1
1998	12	5
2000	10	1
Total number of learners		20

The total number of respondents was twenty which is also the total number of learners whose parents were selected to take part in the study. The age of learners who bears reference in the study ranged from age 10 to18. The average age was 14.1. The mode age or most frequently occurring age was 14 years. The median age was also 14 years.

The grade of learners in 2010 ranged from grade 4 to 10. There were no grade 11 and 12 learners. Fifty-percent of parents who took part in the research indicated that their children were in grade 8 to 9 in 2010, followed by 30 percent whose children were in grade 5 to 7. Fifteen percent were in grade 10, while 5% were in grade 4. See illustration below:

Grade of learners	**Grade 4**	**Grade 5-7**	**Grade 8-9**	**Grade 10**	**Grade 11-12**
Number of respondents	1 (5%)	6 (30%)	10 (50%)	3 (15%)	0 (0%)

Figure 4.2: Demographic data, grades of learners who bear reference in the study

The average grade was 8 to 9. The mode or most frequently occurring grade was also 8 to 9 years. The median grade was also 8 to 9. The age and grades of learners correspond as most of the learners are 14 years of age and more likely to be in grade 8 to 9.

Forty percent (40%) of the parents indicated that their children are boys and 60% indicated that the children are girls.

4.3.2 Awareness of HIV/AIDS programmes in schools

Parents were asked if they are aware of any HIV/AIDS education programmes or activities in schools. Ninety percent (90%) of parents indicated that they are aware of HIV/AIDS programmes in schools, while 10% indicated that they are not aware of any HIV programmes in schools. In the question that followed, parents were asked to indicate which HIV/AIDS programme or programmes in schools they are aware of.

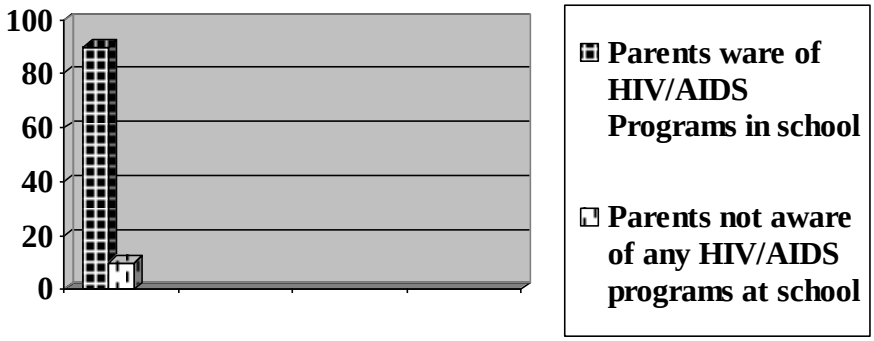


Figure 4.3 Awareness of HIV/AIDS programmes in schools

The ninety percent that are aware of HIV/AIDS programmes in school, (44%) are aware of the programme My Future is My Choice and 38% are aware of Window of Hope. Only 33% are aware of Life Skills Subject. Six percent indicated awareness of a programme called "HIV management".

The data indicated that although 90% of the parents that took part in the study are aware of HIV/AIDS programmes in schools, less than 50% do not know what those programmes are. In particular, there is even less awareness of the Life Skills Subject which may be regarded not surprising since past researches (Mufune, 2008) have indicated that the subject is not being taught in most schools.

4.3.3 Attendance of HIV/AIDS programmes in schools in 2010

Seventy percent of the parents indicated that their children took part in the HIV/AIDS programmes at school in 2010. Twenty percent indicated that their children did not take part in any HIV/AIDS programmes. Ten (10%) indicated that they do not know if their children took part in any of the HIV/AIDS programmes.

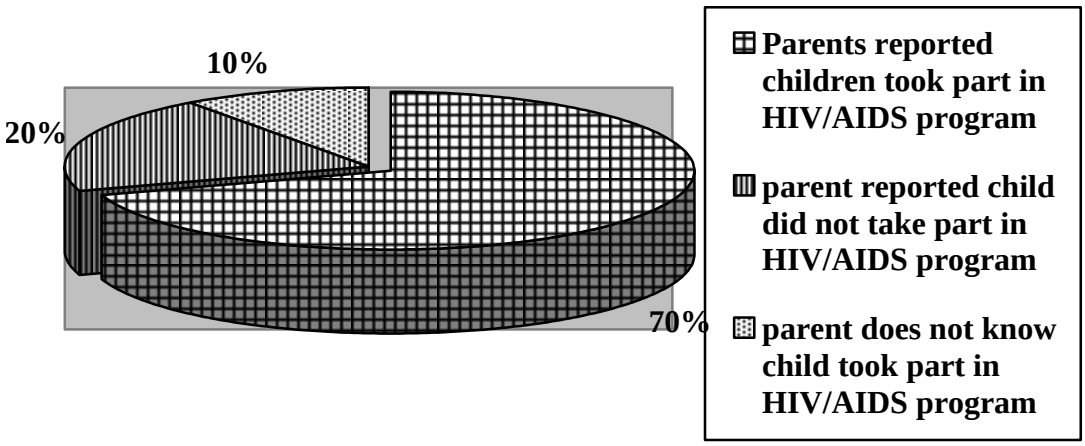


Figure 4.4 Parents' awareness of children's attendance

All parents who took part in the study were selected by teachers because their children took part in the HIV/AIDS programmes in 2010 and it is therefore in line with the findings from interviews with teachers (teachers) that some did not inform parents or asked their permission for learners to take part in the HIV/AIDS programmes. It is not surprising that some of the parents indicated that their children did not take part or they are not aware that their children took part in the HIV/AIDS programmes in school in 2010 even though the schools confirmed that they did.

4.3.4 Permission to allow child to take part in HIV/AIDS programmes

The researcher did not want to assume that because parents gave consented to their children to take part in HIV/AIDS education, they also agreed with the notion of teaching HIV/AIDS to learners, parents were asked to indicate if they are in agreement with the school teaching HIV/AIDS to learners.

All parents who took part in the study (100%) indicated that they agreed with the school teaching learners about HIV/AIDS and would give permission for their children to be taught about HIV/AIDS in school. However, only 70% stated that they gave permission for their children to take part in the HIV/AIDS programmes in school during the year 2010. This discrepancy can be explained by the earlier mentioned fact that not all schools sought parental consent for learners to take part in HIV/AIDS related programmes or activities.

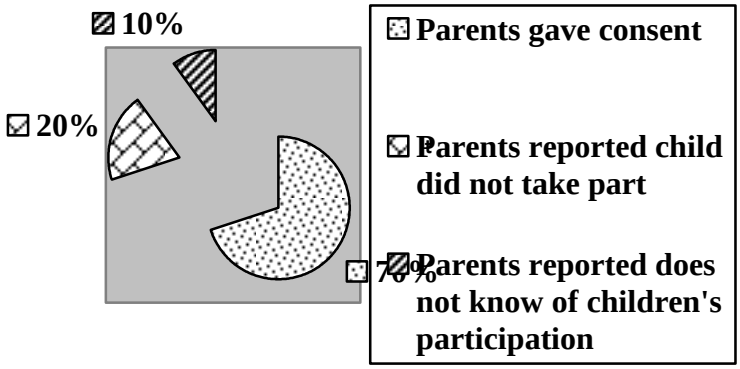


Figure 4.5 Giving of parental consent for child to participate.

