AN IMPLEMENTATION EVALUATION STUDY OF THE "MY FUTURE IS MY CHOICE" HIV AND AIDS EDUCATION PROGRAMME IN THE DIRECTORATE OF EDUCATION, OSHANA REGION, NORTHERN NAMIBIA

by

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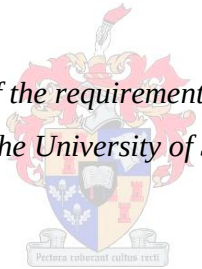

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Declaration

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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Abstract

"My Future is My Choice" (MFMC) is an extra-curricular life skills programme in Namibia aimed at minimising the impact of HIV and AIDS among young people. The programme was introduced fourteen years ago and is believed to have had a significant impact on young people who were enrolled in and graduated from it. The programme targets young people from grades 8 to 12.

The purpose of this study was to assess how the "My Future is My Choice" Programme imparts knowledge and skills to young people in the Ompundja Circuit of the Oshana Directorate of Education, in Northern Namibia. This was an implementation evaluation study, following a qualitative approach to collect in-depth information. Data was collected by two means: focus group interviews with an interview guide as an instrument, and analysis of documents. Purposeful sampling was used to select twenty young people from the population of young people who graduated from the programme. Young people from three secondary schools and one combined school were interviewed.

The outcome of the study indicated that young people who graduated from the programme were better equipped with knowledge and skills that enable them to protect themselves from HIV infection. The study also indicated that the strategies used to implement the programme are crucial to the successful transfer of information to young people enrolled in the programme. However, some challenges which need immediate attention for improvement concern the number of participants, the content, a review of topics and the time allocated to the implementation of the programme.

It is therefore recommended that recipients be consulted for input on what their needs are with regard to HIV and AIDS prevention. As the programme began fourteen years ago, its strategies now require updating and revision of the programme has become necessary. The revision of the programme will enable its facilitators to incorporate new ideas and methods of HIV prevention gained from over a decade of experience. It would also allow for the identification of young people's needs and incorporate relevant topics that are not currently covered in the manual. Hence, collaboration between facilitators, learners,

teachers, parents, communities and programme designers is a key element in ensuring the continued success of the “My Future is My Choice” Programme.

Opsomming

"My Future is My Choice" (MFMC) is 'n bykomende lewensvaardigheidsprogram in Namibië wat die impak van MIV en VIGs onder jongmense wil verminder. Die program is 14 jaar gelede ingestel en het na bewering 'n beduidende uitwerking gehad op jongmense wat daarvoor ingeskryf het en dit voltooi het. Die program is afgestem op jongmense in graad 8 tot 12.

Die doel van die studie was om te bepaal in watter mate die MFMC-program die jongmense in die Ompundja-distrik in die Onderwysdirektoraat van Oshana in Noord-Namibië met kennis en vaardighede toerus. Die studie het 'n implementeringsevaluering behels, en het diepte-inligting met behulp van 'n kwalitatiewe benadering ingesamel. Data is met behulp van fokusgroeponderhoude aan die hand van 'n onderhoudsgids sowel as deur middel van dokumentontleding bekom. Twintig jongmense uit die groep wat die program suksesvol voltooi het, is met behulp van doelgerigte steekproewe gekies en onderhoude is met jeugdiges van drie hoërskole en een gekombineerde skool gevoer.

Die uitkoms van die studie dui daarop dat jongmense wat die program voltooi het oor beter kennis en vaardighede beskik waarmee hulle hulle teen MIV-besmetting kan beskerm. Die studie het ook getoon dat die strategieë wat gebruik word om die program in werking te stel deurslaggewend is vir die suksesvolle oordrag van inligting aan diegene wat vir die program ingeskryf is. Tog is daar bepaalde uitdagings wat onmiddellike aandag verg, soos die aantal deelnemers, die inhoud, die onderwerpe, en die tyd wat vir die inwerkingstelling van die program beskikbaar gestel word.

Daarom word aanbeveel dat, ten einde die MFMC-program te verbeter, diegene wat die program volg oor hulle behoeftes met betrekking tot MIV/vigs-voorkoming geraadpleeg word. Nou, 14 jaar nadat die program die eerste keer in werking gestel is, is dit duidelik dat die strategieë wat gebruik word verouderd is en dat die program dringend hersien moet word. Sodanige hersiening sal die programaanbieders in staat stel om nuwe idees en metodes vir MIV-voorkoming wat nie 14 jaar gelede bekend was nie, by die program

in te sluit. Dit sal ook ’n geleentheid bied om jongmense se werklike behoeftes te bepaal en ander onderwerpe aan te roer wat nie tans in die handleiding verskyn nie dog tersaaklik is. Daarom is samewerking tussen fasiliteerders, leerders, onderwysers, ouers, gemeenskappe en programsamestellers ’n sleutelelement om die voortgesette sukses van die MFMC-program te verseker.

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List of Acronyms

ABC	Abstain, Be Faithful, Condomise
ART	Antiretroviral Treatment
ARVs	Antiretrovirals
AVERT	AIDS Education and Research Trust
HAMU	HIV and AIDS Management Unit
HIV and AIDS	Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome
MDGs	Millennium Development Goals
MFMC	My Future is My Choice
MOE	Ministry of Education
MOHSS	Ministry of Health and Social Sciences
NDP	National Development Plan
PMTCT	Prevention of Mother-to-Child Transmission
RACE	Regional AIDS Committee for Education
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNAM	University of Namibia
UNESCO	United Nations Education, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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CHAPTER 1

INTRODUCTION TO THE STUDY

1.1 Introduction

This study examined the "My Future is My Choice" programme (MFMC). This is a peer education HIV and AIDS prevention life skills programme implemented in some combined and secondary Namibian schools. This study focused on the implementation of the programme in the Ompundja Circuit, which is in the Oshana Education Directorate. The introductory chapter presents a brief background, the rationale and research questions and objectives of the study, as well as the chapter outlines.

1.2 Background to the study

The Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) pandemic remains a critical issue in development in Namibia. The impact is felt in all spheres of life. As a result, the government of the Republic of Namibia has given top priority to the response to HIV and AIDS in all its developmental undertakings. The government has adopted a multi-sectoral approach that calls for committed participation of all stakeholders in the response to the pandemic. Education is one of the biggest government sectors affected by HIV and AIDS. Similar to the study by Brown, Macintyre & Trujillo (2001) cited by Ntombela (2009:11), many schools in Namibia are experiencing the effect of the HIV and AIDS epidemic as teachers, learners and members of their families became infected.

According to Kelly (2000), as cited in Ntombela (2009:14), HIV and AIDS have a tremendous impact on the various constituents in educational systems: students, teachers, and administrators are affected. In spite of government offering free education, young people from homes affected by HIV and AIDS cannot manage to attend school due to psychological stresses, illness or loss of loved ones. In reality food, clothes and other household resources including electricity are unaffordable and this causes affected learn-

ers to be demotivated and quit school. They often stop attending school, especially if no one in the family is earning an income.

