

**PERCEPTION OF TEACHERS TO SEXUALITY EDUCATION IN SECONDARY  
SCHOOLS IN GABORONE, BOTSWANA**

by

**Michael Kasonde**

*Assignment presented in fulfilment of the requirements for the degree  
of Master of Philosophy in the Faculty of Economic and Management  
Sciences at Stellenbosch University*



Supervisor: Prof. Elza Thomson

March 2013

## **DECLARATION**

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date: March 2013

## ABSTRACT

The role of schools as site for sexual health promotion has been widely acknowledged. Studies have shown that the education sector has a strong potential to make a difference in the fight against HIV and AIDS. Comprehensive sexuality education programs are known to delay initiation of sex, reduce number of sexual partners and increase the use of condoms and other forms of contraceptives. The aim of this study was to establish the attitude and perception of teachers to sexuality education in senior secondary schools in Gaborone, Botswana. This was a cross-sectional, quantitative study aimed at establishing the knowledge and attitudes of 25, randomly selected teachers to sexuality education in secondary schools of Gaborone, Botswana. The survey was conducted using a self-administered, closed-ended, structured questionnaire. Out of 25 respondents, 14 were males and 11 females. The mean age was 44.5 years. Eighty percent were married and 20% single. The levels of education of respondents were (60%) with a bachelors' degree in education, 20% with diploma, 12% with masters' degree and 8% with certificate in education. Majority (80%) agreed that sexuality education was appropriate and a high proportion of respondents (97%) were willing to teach sexuality education. A greater number of respondents (72%) indicated that sexuality education should include contraceptives, but 64% were of the view that condoms should not be made available to students in secondary schools. Ninety-two percent agreed that sexuality education delays sexual debut and all respondents agreed that sexuality education increases awareness of HIV and AIDS. Overwhelming number of respondents (96%) agreed that sexuality education promotes condom use. Only forty-four percent indicated that the current school curricula were appropriate for teaching sexuality education. Majority (68%) indicated that the school curricula do not cover topics on abortion and communication and negotiation skills to reduce risks for HIV, other sexually transmitted diseases and pregnancy. The major barriers to sexuality education are culture (60%) and lack of training (24%). Majority of teachers (64%) indicated that they were not trained to teach sexuality education. Teachers in Gaborone secondary schools are knowledgeable on sexuality education and their attitude and perception of sexuality education are mostly positive. Culture and lack of training are the major barriers to teaching sexuality education in secondary schools. Teachers need in-service training to improve their overall knowledge on

sexuality education and modify their cultural beliefs. The school curriculum needs to be updated to include all aspects of sexuality education.

## OPSOMMING

Die rol van skole as 'n terrein vir die bevordering van seksuele gesondheid is wyd erken. Studies het getoon dat die onderwys-sektor 'n sterk potensiaal om 'n verskil te maak in die stryd teen MIV en vigs. Omvattende seksualiteitsopvoeding programme is bekend inleiding van seks te vertraag, die aantal seksuele maats te verminder en die gebruik van kondome en ander vorme van voorbehoedmiddels te verhoog. Die doel van hierdie studie was om die houding en persepsie van onderwysers te seksualiteitsopvoeding in senior sekondêre skole in Gaborone, Botswana te vestig. Dit was 'n deursnee-, kwantitatiewe studie wat gemik is op die stigting van die kennis en houdings van 25 ewekansig geselekteerde onderwysers te seksualiteitsopvoeding in sekondêre skole van Gaborone, Botswana. Die opname is gedoen met behulp van 'n self-gedadministreerde, geslote-einde, gestruktureerde vraelys. Uit 25 respondente, 14 mans en 11 vroue. Die gemiddelde ouderdom was 44.5 years. Tagtig persent getroud is en 20% enkel. Die vlakke van onderwys van die respondente (60%) met 'n bachelors? graad in die onderwys, 20% met die diploma, 12% met die meesters? graad en 8% met 'n sertifikaat in die onderwys. Meerderheid (80%) het saamgestem dat seksualiteit, was toepaslik en 'n hoë persentasie van die respondente (97%) was bereid om seksualiteit te leer. 'N groter aantal van die respondente (72%) het aangedui dat seksualiteitsopvoeding voorbehoedmiddels moet insluit, maar 64% was van mening dat kondome nie beskikbaar gestel word aan studente in sekondêre skole. Twee-en-negentig persent ooreengekom dat seksualiteitsopvoeding verdragings seksuele debuut en al die respondente het saamgestem dat seksualiteitsopvoeding verhoog bewustheid van MIV en vigs. Oorweldigende aantal van die respondente (96%) het saamgestem dat seksualiteitsopvoeding bevorder die gebruik van kondome. Slegs 44 persent het aangedui dat die huidige skoolkurrikula geskik was vir die onderrig van seksualiteit. Meerderheid (68%) het aangedui dat die leerplanne van skole nie dek onderwerpe oor aborsie en kommunikasie en onderhandeling vaardighede om risiko's te verminder vir MIV en ander seksueel oordraagbare siektes en swangerskap. Die belangrikste struikelblokke tot seksualiteit is kultuur (60%) en 'n gebrek van opleiding (24%). Meerderheid van onderwysers (64%) het aangedui dat hulle nie opgelei om seksualiteitsopvoeding te leer. Onderwysers in Gaborone sekondêre skole is kundige op seksualiteit en hul houding en persepsie van seksualiteit is meestal positief. Kultuur en gebrek aan opleiding is die belangrikste struikelblokke om seksualiteitsopvoeding in sekondêre skole te

onderrig. Onderwysers moet in-diens opleiding hul algehele kennis oor seksualiteit te verbeter en hul kulturele oortuigings te verander. Die skool se kurrikulum moet opgedateer word om alle aspekte van seksualiteit in te sluit.

<b>TABLE OF CONTENTS</b>	<b>PAGE NUMBERS</b>
<b>CHAPTER ONE: INTRODUCTION</b>	<b>6</b>
1.1 Introduction	6
1.2 Background	6
1.3 Significance of the study	7
1.4 Research problem and question	8
1.5 Aim and objectives of research	8
1.6 Research methodology	8
1.7 Limitations of the study	8
1.8 Outline of chapters	9
1.9 Conclusion	9
<b>CHAPTER TWO: LITERATURE REVIEW</b>	<b>10</b>
2.1 Introduction	10
2.2 The impression of HIV/AIDS on the world	10
2.3 HIV/AIDS in Botswana	<b>10</b>
2.4 Education and HIV/AIDS	13
2.5 Sexuality education in Botswana	16
2.6 Conclusion	17
<b>CHAPTER THREE: RESEARCH METHODOLOGY</b>	<b>18</b>
3.1 Introduction	18
3.2 Problem statement	18
3.3 Objectives	18
3.4. Research approach	18
3.5 Sampling method	20
3.6 Ethical consideration	21
3.7 Conclusion	21

<b>CHAPTER FOUR: REPORTING OF RESULTS</b>	<b>22</b>
4.1 Introduction	22
4.2 Findings	22
4.3 Discussion	28
4.4 Conclusions	32
<b>CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS</b>	<b>33</b>
5.1. Introduction	33
5.2 Study objectives and study findings	33
5.3 Conclusions	35
<b>LIST OF FIGURES</b>	
Figure 4.1 Education levels of respondents	23
Figure 4.2 Age distribution of respondents	24
Barriers to sexuality education	25
<b>LIST OF TABLES</b>	
Table 4.1 Socio-demographics of respondents	22
Table 4.2 Teachers' willingness to teach sexuality education	24
Table 4.3 Perceptions and attitudes of teachers to key sexuality issues	26
Table 4.4 Knowledge about effective birth control methods	27
Table 4.5 Knowledge about some key sexuality issues	27
Table 4.6 Appropriate age for receiving sexuality education	28
<b>6. REFERENCES</b>	<b>31</b>
<b>APPENDICES</b>	<b>41</b>
Appendix 1. Copy of questionnaire	41
Appendix 2. Ministry of Education permission to conduct research.	47
Appendix 3. Copy of consent	48
Appendix 4. University of Stellenbosch ethical clearance	51

## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 INTRODUCTION**

UNAIDS (2010) reported that in 2009 there were an estimated 2.6 million people who became infected with HIV, nearly 19% fewer than the 3.1 million people newly infected in 1999. UNAIDS indicated that in Sub Saharan Africa (SSA), where the majority of new infections continue to occur; an estimated 1.8 million people become infected in 2009, considerably lower than the estimated 2.2 people in SSA newly infected with HIV in 2001. According to UNAIDS, SSA still bears an inordinate share of the global Disburden and although the rate of new HIV infection has decreased, the total number of people living with HIV continues to rise. Knowledge of the epidemic and how to prevent HIV infection has increased among young people aged 15-24 years; however young people still lack the knowledge and, importantly, often lack the tools they need to practice HIV risk-reduction strategies (UNAIDS).

Over the past few decades, the role of the schools as a site for sexual health promotion has been widely acknowledged (World Bank, 2002). According to the World Bank, countries' education sectors have a strong potential to make a difference in the fight against HIV/AIDS. The World Bank reported that education sectors offer an organized and efficient way to reach large numbers of school-age youth-groups either most at risk or most receptive to efforts to seek to influence behavior. UNESCO (2006) defines sexuality education as an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information. UNESCO pointed out that sexuality education provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality. According to Berger (2008) sexuality education seeks both to reduce the risks of potentially negative outcomes from sexual behavior like unwanted or unplanned pregnancies and infection with sexually transmitted diseases, and to enhance the quality of relationships. It is also about developing young people's ability to make decisions over their entire lifetime.

## 1.2 BACKGROUND OF THE STUDY

UNAIDS (2006) estimated young people between 15 and 24 years account for 45% of all new HIV infection, justifying enhanced efforts to prevent infection among people both in and out of school. Inadequate sexuality education in secondary schools can impact negatively on how young people respond to HIV epidemic especially with regard to HIV prevention practices. Young people have unprotected sexual intercourse with one or more partners, potentially exposing themselves to HIV, other sexually transmitted infections (STIs) or unintended pregnancy (Pearson, 2012). Pearson reported comprehensive sexuality education programs work to delay initiation of sex, reduce the number of sexual partners and increase the use of condoms and other forms of contraception. The perception of teachers to sexuality education in schools can affect how they teach sexuality education in general and HIV/AIDS education in particular. Sexuality education is often discussed and evaluated in terms of its role in reducing adolescent pregnancy and sexually transmitted diseases (STDS) rates (Asekun-Olarinmoye, Fawole, Dairo, Amusan, 2007). Asekun-Olarinmoye et al pointed out the primary goal of sexuality education is much broader-to give young people the opportunity to receive information, to examine their values and to learn relationship skills that will enable them to resist becoming sexually active before they are ready, to prevent unprotected intercourse and to help young people become responsible sexually active adults.