Twenty percent (20%) of the parents who indicated that their children did not take part in any HIV/AIDS programmes and the ten (10%) that also pointed out that they do not know if their children took part in any of the HIV/AIDS programmes were asked if they would have given permission had they been asked. All 30% of these parents indicated that they would have given permission for their children to be included in the HIV/AIDS programmes. The findings that 100 percent of the parents who took part in this study were willing to give permission for their children to take part in HIV/AIDS programmes

is a contradiction to what teachers indicated that there are parents who complain against the school teaching HIV/AIDS to learners as indicated earlier in.

4.3.5 Parent's attitude towards content of HIV/AIDS programmes and activities

Parents were asked about their awareness of what was taught in the HIV/AIDS programmes that their children attended in 2010 at school. Deducing from the topics parents mentioned it is clear that all 70% parents whose are aware of their children's involvement in HIV/AIDS programmes are aware of at least one topic that is taught in the HIV/AIDS programmes at school. None of the parents mentioned a topic that is not included in the education of HIV/AIDS in schools.

Parents were also asked to point out topics that were taught to learners that they were not happy with. Of the 70% of the parents in question, fifty-five percent indicated that they were happy with all the topics taught to learners. Fifteen percent indicated that they were not happy with learners being taught how to use a condom and in addition five percent of the parents indicated that they were not happy with their children being taught about 'pregnancy and reproductive health'.

Parents were asked to indicate if the content of the HIV/AIDS programmes and activities were age appropriate. Sixty (60%) indicated that the content was age appropriate. Ten percent of the parents indicated that the content of the HIV/AIDS programmes was not age appropriate. Unfortunately these parents did not give reasons for their answer despite being asked to do so. Sixty percent indicated that the content was age-appropriate. Exposure to sexuality on television, early maturation and better understanding are some of the most prominent reason given by parents for their support for the content in 2010. Some remarks by parent

Reasons are presented in the Table 4.4:

Table 4.4: Reasons why content is age appropriate

Respondents' answers
"Because she needs to know what HIV/AIDS is and because it is the age that she starts menstruating"
"Many children watch TV and some children watch 'blue movies' where they learn a lot about sexuality"
"Because she is at the age to learn about diseases in general not just HIV"
"It is appropriate they need to know more while they are growing which will help them understand when they are grown"
"Because she is undergoing puberty and they are most vulnerable so they need to be protected"
"Because nowadays children mature earlier and they interact with other children that are infected and affected by HIV"

Parents were also asked to suggest topics that they feel were omitted in the HIV/AIDS programmes that learners attended in 2010. The following topics were suggested

- Abstinence from sexual intercourse
- Christian values and 'the fear of God'
- Respect and how to counsel people who are HIV positive

Abstinence featured prominently as a topic that many parents felt it should be taught but was omitted in the HIV/AIDS programmes in 2010.

4.3.1.6 Parental role in HIV/AIDS programmes/activities

Parents were asked about the contribution they made towards the HIV/AIDS programmes and activities that their children attended at school in 2010. Of the 70% of the parents in question, 60% mentioned that they emphasized at home on various topics that they knew were taught at school. This is in line with what teachers had suggested for parents to do in order to strengthen HIV/AIDS education in schools.

Parents were also asked how the school involved them in the HIV/AIDS programmes/activities. Some parents mentioned that they were invited by the school to witness the giving of awards after learners completed the programmes; others mentioned that they were also invited to give presentations on HIV/AIDS; many were asked permission for their children to take part; and some were asked to talk to learners about HIV/AIDS.

Twenty percent (20%) of the parents indicated that they were not involved by the school. These 20% excludes the Twenty percent who indicated that their children did not take part in any HIV/AIDS programmes and the ten (10%) indicated that they do not know if their children took part in any of the HIV/AIDS programmes. In total 50% of the respondents indicated that they were not involved by the school in any HIV/AIDS programmes that their children attended in 2010.

Parents were asked to narrate a situation when their child asked or needed help concerning HIV/AIDS. This question was intended to ask about the practical roles that parents played in helping their children with regard to HIV/AIDS programme. Parents mentioned that they reminded children to apply what they have learnt at school and answering questions when they asked at home. They indicated that they also encouraged chil-

dren to take part in HIV/AIDS programmes at school, on the Radio and to visit clinics to get more information about HIV/AIDS.

4.3.7 Perceived impact of HIV/AIDS education on learners

Overall respondents indicated increased knowledge of HIV/AIDS as one of the positive changes.

Fifty percent of the parents indicated that their children's decision to abstain from sexual activities as one of the positive changes that resulted from the HIV/AIDS education. These 30% also indicated that another positive change was an attitude of care and respect for people infected with HIV/AIDS. In addition, respondents also mentioned that their children are more open to talk about HIV/AIDS with them than before. One parent remarked that "the child is free to talk to us about HIV, they know how it spreads and they know that there is ARV that prolongs life"

Respondents were also asked to indicate negative impacts of HIV/AIDS education on learners. Only one parent mentioned that the child is overly careful that she does not want to share kitchen utensils with other people at home: *"my child refuses to share a plate or eat in the same plate with other people"*.

4.3.8 Self-perceived competency to teach HIV/AIDS

Respondents were asked if their knowledge and understanding of HIV/AIDS makes them competent to teach their children. Out of the 70% who confirmed that their children took part in the HIV/AIDS programmes in 2010, 45% answered 'yes', 10 % answered 'no' and 15% answered that they don't know. Seventy-four percent (74%) of the teachers felt that the school should not be tasked to provide HIV/AIDS education. Fifty-seven percent reasoned that parents need the education but it cannot be expected of schools to also edu-

cate parents in addition to learners and suggested that parents get the information from the numerous programmes taking place in the community.

4.3.1.11 Suggestions to improve HIV/AIDS education programmes in schools

Parents were asked to give suggestions for improving HIV/AIDS education in school. Parents had the following suggestions (Table 4.3.1.11) and those that stated similar suggestions only one quote is used:

Table 4.5: Suggestions to improve the HIV/AIDS education programmes in schools

Respondents' answers
"Learners should have a subject teaching HIV everyday"
"Children should be taught age appropriate topics"
"All learners who are at an age to understand HIV should be included in all the programmes and activities to do with HIV"
"They should involve the parents in these HIV educational programmes because it doesn't help if only the teachers are teaching at school but at home nobody is telling us about HIV/AIDS"
"The school should also give counseling services to learners who are infected and affected by HIV"
"The school should teach learners who are on ARV treatment to use a condom, stick to one partner and to adhere to ARV treatment"

Parents suggestions ranged from the improving the content to parental involvement. The following is a summary of the suggestions:

- Increase the frequency of teaching HIV/AIDS at school
- Revise the age-appropriateness of the content
- Ensure that all children are included in the programmes
- Inclusion of parents in HIV/AIDS education
- Give counseling services to learners affected and infected by HIV/AIDS
- Teach learners on antiretroviral therapy to adhere

4.4 Conclusion

In total 14 teachers from 10 schools and 20 parents took part in the study. Teachers in the study all agreed that the purpose for teaching HIV/AIDS to learners is to create awareness about the existence of HIV, educate learners on how to protect themselves from HIV infection and how to take care people infected with the virus.