Many young people face difficulties in the attempt to protect themselves from HIV and AIDS infection. The United Nations Economic Commission for Africa (UNECA) (2008:16) indicated that gender inequalities, socio-cultural norms and inadequate access to information/tools are some of the reasons why young people are at greater risk. In addition, the Joint United Nation Programme on HIV and AIDS (UNAIDS) (2008:2) noted that up to 75% of HIV and AIDS infection in sub-Saharan Africa involved young people of 15 to 24 years. Women or girls are at high risk of HIV infection. All these problems faced by young people in an attempt to protect themselves against HIV infection can be credited to some traditional practices which reject HIV prevention messages such as the use of condoms and gender equality.

Furthermore, the UNAIDS (2008) report also maintained that the impact of HIV and AIDS on young people has resulted in weakening family and community cohesiveness; young people are preoccupied with more immediate challenges of physical survival and financial needs. For example, adolescent boys drop out of school or resort to drugs and crime. Girls are also victims, and there is a growing trend of abuse by elderly men and commercial sex work. This, in turn, increases the prevalence of HIV and AIDS in the population of school-aged children.

As a result, there is a need for adequate opportunities for young people, especially those living in developing countries such as Namibia, to develop skills to address HIV and AIDS in their communities. It is important, therefore, that intervention programmes focus on the issues that hinder young people from making decisions to protect themselves against infection.

The Namibian government has acknowledged that the HIV and AIDS crisis is the government's responsibility. As a result, a number of initiatives to counteract the impact of HIV and AIDS were put in place both at governmental and non-governmental levels.

Educational intervention has become a national priority that requires collaboration among many individuals and organisations.

In response to the impact of HIV and AIDS in the education sector, the "My Future is My Choice" (MFMC) programme was established. "My Future is My Choice" is a ten session extra-curricular HIV and AIDS prevention and life skills training programme for young people from 15 to 25 years of age (Ministry of Education, 2006). MFMC is a joint intervention programme of the Government of Namibia and the United Nations Children's Fund (UNICEF). The training package for MFMC was developed by the Ministry of Education and the University of Namibia (UNAM), with technical support from UNICEF and the University of Maryland School of Medicine.

The programme was first piloted in 1996 and augmented in 1998. In 2003, it became an official extra-curricular life skills programme of the Ministry of Education at secondary and combined schools. The Ministry of Education (2008:25), describes the programme as targeting students in grades 8 through 12. MFMC consists of 10 sessions and each session last for 2 hours. In total, learners participate in 20 hours of training and activities. According to the Ministry of Education (2008:25), young people are educated with regard to HIV transmission and prevention, reproductive and sexual health, pregnancy, the use of male and female condoms; they are taught communication skills, how to practise assertiveness and make decisions and are informed about substance use/abuse. Each session starts with some activity or a game and the previous session is revised before proceeding to the specific topic and relevant skills for the session. While some activities are mandatory, others are optional.

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

The programme is based on the peer education principle that recognises that young people are able to discuss, debate, accept information and learn new social skills such as communication, negotiation and decision making skills so that they are able to make safe choices related to their sexual health and associate risk behaviours when a peer is teaching this information and skills. A peer is a person from a similar group, whether in age, class, race or interest. The programme is delivered by young people (who are called peer facilitators) to young people. These peer facilitators are young people who have completed grade 12 and are considered to be role models by adolescents who participate in the programme. Importantly, peer facilitators are volunteers rather than employees. The quality of the peer facilitator as the agent for delivering intervention is one of the most critical aspects of the MFMC programme. Peer facilitators are recruited locally and selected by the school at which the intervention will be delivered. Selected candidates are sent for a ten-day training course. The content of the course includes the introduction to MFMC, facilitation skills and administrative duties during the MFMC session. They are appointed as facilitators upon successful completion of the course.

Peer facilitator's roles are to guide discussions and make possible for participants to make healthy and informed decisions about their lives by imparting information about sexual health and HIV prevention, rather than telling participants what to do. The introduction of the programme to schools is decentralised to all thirteen regions of Namibia. In some regions, the MFMC programme is offered to all schools; in other regions, schools are selected on the basis of need, location, interest of principal/teachers, or other factors, due to limited resources.

Various impact studies and assessments of the MFMC programme have been conducted. Two studies were conducted before MFMC was declared an official extra-curricular life skills programme by the Ministry of Education in 2003. The next two studies were conducted in 2004 and 2008 after the programme became official. The first study was a randomised, longitudinal study, in 1998, followed by an assessment study by the Ministry of Education and UNICEF in 2002. The first study concluded that the MFMC intervention reduces HIV risk behaviours among sexually inexperienced youth. The second study

concluded that there were numerous obstacles to the successful implementation of the programme in terms of logistics, school cooperation and facilitator effectiveness.

In 2004, another programme assessment was done. The 2004 assessment evaluated the state of the MFMC programme from the viewpoints of MFMC participants, the peer facilitators, the master trainers and the senior master trainers. Like the 2002 assessment, the 2004 assessment identified numerous obstacles to the successful implementation of the programme, such as poor communication between facilitators and the programme coordinators, high facilitator turnover, insufficient support for the MFMC across various levels and stakeholders, insufficient monitoring and evaluation, limited skill sets among peer facilitators and the need for refresher training for facilitators.

The last study focusing on the MFMC programme was undertaken in 2008. This study assessed the impact and influence of MFMC on young people, both learners and peer facilitators. It evaluated the quality and ability of facilitators and trainers to deliver the programme; identified and analysed MFMC programme strengths and weaknesses; and made realistic recommendations for improving the programme. As with the previous study, some obstacles were identified.

Despite obstacles in the implementation of the MFMC programme, previous studies and assessments of the MFMC programme in general have concluded that the programme contributes to reducing HIV-related risk behaviours among young people.

1.3 Rationale for the study

The “My Future is My Choice” programme has already been implemented in some combined and secondary schools in Namibia. Various studies and assessments of the MFMC programme have highlighted how MFMC programme empowered young people to think for themselves and be accountable for their destiny (Ministry of Education, 2006:2). Yet concerns about the programme’s effectiveness remain; obstacles to effective implementation identified in the 2002 and 2004 assessments persisted in 2008.

This programme was initiated by the Ministry of Education and the United Nations Children's Fund (UNICEF) to promote responsible behaviours. In addition to HIV and AIDS prevention, MFMC was also established to respond to many other challenges faced by Namibian young people, such as teenage pregnancy, coping with emotions and stress, and alcohol and drug abuse.

Fourteen years after the implementation of the MFMC programme, HIV and AIDS prevalence is declining in the age group targeted by the programme. The Ministry of Health and Social Services (MOHSS) (2008a: 30) has noted a decrease in HIV prevalence in the 15 to19 year age group from 12% in 2000 to 10% in 2004. There was no change in 2006 but a decrease to 5.1% followed in 2008. A decrease from 22% to 18% to 16% for the respective periods was recorded for the 20 to 24 year old group.

According to the United States Agency for International Development (USAID) (2010:1), this welcome decline in HIV can be attributed to the following three factors: reduction of risk behaviours which has led into fewer infections, pool saturation where those most likely to be infected have already been infected and Namibia's high antiretroviral therapy covering 87% of the country. Antiretroviral Treatment (ART) is believed to reduce viral load and infectivity.

Although other factors contributed to the decline of HIV in Namibia, the MFMC programme can also be credited with this success. The Ministry of Health and Social Services (2006:7) indicated that by 2004, the Ministry of Education through its two HIV extra-curricular life skills programmes; "My Future is My Choice" had reached 70% of all secondary schools (out of 400 in total) and Windows of Hope 40% of primary schools (out of 1200 in total).