It is not known how teachers perceive sexuality education in secondary schools in Gaborone, Botswana. UNESCO (2010) reported it is important to acknowledge that teachers have their personal, cultural and traditional beliefs and values and these affect their comfort, willingness and ability to teach sensitive topics in the appropriate language. UNESCO emphasized like other members of society, teachers live within a network of cultural and traditional beliefs that must be acknowledged and addressed if they create a barrier to effective teaching. Teachers' confidence about teaching sex education could depend on their negative outcome expectations because sex education in general is not value-free, but loaded with meaning and a teacher might consider that parts or the whole content of a program contradicts her/his own values and norms, those of the students or the parents, or values and norms in the community in general (Helleve, Flisher, Onya, Mathews & Aaro et al, 2009). According to the Global Campaign for Education (CGE) (2004) education is so strongly predictive of better knowledge, safer behavior and reduced HIV

infection rates that it has been described as the ‘social vaccine’ and United Nations and World Bank experts say ‘it may be the single most effective preventive weapon against HIV/AIDS’.

### **1.3. SIGNIFICANCE OF THE RESEARCH**

Sexuality education plays an important role in raising awareness about HIV among adolescents in schools. How teachers perceive sex education impacts on the effectiveness of such programs in schools. The results from this research study will assist to improve sex education in secondary schools in Gaborone, Botswana

### **1.4 RESEARCH PROBLEM AND QUESTION**

Young people in secondary schools engage in sexual intercourse at an age when they are not physically and emotionally ready. They therefore put themselves at risk of HIV infection. Sex education in secondary schools has been shown to delay sexual debut, increase condom use and increase HIV/AIDS awareness. The research problem is the attitude and perception of teachers to sex education is not known in secondary schools of Gaborone, Botswana. Therefore the research question was: What knowledge, perceptions and attitudes do teachers have about sex education in secondary schools in Gaborone, Botswana?

### **1.5 AIM AND OBJECTIVES OF RESEARCH**

The aim of this research was to establish the knowledge, perception and attitudes of teachers towards sex education in secondary schools in Gaborone, Botswana in order to make recommendation for improving sex education in schools.

The objectives of research were:

- To establish teachers’ perception of appropriateness of the current school curriculum to sexuality education
- To determine the level of knowledge of sex education among teachers in secondary schools
- To establish attitudes and perception of teachers to sex education in secondary schools.
- To make recommendations for improving sexuality education in secondary schools

## 1.6 RESEARCH METHODOLOGY

This was a cross-sectional, quantitative study aimed at establishing the perception, knowledge and attitudes of teachers to sexuality education in secondary schools of Gaborone, Botswana. Twenty five teachers were randomly selected and a closed-ended, Likert-like type questionnaire was administered. Data analysis was done by using descriptive statistics with the determination of frequencies and means.

## 1.7 LIMITATIONS OF THE STUDY

Even though sampling was robust, the survey had a relatively small sample size. The survey involved both public and private schools. It could have been more appropriate to compare data between the private and public schools. Involving only teachers in senior secondary schools limited the depth of the data obtained during the survey. Some participants could have given answers which they thought the researcher wanted to hear because the researcher was present when some of the questionnaires were being answered. The presence of the researcher when some questionnaires were being answered could have induced social desirability bias as well as central tendency bias. McLeod (2008) reported that Likert scales may be subjected to distortion from several causes. McLeod (2008) pointed out that respondent may avoid using extreme responses category-central tendency bias or they may try to portray themselves or their organization in a more favorable light-social desirability bias.

## 1.8 OUTLINE OF THE CHAPTERS

**Chapter one** covers an overview of the entire research process. It highlights the background to the study as well as the significance of the study. Chapter one also discusses the research problem and research question. The objectives of the study are also highlighted. This chapter also gives an introduction to the research methodology used and the limitation of the data collection technique.

**Chapter two** revisits the literature on sexuality education in schools and also defines sexuality education with emphasis on its importance in the fight against HIV among children and young adults.

**Chapter three** covers the study's research design and methodology. The research design is discussed, and the data collection technique is mentioned. The chapter also mentions the

geographical area of the research, the research participants, sampling technique and how data was analyzed.

**Chapter four** covers the results of the study and presents the findings on socio-demographics, knowledge and attitude/perception of teachers.

**Chapter five;** discussion of the results is done with reference to the aim and objectives of the study. Possible solutions to the limitations of the study are put forward and recommendations are proposed for possible practical use of study results.

## **1.9 CONCLUSION**

Chapter one provides an overview of the entire research process. In chapter two, literature on sexuality education is discussed with an emphasis on HIV and AIDS.

## **CHAPTER TWO**

### **HIV/AIDS IN PERSPECTIVE**

#### **2.1 INTRODUCTION**

The focus is on the status of the HIV and AIDS pandemic globally, in Sub-Saharan Africa and in Botswana. The impact of the pandemic on the socio-economics of Botswana is placed in context to indicate the impact on the socio-economic sectors. The vulnerability of children and adolescents to HIV provides a siren to draw the attention to this sector of the population that will be the adults of tomorrow. The role of teachers in schools in combating the epidemic can make a positive contribution by guiding young people towards a more rewarding future.

#### **2.2 THE IMPRESSION OF HIV/AIDS ON THE WORLD**

UNAIDS 2010 reported that in 2009, there were an estimated 2.6 million people who became infected with HIV, nearly 19% fewer than the 3.1 million people newly infected in 1999. UNAIDS indicated in Sub Saharan Africa (SSA) where the majority of new infections continue to occur; an estimated 1.8 million people become infected in 2009, considerably lower than the estimated 2.2 people in SSA newly infected with HIV in 2001. According to UNAIDS, SSA still bears an inordinate share of the global HIV burden and although the rate of new HIV infection has decreased, the total number of people living with HIV continue to rise. UNAIDS reported despite extensive progress against a number of indicators on the global scale, many countries will fail to achieve millennium development goal 6: halting and reversing the spread of HIV. Knowledge of the epidemic and how to prevent HIV infection has increased among young people aged 15-24 years, however, young people still lack the knowledge and more important often lack the tools they need to practice HIV risk-reduction strategies (UNAIDS).

#### **2.3 HIV/AIDS IN BOTSWANA**

Preliminary results show there were 2,038,228 persons enumerated in Botswana during the 2011 population and housing census, compared with 1,680,863 enumerated in 2001 ([www.cso.gov.bw](http://www.cso.gov.bw), retrieved on 19/04/12). Botswana is one of the hardest hit countries by the HIV/AIDS epidemic in the world with the national prevalence of about 17.6 percent (Botswana AIDS impact survey (BAIS), 2008; 27). HIV in Botswana is spread mainly by the heterosexual

route (Macdonald, 1996). In Botswana, South Africa and Zambia, AIDS is the leading cause of death and the mortality rates for the 15-49 age group in these countries have increased dramatically (Joint United Nations Program on HIV/AIDS, US Census Bureau, 2004).

### **2.3.1 Risk factors for HIV infection in Botswana**

The following risk factors have been identified as playing important roles in the spread of the HIV epidemic in Botswana.

#### **• Mobile population**

Botswana has one of the most mobile populations in the world and for years, Botswana has had to be mobile and live regularly in two to four different abodes, on a cattle post, in farmlands, a village and towns (International encyclopedia of sexuality, 2006). The encyclopedia reported that circulating often between these areas for extended periods, especially during long weekends, has proved to be one of the driving forces of the HIV epidemic in Botswana. Botswana is also a transport hub for Zimbabwe, South Africa, Namibia and Zambia all of which share the high prevalence rates that characterize the HIV pandemic in Southern Africa (Botswana National Strategic framework for HIV/AIDS, 2003-2009).

#### **• Early sexual debut**

BAIS (2008) reported early sexual debut is one of the risk factors for HIV infection in Botswana. According to BAIS, of 764,160 respondents who ever had sexual intercourse, 53% had first sexual intercourse when aged 15-19 years. David and Dick (2006) reported delaying the age at which young people first engage in sexual intercourse can protect them from infection. David and Dick (2006) pointed out that adolescents who begin sexual activity early are at a higher risk of becoming infected with HIV. They noted research in different countries have shown that adolescents who start sexual activity early are more likely to have sex with high-risk partners or multiple partners and are less likely to use condoms.

#### **• Concurrent sexual partners**

Concurrent multiple sexual partners in Botswana contributes to sexual transmission of HIV. Concurrency changes the reachable path of infection and accelerates transmission (Martin Morris

Nairobi PSI May 2010). In a report on concurrent partnerships in Botswana, Cater (2007) reported 23 % had sex with someone else while in a sexual relationship with a partner from the last 12 months while 7.7% reported being in two or more concurrent partnerships at the time of survey. 23.8% had more than 1 sexual partner either concurrently or serially in the last months while 18.6% reported multiple and concurrent partnerships.

**•Low male circumcision.**

According to BAIS 2008 among the males aged 10-64 years, only 11.8% reported being circumcised. These low levels of circumcision in Botswana increases the risk of HIV transmission. The scientific evidence accumulated over more than 20 years shows that among the strategies advocated during this period for HIV prevention male circumcision is one of, if not the most efficacious epidemiologically, as well as cost-wise (Wamail RG et al, 2011). This is supported by trials on safe male circumcision in South Africa, Uganda and Kenya that showed compelling evidence that SMC is 60% effective in reducing the risk of acquiring HIV in circumcised men (WHO, 2007).

**•Marginalization of gay people**

The department of civil and national registration in Botswana refused to register a group called lesbian, gays and bisexuals of Botswana (LeGaBiBo) because the organization was ruled to be contrary to the Botswana penal code, which outlaws male and female homosexual acts in the country, ([Globalgaz.com/Africa/Botswana](http://Globalgaz.com/Africa/Botswana), 2012). There is widespread denial of homosexuality in the country and this is putting both homosexuals as well as heterosexuals at risk of HIV infection. Stefan Baral et al (2009) reported that men who have sex with men (MSM) are a high-risk group for HIV infection and concurrency of sexual partnerships with partners of both genders may play important roles in HIV spread in these populations. According to UNAIDS up to 20% new HIV infections in Senegal and 15% in Kenya and Rwanda could be linked to unprotected sex between men. UNAIDS also reported evidence suggest that in SSA as elsewhere in the world, the majority of MSM also have sex with women. Therefore by marginalizing homosexuals in Botswana, the HIV epidemic continues to grow not only in the homosexual communities but in the general populations as well.