Teachers indicated that learners' attitudes towards HIV can be categorised in three ways: the seemingly not bothered, the seemingly bothered and the seemingly bothered but shy and easily pressured by others not to take part. According to teachers who took part in this study most parents are supportive of the school teaching HIV/AIDS to learners. Parents confirmed this finding that when all parents who took part in the study (100%) indicated that they agreed with the school teaching learners about HIV/AIDS. However, not all parents in the study were aware of their children's involvement in HIV/AIDS education programmes in 2010. Only seventy percent of the parents indicated that their children took part in the HIV/AIDS programmes at school in 2010. Sixty percent of the schools in this study reported that they did not involved parents in the school's HIV/AIDS programmes. The number of schools that did not involve parents is higher compared to the 40% of schools reported that they involved parents.

Of the 70% of the parents were aware of their children's involvement, 60% mentioned that they emphasized at home on various topics that they knew were taught at school. Some parents mentioned that they were invited by the school to witness the giving of awards after learners completed the programmes; others mentioned that they were also invited to give presentations on HIV/AIDS; many were asked permission for their children to take part; and some were asked to talk to learners about HIV/AIDS. Parents are of the opinion that topics such as abstinence from sexual intercourse, Christian values and 'the fear of God', respect for people infected with HIV as well as how to counsel people who are HIV positive, are omitted. Abstinence featured prominently as a topic that many parents felt it was omitted in the HIV/AIDS programmes in 2010. The support for abstinence is perhaps understandable in light of the findings that 50% of the parents indicated that their children's decision to abstain from sexual activities as one of the positive changes that resulted from the HIV/AIDS education.

Of the 70% who confirmed that their children took part in the HIV/AIDS programmes in 2010, 45% answered that their knowledge and understanding of HIV/AIDS makes them competent to teach their children about HIV/AIDS, while 10 % answered that they are not competent and 15% answered that they don't know.

CHAPTER 5. DISCUSSIONS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter contains a discussion of the findings of the study. One of the components of qualitative research is the use of various methods to collect data, a concept referred to as triangulation (Christensen et al, 2011:53) These provides better understanding of the phenomenon under study. For this research a questionnaire was used a research instrument to gather data from parents and in-depth interview was used to collect data from teachers. This chapter is a synthesis and discussion of the findings of the study based on data provided by teachers and parents. The chapter ends with the recommendations and conclusions drawn from the findings on how to improve the parental involvement of parents in HIV/AIDS education in schools.

5.2 Demographic information of the respondents

In total 14 teachers from 10 schools took part in the study. Convenience Sampling was used to select the sample after it was discovered that some teachers that were involved in HIV/AIDS education had since left the schools and in some cases the schools only had one teacher responsible for HIV/AIDS education. Twenty-nine (29%) of the teacher respondents were male and 71% were female teachers. The total number of parents who took part in the study was twenty.

The age of learners who bears reference in the study ranged from age 10 to18 years. The average age was 14 years. The grade of learners in 2010 who bear reference in the study ranged from grade 4 to 10. There were no grade 11 and 12 learners even though they were open for inclusion. Fifty-percent of parents who took part in the research indicated that their children were in grade 8 to 9 in 2010, followed by 30 percent whose children

were in grade 5 to 7. Fifteen percent were in grade 10, while 5% were in grade 4. This means that the average grade of learners in 2010 who bear reference to the study as indicated by parents was 8 to 9.

The gender, age and grade of respondents were not considered in the sampling method because convenience sampling does not require it. The criteria for inclusion in the study are that teachers must have taught HIV/AIDS in 2010 and parents must have had learners who attend HIV/AIDS programmes or activities in 2010. In Namibia, the HIV/AIDS programmes are offered to learners from grade four (Window of Hope), grade five to twelve (Life Skills subject) and grade 8 to 12 (My Future is My Choice). The average age of learners whose parents took part in the study can be explained by the fact that learners enter grade 8 around 14 years of age since they start school at age 6 or 7.

5.3 The objective of teaching HIV/AIDS to learners and parent's awareness of programmes

Teachers in the study all agreed that the purpose for teaching HIV/AIDS to learners is to create awareness about the existence of HIV, educate them on how to protect themselves from infection and how to take care people infected with the virus. Teachers were also asked about the values or behaviour changes they want learners to learn from the HIV/AIDS education programmes. Teachers gave various answers that include accepting and treating HIV infected people with respect, abandoning cultural practices that increase risk of infection, abstinence and self respect. All teachers mentioned safe sexual behaviour that acknowledges the existence of HIV as one of the values they would like learners to learn.

The aim of teaching HIV/AIDS education to learners is noble and plausible because it reinforces the acknowledgement of the existence of HIV in our society. However, because the subject concerned, sexual behaviour (HIV infection mostly through sexual intercourse), is embedded in culture, the school alone cannot claim these privilege alone. The school must include custodians of culture if it is to change and challenge negative cultural practices in society that infringe on their ability to make sensible decisions that prevent HIV infection or prolong life after infection.

The literature review for this study (see chapter two) revealed that social comparison theory postulates that people tend to conform to the attitudes and behaviour of others similar to themselves (parents), partly because those others provide information about social reality, and partly because conformity may be socially rewarding (Goethals & Darley, 1977).

The study also indicated that teachers are well aware of some of the negative cultural practices that increase vulnerability to HIV infection in their community. Forty –three (43%) of the teachers identified 'the culture of silence' or not talking about sex and sex related matters as the main cultural norm and practice that prevent learners from fully implementing what they are taught at school about HIV/AIDS. Twenty 22% percent mentioned intergeneration sex as another factor. Seven percent (7%) blamed the cultural practice by the Herero tribe called 'tjiramue' or encouraging young people to have sex with their cousins as another cultural practice counteracting efforts made by the education system to prevent the further spread of HIV among learners.

Teachers also mentioned the apathetic attitude of learners towards HIV, the fact that there are some learners who do not believe condoms can protect from HIV infection as well as the wide spread belief that a man can have more than one girlfriend at a time as cultural practices that hinder effective HIV/AIDS education. These finding is in line with the observation made by the Ministry of Health and Social Services when it stated that

"It is not so much denial of risk as it is resignation. There is a lingering sense among these individuals that there is nothing that can be done to prevent infection...some Namibians do not believe in the efficacy of condoms" (Ministry of Health and Social Services, 2009:29).

Learners come from different social setups and hence consideration of their social environment in the effort to change sexual behaviour cannot be stressed enough. Involvement of all those that are responsible for transferring and shaping culture from one generation to the next (parents and the education) is vital. The National Institute for Education Development best captures this sentiment by warning that if culture continues to be an excuse why HIV and AIDS can not be discussed openy, the disease will not only destroy society but also its culture (NIED, 2006:5).

5.4 Learners and parents current attitude towards HIV/AIDS

According to teachers, learners' attitudes towards HIV can be categorised in three ways: the seemingly not bothered, the seemingly bothered and the seemingly bothered but shy and easily pressured by others not to take part. Seventy-eight (78%) Eleven of the teachers reported that most learners want to learn about HIV while three respondents are of the opinion that many learners do not want to learn about HIV. Ninety (90%) of the teachers who think learners do not want to learn about HIV are from combined and secondary schools while only 10% are from primary schools. This is perhaps in line with the findings that primary school children are more impressionable and easier to teach about HIV/AIDS compared to when they are older (Dyson, 2010).