Despite these positive stories about MFMC, some schools are not implementing the programme correctly. This study therefore aims to evaluate the implementation of "My Future is My Choice". Specific emphasis was placed on determining which elements are

crucial for successful implementation and how the programme can be improved to impart HIV information and reduce the risk of HIV infections among young people. This study is considered to be important for helping decision makers and planners to understand the position of young people in the "My Future is My Choice" programme.

1.4 Research questions and objectives

The main research question of this study is: what are the critical factors for successful implementation for the MFMC programme to impart HIV and AIDS information and equip young people with necessary skills to assist in reducing the risks of becoming infected? In order to find answers to the main question, the following sub-questions were formulated:

- Is the programme implementation effective in meeting its goals?
- Is the programme delivery responsive to the needs and priorities of the participants in the programme?
- What positive impact has the implementation of the programme made on the lives of the participants in terms of HIV and AIDS knowledge, skills and behaviours?
- What lessons can be learned from the implementation of the programme that can be used to improve the programme?

The main objective of the study was to assess the implementation of the MFMC programme.

1.5 Research design and methodology

Evaluation research design was used to assess the implementation of the MFMC programme. Focus group interviews and document analysis of various reports were used as methods of data collection. An interview guide with semi-structured questions was used as a research instrument. The target population of this study was young people in the Ompundja Circuit in the Directorate of Education, Oshana region who enrolled as learners in and graduated from the MFMC programme. Four of the twelve schools that have

implemented the MFMC programme in the Ompundja circuit participated in the study. Random sampling was used to select young people, while convenience sampling was used to choose the schools and the circuit. Accordingly, 20 young people selected through purposeful random sampling were interviewed.

1.6 Outline of chapters

The thesis consists of six chapters. Chapter 1 introduces the study and presents the following topics: a brief background to the study, rationale for the study, research questions and objectives and chapter outlines. Chapter 2 comprises the literature review, while Chapter 3 presents an overview of HIV and AIDS in Namibia and provides the context for the study. Chapter 4 deals with the methodology of the study, looking at aspects such as the research design, population and sampling, criteria for selection, the interview as a data collection method, organisation and analysis of data, ethical considerations, and the validity and reliability of the study. The presentation of data and the analysis of information are contained in Chapter 5, while Chapter 6 presents the discussion on the findings and recommendations of the study.

1.7 Conclusion

This chapter has presented the background of the study, highlighting the factors that led to the establishment of MFMC programme in the Namibian schools. As a result of the impact of HIV and AIDS in the education sector and the country in general, the "My Future is My Choice' programme was established as part of the Ministry of Education's response to HIV and AIDS. After the establishment of MFMC programme various impact studies and assessments were carried out. In general, all studies concluded that the programme contributed to the reduction of HIV related risk behaviours among young people. This study will evaluate the implementation of MFMC programme in the Directorate of Education in Oshana region, Northern Namibia.

CHAPTER 2

LITERATURE REVIEW ON MFMC PROGRAMME

2.1 Introduction

This chapter presents a review of the literature. A brief overview of the impact of HIV and AIDS in sub-Saharan Africa will be discussed to set the context. Peer education and HIV prevention will also examined, together with theories of peer education, specifically considering the relevance of peer education to HIV and AIDS prevention, and critiques of peer education. Lastly, implementation evaluation will be considered.

2.2 The impact of HIV and AIDS on Public Sector in sub-Saharan Africa

It is estimated that 27 million people live with HIV and AIDS in sub-Saharan Africa. Amongst these people, almost two-thirds of all are adults and children. The region is classified as the worst in the world in terms of population affected by the epidemic. According to the (UNAIDS/WHO, 2006) cited in the Ministry of education (2008:12) as of 2006, an estimated 2.8 million people became infected in sub-Saharan Africa annually. Although rates of new infections peaked in many countries in sub-Saharan Africa in the late 1990s, the overall prevalence of HIV recently has been declining. Notwithstanding this, the prevalence rates in many Southern African countries are still exceptionally high compared to the rest of the world. While there are indications that HIV prevention efforts are having significant positive effects in certain regions of Africa (World Bank, 2007; UNAIDS/WHO, 2007) cited in the Ministry of education (2008:12) it is certain that more needs to be done to prevent the spread of new infections, especially among the youth.

While sub-Saharan Africa continues to bear the largest burden of HIV infections in the world, this has significant implications for countries including Namibia, especially in terms of their ability to reach the Millennium Development Goals (MDGs) of reducing poverty and improving the overall health and wellbeing of their citizens.

According to the AIDS Education and Research Trust (AVERT) (2010:6), children face especially difficult trauma and hardship when their lives are affected by HIV and AIDS. HIV and AIDS not only cause children to lose their parents or guardians, but sometimes their childhood as well, meaning that some children had to go through traumatic experiences like abuse before they turn 18 years of age.

HIV and AIDS present numerous barriers to school attendance. Children take on more responsibilities to earn an income, produce food, and care for family members as a result of parents and family members becoming ill. It is harder for these children to access adequate nutrition, basic health care, housing and clothing. Some of them are unable to afford school fees and other such expenses. This particularly is a problem among children who have lost their parents to AIDS and who often struggle to generate some income. A decline in school enrolment therefore is one of the most visible effects of the epidemic. AVERT (2010:6) points out that, as good basic education is one of the most effective and cost-effective ways of fighting HIV, a decline in school enrolment will have an effect on prevention.

According to UNAIDS (2002) cited by AVERT (2010:8) young people who have not spent much time in school are twice as likely to be infected with HIV as those who complete primary education. In addition Kirby, Laris and Rolleri (2008:2) indicated that teaching about sex and HIV before young people start sexual activity reduces their risk of contracting HIV. Hence, education is playing a major role in HIV prevention among young people.

The impact of HIV and AIDS is clearly felt in the education sector, and education also presents an important opportunity for intervention. AVERT (2010:7) points to a circular relationship between AIDS and the education sector meaning that the education sector suffers from the worsening of the epidemic because teachers, learners and members of their families fall ill and die, and this will most likely increase the incidence of HIV

transmission. It is true that AIDS can affect education in a variety of ways, but it is also true that there are many ways in which education can help the fight against AIDS.

UNAIDS (2002) in AVERT (2010:7) quoted Peter Piot, who stressed that AIDS will continue to spread rampantly in the absence of education, and uncontrolled AIDS will put education out of reach.

According to UNAIDS (2008), HIV and AIDS have impacted life expectancy in many countries of sub-Saharan Africa, with AIDS erasing decades of progress in extending life expectancy. In the most affected countries, average life expectancy has fallen by twenty years because of the epidemic. In Swaziland, for instance, life expectancy is only 31 years less than comparing it to the time when there was no AIDS. This impact is to a certain extent due to child mortality due to the increase in babies born with HIV infection acquired from their mothers. Adults aged between 20 and 49 furthermore account for 60% of all deaths in sub-Saharan Africa. This figure stood at 20% between 1985 and 1990, in the early stages of epidemic. AIDS therefore affects adults in their most economically productive years and thereby wipes out those people who could respond to the crisis (AVERT, 2010:8).

The way forward is prevention. It is crucial to prevent young people from becoming infected with HIV. If efforts are made to prevent adults becoming infected with HIV, and to care for those already infected, fewer children will be orphaned through AIDS in the future.