**•Low perception of risk**

In a longitudinal study of adolescents in Kwa-Zulu Natal, South Africa, it was reported while risk perception, the calculation of risk and behavior are consistent for some adolescents, a significant proportion of adolescents, particularly among those that consider themselves at low risk of HIV infection in the next 12 months, have inaccurate perceptions of their HIV risk. This may be due to lack of information or denial (Rutenberg et al; international conference on AIDS 2002 July 7-12; 14). Rutenberg and others also reported people in Southern Africa appear to be overconfident in their ability to avoid getting HIV/AIDS and this is helping to fuel the spread of the disease in this region. Knowledge of the epidemic and how to prevent HIV infection has increased among young people aged 15-24 years, however, young people still lack the knowledge and often lack the tools they need to practice HIV risk-reduction strategies(UNAIDS).

**•Gender inequality**

Botswana is a patriarchal society - women are subordinate to men and have historically endured various forms of discrimination and disempowerment (Ministry of Finance and Development Planning and UN Botswana 2004:39). Young females are particularly at risk because of their inability to negotiate safer sex especially if in a sexual relationship with older men and may be physiologically more prone to HIV (BAIS).This is supported by UNICEF (2011) who reported Botswana as in most high prevalence countries, HIV and AIDS has a strong gender dimension with a disproportionate spread of infection and prevalence amongst girls.

**•Alcohol and high-risk sexual behavior**

Weiser (2006) reported heavy alcohol consumption is strongly and consistently associated with sexual risk behaviors in both men and women in Botswana. Weiser noted there was a dose-related relationship between alcohol consumption and unprotected sex for both genders, in that heavy drinkers (>14 drinks/week for women,>21 for men) had higher odds of unprotected sex compared to moderate drinkers.

## 2.4 EDUCATION AND HIV/AIDS

Education is critical for the development and generation of human capital (UNDP, 2003). An educated population and workforce are fundamental to national health (World Bank, 2002). The World Bank reported that combined with sound economic policies; education is generally a key factor in promoting social well-being and poverty reduction, because it directly affects national productivity, which in turn determines living standards and a country's ability to compete in the global economy. By the mid-1980s the widespread recognition that deadly diseases can be transmitted through sexual intercourse made it politically untenable to argue that sexuality education should not be taught in schools (Asekun-Olarinmoye, 2007). Asekun-Olarinmoye reported the substance of the debate over sexuality education has also changed largely in response to the need to combat HIV/AIDS.

Education even in the absence of HIV-specific interventions, offers an important measure of protection against HIV and AIDS by ensuring that all have access to good quality, equitable education (Kelly, 2006b:1). The global campaign for education (GCE) has estimated that universal primary education would prevent 700,000 new HIV infections each year (GCE, 2004). In most countries, children between the ages of five and thirteen spend time in schools influencing their attitudes and future behaviors (UNESCO). Thus schools provide a practical means of reaching large numbers of young people from diverse backgrounds in ways that are replicable and sustainable (Gordon, 2008). Schools can also play an important role as centers of support and care for those infected or affected by HIV/AIDS (UNAIDS Inter-agency task team on education (IATT), 2009, 14-15). IATT reported education builds young women's self-esteem and capacity to act on HIV prevention messages, improving their economic prospects and education bring about an improvement in attitudes towards people living with HIV thereby reducing stigma and discrimination. This was supported by the World Bank (2002) which pointed out substantial evidence shows that education profoundly affects young people's reproductive lives. The World Bank further concluded better educated women are more likely, in comparison with their peers, to delay marriage and child bearing, have fewer children and healthier babies, enjoy better earning potential, have stronger decision making and negotiation skills as well as higher self-esteem and avoid commercial sex. There is a clear link between school attendance and higher levels of education and later sexual debut and studies have shown

that girls who have completed secondary education have a lower risk of HIV infection and practice safer sex than girls who have only finished primary education (IATT, UNAIDS 2009). Both HIV prevalence and incidence are high among the non-formal and those with no education in Botswana (BAIS, 2008). The BAIS results showed the higher the education level, the lower the HIV prevalence and incidence rates. The World Bank (2002) reported education is among the most powerful tools for reducing the social and economic vulnerability that exposes women to a higher risk of HIV/AIDS than men. Girls' education can go far in slowing and reversing the spread of HIV by contributing to poverty reduction, gender equality, female empowerment and awareness of human rights (World Bank).

IATT reported by ensuring access to quality education for all, countries can avoid escalating health-care, social and economic costs associated with rising HIV prevalence and AIDS -related impact. According to UNESCO (2009) effective sexuality education can provide young people with age- appropriate, culturally relevant and scientifically accurate information. UNESCO reported sexuality education includes structured opportunities for young people to explore their attitudes and values and to practice the decision-making and other life skills that they will need to be able to make informed choices about their sexual lives. Few young people receive adequate preparation for their sexual lives and this leaves them potentially vulnerable to coercion, abuse and exploitation, unintended pregnancy and sexually transmitted infections (STIs) including HIV (UNESCO).

UNESCO pointed out that many young people approach adulthood faced with conflicting and confusing messages about sexuality and gender and this is often exacerbated by embarrassment, silence and disapproval of open discussion of sexual matters by adults, including parents and teachers at the very time when it is most needed. The HIV epidemic varies greatly in different regions of the world, but in each of these epidemics young people are at the Centre, both in terms of new infection as well as being the greatest potential force for change if they can be reached with the right interventions (David, Bruce, 2006).

According to Iyoke et al (2006) imparting sexuality education to in-school adolescents should have an extended effect to positively affect out-of-school adolescents who often look up to in-

school adolescents as role models. Yoke et al (2006) reported adolescents are known to be vulnerable to peculiar reproductive health problems such as early initiation of sexual activity, teenage unplanned pregnancy, unsafe abortion, sexual violence and abuse, early marriage, harmful traditional practices including pubertal initiation rites. They pointed out studies in adolescent reproductive health problems in Nigeria recommend that the introduction of sexuality education is paramount in efforts to rid adolescents of ignorance on sexuality/reproductive health issues and suggest the use of in-school programs involving primary, secondary and tertiary levels of education. Effective methodology for improving sexual health has been identified but anxieties about teaching sex education and lack of training are still major concerns (Mellanby et al, 1996). Mellanby (1996) reported providing teachers with information are an inadequate response without subsequent training and allocation of time to the design of new strategies for use in the class room. Mellanby et al (1996) reported an important programmatic factor is that HIV/AIDS prevention is often included as part of comprehensive programs addressing sexuality and relationships. They argued that such programs can be challenging for teachers to implement, especially with regards to topics such as sexuality, condom use and reproduction and when using interactive teaching methods. Barriers to the effective implementation of sex, relationships and HIV education in schools include inadequate resources and community opposition as well as authoritarian and didactic approaches on the part of teachers (Gordon, 2007). Gordon (2007) reported a range of approaches to sex, relationships and HIV education include those that seek to eliminate risk altogether (abstinence-only approaches), through those that seek to reduce risk (e.g. encouraging delay of sexual debut or condom use) to those that seek to reduce vulnerability by addressing underlying factors that contribute to sexual ill-health, such as poverty and gender inequality, abuse and violence.

According to Ball (1996) and Rakgoasi and Campbell (2004) as quoted by Fako, (2010) the majority of young people in Botswana begin sexual intercourse when they are between the ages of 15 and 17 and many young people engage in risky sexual behavior due to peer pressure, exchange of sex for material goods or money and juvenile competition for prestige that includes sex with multiple partners. According to UNAIDS (2010) HIV infections are much higher for girls than boys in the 15-24 age-group and early exposure to older men with a longer sexual

history is considered to have counted for the higher infections among adolescent girls, thereby bringing into play intergenerational sexual intercourse as a significant risk factor.

In Botswana patriarchal sex/gender systems relegate males to positions of power and women to subordinate positions within the context of cultural beliefs and practices (Continuum complete international encyclopedia of sexuality, 2006). They reported that patriarchal beliefs are based on cultural beliefs.

## **2.5 SEXUALITY EDUCATION IN BOTSWANA**

According to Noorman (2006) Botswana has no policy on sex education. Noorman reported the issues of sexuality are highlighted in the National Population Policy and are discussed under reproductive health. They pointed out the school curricula offer adolescent and sexual reproductive health through guidance and counseling and other school subjects, such as science, also subscribe to the idea of sexual and reproductive health. This point was emphasized by Francoeur and Noonan as quoted by Mimi Melles, (2009), who reported there is no formal sex education in schools in Botswana and studies show that many parents are uncomfortable talking about sexuality with their children. A teenager's primary source of information regarding sexuality is his or her peer group, all of whom are experiencing and reinforcing the same behavior and the family, the major socializer of other behaviors, is not as powerful a force in shaping responsible sexual discussions (Asekun-Olarinmoye, 2007). Effective sexuality education is a vital part of HIV prevention and is also critical to achieving Universal Access targets for reproductive health and HIV prevention, treatment, care and support (UNAIDS 2006).

According to Noonan (2006) gender differences occur in the education of females and males - while they are equal enrollments rates for females and males in the first nine years of schooling, the enrollment figures for males outnumber those for females in higher levels of education, including vocational training schools.

There is a high incidence of teenage pregnancy in Botswana and this is indicative of unprotected sex and therefore has serious implications for the spread of HIV infections as well as other STDs (Noonan, 2006). Molosiwa and Moswela (2012) reported pregnancy is the main reason for girls

to discontinue from school in large numbers in Botswana. Molosiwa and Moswela pointed out a total of 1057 girls discontinued from school because of pregnancy alone in 2007. They also reported the dropout rate is higher in rural than in urban centers and concluded that this was perhaps due to the amount of education girls have access to on issues relating to health and sexuality. According to Botswana Millennium Development Goals status report (2010) although girls who fall pregnant can be re-admitted into the education system six months after giving birth, not all girls return to school.

Sexual and reproductive ill-health is a major contribution to the burden of disease among young people (UNESCO, 2009). UNESCO reported ensuring the sexual and reproductive health of young people makes social and economic sense: HIV infection, other STIs, unintended pregnancy and unsafe abortion all place substantial burdens on families and communities and upon scarce government resources and yet such burdens are preventable and reducible. According to UNESCO promoting young people's sexual and reproductive health, including the provision of sexuality education in schools, is thus a key strategy towards achieving the Millennium Development Goals (MDGs), especially MDG 3 (achieving gender equality and empowerment of women), MDG 5 (reducing maternal mortality and achieving universal access to reproductive health) and MDG 6 (combating HIV/AIDS). There is increasing evidence from several countries that where HIV prevalence is decreasing, it is young people who are reversing the trends because young people are much more likely to adopt and maintain safe behaviors, and it is therefore important to implement interventions early. The aim of this study was to establish how the perception of teachers affects sexuality education in secondary schools in Gaborone, Botswana.