It also appears that learners' negative attitude towards HIV/AIDS has not been addressed with the involvement of parents. Teachers are perhaps the best candidates to assess learners' attitudes towards HIV/AIDS because in many instances they introduce the topic of HIV/AIDS to them. Many parents may not be able to 'pick up' the negative attitudes

of learners towards HIV/AIDS due to the culture of silence or taboo associated with discussing sexuality. It is for these very reasons that teachers can collaborate with parents to change learners' attitudes towards HIV.

At this point of the analysis, the reader may question how the researcher can make such a claim considering that learners probably mirror their parents' attitudes towards HIV/AIDS. Teachers who took part in this study were asked about parents' attitudes towards HIV education offered in school. Parents' attitudes towards HIV/AIDS education is an important theme because parents' attitudes will influence the role they play in support the school can influence learners' attitudes as well. According to these teachers most parents are supportive of the school teaching HIV/AIDS to learners. Parents confirmed the finding that most are in support of the school teaching HIV/AIDS to learners. All parents who took part in the study (100%) indicated that they agreed with the school teaching learners about HIV/AIDS and would give permission for their children to be taught about HIV/AIDS in school. This finding is in line with Dyson's (2010) observation that there has been a generalization over the years that parents are against sexual health education of any sort and this is due to the fact that sexuality education has become a highly contested field and those who oppose it are mostly highly vocal and relentless in promoting their point of view thereby giving the impression that they represent a large portion of the community opinion.

However, only 70% stated that they gave permission for their children to take part in the HIV/AIDS programmes in school during the year 2010 because 30% were not aware of their children's involvement in HIV/AIDS programme. These findings is in line with findings of a study by Ogunjimi (2006) on the disposition of students and parents towards the inclusion of sex education in the school curriculum in Cross River State, Nigeria, that found that the majority of the students (70%) and parents (93.89%) were in support of the inclusion of sex education in the school curriculum.

5.5 parental awareness of learners' attendance

There was a discrepancy in the number of parents who were aware of their children's involvement in HIV/AIDS education and confirmation by the school that the child attended HIV/AIDS programmes. All parents who took part in the study were selected by teachers because their children took part in the HIV/AIDS programmes in 2010. However, twenty percent of the parents indicated that their children did not take part in any HIV/AIDS programmes. Ten (10%) indicated that they do not know if their children took part in any of the HIV/AIDS programmes. Only seventy percent of the parents indicated that their children took part in the HIV/AIDS programmes at school in 2010.

This can be explained perhaps by the findings from interviews with (teachers) that some schools did not inform parents or asked their permission for learners to take part in the HIV/AIDS programmes. It is therefore not surprising that some of the parents indicated that their children did not take part or they are not aware that their children took part in the HIV/AIDS programmes in school in 2010 even though the schools confirmed that they did. In addition, because some parents are said to not approve that of the school teaching about HIV/AIDS, learners may not inform parents of their involvement.

One of the reasons indicated by writers to explain why parents sometimes oppose sexual health education is that the topics taught are inappropriate for their children. Walker and Milton (2006) explained that education on sexuality encourages young people to become sexaully active is widespread in countries like Australia and the United Kingdom. Parents who took part in this study did not indicate the false belief that education given at school on sexuality encourages yound people to practice sex. Only teachers indicated that parents do. There were no self reports of this belief by parents.

5.6 The practice of involving parents in HIV/AIDS education in schools

To establish the practice of involving parents in HIV/AIDS education the schools were asked if they involved parents in HIV/AIDS education during 2010 academic year. Of the schools that took part in the study, forty percent reported that they involved parents in the school's HIV/AIDS programmes. The number of schools that did not involve parents is higher compared to the schools that involved parents. Although theis study revealed that as much as 90%) of parents indicated that they are aware of HIV/AIDS programmes in schools, less than 50% do not know what the programmes are. Even more despairing is the revelation by 60% of the schools that they did not involve parents in the HIV/AIDS programmes.

Teachers from the schools that indicated that they did not involve parents in the HIV/AIDS programme explained why they did not involve parents; Two schools indicated that it just did not do it but promised to do it in the next year; one combined school was supposed to have the programme My Future is My Choice but said the facilitator never turned up; the school had HIV activities organized by the school's AIDS club instead and there were no programmes that 'required' parents to be involved; three schools apologetically explained that it did not follow the right procedures by omitting to invite parents.

The practice of involving parents in HIV/AIDS education is not being practiced by all schools. It also appears as if some teachers are not aware that this is a recommended practice from NIED. NIED (2006:12) explained that itt is vital that parents, guardians and care-givers are involved in sexual health education to enable them to support programmes in school. NIED further explained that involving parents will encourage them to support the work of the school in matters of sexual health, and will provide valuable information for parents as well.

5.7 Parents' current roles in HIV/AIDS education

Parents were asked about the contribution they made towards the HIV/AIDS programmes and activities that their children attended at school in 2010. Of the 70% of the parents were aware of their children's involvement, 60% mentioned that they emphasized at home on various topics that they knew were taught at school. Some parents mentioned that they were invited by the school to witness the giving of awards after learners completed the programmes; others mentioned that they were also invited to give presentations on HIV/AIDS; many were asked permission for their children to take part; and some were asked to talk to learners about HIV/AIDS.

Parents were asked to narrate a situation when their child asked or needed help concerning HIV/AIDS. This question was intended to ask about the practical roles that parents played in helping their children with regard to HIV/AIDS programme. Parents mentioned that they reminded children to apply what they have learnt at school and answering questions when they asked at home. They also mentioned that they also encouraged children to take part in HIV/AIDS programmes at school, on the Radio and to visit clinics to get more information about HIV/AIDS.

Teachers were also asked about the roles and contributions they expect parents to make towards HIV/AIDS education for learners. All teachers from ten schools agreed that parents can and should play a role in HIV/AIDS education offered in school. Teachers explained that they expect parents to ask learners to be involved in taking care of sick relatives. One respondent explained that this will help learners realize that the disease exists. Parents are also expected to act as role models for their children by avoiding practices that increase risk of HIV infection because this will enforce the lessons learnt at school. Teachers also advised parents to avail themselves when asked to participate in school HIV/AIDS activities and programmes. They explained that Parents can play a role in

encouraging and ensuring that learners participate in HIV/AIDS programmes even if they are voluntary.

All above mentioned roles are in line with suggestions made by NIED. NIED gave the following tips on how to involve parents:

- Organise a session to educate parents about sexual health.
- Hold a meeting to inform parents about what their children will be learning and explain that sexual health education in Namibian schools is called for by the Government's *National Policy on HIV/AIDS for the Education Sector* and the curriculum. In cases of learners who stay in the hostel, teachersare encouraged to send information home with children during the school holidays
- Assign homework in the form of interviews, brainstormers and comparing-opinion activities related to sexual health that children are encouraged to share with their parents.

5.8 Motivation for involving parents

It is particularly interesting to find out why some schools involved parents and others did not. Teachers in explained that the reason for involving parents should help educate their children about HIV and the dangers of falling pregnant at a young age. Another school stated that parental involvement is necessary as it is still the duty of parents to talk to their children. His colleague added that the school would like parents to add to what the learners are taught in school. Even more profound is the observation made by one of the teachers is that most parents are not well informed about HIV and are happy to know that their kids are being taught.