2.3 Definition of Peer Education

UNAIDS (2006:5) explains that peer education involves an approach to education that provides a channel of communication through a particular method based on a particular a philosophy and using a particular strategy. ‘Peer’ denotes persons of equal standing with one another concerning age, grade or status and therefore belonging to the same social group.

However, Adamchak (2006:5) indicates that the difficulty with defining peer education arises because the process and methodology involved, as well as the channel of communication and strategies vary considerably depending upon the programme, context, and the target group.

Peer education programmes have been used as a health promotion strategy in public health for many years and have been implemented in a variety of settings such as schools, universities, workplaces, churches, street settings, and community halls to promote various positive health behaviours such as stopping smoking, preventing violence, substance abuse and HIV.

Peer education can thus be described as the use of members of a given group to effect change of behaviours among other members of the same group. Mead (2010:3) concluded that peer education often results in the change of knowledge, attitudes, beliefs, or behaviours at the individual level. However, peer education can also lead to changes in groups or a society through changing norms and encouraging the kind of action that facilitates changing programmes and policies.

2.4 Theories of peer education

According to Mead (2010:2), education and training forms the most important components of peer education. Peer education is regarded an effective behavioural change strategy and is composed of four well-known behavioural theories; the Social Learning Theory, Theory of Reasoned Action, Diffusion of Innovation Theory and the Theory of Participatory Education.

According to Bandura (1986) cited in Mead (2010:3), Social Learning Theory is stresses that people serve as role models of other people's behaviour. Based on the individual's value and interpretation system some people are capable of bring out behavioural change in certain people. In addition, Fishbein and Ajzen (1975) in Mead (2010:3), explain that

the Theory of Reasoned Action believes that behavioural change is an individual's perception of social norms or beliefs about a particular action. Rogers (1983) in Mead (2010:3), the Diffusion of Innovation Theory stated that in any given society, there are opinion leaders who act as agents of behavioural change by disseminating information and influencing group norms in their community.

The Theory of Participatory Education has also been important in the development of peer education; according to Freire (1970), cited in Mead (2010:3) noted that lack of participation in the community or group level, economic and social conditions are basically caused by the lack of power. As a result, lacks of power are major risk factors for poor health. Empowerment in Freire's sense results from the full participation of the people affected by a given problem or health condition; through such dialogue the affected community collectively plans and implements a response to the problem or health condition in question.

2.5 Why peer education is important in HIV and AIDS prevention

Peer education works very well because members of the same peer group can immediately grasp the problems their peers are experiencing and empathise with their peers. They understand their peers' needs, interests and communication styles and what will draw them to and push them away from education efforts. In addition, young people already turn to one another for information and advice because they see their peers as credible and comfortable sources of information, especially on such sensitive topics as reproductive health, HIV and AIDS and other Sexually Transmitted Infections (STIs).

The study conducted by the Ministry of Education (2008:17-18) indicated that in the past decades, peer education programmes have been instrumental in the areas of public health as well as adolescent sexual and reproductive health, with emphasis on HIV prevention. International public health literature such Horizon by the Population Council (2011:1) indicates that the use of peer education in the fight against HIV and AIDS has become

widespread. Because of this popularity, the effect of peer education in the areas of HIV and AIDS prevention, care and support have increased.

Pearson and Michell (2000:21) indicated that, in order to address the HIV and AIDS pandemic among young people, prevention programmes should use members of a given group to effect changes among the members of the same group. The authors found that evidence indicates that a peer group is a primary influence in the lives of young people, such that both risk-taking and non-risk-taking behaviours are learned through peer relationships. They stressed that HIV prevention peer education programmes should recognise the important role played by peers in influencing other young people's behaviour. They support the premise that young people are more apt to alter their behaviour if peers that they trust and like advocate the change.

Mead (2010:4) points out that young people are faced by difficulties of obtaining clear and correct information on issues such as sex and substance use. This is most likely increase the frequency of HIV transmission and other Sexually Transmitted Infections (STIs) in young people. This opinion is in contrast from the Southern African AIDS Trust (2006:7) which indicated that many people believes that sex education encourages youth to experiment sex and become promiscuous. However, various studies around sex education such as Kirby *et al* (2008:2) contacted in many countries have shown that youth who get sex education before they start having sex wait longer before having sex comparing to youth who have not had sex education. Therefore, good sex education is helpful to sexually active youth. It help protects them against HIV and other STIs, as well as unwanted pregnancy. Sex education teaches young people who will have sex for the first time to use condoms or contraceptives.

Some of the reasons why it is difficult to obtain clear information on issues related to sex are due to socio-cultural norms and taboos, economic deprivation or lack of access to information. In some instances, information is available but it is given in an authoritarian and judgemental manner, and in many cases it is not in agreement with young people's values, viewpoints and lifestyle. Mead (2010:4) further clarified that peer education is

the effective technique of dealing with issues affecting the young people because they turn to listen and participate well, when the discussion is facilitated by members of the their group.

According to AVERT (2010:6), people learn more by being involved, than by just being supplied with information. The author explains that peer education is effective because it is participatory and involves the young people in discussion and activities. Peer education therefore is an appropriate way to communicate in the context of HIV and AIDS. This statement is supported by Akoulouze, Rugalema and Khanye (2001:18) who stated that peer education programmes increase communication between sexual partners. Young people are free to discuss issues considered taboo without fear of being judged. It empowers young people to take action in their own lives. Examples of participatory activities used in peer education are games, art competitions and role play. All of these activities help young people to see things from a new perspective without being told what to think or do.

Mead (2010:4) explains that sharing a conversation on HIV and AIDS with people of the same age or social group creates a relaxed and safe learning environment for young people because they are free to ask questions on taboo subjects and are able to discuss without fear of being judged and labelled. They thus discuss issues that are difficult to discuss with adults, yet, at the same time, gain insights through mutual sharing of experiences, knowledge and information.

Campbell, cited by the Ministry of Education (2008:17), echoes this sentiment by stating that young people learn more about HIV and sexuality and open to speak if the lesson is facilitated by the peer rather than someone from a group not similar to theirs, an example teacher. Peer facilitators are expected to both teach and model desired behaviours. A peer facilitator who performs as a role model can strengthen learning and influence group behaviours by formal means as well as informal interactions.

Mead (2010:4) has noted that peer education is the best HIV and AIDS prevention strategy. This was revealed in a study done on 21 peer education and HIV and AIDS prevention programmes in 10 African countries, Asia, Latin America and the Caribbean. According to Backett-Milburn and Wilson (2000), Milbon (1995), and Turner and Shepherd (1999) who are cited in the Ministry of Education (2008:18), there are many reasons for using peer education in HIV prevention. Amongst other reasons peer programmes is cost effective compared to professionally trained and paid staff; it also helps young people to gain work experience and grow professionally. Through peer education conventional education methods can be used to reach those difficult to reach groups.

2.6 Critics of peer education

Despite the fact that peer education as a health promotion strategy for young people is popular and generally viewed in positive terms, it is not without challenges. According to a study on peer education conducted by Mellanby, Rees and Tripp (2000:540), there was no difference in improvement in sexual behaviour (condom use or number of sexual partners) between programmes facilitated by adults and those facilitated by young people. They argued that this evidence indicated that both adults and peers have equal roles to play and that preference should not be given to peers.