## **2.6 CONCLUSION**

It is clear from the literature that education plays a pivotal role in the fight against the HIV pandemic the world over. Providing sexuality education may be the most important strategy to combat the spread of HIV among children in schools. In chapter three, the geographical area where the research was conducted is highlighted and data collection method is discussed, including the sampling techniques and data analysis methods.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

The focus of this chapter is on the design of the research, sampling techniques, data collection instrument used and research ethics.

#### **3.2. PROBLEM STATEMENT**

Young people in secondary schools engage in sexual intercourse at an age when they are not physically and emotionally ready. They therefore put themselves at risk of HIV infection. Sex education in secondary schools has been shown to delay sexual debut, increase condom use and increase HIV/AIDS awareness. The research problem is that the attitude and perception of teachers to sex education is not known in secondary schools of Gaborone, Botswana. Therefore the research question was: What knowledge and attitudes do teachers have about sex education in secondary schools in Gaborone, Botswana?

#### **3.3 OBJECTIVES OF THE STUDY**

The objectives of research were:

- To establish teachers' perception of appropriateness of the current school curriculum to sex education
- To determine the level of knowledge of sex education among teachers in secondary schools
- To establish attitudes of teachers to sex education in secondary schools.
- To make recommendations for improving sex education in secondary schools

#### **3.4 RESEARCH METHOD**

Gaborone, the study area is the administrative and commercial capital of Botswana. The population of Botswana is estimated at 2,033,000 according to the 2011 population census. The education system in Botswana is a 7-3-2 system-7 years of primary education, 3 years of junior secondary education and 2 years of senior secondary education. This was a cross-sectional, quantitative study aimed at establishing the knowledge and attitudes of teachers to sex education

in secondary schools of Gaborone, Botswana. According to Christensen et al (2011), in a cross-sectional study, the data are collected from research participants during a single, relatively brief period. Christensen (2011) defined a qualitative research study as one that collects some type of numerical data to answer a given research question. It was also a non-experimental quantitative research which is defined as a type of quantitative research in which the independent variable is not manipulated by the researcher (Christensen, 2011). According to Christensen (2011) typically this is a descriptive type of research in which the goal is to provide an accurate description or picture of a particular situation or phenomenon or to describe the size and direction of relationships among variables.

The target population was secondary school teachers educating final year students in Gaborone in Botswana. The rationale for choosing this group of teachers is they are teaching students who are about to enter adulthood. A survey was the research method used for this study. A survey is a research method where individuals fill out a questionnaire or are interviewed about their attitudes, activities, opinions and beliefs (Christensen, 2011). According to Creswell (2005) a survey design provides a quantitative or numeric description of trends, attitude or opinion of a population by studying a sample of that population and from sample results, the researcher generalizes or makes claims about the population. Advantages of a survey include the economy of the design and rapid turnaround in data collection (Creswell, 2005). Data was collected through a self-administered, closed-ended, structured questionnaire. A questionnaire is a self-report data collection instrument that is filled out by research participants (Christensen, 2011). Christensen (2011) reported questionnaires measure participants' opinions and perceptions and provide self-reported demographic information. The questionnaire covered the knowledge of and attitudes of teachers to sex education in secondary schools as well as the teachers' perception of the appropriateness of the school curriculum to sexuality education. According to Christensen (2011) advantages of questionnaires include: good for measuring attitudes and eliciting other content from research participants, inexpensive, quick turnaround for group-administered questionnaires, closed-ended items can provide exact information needed by researcher, easy of data analysis for closed-ended items and questionnaires are useful for exploration as well as hypothesis testing research. The questionnaire was designed for this survey. Likert scales were used to measure items on the questionnaire.

The summated rating scale or Likert scaling is when each participant rates multiple items designed to measure one construct and a single score is obtained for each participant by summing his or her item scores (Christensen, 2011). According to Spector (1992) these scales are widely used across the social sciences to measure not only attitude, but opinions, personalities but descriptions of peoples' lives and environments as well. Spector (1992) reported multiple items improve reliability by allowing random errors of measurement to average out.

McLeod (2008) reported validity of Likert scale attitude measurement can be compromised due to social desirability-individuals may lie to put them in a positive light. McLeod (2008) emphasized offering anonymity on self-administered questionnaires reduce social pressure, and thus may likewise reduce social desirability bias. Paulhus (1884) as quoted by McLeod (2008) found more desirable personality characteristics were reported when people were asked to write their names, addresses and telephone numbers on their questionnaire than when told not to put identifying information on the questionnaires. To avoid social desirability bias, participants in this survey were instructed not to put their any identifying information on the questionnaires.

Data collection took place during the months of August and October, 2012. The data collected was subjected to quantitative analysis. Data was entered and analyzed using statistical package for social sciences (SPSS).

### **3.5 SAMPLING METHOD/INCLUSION CRITERIA**

At the beginning of 2009 there were 171,896 students in Botswana in all secondary schools in the country and sixty percent of those students were females; student to teacher ratio of 26:1 ([www.neweconomia.com](http://www.neweconomia.com). Retrieved on 16/05/12). There are 8 schools in Gaborone offering senior secondary school education. The sampling technique was a multi-stage sampling. The first stage involved random sampling by which 5 secondary schools were selected using a table of random numbers with the list of all the senior secondary schools in the city of Gaborone as a sampling frame. The second stage involved random sampling to select 5 teachers from a list of final year teachers in each selected school using a table of random numbers. Random sampling methods are preferred because they produce representative samples when the goal is to

generalize from a specific sample to a population (Christensen, 2011). According to Christensen (2011) when the objective is when a sample is to represent or “mirror” the population, the best way is to use an equal probability of selection method (EPSEM) which is defined as a sampling method in which each individual member of the population has an equal chance of being selected for inclusion in the sample. The simple random sampling method which was used in this research study is an example of EPSEM.

A total of 25 secondary school teachers teaching final year secondary school students were randomly selected from 5 secondary schools in Gaborone. Five teachers were randomly selected from each school. Only teachers who had been teaching final year students for  $\geq 2$  years were recruited.

### **3.6 ETHICAL CONSIDERATIONS**

Permission to conduct this research was sought from the research ethics committee of the University of Stellenbosch, South Africa and Botswana ethics committee of the Ministry of Education. Further institutional permission from heads of schools as well as consent of respondents was obtained. The respondents were instructed not to provide names on the questionnaires to maintain confidentiality. Hard copies of the questionnaires were stored in a locked cabinet at the researcher’s office when not in use for data entry or analysis. This data will be destroyed after three years.

### **3.7 CONCLUSION**

This chapter explained how the research was conducted, from selection of the research participants, sampling method used, data collection instrument to the data analysis. Ethical considerations undertaken during the research are also highlighted. In chapter four, the results from the study are presented with the aid of diagrams and tables.

## CHAPTER FOUR

### RESULTS

#### 4.1 INTRODUCTION

A survey using a Likert scale questionnaire was employed to establish the perception and attitude of teachers toward sexuality education as well as the level of knowledge of them about sexuality education in secondary schools of Gaborone, Botswana. In this chapter, the socio-demographics of the participants are presented and the research findings are discussed with the aid of tables, figures and graphs. The problem statement provides guidance for the project known in secondary schools of Gaborone, Botswana. Therefore the research question was: What knowledge and attitudes do teachers have about sex education in secondary schools in Gaborone, Botswana?

The objectives elaborate on the question and serves as a road map to produce meaningful results:

- To establish teachers' perception of appropriateness of the current school curriculum to sex education
- To determine the level of knowledge of sex education among teachers in secondary schools
- To establish attitudes of teachers to sex education in secondary schools.
- To make recommendations for improving sex education in secondary schools

#### 4.2 FINDINGS

##### 4.2.1 Socio-demographics

Table 4.1, figures 4.1 and 4.2 summarize the demographic data of the respondents. All 25 respondents completed the questionnaire successfully. There were 14 males and 11 females. Majority of respondents 13 (52%) were between 40-49 years old, followed by 31-39 years old who were 6 (24%). There were 3 (12%) 25-30 years old while 50-59 years were 2 (8%) and only one respondent was over 60 years. All respondents were Christians.

**Table 4.1**

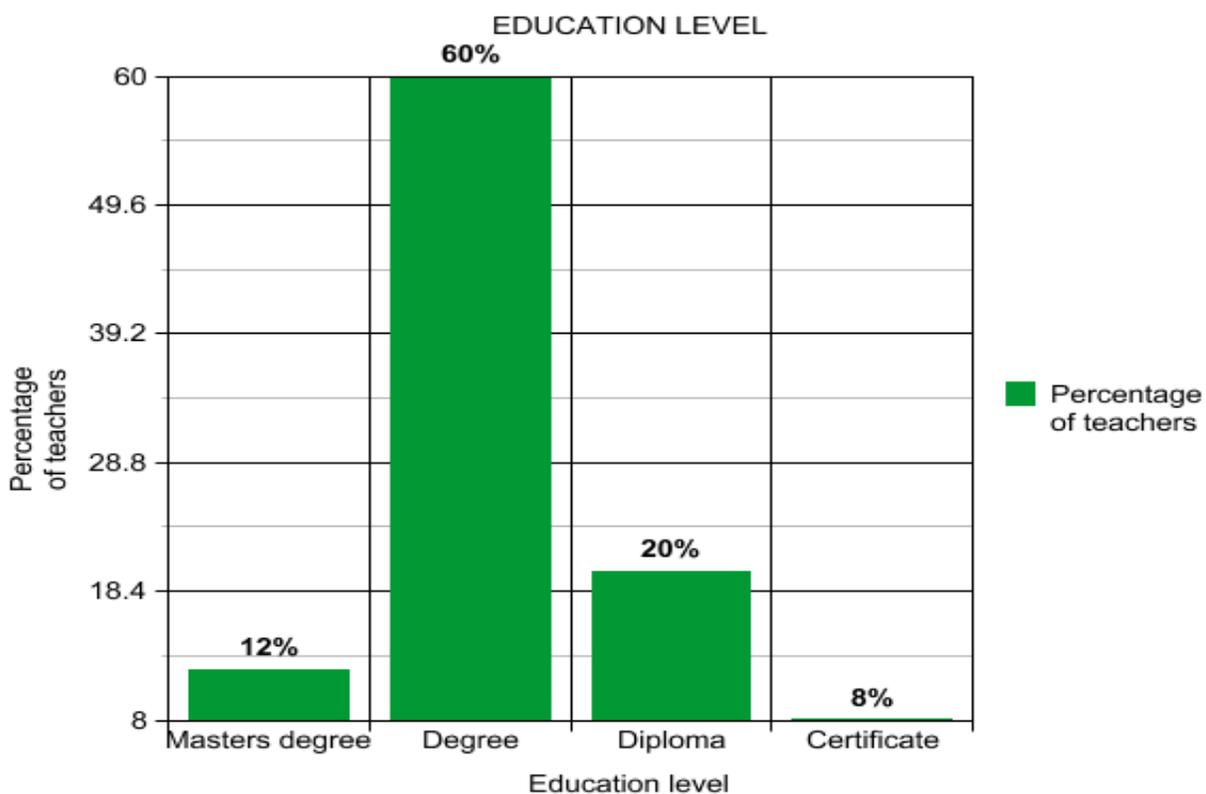
**Socio-demographics of respondents-Gender, marital status and religion**