Most schools that did not involve parents indicated that they did not do so due logistic and poor planning. Two schools indicated that it just did not do it. One combined school

explained that it was supposed to have the programme My Future is My Choice but the facilitator never turned up. The school did organize activities but there were no programmes that 'required' parental involvement. Three schools apologetically explained that it did not follow the right procedures by omitting to invite parents. The practice of involving parents in HIV/AIDS education is not being strictly adhered to by many schools (60%).

5.9 Parents' attitude towards content of HIV/AIDS

Parents were asked about their awareness of what was taught in the HIV/AIDS programmes that their children attended in 2010 at school. Deducing from the topics parents mentioned it is clear that all 70% parents whose are aware of their children's involvement in HIV/AIDS programmes are aware of at least one topic that is taught in the HIV/AIDS programmes at school. None of the parents mentioned a topic that is not included in the education of HIV/AIDS in schools.

This also shows that parents do not have false beliefs about what is being in the HIV/AIDS programmes and activities at school. The literature indicated that parents who are against the teaching of sexuality health education and any related topics believe that children are being encouraged to have sex. This was also confirmed by teachers who took part in this study who mentioned that some parents had complained to the school that it is teaching their children how to have sex. Some parents are reported to have accused some schools of encouraging learners to fall pregnant. The research is not concluding that there are no parents who hold false beliefs about what is taught in school as indicated by teachers who took part in the study. It is simply stated that none of the parents indicated false beliefs.

Parents were also asked to point out topics that were taught to learners that they were not happy with. Of the 70% of the parents in question, fifty-five percent indicated that they were happy with all the topics taught to learners. Fifteen percent indicated that they were

not happy with learners being taught how to use a condom and in addition five percent of the parents indicated that they were not happy with their children being taught about 'pregnancy and reproductive health'.

Parents were also asked to indicate if the content of the HIV/AIDS programmes and activities were age appropriate. Sixty percent (60%) indicated that the content was age appropriate. Ten percent of the parents indicated that the content of the HIV/AIDS programmes was not age appropriate. Unfortunately these parents did not give reasons for their answer despite being asked to do so. Sixty percent (60%) indicated that the content was age-appropriate. Exposure to sexuality on television, early maturation and better understanding are some of the most prominent reason given by parents for their support for the content in 2010.

Unlike the Dilworth's claim (2009) that parents are unaware of other influences on their children's sexuality, the majority of parents (60%) are aware of the influence of many other sources of information on sexuality such as the mass media and are aware of the many indications (puberty) that learners need information on sexuality including HIV/AIDS.

Parents are of the opinion that topics such as abstinence from sexual intercourse, Christian values and 'the fear of God', respect for people infected with HIV as well as how to counsel people who are HIV positive, are omitted. Abstinence featured prominently as a topic that many parents felt it was omitted in the HIV/AIDS programmes in 2010. This findings are in line with findings in a study conducted by Dailard (2001) in the United states of America were parents believe that sexual health education should encourage young people to delay sexual activity. In addition, parents in the USA added that it should also encourage learners to use birth control and practice safe sex once they become or choose to be sexually active, something that parents in this study did not suggest.

Since content analysis of all three programmes (Window of Hope, My Future is My Choice and the Life Skills subject) reveal that the ABC (abstinence, be faithful, use a condom) model is being taught to learners, parents' suggestions draws attention to the fact that some schools are not informing parents about the content of programmes hence perpetuating the belief that this topics are not being taught. The researcher agrees with Kelly (2000) who stated that many HIV/AIDS education programme delivery is exclusively in the hands of the school, again with minimal involvement of parents. One of the topics that NIED (2006) had suggested for inclusion in the orientation of parents to the HIV/AIDS programmes in school is "to hold a meeting to inform parents about what their children will be learning and explain that sexual health education in Namibian schools is called for by the Government's *National Policy on HIV/AIDS for the Education Sector* and the curriculum."

5.10 Parents' perceptions of the impact of HIV/AIDS education

Fifty percent of the parents indicated that their children's decision to abstain from sexual activities as one of the positive changes that resulted from the HIV/AIDS education. These 30% also indicated that another positive change was an attitude of care and respect for people infected with HIV/AIDS. In addition, respondents also mentioned that their children are more open to talk about HIV/AIDS with them than before. These findings are in line with findings by Chandan et al (2008) on one of the school programme 'My Future is My Choice' that it is effective in positively improving knowledge, attitudes, and beliefs of young people with regard to HIV/AIDS.

Only one parent mentioned that the child is overly careful that she does not want to share kitchen utensils with other people at home

5.11 Parents' competency to teach about HIV/AIDS

Parents were asked if their knowledge and understanding of HIV/AIDS makes them competent to teach their children. Of the 70% who confirmed that their children took part in the HIV/AIDS programmes in 2010, 45% answered 'yes', 10 % answered 'no' and 15% answered that they don't know.

Self-perceived competency among parents who took part in this study is below 50% and the researcher is of the opinion that this is not good especially since parents are expected by teachers to talk to learners about HIV/AIDS. Research has indicated that one of the reasons many parents are not talking about HIV/AIDS is that they themselves lack basic understanding of HIV/AIDS (Dilworth, 2009; Dyson, 2010).

Teachers have also noted that some learners live with grandparents and there is a need to educate them about the importance of teaching learners about and human sexuality. The concept of discussing sex related topics is a foreign concept to them and they need to be made to understand that it is for the good of the learners. Since many teachers cited that parents are in need of information to effectively educate learners, we asked them if the school should be educating parents; 26% felt that the school can be tasked to provide parents with education on sexual health and HIV/AIDS. Only 74% of the teachers felt that the school should not be tasked to provide HIV/AIDS education. Fifty-seven percent reasoned that parents need the education but it cannot be expected of schools to also educate parents in addition to learners and suggested that parents get the information from the numerous programmes taking place in the community.

There were 5 questionnaires that could not be included in the study due to illegibility and incompletion, and another five that were not returned. The researcher suspects that some of these questionnaires were given mostly to grandparents.

5.12 Suggestions by parents to improve HIV/AIDS education

Parents suggestions ranged from the improving the content to parental involvement. The following is a summary of the suggestions:

- Increase the frequency of teaching HIV/AIDS at school
- Revise the age-appropriateness of the content
- Ensure that all children are included in the programmes
- Inclusion of parents in HIV/AIDS education
- Give counseling services to learners affected and infected by HIV/AIDS
- Teach learners on antiretroviral therapy to adhere

Some of the suggestions by parents are in line with recommendations by authors who have studied some of the programmes. Many programmes have been critisized for giving learners the options of whether to participate or not because it is reasoned that learners who percieve themselves not at risk of HIV infection would often not volunteer. For example, My Future is My Choice has been criticized for not reaching all learners and for giving learners a choice to either participate or not since most learners who are more vulnerable may not choose to participate hence remaining vulnerable to HIV infection (Chandan et al., 2008). Teachers in this study have suggested that one of the roles that parents can play is to encourage learners to participate in HIV/AIDS activities and programmes at school.