Another critique of peer education is cited by Adamchak (2006:5), who argues that its relative cost-effectiveness vis-à-vis other intervention strategies has not been tested or proven. There, for example, are no rigorous comparisons of the cost-effectiveness of training of peer facilitators versus other kinds of facilitators (teachers and health workers). Moreover, when implemented properly and done well, peer education requires rigorous planning, coordination, supervision, resources and careful budgeting and monitoring.

Turner and Shepherd (1999), in Ministry of Education (2008:19) also argue that peer education approach lacks theoretical basis. In their review of the literature, Turner and Shepherd (1999), in the Ministry of Education evaluation (2008:19), further argued that

there is little reference to theory in the literature on peer education, such that peer education is termed 'a method in search of a theory' rather than the application of theory to practice. They cautioned, however, that this does not negate the various theories, such as Social Learning Theory, the Theory of Participatory Education, and Diffusion of Innovations Theory, as applied to peer education. However, they argued that peer education is not born out of a strong theoretical base that would give credence to its effectiveness as a method.

The evaluation study on My Choice, My Future programme conducted by Trenholm, Devaney, Fortson, Quay, Wheeler & Clark (2007:2) in Powhatan, a Virginia county school, revealed that the My Choice, My Future programme did not have a positive impact on the sexual behaviour of students. They also indicated that at the final follow-up (on average, five years after a student entered the study), students from the treatment group were only as likely to abstain from sex as students from the control group. The treatment group also did not indicate any likelihood to remain abstinent, also had several sexual partners and did not report waiting longer than the control group to start having sex. Their use of condoms or birth control also matched that of the control students, therefore they were as exposed to pregnancy, having babies or acquiring Sexually Transmitted Diseases (STDs).

In addition, the My Choice, My Future programme was found to have no impact on other risk behaviours. According to Trenholm *et al.,* (2007:2) there was no difference between the students assigned to the intervention and control groups, the possibility for all of them to smoke cigarettes, drink alcohol, and use marijuana was the same.

On the other hand, My Choice, My Future was reported to lead to significant gains in knowledge of Sexually Transmitted Diseases (STDs) among students assigned to the programme. Compared with students in the control group, students assigned to receive the My Choice, My Future intervention had significantly greater knowledge of the risks and consequences associated with STDs. My Choice, My Future students were significantly more likely than were control students to correctly identify birth control as not

preventing STDs. On the other hand, My Choice, My Future students were also more likely to incorrectly identify condoms as never preventing STDs (Trenholm *et al.*, 2007:2).

Despite the critique, there is a general agreement that peer education is a useful strategy in HIV prevention among young people. According to Swartz (2003) criticism against peer education probably reflected poor implementation rather than that peer education was inherently problematic. In agreement with Swartz, Mead (2010:3) concluded that the evaluation of peer education programmes that promote safer sexual behaviour and HIV prevention practices in sub-Saharan Africa and elsewhere in the world has shown that peer education that is designed and implemented properly can impact positively on young people's knowledge, attitudes and self-efficacy. The impact on the behaviour of peer facilitators and their target peers has also been positive, though to a lesser extent.

Adamchak (2006:11) indicated that, broadly speaking, peer education programmes were found to be effective in terms of increasing knowledge, and some interventions were able to reduce risk behaviours associated with sexual activity (i.e. number of sexual partners and use of condoms). However, changes in other aspects of sexual behaviour, particularly in terms of increasing abstinence, are often limited. A review of eleven evaluated school-based HIV prevention programmes for Africa Youth done by Gallant & Maticka-Tyndale (2004:1337) as well as a systematic review of schools-based sexual health interventions in sub-Saharan Africa done by Paul-Ebhohimhen, Poobalan & Van Teijlingen (2008:11) reached similar conclusions, confirming the effectiveness of peer education. While programme effects often include statistically significant effects on knowledge and attitudes, behaviour is much more challenging and difficult to change.

2.7 Programme Implementation and Evaluation

Implementation concerns the carrying out, execution, or practice of a plan, a method, or any design for doing something. As such, implementation is the action that must follow any preliminary thinking for something to actually happen. Therefore, programme im-

plementation is a series of activities designed to put into place an intervention with defined components. A programme implementation is not a single event but involves multiple stages and takes place over time. It is an interactive process that involves ongoing decision making.

Nowadays, the need for identifying and overcoming problems associated with the process of implementation is critical. According to Mihalic, Irwin, Fagan, Ballard and Elliot (2004:6) identifying an effective programme is followed having to implement it properly which face practitioners with many challenges. A sound programme will not produce the desired results if it is implemented poorly. It is therefore vital to monitor the implementation process to identify and help resolve problems, provide feedback and ensure that programmes are implemented with fidelity to their original intent and design. In addition, Mihalic *et al*., (2004) emphasise that it is important to gather and disseminate information regarding factors that enhance the quality and fidelity of implementation. They have identified three critical components of successful programme implementation which includes assessment, effective organisation and qualified staff.

Furthermore, they have indicated that to implement the programme effectively, an organisation needs administrative support, agency ability, shared vision and interagency links. Every successful programme depends on strong administrative support. This is important, because, first and foremost, decisions about adopting a programme are generally made at the administrative level, while decisions about implementing a programme are usually made at lower organisational levels (e.g. by the programme coordinator and teachers).

In general, the main purpose of doing evaluation is to give helpful advice to a variety of stakeholders such as supporters, patron, client groups, staff and other relevant constituencies. A very useful feedback is the one that assists in making decision, (Jacobson, 1991:144).

According to Trochin (2006:2), there is no single type of evaluation, they are many depends on the purpose and object being evaluated. However, the most important basic distinction in evaluation types is that between formative and summative evaluation.

Furthermore, Trochin (2006:3) explained that formative evaluation consists of various types of evaluation: needs assessment determines who needs the programme, how great the need is and what might work to meet the needs.

As defined above, implementation evaluation monitors the progress or delivery of the programme. Jacobson (1991:146) pointed out that one of the benefit of conducting implementation evaluation; it helps in making decision whether the programme is relevant for the targeted group.

In general, Trochin (2006:7) added that implementation evaluation gives information concerning the programme if it is appropriate and successful towards its targeted group. Also it provides information regarding the level of service provided and if the resources are enough to continue with the prevention efforts made.

Trochin (2006:7) further indicated that this evaluation consists of a set of procedures that can provide timely information for improving implementation by identifying a programme's strengths and weaknesses. It is essential to keep in mind that the driving force behind all evaluation is to optimise the effectiveness of HIV prevention services. The implementation evaluation information allows evaluators to distinguish an ineffective intervention from one that is ineffectively implemented.

HIV prevention intervention must be accountable to its stakeholders in terms of two aspects: the quality of implementation and the effectiveness of the intervention. According to Chen (1994), in Trochin (2006:8), evaluation addresses management and operational issues that are critical to programme managers, administrators and funders.

Despite the known benefits of implementation evaluation, many decision makers continue to believe that the only valuable measure of a programme is to conduct outcome evaluation to determine its effectiveness in achieving outcome objectives.

Implementation evaluation looks beyond the theory of what the programme is supposed to do and instead evaluates how the programme is being implemented. This evaluation determines whether the components identified as critical to the success of the programme are being implemented. The evaluation determines whether the target population is being reached and is receiving the intended services. This is an ongoing process in which repeated measures may be used to evaluate whether the programme is being implemented effectively.