<b>Characteristics</b>	<b>no</b>	<b>%</b>
<i><b>Gender</b></i>		
Male	14	56
Female	11	44
<i><b>Marital status</b></i>		
Married	15	80
single	5	20
<i><b>Religion</b></i>		
Christian	25	100
Moslem	0	0

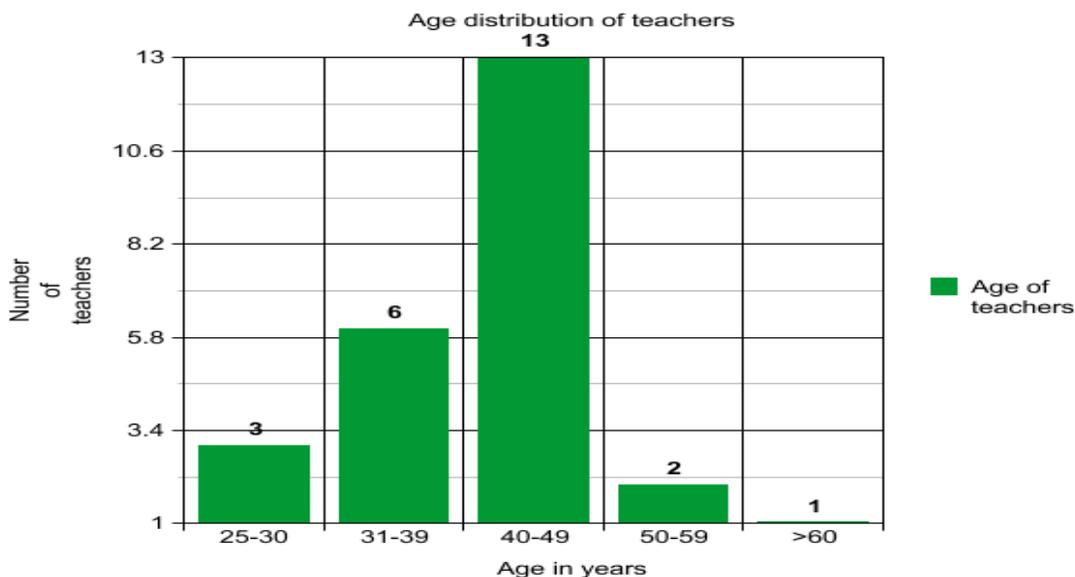
**Figure 4.1**

**Education level of respondents**

Majority (60%) have a bachelors degree, 20% a diploma, 12% masters degree and 8% certificate



**Figure 4.2**  
**Age distribution of teachers - mean age is 44.5 years**



**4.2.2 Perception and Attitude about some key sexuality issues**

The perception and attitude of teachers toward key sexuality issues were assessed by asking them to indicate whether they agreed or disagreed with certain statements. Majority of respondents 20 (80%) agreed sexuality education is appropriate for their students. All respondents rated sexuality education as important and 92% were willing to teach sexuality education if it was officially introduced in their schools (Table 4.2).

**Table 4.2**  
**Teachers’ willingness to teach sexuality education**

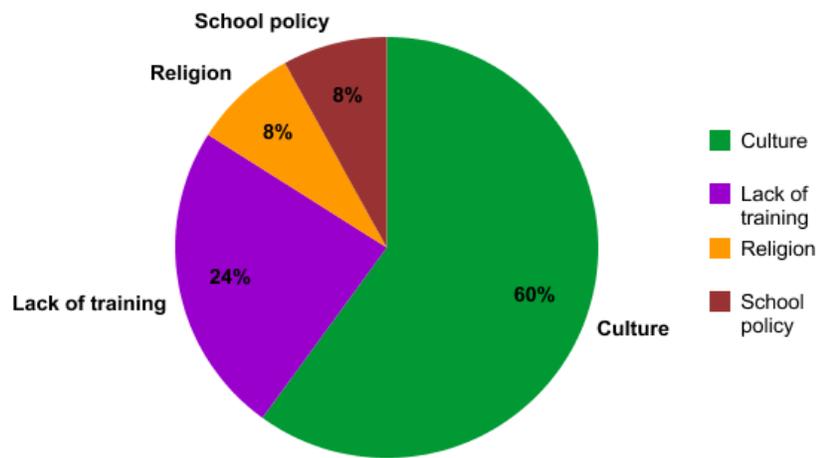
Items	Frequency	percentage
•Very willing	22	88
•Just willing	10	40
•Not willing	2	8
•Actively opposed	0	0
•No response	0	0

Many respondents 16 (64%) did not agree condoms should be made available to students in their schools and only 9 (36%) agreed. Most of respondents (72%) agreed sexuality education should include contraception while a sizable number 28% disagreed. On the question of whether sexuality education promotes promiscuity among students, 18 (72%) respondents believed sexuality education does not promote promiscuity while 28% had a view that it promotes promiscuity. Majority of teacher cited culture as a barrier to sexuality education followed by lack of training (Figure 4.3)

**Figure 4.3**

**Barriers to sexuality education**

BARRIERS TO SEXUALITY EDUCATION



M.Kasonde

Prominent barrier to sexuality education is culture (60%) followed by lack of training (24%) and 4% each for school policy and religion as barriers.

**Table 4.3**  
**Perceptions and Attitude of teachers to key sexuality issues**

Variables	Perception/Attitude					
	Correct			Incorrect		
	Male	Female	Total	Male	Female	Total
<b>Total</b>						
•Importance of sexuality education	14	11	25	0	0	0
•Willingness to teach sexuality education	14	9	23	0	2	2
•Condoms should be made available in secondary schools‡	7	2	9	4	12	16
•Sex education should include contraceptives	12	8	20	2	3	5
•Sex education should be incorporated in secondary schools.	13	11	24	1	0	1
•Teachers should be at the forefront in teaching sexuality education	14	9	23	0	2	2

Perception and attitude was almost same between males and females except on the issue of providing condoms to students in secondary school=males more positive than females

#### **4.2.3 Knowledge of teachers about sexuality education.**

Table 4.3 summarizes the knowledge of teachers about sexuality education. Majority of teachers were knowledgeable about some key sexuality issues. On whether sexuality education delay sexual debut among school-going students, 92% of respondents agreed and 8% disagreed. All 25

respondents also agreed that sex education increases awareness about HIV and AIDS among the youth in schools. Twenty-one (96%) respondents agreed that sex education promotes condom use and 96% also agreed that sexuality education prevents teenage pregnancy.

Effective protection against sexually transmitted diseases was represented by 22 respondents (88%) who chose abstinence and 17 (68%) preferred condoms. Most respondents correctly indicated the effective birth control methods, with abstinence the most chosen method, followed by condoms and oral contraceptives (Table 4.4).

**Table 4.4**  
**Effective non-surgical birth control methods-Total number of responses for each method**

		<b>Count</b>	<b>%</b>
Effective contraceptive	.Abstinence	20	80
	.Condoms	16	64
	.Oral hormonal contraceptives	16	64
	.Injectable contraceptives	15	60
	.IUCD	15	60

Sixteen (64%) of respondents indicated that sexuality education was not part of their training as teachers while 36% indicated that they were trained in sexuality education.

**Table 4.5**  
**Knowledge about some key sexuality issues**

variables	Correct knowledge			In-correct knowledge			
	males	female s	total	males	female s	total	
Sex education delays sexual debut	13	10	23	1	1	2	
Sex education increases HIV/AIDS awareness	14	11	25	0	0	0	
‡ Sex education promotes condom use	14	7	21	0	4	4	
Sex education prevents teenage pregnancy	13	9	21	1	3	4	
Effective protection against STIs	12	9	20	2	3	5	
‡ Effective birth control methods	8	10	18	6	1	7	
Pregnancy can result from a girls first sexual intercourse	14	11	25	0	0	0	

‡=Significant gender difference in knowledge

The factor of knowledge is almost identical between males and females except on the issue of condoms where males are more knowledgeable than females; females more knowledgeable on effective birth control methods.

**TABLE 4.6**  
**Appropriate age for receiving sexuality**  
**education according to respondents**

Age (years)	number	percentage
<10	4	16
10-14	14	56
15-19	7	38
>20	0	0

Majority of respondents chose 10-14 years as the most appropriate age group at which to initiate sexuality education

### **4.3 DISCUSSION**

The World Bank (2002) reported with the growing recognition that attitudes and beliefs are formed early in life, more reproductive health programs are being implemented in primary schools with the aim of reaching students before they become sexually active and in many cases, drop out of school (because of becoming pregnant, contracting an infection, caring for a sick relative, or being orphaned). An impact on children and young people before they become sexually active can be made by comprehensive sexuality education to be part of the formal school curriculum, delivered by well-trained and supported teachers (UNESCO, 2009). UNESCO reported teachers remain trusted sources of knowledge and skills in all education system and they are a highly valued source in the education response to AIDS.