5.13 Recommendations

The research findings indicated that 70% of parents who took part in this were aware of their children's involvement in HIV/AIDS programmes and activities at school. However there were the 30% who indicated that they were not aware. Based on the findings of the study, the following recommendations are made:

- School inspectors and principal should ensure that teachers follow the guidelines given by the National Institute for Education Development in Namibia to ensure that the practice of involving parents in the HIV/AIDS education programmes is being followed.

- It is recommended that schools follow the guidelines given by the National Institute for Education Development in Namibia on how to ensure parental involvement in HIV/AIDS programmes.

- It is also recommended that schools make it a standard practice of entering into dialogues with schools on the content of HIV/AIDS programmes to reduce hostility form parents as a result of misunderstandings about what is being taught in HIV/AIDS programmes.

- Schools are are also advised to follow best practices cited in this study of various ways that it can involve parents in order to help them share the responsibility of educating children about HIV/AIDS.

- Schools that had difficulty involving parents in the past or who faced hostility from parents as a result of teaching HIV/AIDS are advised to inform the regional offices of such incidences and to make use of leaders and expertise from the education ministry to intervene.

- Schools are are adviced to encourage parents to make enquieries about HIV/AIDS programmes offered at schools.
- Parents are encouraged to approach schools for clarification on any matter concerning HIV/AIDS education
- It is also recommended that the education ministry conducts a study country wide on the involvement of parents in HIV/AIDS education in schools as recommendations from such a study will can help to improve the effectiveness of programmes in schools.

5.14 Conclusion

This chapter contains a discussion of the findings of the study on the role of parents in HIV/AIDS education offered in schools in 2010, in Oshana Education Directorate. In total 14 teachers from 10 schools and 20 parents took part in the study.

The study indicated that teachers are well aware of some of the negative cultural practices that increase vulnerability to HIV infection in their community. The school must then include custodians of culture (parents0 if it is to change and challenge negative cultural practices in society that infringe on their ability of young people to make sensible decisions that prevent HIV infection or prolong life after infection. Teachers also confirmed that learners have an apathetic attitude towards HIV/AIDS and this is in line with observations made by the Ministry of Health and Social Services in 2009. It also appears that learners' negative attitude towards HIV/AIDS has not been addressed with the involvement of parents. All parents who took part in the study (100%) indicated that they agreed with the school teaching learners about HIV/AIDS and would give permission for their children to be taught about HIV/AIDS in school. This research has demonstrated that parents who oppose sexual health education are fewer compared to those who have indicated support. There was a discrepancy in the number of parents who were aware of their

children's involvement in HIV/AIDS education and confirmation by the school that the child attended HIV/AIDS programmes. This can be explained perhaps by the findings from interviews with (teachers) that some schools did not inform parents or asked their permission for learners to take part in the HIV/AIDS programmes.

Parents who took part in this study did not indicate the false belief that education given at school on sexuality encourages yound people to practice sex. All teachers from ten schools agreed that parents can and should play a role in HIV/AIDS education offered in school. However the practice of involving parents in HIV/AIDS education is not being practiced by all schools. It also appears as if some teachers are not aware that this is a recommended practice from NIED.

Since content analysis of all three programmes (Window of Hope, My Future is My Choice and the Life Skills subject) reveal that the ABC (abstinence, be faithful, use of condoms) model is being taught to learners, parents' suggestions draws attention to the fact that some schools are not informing parents about the content of programmes hence perpetuating the belief that this topics are not being taught.

Self-perceived competency among parents who took part in this study is below 50% and the researcher is of the opinion that this is not good especially since parents are expected by teachers to talk to learners about HIV/AIDS.

Some of the suggestions by parents on how to improve HIV/AIDS education ranged from the improving the content to parental involvement. Some of the suggestions by parents, such as the voluntary requiredment of learner participation, are in line with recommendations by authors who have studied some of the programmes.

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Addendum A: Interview guide (In-depth Interview)

Interview Guide Questions for teachers

1. What is the purpose of the school teaching HIV?
2. What values/ behavior changes do you want learners to learn?
3. Did you involve parents in the HIV programmes in 2010?

3.1. References to parents as sources of information
3.2. Obtaining parental consent for children's participation
3.3. Pre-service meetings with parents to explain the purpose of the programme
3.4. Inclusion of parents in the design or pilot testing of programmes
3.5. Active involvement by parents in components of the programme
3.6. Providing sexuality education to parents to prepare them to serve as co-educators in the programme.

4. What are parent's attitudes towards HIV education the school offers?
5. Is there any role that parents can play that would be beneficial to learners to learn better on how to implement what you teach them?
6. What cultural norms/practices or any other practice that negatively influences learners not to practice what they are taught in HIV education?

Thank you for participating in the focus group interview. Is there anything else that you would like to tell me that you feel is important and was not covered in the discussion?

Addendum B: Questionnaire for parents

RESEARCH QUESTIONNAIRE

You are asked to participate in a research study conducted by Reginald Tuleni Ndokotola, a student from the Africa Centre for HIV and AIDS and the Management Sciences Faculty at Stellenbosch University. The results of this study will anonymously be processed into the study report on the role of parents in HIV/AIDS education offered in schools in Oshana Region. You were selected as a possible participant in this study because your child attended Life Skills, Window of Hope or My Future is My Choice at school in 2010.

INSTRUCTIONS:

- ALL PARTICIPANTS ANSWER SECTION 1 AND 2.
- BASED ON THE ANSWERS YOU PROVIDED IN SECTION 1 AND 2 ANSWER ONLY SECTION 3 OR 4 OR 5

SECTION 1: DEMOGRAPHIC DATA

1.1. Indicate the year in which your child was born?

_____

1.2. What grade was your child in 2010?

Grade 4	Grade 5-7	Grade 8-9	Grade 10	Grade 11-12

1.3. What is the sex of your child?

Male	
Female	

1.4. How long did your child attend the school he/she attended in 2010?

1 year	
2 years	
3 and more years	

2. SECTION TWO: ATTITUDE AND PRACTICE

2.1. Are you aware of any HIV/AIDS education programmes or activities in schools?

YES	
NO	

(If you answered 'yes', proceed to the next question)

(If you answered 'no', proceed to question 2.4)

2.2. If you answered yes to question 2.1. , indicate the HIV/AIDS education programmes or activities in schools that you are aware of? Tick in the appropriate box (es)

Window of Hope	
My Future is My Choice	
Life Skills	
Other	Specify:

2.3. If you answered YES to question 2.1., did your child attend any of the programmes or activities you have mentioned above during 2010 academic year?

YES	
NO	

I DON'T KNOW	

(If you answered YES, proceed to question 3)

(If you answered 'no' or 'I don't know', proceed to the next question)

2.4. Would you agree to have your child taught HIV/AIDS education in school?

YES	
NO	

(If you answered 'yes', proceed to question 4)

(If you answered 'no', proceed to question 5)

3. SECTION 3: ATTITUDE AND PRACTICE

INSTRUCTIONS: If you answered YES to question 2.3 answer the following questions.

3.1. Did you give permission for your child to be involved in HIV/AIDS education programmes or activities?

YES	
NO	

3.2. Do you agree with the school teaching and involving your child in HIV/AIDS education programmes or activities?

YES	
NO	

3.3. What was taught in the HIV/AIDS education programmes or activities that your child attended?

_____

_____

_____

_____

_____

3.4. What contribution did you make to help your child learn what was taught at school in the HIV/AIDS education programmes or activities?