This type of evaluation is geared to fully understanding how a programme works and how it produces the results that it does. It is useful for accurately portraying to outside parties how a programme truly operates.

2.8 Evaluation of Life Skills Programmes

As mentioned above, the most important purpose of programme evaluation is to assess the extent to which the goals of the programme are being met. In addition, evaluation could confirm the worth and value of a programme and point out the need of improvement or if necessary provide evidence that there is a need to terminate the programme (Stufflebeam & Shinkfiel, 2007:46).

Programme evaluation can serve worthwhile purposes. Currently, available research from other African countries shows that life skills programmes have few positive outcomes for adolescents of high school age. According to the evaluation study conducted by Kinsman, Nakiyingi, Carpenter, Quigley, Pool & Whitworth (2001:42) in Uganda, a life skills programme which included basic HIV and AIDS information, role-play activities, and condom and negotiation skills, discovered that there were no considerable differences between the intervention group and the control group on most of the measured outcomes. Where significant differences were found, they were attributed to a decrease

in safer attitudes in the control group as opposed to an increase in safer attitudes in the intervention group. It was thus concluded that the life skills programme had little effect. Furthermore, an evaluation of a Ugandan life skills programme at primary school level also indicated a considerable decrease in sexual activity amongst the intervention group, with sexual activity in the control group remaining unaffected. Those in the intervention group also had significantly fewer sexual partners, while the number of sexual partners for the control group remained unchanged (Shuey, Babishangire, Omiat & Bagarukayo, 1999:411).

Another evaluation of the South African life skills programmes at schools by James, Reddy, Ruiter, McCauley & Van den Borne (2006:290) showed that there was improvement on HIV and AIDS knowledge; however, the programmes had no positive effects on attitudes and sexual behaviours. The study identified problems in the quality and consistency with which life skills programmes are implemented, citing that those who had received full implementation as opposed to partial implementation demonstrated improvement with regard to sexual attitudes and feelings of social support. Furthermore, the study demonstrated that positive outcomes for the intervention group who received full implementation did not show consistent positive outcomes, as there was only a short-term increase in condom use.

Life skills programmes with primary school learners are reported to have had more positive effects. An evaluation of a Tanzanian life skills programme at primary school level indicated that the intervention group had not only higher levels of HIV and AIDS knowledge than the control group, but also had safer sexual norms and intentions (Klepp, Ndeki, Leshabari, Hannan & Lyimo, 1997:1934).

In general, the review of the life skills programmes indicate the need to pay greater attention to the broader social contexts in which young people live, which can hinder behavioural change and undermine well-intentioned programmes. The review cogently argues for the need to situate youth HIV-prevention programmes within the broader context of youth and social development. The studies indicate that, while having no significant ef-

fect on secondary school adolescents, life skills programmes seem to have a greater impact on younger people.

2.9 Criteria to measure the success of the implementation

It is not always easy to measure the impact of programmes, according to Campbell and MacPhail (2002) in the Ministry of Education (2008:24) who have pointed out that the difficulty lies in not really having determined what the mechanisms that influence success or failure are. These authors have furthermore indicated that programmes do not exist in isolation; therefore it is difficult to attribute behavioural change to a programme as opposed to contextual or environmental factors. Behavioural change itself is difficult to determine as one can only rely on self-reported measures. Often an increase in knowledge is used as a measure of impact; however, in another study, Campbell (2005) indicated that a programme that results in increased knowledge does not necessarily have a significant impact on behaviour.

According to the Population Council (2000), cited in the study conducted by the Ministry of Education (2008:25) the process evaluation is the most effective in measuring the success of programme implementation and monitoring peer education programmes. Such an evaluation may be conducted by means of field visits, activity reports, regular meetings, focus group discussion and qualitative surveys with young people and facilitators. Such monitoring activities make it possible to assess progress and make improvements. The study reveals that there were limited cases where some important information were not documented, it is assumed that there was little knowledge about the process involved in such interventions, and that little evidence about their effectiveness exists. The Population Council (2000) in the Ministry of Education (2008:25) further mentioned that Ghana and Thailand are exceptions as a social network analysis is used to in these countries to deal with issues such as recruitment, supervision, retention, initiation and intensity of contacts, quality/accuracy of information, and referrals to other services.

Some of the obstacles to sufficient monitoring of the peer education programmes involve the inadequacy of funds provided by donors to assess the successes of the programmes.

Despite such challenges, it is necessary to find quality methods of evaluating and monitoring peer education programmes, as it is only through monitoring and evaluation activities that these programmes can be improved.

The Population Council (2000) study referred to above further indicated that various types of assessment such as the evaluation of outcomes have to be conducted to measure the success of implementing a programme. Despite the fact that there currently is a lack of rigorously evaluated HIV and AIDS peer education programmes; the study concluded that there is a great need for more longitudinal studies to be carried out in order to assess behavioural changes over longer periods of time.

The quality of the programme is a major concern. Field visits are crucial tools for assessing the success of the programme. In order to measure the success and quality of the programme, one needs to have an understanding of the process of programme implementation. This means that process and quality indicators would have to be developed in order to track the quality of programme implementation.

Regular meetings are equally important in evaluating the success of the implementation. Through meetings, the necessary technical assistance is provided to the people involved in the implementation of the programme. Meeting and interaction with the beneficiaries help one to know the basic realities and the benefits delivered by the people involved in the programme and create an opportunity for problems to be highlighted and sorted out.

2.10 Conclusion

HIV and AIDS have major implications for countries in sub-Saharan Africa in terms of the country's ability to reach the Millennium Development Goals of reducing poverty and improving the overall health and wellbeing of its citizens. The impact of HIV is felt at every level of society and affects all individuals, families and communities, the fundamental building blocks of social and economic development.

It is believed that peers talking among themselves and determining a course of action is key to peer education's influence on behavioural change. Various studies have indicated that, in order to address the HIV pandemic among young people, prevention programmes should involve members of a given group to effect change among the members of the same group. Because of this understanding, the effect of peer education in the areas of HIV and AIDS prevention, care and support have increased. Despite the fact that peer education as a health promotion programme for young people is popular and generally viewed in positive terms, it is not without challenges. Some studies on peer education concluded that there no improvement was noted and that peer education sometimes is costly.

Peer education programmes were found to be effective in terms of increasing knowledge and some interventions such as sex education were able to reduce risk behaviours associated with sexual activity. Implementation evaluation monitors the progress or delivery of the programme. The advantage of conducting implementation evaluation is that it helps to determine the appropriateness of the programme for the intended participants. In general, programme implementation evaluation provides information about whether the programme is reaching its intended audience; the level or extent of service provided; and the resources required to support the prevention efforts, such as providing information for improving intervention implementation; providing a context for understanding the effectiveness of intervention; and meeting accountability needs.

CHAPTER 3

"MY FUTURE IS MY CHOICE" PROGRAMME IN NAMIBIAN CASE STUDY

3.1 Introduction

This chapter presents a short profile of the country, factors contributing to HIV infection such as gender inequity and inequality, poverty and unemployment, alcohol/drug use and abuse and youth and pressure among young people in Namibia. Also included in this chapter is a brief overview of HIV and AIDS-education programmes such as "My Future is My Choice" and Window of Hope in Namibia. Like other government sectors, the education sector did not runaway the negative effects of HIV and AIDS Epidemic. HIV and AIDS impacted the supply, demand and quality of the educational services. At the end, the management and implementation of MFMC in the Namibian schools and Oshana region in particular will be considered.