General knowledge of key sexuality issues was high among respondents even though some had incorrect attitude and their perception of sexuality education was in some cases not positive with regards to some key sexuality issues. All respondents agreed sex education increases awareness about HIV and AIDS among the youth in schools. Even though a majority of respondents (96%) agreed that sexuality education promotes condom use among adolescents in secondary school, 64% did not agree condoms should be made available to students in their schools. This was reinforced that only 68% picked condoms as an effective protective method against STIs;

Inyaniwura (2004) found similar results in Nigeria. He reported among teachers in Sagamu State, Nigeria a majority disapproved of the idea of providing condoms in schools because they felt they could promote promiscuity. Singh, Bankole and Woog (2005) indicated young people who choose to be sexuality active should have access to information on sources of contraceptives, particularly condoms and how to use these methods to achieve maximum protection. Asekun-Olarinmoye (2007) reported preventing unprotected intercourse and helping young people become responsible, sexually healthy adults cannot be achieved if the teachers themselves are deficient in the very knowledge and skills they are supposed to impart. Young people have unprotected sexual intercourse with one or more partners, potentially exposing themselves to HIV, other sexually transmitted infections (STIs) or unintended pregnancy (Pearson, 2012). By age 18 years, 6 of 10 teenage females and nearly 7 of 10 males worldwide have engaged in sexual intercourse (Asekun-Olarinmoye et al, 2007). Condoms should be made available in secondary schools where students can easily access them. Condoms, when used correctly and consistently are highly effective in preventing HIV and other STIs (WHO, 2011).

Fako (2010) reported the majority of young people in Botswana begin sexual intercourse when they are between the ages of 15 and 17 and many young people engage in risky sexual behavior due to peer pressure, exchange of sex for material goods or money and juvenile competition for prestige that includes sex with multiple partners. Fifty-six percent of respondents indicated 10-14 years is the right age for receiving sexuality education. There is evidence in the literature review sexuality education should start earlier. According to Singh, Bankole and Woog (2005) young peoples' need for sex education is evidenced by their typically early initiation of sexual activity, the often involuntary context within which they have sexual intercourse, high-risk sexual behaviors and the inadequate levels of knowledge of means of protecting their sexual health. Singh et al (2005) reported the earliness of initiation of sexual intercourse has implications for the age by which sexuality education should be provided. The challenge for sexuality education is to reach young people before they become sexually active, whether this is through choice or necessity (e.g. in exchange for money, food or shelter, coercion or exploitation (UNESCO, 2009). It is clear that for sexuality education to have any meaningful contribution toward the fight against HIV and AIDS, it should start in primary schools and reinforced in secondary schools. There is increasing evidence from several countries where HIV prevalence is

decreasing, it is young people who are reversing the trends because they are more likely to adopt and maintain safe behaviours and it is therefore important to implement interventions early (WHO,2006).

The biggest barrier to sexuality education identified by the respondents was culture (60%) followed by lack of training (24%). According to UNESCO one of the common concerns about provision of sexuality education is that sexuality education is against local culture and religion. UNESCO stresses the need for cultural relevance and local adaptation, through engaging and building support among the custodians of culture in a given community. UNESCO reported key stakeholders, including religious leaders, must be involved in the development of what form sexuality education takes. However, UNESCO also stresses the need to change social norms and harmful practices that are not in line with human rights and increase vulnerability and risk, especially for girls and young women. UNESCO (2010) emphasized like other members of society, teachers live within a network of cultural and traditional beliefs that must be acknowledged and addressed if they create a barrier to effective teaching.

Abstinence was the preferred method of effective birth control by majority of respondents. According to Kirby (2007) there is no evidence to suggest that any abstinence program delays the initiation of sex, hastens the return to abstinence, or reduces the number of sexual partners. Kirby (2007) reported in contrast, a substantial majority of sex education programs are effective and the positive outcome includes delaying initiation of sex, reducing the frequency of sex, reducing the number of sexual partners and increasing condom or contraceptive use. It appears many teachers do not want to discuss the topic of condoms with their students as indicated where many teachers are against making condoms available in secondary schools. This has to change for sexuality education to be effective.

The World Bank (2002) reported evidence shows that education profoundly affects young peoples' reproductive lives. They reported better educated women are more likely than their peers, to delay marriage and child-bearing, have fewer children and healthier babies, enjoy better earning potential, have stronger decision making and negotiation skills as well as higher self-esteem and avoid commercial sex. Effective methodology for improving sexual health has been

identified but anxieties about teaching sex education and lack of training are still major concerns (Mellanby, Phelps, Crichton & Tripp, 1996). UNESCO reported teachers may be willing to teach sexuality education but are uncomfortable, lacking in skills or afraid to do so. Majority of respondents (92%) indicated they were willing to teach sexuality education but a sizable number (24%) cited lack of training as a barrier. Teachers' wariness of sexuality education is often exacerbated by a lack of training, which leaves many feeling unprepared to teach the subject (Asekun-Olarinmoye, 2007). As UNESCO (2009) noted well-trained, supported and motivated teachers play a role in the delivery of good quality sexuality education, clear sectoral and school policies and curricula help to support teachers in this regard.

Many teachers indicated they should be at the forefront in teaching sexuality education. This is encouraging because with such a positive attitude towards sexuality education, it is easy to implement in secondary schools in Gaborone. In most countries, children between the ages of five and thirteen spend time in schools influencing their attitudes and future behaviors (UNESCO). Thus schools provide a practical means of reaching large numbers of young people from diverse backgrounds in ways that are replicable and sustainable (Gordon, 2008).

More males than females were willing to teach sexuality education. According to Noonan (2006), in many societies attitudes and laws stifle public discussion of sexuality and sexual behavior – for example in relation to contraception, abortion, and sexual diversity. Noonan reported that, more often than not, men's access to power is left unquestioned while girls, women and sexual minorities miss out. The international encyclopedia of sexuality reported that, in Botswana, patriarchal sex/gender systems relegate males to positions of power and women to subordinate positions within the context of cultural beliefs and practices. This could contribute why women were not as willing as men to teach sexuality education. Additionally, according to international encyclopedia of sexuality, most people in Botswana do not feel very comfortable talking about their own sexuality, including autoeroticism.

Even though the majority of respondents (88%) indicated the current school curricula is appropriate for teaching sexuality education, a large number (68%) indicated it does not include abortion and communication and negotiation skills to reduce risks for HIV, other STDs and

pregnancy. A sizable number of respondents (32%) also indicated the school curricula do not cover issues related to teen pregnancy. It appears the school curriculum is not comprehensive in covering all aspects of sexuality education. Making an impact on children and young people before they become sexually active, comprehensive sexuality education must become part of the formal school curriculum, delivered by well-trained and supported teachers (UNESCO, 2009). Hindin and Fatusi (2009) reported most youth obtain at least some education-particularly with the international recognition of the importance of schooling (e.g., the Millennium Development Goals); school-based programs appear to be a logical choice for sexual and reproductive health education. This was supported by David and Bruce (2006) who reported that even though HIV/AIDS information and life-skills education can be provided to young people in a number of ways, schools are a key setting for providing information and teaching adolescents the life skills necessary to prevent HIV/AIDS.

According to Donovan (1998) although sex education is often discussed and evaluated in terms of its role in reducing adolescent pregnancy and STD rates, supporters say its primary goal is broader: to give young people the opportunity to receive information, examine their values and learn relationship skills that will enable them to resist becoming sexually active before they are ready, to prevent unprotected intercourse and to help young people become responsible, sexually healthy adults. Education is among the most powerful tools for reducing the social and economic vulnerability that exposes women to a higher risk of HIV/AIDS than men (The World Bank, 2002). The World Bank reported girls education can go far in slowing and reversing the spread of HIV by contributing to poverty reduction, gender equality, female empowerment, and awareness of human rights. The World Bank further reported countries' education sectors have a strong potential to make a difference in the fight against HIV/AIDS because they offer an organized and efficient way to reach large numbers of schools-age youth-the groups either most at risk or most receptive to efforts to seek to influence behavior. While it is not realistic to expect an education program alone can eliminate the risk of HIV and other STIs, unintended pregnancy, coercive or abusive sexual activity and exploitation, properly designed and implemented programs can reduce some of these risks and underlying vulnerabilities (UNESCO, 2006). It is therefore important that the school curricula cover all aspects of sexuality education.

#### **4.4 CONCLUSION**

Majority of teachers have positive attitudes towards sexuality education in secondary schools of Gaborone, Botswana. However, there is a conflict on the issue of contraceptives; even though majority indicated the topic on contraceptives should be taught in schools, many teachers were against providing condoms to students in secondary schools. A greater number of respondents showed willingness to teach sexuality education. The positive attitude towards sexuality education provides an opportunity for policy makers to introduce sexuality education in secondary schools.

Both males and females are equally knowledgeable on majority of key sexuality education issues except on whether sexuality education promotes condom use with males more knowledgeable than females. However, females are more knowledgeable on effective birth control methods than their male counterparts. The majority of respondents (88%) indicated the current school curricula is appropriate for teaching sexuality education even though a large number (68%) indicated that it does not include abortion and communication and negotiation skills to reduce risks for HIV, other STDs and pregnancy.

Culture and lack of training are the major barriers to teaching sexuality education in secondary schools. The teachers need in-service training to improve their overall knowledge on sexuality education. Chapter five will put the research findings into perspective; looking back at the aim and objectives of the study.

## **CHAPTER FIVE**

### **CONCLUSIONS AND RECOMMENDATIONS**

#### **5.1. INTRODUCTION**

This chapter summarizes the main findings of the study in relations to the research objectives, conclusions of the study and discusses recommendations based on the findings of the study and possible solutions to the limitation of the study.

#### **5.2 OBJECTIVES AND FINDINGS**

The objectives of a research project is linked to a problem statement where in this instance in secondary schools of Gaborone, Botswana what knowledge, perceptions and attitudes do teachers have about sex education in secondary schools in Gaborone, Botswana? Each objective provides a solution to the identified problem and the findings of the research provide support for the end result.

##### **5.2.1 Objective 1**

**To establish teachers' perception of the appropriateness of the current school curricula to sexuality education.**

Overall, 44 percent of teachers agreed their school curricula was appropriate for teaching sexuality education in secondary schools 12% disagreed and 44% were not sure. It can be concluded the teachers' perception of the appropriateness of the school curricula was not adequate. Though the majority indicated the curricula cover topics such as HIV/AIDS, condoms, contraceptives and teen pregnancy, they also noted topics such as abortion and communication and negotiation skills to reduce risks for HIV/AIDS and pregnancy are not adequately covered. The school curriculum needs to be updated to include all aspects of sexuality education. UNAIDS (2009) reported well-planned and implemented life skills or sex and HIV education interventions, even when provided for short periods, have been found to knowledge; develop skills(i.e. self-efficacy to refuse sex and obtain male and female condoms) and positive attitudes required to change risk behavior .

### **5.2.2 Objective 2**

**To determine the level of knowledge of sexuality education among secondary school teachers in Gaborone.**

Secondary school teachers in Gaborone are knowledgeable about key elements of sexuality education and are willing to teach the topic in their schools. Even though the majority indicated contraceptives should be part of sexuality education, many teachers did not want condoms to be made available to students in their schools. This indicates teachers need to understand all aspects of sexuality education. Many teachers acknowledged they were not trained in sexuality education and lack of training was only second to culture as a barrier to teaching sexuality education. Teachers need training so they can overcome their own anxieties and modify their attitude and perception towards sexuality education.