_____

_____

_____

_____

_____

3.5. How were you involved by the school in the HIV/AIDS education programmes or activities that your child attended?

_____

_____

_____

_____

_____

3.6. What was taught in the HIV/AIDS education programmes or activities that your child attended in 2010 that you were not happy with? Tick in the appropriate box (es)

1. Puberty and changes in male and female body	
2. Pregnancy and reproductive health	
3. Methods of contraception	
4. HIV and STI transmission	
5. Abstain, Be faithful and Condom use	
6. How to use a condom	
7. Stigma and discrimination against PLWHA	
8. Voluntary Counselling and Testing, and ARVs	
9. Health and social risks of alcohol and	
10. drug abuse	
11. other: specify	

3.7. What positive changes do you think HIV/AIDS education programmes or activities had on your child?

_____

_____

_____

_____

_____

3.8. What negative changes do you think HIV/AIDS education programmes or activities had on your child?

_____

_____

_____

_____

_____

3.9. What else would you like your child to be taught in the HIV/AIDS education programmes or activities that your child attended in 2010 that was not taught but should be taught?

_____

_____

_____

_____

_____

3.10. Considering the age of your child in 2010, was the content of the HIV/AIDS education programmes or activities that your child attended age-appropriate? Please motivate your answer?

YES	
NO	

_____

_____

_____

_____

_____

3.11. Tell us about a situation when your child asked or needed your help with understanding HIV/AIDS?

_____

_____

_____

_____

_____

3.12. Do you think your knowledge and understanding of HIV/AIDS makes you competent to teach your child about HIV/AIDS?

YES	
NO	

3.13. What recommendations or suggestions would you give to the school to improve the HIV/AIDS education programmes or activities they teach to learners?

4. _____

_____

_____

_____

_____

5. SECTION FOUR: ATTITUDE AND PRACTICE

INSTRUCTIONS: If you answered YES to question 2.4 answer the following questions.

5.1. From what age should your child be taught or be involved in HIV/AIDS education programmes or activities in school?

_____

5.2. At the age that is appropriate for your child to be taught about HIV/AIDS, what information/education do you think your child should be taught at school?

_____

_____

_____

_____

_____

5.3. What information/education about HIV/AIDS do you think your child should NOT be taught at school? Tick in the appropriate box (es)

1. Puberty and changes in male and female body	
2. Pregnancy and reproductive health	

3. Methods of contraception	
4. HIV and STI transmission	
5. Abstain, Be faithful and Condom use	
6. How to use a condom	
7. Stigma and discrimination against PLWHA	
8. Voluntary Counselling and Testing, and ARVs	
9. Health and social risks of alcohol and	
10. drug abuse	
11. other: specify	

5.4. Do you think your knowledge and understanding of HIV/AIDS makes you competent to teach your child about HIV/AIDS?

YES	
NO	

5.5. Do you think there is any role you can play together with the school to help your child learn about HIV/AIDS? Specify those roles.

_____

_____

_____

_____

_____

5.6. What recommendations or suggestions would you give to the school to improve the HIV/AIDS education programmes or activities they teach to learners?

_____

_____

_____

_____

_____

_____

_____

_____

5.7. What reasons do you have not to allow your child to be taught or be involved in HIV/AIDS education or activities in school? Tick in the appropriate box (es)

1. Learners should not be taught about HIV/AIDS	
2. Learners should not be taught any sex related topics	
3. I don't want strangers teaching my children about HIV/AIDS	
4. It is against my church beliefs to talk to children about sex related topics	
5. It is against my culture to teach children about any sex related topics	
6. The schools are encouraging learners to have sex as long as they use condoms	

5.8. Who or what should be your child's source of information about HIV/AIDS? Tick in the appropriate box (es)

TV	

RADIO	
Internet	
Newspapers/Magazines	
Family members in-cluding myself	
Other (please specify) ……	
NONE	

5.9. What recommendations or suggestions would you give to the school with regard to the HIV/AIDS education programmes or activities they teach to learners?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for answering the questionnaire

Addendum C: Letter to the Ministry of Education

AFRICA CENTRE FOR HIV/AIDS MANAGEMENT

07 November 2011

Ministry of Education
The Permanent Secretary
Private Bag 13186
Windhoek
Namibia

Dear Sir / Madam

Re: Intention to conduct a research project with parents and teachers of learners who attended Life Skills lessons in 2010 at schools in Oshana Region

Ms. Reginald T. Ndokotola, a Master of Philosophy student in HIV and AIDS Management, (Student Number: 159309379, at the Africa Centre for HIV/AIDS Management at Stellenbosch University intends to conduct research with parents of learners from schools in the Oshana Region as well as teachers.

In order to identify parents of learners, the student will need attendance registers of learners who attended My Future is My Choice and Window of Hope Program in 2010 in 8 schools in Oshana Region. The target group will be parents and not learners. This letter is intended to give authenticity of Ms. Ndokotola's request for attendance registers mentioned above in order to identify parents who will take part in the study. In addition to parents, research participants will also include teachers involved in the above-mentioned programs and therefore we humbly request permission for Ms. Ndokotola to interview 2 educators from each of the 8 schools in Oshana Region.

Schools will be randomly selected. Parents will be given a completely anonymous self-administered questionnaire that contains both open and close ended questions that asks their experience, knowledge and opinion of the Life Skills programs, and their recommendations thereof. Teachers will be will be interviewed by the researcher using a questionnaire. The completed questionnaire will be collected and all necessary precautions will be taken to ensure that the questionnaires are not accessible by any other person. The research is primarily academic but the results of the study will be submitted to the Ministry of Health and Social Services.

We therefore kindly request permission for Ms. Reginald Ndokotola to carry out this study at the schools in Oshana Region. The study should run in November before the closing of the academic year 2011. Feel free to contact us if you have any further questions.

Kind Regards

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Africa Centre for HIV/AIDS Management
Stellenbosch University
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F: + 27 21 808 3015
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Addendum D: First permission letter from the Ministry of Education

FROM :DIRECTORATE – PQA FAX NO. :061 2933922 Nov. 16 2011 12:40PM P1

REPUBLIC OF NAMIBIA
MINISTRY OF EDUCATION
Private Bag 13186, Windhoek

Tel: 061 293 3278
Fax: 061 293 3922

Ref: 11/2/1
Enquiries: Mr. M. Gqwede

10 November 2010

Ms Reginald Ndokotola
Intermediate Hospital Oshakati
OSHAKATI

For Attention: Identified School Principals

MS REGINALD NDOKOTOLA: REQUEST FOR PERMISSION TO CARRY OUT A RESEARCH STUDY IN EIGHT (8) SCHOOLS AT OSHANA REGION.

1. Ms Ndokotola, a social worker at Intermediate Hospital Oshakati, has approached my office to request permission to conduct a research study in eight (8) identified schools at Oshana Region in fulfilment of the requirements for Master of Philosophy in HIV and AIDS Management at Stellenbosch University in South Africa. She is known to the Diagnostic Advisory and Training Services (DATS) division of the Ministry of Education as she served as an Assistant Regional School Counsellor and currently a very reliable resource person that Oshana Region depends on for handling some learner referral cases to social workers.