3.2 Contextual background of Namibia

Namibia is located in the south-western part of Africa. According to the National Planning Commission (2007:3) the country's population comprises approximately 2,000,000 inhabitants. The Republic of Namibia obtained independence from South Africa on March 21, 1990, after more than 100 years of colonisation by both Germany (1885-1915) and South Africa and decades of armed and diplomatic struggle against apartheid and white minority rule.

It is one of the most sparsely populated countries in Africa with an average population density of 2.5 per person per square kilometre. The country is classified as a lower-middle income country and is heavily dependent on the extraction and processing of minerals for export. Despite a good economic status, the country has the highest Gini coefficient in the world at approximately 0:6. The Gini-coefficient measures the inequality of income distribution across various segments of society (Ministry of Health and Social Services, 2008b:6).

The most inhabited part of the country is the north, followed by the central plateau and the Walvis Bay-Swakopmund corridor at the coast. Although the country's population remains predominantly rural, the rapid growth of informal settlements around the country's towns reflects the significant increase in urbanisation, with high rural-urban migration ostensibly motivated by a search for economic opportunities.

The large movements of people have created serious social, security, environmental and political problems for the urban areas and have contributed to the large number of female-headed households in rural areas and temporary sexual relationships in urban areas.

The study conducted by the Ministry of Health and Social Services (2008c:16) indicated that there was a decrease in HIV prevalence among 15 to 19 year-olds, from 12% in 2000 to 10% in 2004, but remaining at that level in 2006, and a decrease among 20 to 24-year olds from 22% to 18% to 16% between 2002 and 2006. Furthermore, it was noticed that life expectancy also declined drastically from 62 years in 1996 to 44 years in 2006 as a result of HIV and AIDS prevalence in Namibia. Despite the fact that the epidemic is currently on the decrease, there is still a need for highly effective HIV prevention strategies.

If more appropriate interventions are not taken to respond to the HIV and AIDS pandemic among the young people, Namibia will not achieve its Vision 2030 goal of being one of the industrialised nations. According to the World Bank (2007), about half of the Namibian population is under the age of 18, therefore the country has a very youthful population. In fact, the proportion of young people versus the general population is growing. This is expected to peak over the next twenty years and lead to a demographic bulge in the youth population. USAID (2007), cited in the Ministry of Education study (2008:9), has estimated that 62% of the Namibian population are under the age of 24. This is a reality that presents both opportunities and risks for the health, development and well-being of the children and youth of Namibia.

As with any other infectious diseases, HIV and AIDS in Namibia are greatly influenced by the cultural, economic and social context. It is therefore crucial to be aware of these factors that affect and, in some cases, cause the spread of HIV and AIDS. It requires everyone's effort to work to address these factors if we are going to succeed in turning the tide of this disease.

According to the Ministry of Education (2003:5), HIV and AIDS present the largest single threat to the development of Namibia. The impact of HIV is felt at every level of society and affects all individuals, families and communities, the fundamental building blocks of social and economic development. HIV transmission in Namibia mainly occurs through penetrative heterosexual sexual intercourse among the general population as in other countries in the sub region that are faced with generalised epidemics. Against this background young people in Namibia are extremely at risk of HIV and it is important to provide HIV prevention programmes for them (Ministry of Education, 2008:12).

The Namibian National Sentinel Survey (MOHSS, 2008c:11) indicated that 50% of all new infections occur among people aged 15 to 49 Furthermore, the study points out that adolescent girls, in particular, run very high risks of being infected. In sub-Saharan Africa, for example, more than two-thirds of newly infected 15- to 19-year olds are women. Kopelman and Van Niekerk (2005:62) indicate that the disempowered status of women and girls in society places females at greater risk because they do not have bargaining power to practise safe sex and are sometimes victims of coercive sex and rape. Against this information, significant progress to curb the epidemic and reduce the rate of new infections among young people, especially young women, is critical.

As mentioned above, even though the HIV prevalence in Namibia has decreased to 17.8% in 2008, the country remains one of the worst affected in the world (MOHSS, 2008c:11). The study conducted by the HIV and AIDS Management Unit (HAMU) in the Ministry of Education (2008:12) revealed the adult HIV prevalence rate as standing at 20% and this elides important inter-regional variations within Namibia, with the most affected regions being Caprivi in the north-east (43%), Oshana in the north (25%), and

Erongo in the central part (27%). In a population of approximately two million people, it is estimated that 195 000 people are living with HIV in Namibia. The study by (UN-AIDS/WHO, 2006:13-14 and The government of Namibia MOHSS, 2008) in the Ministry of Education (2008:12) stated that although prevention of mother-to-child transmission (PMTCT) coverage rates have improved considerably in the last few years (from 1% in 2003 to 49% in 2007), mother-to-child transmission is still a matter of serious concern, as indicated by a high antenatal prevalence rate of 40% in parts of the Caprivi strip. Given that, according to the Demographic Health Survey (2006) cited by the Ministry of Education (2008:12), nearly 50% of young Namibian women will have had at least one child by age 21, preventing new infections among young women is an essentially important strategy to protect the future generation. With infection rates among young women being three times higher than among young men, this is a cause for concern. According to the Ministry of Health and Social Services (2008c:vii) the rate of HIV infection is estimated at 4% amongst young men aged 15 to 24 comparing to 13.9% of young women. Looking at these statistics it shows that much more must be done to prevent HIV transmission among young people.

3.3 Factors contributing to the spread of HIV amongst the Youth in Namibia

3.3.1 Gender inequity and inequality

HIV is spread through sexual contact and the unequal power relations between men and women constitute one of the contributing factors. Decisions about when, where and how to have sex, for example, are made more by the men than by the women. Gender differences affect the risk of and vulnerability factors for HIV and AIDS in many ways. Women and girls are unable to insist on condom use without fear of a negative reaction from the man, including violence; women/girls who carry condoms may be viewed as promiscuous or as having the disease; women are often unable to refuse sex without fear of 'punishment' by men, and women are not able to demand faithfulness from their partners. These situations are the result of gender inequality, but expose both men and women to the disease because of both partners engaging in risky behaviour.

Until both men and women change their attitude, HIV and AIDS will continue to spread among both women and men.

3.3.2 Poverty and unemployment

Namibia faces numerous social and economic challenges, including pervasive poverty, high unemployment rates and acute socio-economic inequalities. According to Duddy (2010:1), 51.2% of the general population is unemployed. The statistics show that unemployment is higher among youth as 83% of 15 to 19 year olds and 67% of 20 to 24 year olds respectively are not employed.

Martin, Joseph, Bezuidenhoudt, Cloete, Hyman, Hako & Sampson, (2005:26) point out that poverty affects the spread of HIV and AIDS because it can lead to risky behaviour in an effort to survive financially. People who have no prospects of getting jobs to ensure a livelihood lose hope for the future and see no value in protecting themselves against disease. For both young and old people the immediate problems of poverty are so overwhelming that they fail to be concerned about contracting HIV and AIDS.