### **5.2.3 Objective 3**

**To establish attitude and perception of teachers towards sexuality education.**

The majority of teachers have a positive attitude and a good perception towards sexuality education. Majority of respondents rated sexuality education as important and were willing to teach sexuality education. However, a good number did not agree that condoms should be made available to their students and about a third of respondents were of the view sexuality education promotes promiscuity among students. Despite this it can be concluded attitude and perception of teachers are not barriers to teaching sexuality education in secondary schools.

The majority of teachers cited culture as the biggest barrier to provide education on sexuality in secondary schools. Training can improve the attitude and modify the culture of teachers. UNESCO (2010) emphasized like other members of society, teachers live within a network of cultural and traditional beliefs that must be acknowledged and addressed if they create a barrier to effective teaching.

### **5.2.4 Objective 4**

**To make recommendations for improving sexuality education in secondary school.**

The following recommendations are proposed based on the findings of the study.

- Teachers need training in sexuality education in order to overcome their anxieties about sexuality education and rid them of any negative cultural beliefs they may have regarding sexuality education.
- The school curricula should include all aspects of sexuality education for it to be effective.
- Sexuality education when introduced should start in primary schools. As noted by UNAIDS (2009) contrary to what policy-makers, parents and communities at times wish to believe, many young people are sexually active from their mid teenage years onwards-with the vulnerable years being the ages of 15-24.UNAIDS pointed out that early interventions, starting at the primary level of schooling-and before onset of adolescence or dropping out of school-are therefore critical and potentially life-saving.
- Condoms should be provided in secondary schools because students engage in sex. Condoms, when used correctly and consistently are highly effective in preventing HIV and other STIs (WHO, 2011).

### **5.2.5 Recommendations for future research**

- A study with a larger sample including teachers in primary schools should be conducted to gain a better picture of the challenges of sexuality education in schools of Botswana.
- There is the possibility to produce a project with central tendency and social desirability biases, to avoid the situation researchers should not be present when respondents are answering questionnaires especially those concerning attitude measurement.

### **5.3 CONCLUSION**

Teachers in Gaborone secondary schools are mostly knowledgeable on sexuality education and their attitude and perception of sexuality education are positive. Teachers need in-service training to improve their overall knowledge on sexuality education and modify their cultural beliefs which may be affecting their attitude towards sexuality education. The school curriculum needs to be updated to include all aspects of sexuality education. The Government of Botswana should develop a policy on sexuality education which will help schools to produce a more comprehensive coverage of sexuality education in line with recommendation by UNESCO. The teachers need support from all stakeholders of sexuality education-government, parents, religious and community leaders for them to deliver sexuality education effectively. Attitudes, perceptions and knowledge of teachers on sexuality education are not obstacles to introducing sexuality education in secondary schools of Gaborone, Botswana. It is important that young people understand all aspects of sexuality including factors that put them at risk for unplanned pregnancy and sexually transmitted diseases including HIV. Further research on sexuality education with participants from rural areas and primary schools is needed to get more information on this important tool for fighting HIV/AIDS in Botswana.

**REFERENCES**

1. UNDP, Human Development Report Millennium Goals: A Compact among Nations to End Poverty; 2003
2. Botswana AIDS impact survey, 2008
3. Inter-Agency Task Team on Education; A strategic approach: HIV and AIDS and Education, May2009; 14-15.
4. Kaiser family foundation; July 2007: 6.The Multi-sectoral Impact of the HIV/AIDS Epidemic-A Primer.
5. Raymond Noonan, 2006.International encyclopedia of sexuality.  
<Http://www.kinseyinstitute.org.ccies>
6. Iyoke C.A et al, 2006.Teachers' attitude is not an impediment to adolescent sexuality education in Enugu, Nigeria. African Journal of Reproductive Health Vol 10.No 1.
7. Mimi Melles. Youth's Reproductive and Sexual Health in Botswana. Advocates for Youth.2009
8. Thabo T.Fako.The connection between poverty, sexual activity, knowledge about HIV/AIDS and willingness to test for HIV infection among young people. European Journal of social sciences-Vol 15, 2010
9. Serefete Molosiwa and Moswela Bernard: Girl-pupil dropout in secondary schools in Botswana: Influencing factors, prevalence and consequences. International Journal of Business and Social Science. Vol 3 No7; April 2012.

10. UNAIDS 2010. Monitoring Country Progress. Botswana.
11. Joint United Nations Program on HIV/AIDS, 2004, US Census Bureau.
12. UNESCO 2010. Levers of success: Case studies of national sexuality education programs  
Kenya: Growing up and sexual maturation. Targeting the quality of education in rural  
primary Schools.
13. Global Campaign for Education, 2004 ([www.Campaignforeducation.org](http://www.Campaignforeducation.org)). Retrieved  
on 12/4/12
14. Ester O Asekun-Olarinmoye et al, 2007. Knowledge, attitudes and perceptions of the  
teachers' role in sexuality education in public schools in Nigeria. *Int. Adolesc  
Med Health* 2007; 19(4):425-434
15. Christensen B.L, Johnson B.R, and Turner L.A. *Research Methods, Design and  
Analysis: Eleventh Edition*; 2011. Pearson.
16. Mellanby A.R, Phelps F.A, Crichton N.J, Tripp J.H. School sex education, a process  
for evaluation: methodology and results. *Health education research*. Vol 11 no.2, 1996.
17. John W. Creswell: *Qualitative, quantitative, and mixed method approaches*. 2<sup>nd</sup> edition. 2005
18. Helleve A., Flisher, A. J., Onya, H., Kaaya, S., Mukoma, W., Swai, C., **et al. (2009)**. et al.  
Teacher's confidence in teaching HIV/AIDS and sexuality in South African and Tanzanian  
schools. *Scandinavian journal of public health*. 2009. Sage
19. Paul E. Spector: *Summated Rating Scale Construction. An Introduction*. SAGE, 1992.
20. Botswana Millennium Development Goals –Status report, 2010  
([web.undp.org/Africa/mdg/Botswana-2010](http://web.undp.org/Africa/mdg/Botswana-2010)). Retrieved on 20/09/2012).

21. Helleve A, Flisher A.J, Onya H, Mathews C.Aaro L.E et al.The association between students' perceptions of a caring teacher and sexual initiation. A study among South African high school students. Health Education Research.Vol.26 no.5 2011
22. Donovan .School-based sexuality education: The issues and challenges. FanPlann Perspect 1998; 30(4):188-93.
24. The World Bank. Education and HIV/AIDS, A window of hope, Washington, DC: 2002.
25. Stefan Baral et al, 2009.HIV prevalence, risks for HIV infection and human rights among men who have sex with men (MSM) in Malawi, Namibia and Botswana.
26. Botswana National Strategic framework for HIV/AIDS, 2003-2009
27. ILO; HIV/AIDS and work, 2006.Global estimates, impact on children and youth, and response
28. Rutenberg N et al; international conference on AIDS 2002 July 7-12; 14
29. Carter, MW et al, Concurrent sexual partnership in Botswana; AIDS Behavior 2007 11(6) p 822-830
30. WHO, 2007. Understanding the results of male circumcision studies for AIDS prevention.
31. Sheri D Weiser, Karen Loiter, Michele Heisler, Willi McFarland, Fiona Percy-de Korte et al. A population-based study on alcohol and high-risk sexual behaviors in Botswana. Plos Med.2006
32. Botswana 2011 census and population preliminary report. ([www.cso.gov.bw](http://www.cso.gov.bw), retrieved on 19/04/12)

33. Ministry of Finance and Development Planning and UN Botswana 2004:39
35. Singh, S., Bankole, A., Woog, V. 2005. Evaluating the Need for Sex Education in Developing Countries: Sexual Behavior, Knowledge of Preventing Sexually Transmitted Infections/HIV and Unplanned Pregnancy. *Sex Education*, 5(4), 307-331.
36. Ross, D., Dick, B., Ferguson, J. 2006. Preventing HIV/AIDS in Young People: A Systematic Review of the Evidence from Developing Countries. Geneva: WHO.
37. Kirby, D.B. 2007. Emerging answers 2007: Research findings on programs to reduce teen pregnancy and sexually transmitted diseases. Washington, DC: National Campaign to Prevent Teen and Unwanted Pregnancy.
40. Berger Bernard S, Kahzami S, Selmaoi S, Carvalho G: Sex education: teachers' and future teachers' conceptions and social representations; what relevance for teachers' training. XIII. IOSTE Symposium, The Use of Science and Technology Education for Peace and Sustainable Development. September 21-26, 2008, Kuşadası / Turkey
41. McLeod S.A (2008). Likert Scale. Retrieved from <http://www.simplypsychology.org/Likert-Scale> on 10/12/2012

## Appendix 1

### QUESTIONNAIRE

This questionnaire will be used to assess the attitude of teachers to sex education, their knowledge of sex education and their perception of appropriateness of the school curriculum to sex education in senior secondary schools in Gaborone, Botswana. This questionnaire has been prepared by a student of masters of philosophy in HIV/AIDS management at the University of Stellenbosch

Thank you for taking your time to answer this questionnaire.

#### **Instructions:**

1. Please do not put your name on the questionnaire since all responses are confidential.
2. This questionnaire should be filled-in by teachers teaching final year students in senior secondary schools
3. Follow the instructions for each question
4. Return the questionnaire in the envelope provided.

#### **1. Socio-demographics**

1. What is your age?

- (a) 25-30 years
- (b) 31-39 years
- (c) 40-49 years
- (d) 50-59 years
- (e) >60 years

2. Gender

- ( a) Male (b) Female

3. Your marital status

(a).single

(b) married

(c) Divorced

(d) Separated

(e) Widow/widower

(f) co-habiting

4. What is your religion?

(a) Christian

(f) Muslim

5. What is your professional qualification? (choose highest qualification attained)

(a) Masters level

(b) Degree

(c) Diploma

(c) Certificate

## **2. Attitude of teachers toward sex education**

1) Sex education is appropriate for your students.

(a) I strongly agree

(b) I agree

(c) I somewhat agree

(d) I don't agree

(e) I strongly disagree.

2. What is the biggest barrier to sex education? (Choose one)

(a) School policy

(b) culture

(c) parents

(d) Lack of training

(e) Religion

3. How do you rate the importance of sexuality education?

(a) Very important

(b) important

(c) somewhat important

(d) not important

(e) I don't Know

4. What is your willingness to teach sexuality education if officially introduced?

(A). Very willing

(b) just willing

- (c). Not willing (d). Actively opposed  
(e).No response.