2. It has always been the conviction of this Ministry that the teaching and learning in schools should not be disrupted whatsoever owing to individual, community or organizational activities, including carrying out research.

3. It is always crucial to have the input of the school principal in mapping out the modalities to ensure that disruptions of teaching and learning activities do not take place in the process of carrying out a research study.

4. Therefore, permission to carry out a research study in eight identified schools is thus hereby conditionally granted pending the result of your discussions with school principals.

Yours in Education

Mr A. ILUKENA
PERMANENT SECRETARY

14 NOV 2011

Cc – The Regional Education Director: Oshana Region

Addendum E: Second permission letter from the Ministry of Education

REPUBLIC OF NAMIBIA

MINISTRY OF EDUCATION

Tel: 264 61 2933200
Fax: 264 61 2933922
E-mail: mshimho@mec.gov.na
Enquiries: MN Shimhopileni

Private Bag 13186
Windhoek
NAMIBIA

13 December 2011

File: 11/5/1

Ms Reginald Ndokotola
Intermediate Hospital Oshakati
Private Bag 553
OSHAKATI

Dear Ms Ndokotola

RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY IN TWO ADDITIONAL SCHOOLS IN OSHANA REGION

Your letter dated 30 November 2011 on the subject above, has reference.

It has been stated in the letter that the study would be conducted in November and ironically, the letter of request is dated 30 November 2011. One wonders now when in November would the activity be conducted since the month of November is over. Notwithstanding, we feel obliged to respond.

Since you were granted permission to go into 8 schools previously, in principle, you got the permission already. Nevertheless, for the two additional schools, you are kindly advised to approach the Regional Council through the Directorate of Education for authorization thereof.

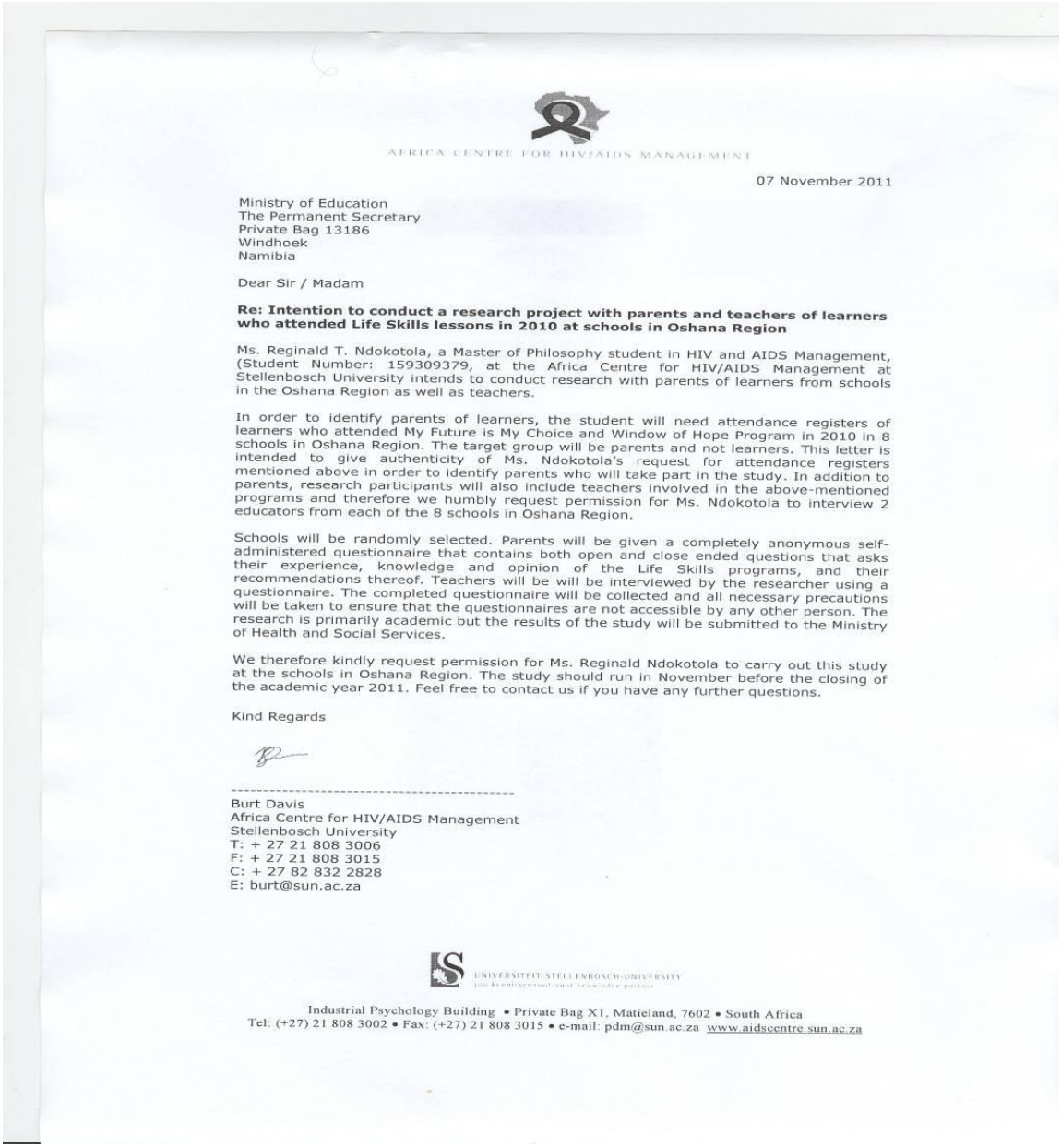
Thank you for your cooperation.

Yours faithfully

A Ilukena
PERMANENT SECRETARY

MINISTRY OF EDUCATION
Office of the Permanent Secretary
15 DEC 2011
Private Bag 13186, Windhoek Namibia

Addendum F: Letter from the University of Stellenbosch



AFRICA CENTRE FOR HIV/AIDS MANAGEMENT

07 November 2011

Ministry of Education
The Permanent Secretary
Private Bag 13186
Windhoek
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In order to identify parents of learners, the student will need attendance registers of learners who attended My Future is My Choice and Window of Hope Program in 2010 in 8 schools in Oshana Region. The target group will be parents and not learners. This letter is intended to give authenticity of Ms. Ndokotola's request for attendance registers mentioned above in order to identify parents who will take part in the study. In addition to parents, research participants will also include teachers involved in the above-mentioned programs and therefore we humbly request permission for Ms. Ndokotola to interview 2 educators from each of the 8 schools in Oshana Region.

Schools will be randomly selected. Parents will be given a completely anonymous self-administered questionnaire that contains both open and close ended questions that asks their experience, knowledge and opinion of the Life Skills programs, and their recommendations thereof. Teachers will be will be interviewed by the researcher using a questionnaire. The completed questionnaire will be collected and all necessary precautions will be taken to ensure that the questionnaires are not accessible by any other person. The research is primarily academic but the results of the study will be submitted to the Ministry of Health and Social Services.

We therefore kindly request permission for Ms. Reginald Ndokotola to carry out this study at the schools in Oshana Region. The study should run in November before the closing of the academic year 2011. Feel free to contact us if you have any further questions.

Kind Regards

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