5. Condoms should be made available to students in senior secondary schools.

- (a) I strongly agree (b) I agree  
(c) I somewhat agree (d) I don't agree  
(e) I strongly disagree

6. Sex education should include contraceptives.

- (a) I strongly agree (b) I agree  
(c) I somewhat agree (d) I don't agree  
(e) I strongly disagree

7. Who should teach sex education at your school? (choose one)

- (a) All teachers (b) Teachers teaching biology courses  
(c) Teachers trained in sex education  
(d) No one should teach sex education (e) I don't know

8. Sex education should be incorporated in secondary schools.

- (a) I strongly agree (b) I agree  
(c) I somewhat agree (d) I don't agree  
(e) I strongly disagree

9. Teachers should be at the forefront in teaching sex education.

- (a) I strongly agree (b) I agree

- (c) I somewhat agree (d) I don't agree  
(e) I strongly disagree

10. Sex education promotes promiscuity among students

- (a) I strongly agree (b) I agree  
(c) I somewhat agree (d) I don't agree  
(e) I strongly disagree

**2. Knowledge of teachers about sex education in schools.**

1. Sex education delay sexual debut among school-going students.

- (a) I strongly agree (b) I agree  
(c) I somewhat agree (d) I don't agree  
(e) I strongly disagree

2. Sex education increases awareness about HIV/AIDS among the youth in schools.

- (a) I strongly agree (b) I agree  
(c) I somewhat agree (d) I don't agree  
(e) I strongly disagree

3. Sex education promotes condom use.

- (a) I strongly agree (b) I agree  
(c) I somewhat agree (d) I don't agree  
(e) I strongly disagree

4. Sex education was part of your training as a teacher

- (a.) Strongly agree
- (b) Agree
- (c) not sure
- (d) Disagree
- (e) Strongly disagree

5. What is the appropriate age for students to receive sex education? (choose one)

- (a) < 10 years
- (b) 10 -14
- (c) 15-19
- (d) >20 years

(e) Sex education is not appropriate for secondary school students.

6. Sex education prevents teenage pregnancy

- (a) I strongly agree
- (b) I agree
- (c) I somewhat agree
- (d) I don't agree
- (e) I strongly disagree

7. The following are effective protection against sexually transmitted diseases

(Choose all that apply)

- (a) Abstinence
- (b) Condoms
- (c) oral contraceptives
- (d) injectable contraceptives
- (e) Intrauterine contraceptive device

8. The following are effective birth control method/s. (Choose all that apply)

- (a) Abstinence
- (b) Condoms
- (c) oral contraceptives
- (d) injectable contraceptives
- (e) Intrauterine contraceptive device

9. Using a condom at the same time as another form of contraceptive prevent both

sexually transmitted diseases and pregnancy (choose one)

(a) I strongly agree

(b) I agree

(c) I somewhat agree

(d) I don't agree

(e) I strongly disagree

10. Pregnancy can result from a girl's first sexual intercourse

(a) I strongly agree

(b) I agree

(c) I somewhat agree

(d) I don't agree

(e) I strongly disagree

### 3. Appropriateness of the school curriculum to sex education

1. The school curriculum is appropriate for teaching sex education.

(a) I strongly agree

(b) I agree

(c) I somewhat agree

(d) I don't agree

(e) I strongly disagree

2. Does your school curriculum address each of the following topics: (mark yes or no for each item).

	<b>Yes</b>	<b>No</b>
(a) Contraceptives	0	0
(b) Sexually transmitted diseases	0	0
(c) Teen pregnancy	0	0

(d) Abortion	0	0
(e) HIV and AIDS	0	0
(f) Condoms	0	0
(g) The relationship between alcohol and other drugs use and the risk for HIV, other STDs and pregnancy	0	0
(h) Communication and negotiation skills to reduce risks for HIV, other STDs and pregnancy.	0	0

TELEPHONE: 3655469  
TELEX: 2944 THUTO BD  
FAX: 3185167



REPUBLIC OF BOTSWANA

MINISTRY OF EDUCATION  
AND SKILLS DEVELOPMENT  
PRIVATE BAG 005  
GABORONE

REFERENCE : E1/20/2 XX11 (9)

22<sup>nd</sup> June 2012

Dr Michael Kasonde  
CDC Botswana  
P Box 90  
Gaborone

Dear Madam/Sir

**RE: REQUEST FOR A PERMIT TO CONDUCT A RESEARCH STUDY**

We would like to acknowledge receipt of your application for research permit to conduct a study. This serves to grant you permission to conduct your study in the sampled areas in Botswana to address the following research objectives/question/topic:

**Perception Of Teachers To Sexuality Education In Secondary School In Gaborone, Botswana.**

It is of paramount importance to seek **Assent** and **Consent from** Regional Education Office, Secondary Schools in Gaborone and Teachers of the schools that you are going to collect data from. You are advised to exclude Gaborone Senior Secondary School from your sample. We hope that you will conduct your study as stated in your proposal and that you will adhere to research ethics. Failure to comply with the above stated, will result in immediate termination of the research permit. The validity of the permit is from **22<sup>nd</sup> June 2012 to 21<sup>st</sup> June 2013**.

**You are requested to submit a copy of your final report of the study to the Ministry of Education and Skills Development, in the Department of Educational Planning and Research Services, Botswana.**

Thank you.

A handwritten signature in blue ink, appearing to read 'O A Mmereki'.

---

O A Mmereki  
For / Permanent Secretary



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY  
jou kennisvenoot • your knowledge partner

**STELLENBOSCH UNIVERSITY  
CONSENT TO PARTICIPATE IN RESEARCH**

---

PERCEPTION OF TEACHERS TO SEXUALITY EDUCATION IN SECONDARY SCHOOLS IN

GABORONE, BOTSWANA.

You are asked to participate in a research study conducted by Dr. Kasonde Michael (MBchB, Diploma HIV/AIDS management) from the AIDS Africa Centre at Stellenbosch University. The results of this study will contribute to a research paper which will be submitted as a part requirement for a Masters of philosophy degree in HIV/AIDS management. You were selected as a possible participant in this study because you are a teacher for final year students at a senior secondary school in Gaborone, Botswana.

**1. PURPOSE OF THE STUDY**

The aim of this research is to establish the knowledge and attitudes of teachers toward sex education in secondary schools in Gaborone.

**2. PROCEDURES**

If you volunteer to participate in this study, we would ask you to do the following things:

You will be asked to fill in a questionnaire which will be made available to you. The questionnaire is expected to be completed during your duty shift. You are required to return the questionnaire in an envelope provided.

**3. POTENTIAL RISKS AND DISCOMFORTS**

There are potential discomforts expected when answering personal questions about attitude toward sex education. Participants who complain about discomfort will be referred for counseling at local counseling centers.

**4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

The results may contribute toward improving sex education in secondary schools in Botswana

**5. PAYMENT FOR PARTICIPATION**

## **6. NO PAYMENTS WILL BE PROVIDED FOR PARTICIPATION IN THIS RESEARCH**

## **7. CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of securing hard copies questionnaires in lockable cabinets at the researcher's office when not in use for data entry or analysis. This data will be destroyed after three years.

The results will be made available to the Africa Centre for HIV/AIDS Management as the institution supervising the research. In reporting the results, care will be taken not to report results in a way that would enable any participants to be identified and/or stigmatized in their views.

## **8. PARTICIPATION AND WITHDRAWAL**

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

## **9. IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about the research, please feel free to contact:

1. Dr. Kasonde Michael

Box 90,

Gaborone, Botswana

Cell +267 71875339

Email [m.kasonde@yahoo.com](mailto:m.kasonde@yahoo.com)

2. Prof Elza Thomson

Africa Centre for HIV/AIDS Management, University of Stellenbosch

South Africa

Phone + 27 21 808 3006

Email: [elzathomson@gmail.com](mailto:elzathomson@gmail.com)

**10. RIGHTS OF RESEARCH SUBJECTS**

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms. Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

**SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE**

The information above was described to me by *Dr. Kasonde Michael* in English and aim in command of this language. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study and I have been given a copy of this form.

\_\_\_\_\_

**Name of Subject/Participant**

\_\_\_\_\_

**Name of Legal Representative (if applicable)**

\_\_\_\_\_

**Signature of Subject/Participant or Legal Representative**

\_\_\_\_\_

**Date**

**SIGNATURE OF INVESTIGATOR**

I declare that I explained the information given in this document to \_\_\_\_\_ [*name of the subject/participant*] and/or [*He/she*] was encouraged and given ample time to ask me any questions. This conversation was conducted in English and no translator was used.

\_\_\_\_\_

**Signature of Investigator**

\_\_\_\_\_

**Date**



UNIVERSITEIT STELLENBOSCH UNIVERSITY  
Jou kennisvennoot • your knowledge partner

10 August 2012

Tel.: 021 - 808-9003  
Enquiries: Mr. Winston A Beukes  
Email: [wabeukes@sun.ac.za](mailto:wabeukes@sun.ac.za)

**Reference No. DESC66/2012**

Dr Michael Kasonde  
Africa Centre for HIV and AIDS Management  
Stellenbosch University

Dr Kasonde

**LETTER OF ETHICS CLEARANCE**

With regard to your application, I would like to inform you that the project, *Perception of teachers to sexuality education in secondary schools in Gaborone, Botswana*, was approved on the following proviso's:

1. The researcher will remain within the procedures and protocols indicated in the proposal, particularly in terms of any undertakings made in terms of the confidentiality of the information gathered.
2. The research will again be submitted for ethical clearance if there is any substantial departure from the existing proposal.
3. The researcher will remain within the parameters of any applicable national legislation, institutional guidelines and scientific standards relevant to the specific field of research.
4. The researcher will consider and implement the foregoing suggestions to lower the ethical risk associated with the research.
5. This ethics clearance is valid for one year from 10 August 2012 to 09 August 2013.

We wish you success with your research activities.

Best regards



MR WA Beukes

REC Coordinator: Research Ethics Committee: Human Research (Humaniora)  
Registered with the National Health Research Ethics Council (NHREC): REC-050411-032



Afdeling Navorsingsontwikkeling • Division for Research Development

Privaatsak/Private Bag X1 • Matieland 7602 • Suid-Afrika/South Africa  
Tel: +27 21 808 9184 • Faks/Fax: +27 21 808 4537  
[www.sun.ac.za/research](http://www.sun.ac.za/research)