3.3.3 Alcohol/Drug Use and Abuse

In addition to the everyday challenges of poverty and unemployment, another pressing social issue confronting Namibian youth is alcohol and drug abuse. In Namibia, alcohol abuse is recognised as a common problem among young people and is associated with various social, economic and health problems. According to the report of the Ministry of Health and Social Services (2008a:44), up to 90% of violent crimes in Namibia are estimated to be alcohol related. Alcohol and drug use and abuse contribute to the spread of HIV and AIDS because these substances impair people's judgement, cause them not to use condoms, leads to behaviour such as rape and violence and cause people to stop not caring whom they have sex with.

According to Adejide (2006), cited in the study conducted by the Ministry of Education (2008:11), the use and abuse of alcohol among young people is of great concern. There

are indications of an increase in alcohol consumption among children and young adults between 10 to 25 years right across sub-Saharan Africa. Early experimentation with alcohol is common among Namibian youth. A UNICEF (2006) finding cited in the Ministry of Education (2008:11) showed that Namibian youth (15-24) on average started drinking at 15 years of age and that five out of ten of the young people who had been surveyed had already tried alcohol.

Mufune (2003), also referred to by the Ministry of Education (2008:11), indicated that in the context of HIV prevention, alcohol use and abuse is considered a driving factor for HIV transmission. For example, the UNICEF study (2006) mentioned above also found that drinking alcohol increased the probability of youth having taken one or more sexual risks by a factor of 3.5. In the same study by the Ministry of Education (2008:11), it is reported that Parker and Connolly (2007) also found that among those sampled, risk behaviour related to HIV was also related to the consumption of too much alcohol. Alcohol and drugs can aggravate feelings of loneliness and low self-esteem and make someone feel the need for emotional and physical satisfaction more than usual. In these moments of emotional vulnerability, people are more likely to put themselves at risk to gain some short-term gratification.

3.3.4 Youth and Peer pressure

As defined by Brandon (1996:1), peer pressure occurs when friends persuade you to do something that you do not want to do. Peer pressure can be broken down into two areas; good peer pressure and bad peer pressure.

Martin *et al.* (2005:28) pointed out that, many young people feel forced to behave in ways that will be approved by their peers because they are very sensitive to the opinions of their peers and do not want to ignore peer norms. Such a strong peer influence may have negative aspects: Young people may feel obliged to engage in sexual practices to fit in with peer, thereby risking transmitting HIV or may fail not to take measures needed to protect themselves against HIV transmission.

The same study indicated that HIV prevention programmes among young people are more likely to succeed if it is facilitated by young people themselves. This is more effective because the information is coming from within (peers) and not from outsiders.

In order to minimise the number of new infections among the youth, factors contributing to the spread of HIV and AIDS, such as socio-cultural beliefs, stigma and discrimination, gender inequality, poverty, unemployment, alcohol and drug abuse, access to condoms, and the lack of productive activities for youth, need to be addressed. It is believed that education and communication programmes that are aimed at HIV prevention among young people have a greater chance of success if they make use of young people who are closer in age to those who are targeted in such programmes (Martin *et al.,* 2005:29).

3.4 HIV and AIDS and Education programmes in Namibia

The first cases of HIV infection in Namibia was reported in 1986, 25 years ago. From there, the epidemic proceeded to grow rapidly until 2002 and has since started to decrease. However, HIV prevalence differs from region to region in the country. Overall HIV prevalence in Namibia can be summarized as follows: 1986 first four cases of HIV reported, 1992 – 4.2%, 2002 – 22.0%, 2004 – 19.7%, while in 2008 – 17.8% (Ministry of Health and Social Services (National Sentinel Survey, 2008c:34).

The Ministry of Education (2003:1) has already been quoted as indicating that Namibia is one of the five countries in the world most affected by HIV and AIDS. Furthermore, the National Planning Commission (2003:40) has indicated about 28% of deaths in the country are AIDS related. The Commission describes the impact of the epidemic as profound, affecting many sectors and reaching across generations. AIDS has caused a decline from 62 years in 1991 to 49 years 2001 in the life expectancy at birth in Namibia while it had been on the increase before the onset of AIDS. This cost of the epidemic has taken a staggering financial and emotional toll. Included in these costs are the increasing expense of medical care and the loss of workers, parents and children. The same docu-

ment also indicated that about 247,000 children are made vulnerable or orphans by AIDS. With almost one in every five persons living with HIV, this incurable, lifelong infection is robbing communities of bread winners, leaders and knowledge and skills that are needed to ensure livelihoods and economic development (Beresford, 2005:32).

The Ministry of Education study (2003:1) also indicated a continuation of the increase in the number of reported deaths in the age group 15 to 49 years. More than 50% of all deaths in hospitals involved this age group by 2000. It is estimated that young people of 10 to 24 years account for up to 60% of all new HIV infection, with women and girls being particularly vulnerable. The statistics show that HIV infections and deaths are increasing in the economically active age group of up to 49 years, therefore HIV and AIDS are expected to continue to impact both the education system and human development in Namibia.

The above information clearly indicates that there is a great need for more HIV and AIDS prevention programmes among the youth to avoid massive loss of lives and investment in education and the resultant negative effects on development.

However, the increasing recognition of the importance of the role that the education sector can play in the prevention of HIV infection; in the support of infected and affected people; and in maintaining service delivery despite the impact of AIDS has led to the education sector's role expanding from its earlier role as a partner of other organisations in HIV prevention activities (Ministry of Education, 2003:1).

In response to the spread of the HIV and AIDS pandemic, the Ministry of Education, together with UNICEF, has established Window of Hope (WoH) and My Future is My Choice (MFMC), extra-curricular life skills programmes focusing on HIV prevention, care and support in order to reduce the HIV impact amongst learners. The Window of Hope programme is aimed at grades 4 to 7, while My Future is My Choice focuses on grades 8 to 12.

The Window of Hope programme is divided into two phases: the Junior Window is for grades 4 to 5, while the second phase, the Senior Window, is for grades 6 to 7. This programme is voluntary and parents or caregivers need to give consent for a particular learner to be recruited.

Through MFMC, young people can be reached fairly easily for HIV and AIDS information, and information regarding prevention, as well as care and the promotion of health in schools.

3.5 The "My Future is My Choice" programme

As mentioned earlier, HIV is a very serious threat to young people in Namibia. Olson (2011:1), in referring to the HIV prevalence among adults 15 to 49 years of age states that, the MFMC programme was designed amongst others to strengthen young peoples' communication, negotiation and decision making skills. It is expected that reaching young people, through young people, with sexual health information it will empower them to make safe choices on issues related to sexual and other health related risk behaviours.

As referred to in the study conducted by the Ministry of Education (2008:25), MFMC is a peer education, life skills HIV prevention programme. This programme was first introduced in 1996 in a few schools in Namibia and increased to include many other schools in 1998. MFMC has now been in operation for 14 years. In 2003, MFMC was made an extra-curricular life skills programme targeting secondary and combined schools.

One of the main purposes of MFMC is to provide adolescents with skills and information that enable them to improve their ability to make health choices and reduce high risk behaviours. This is confirmed in the study conducted by the Ministry of Education (2008:29) that one of the main objective of MFMC programmes is to protect young people from HIV infection, unplanned pregnancies as well as other sexually transmitted diseases.

In the peer education model, MFMC is facilitated by young people known as 'peer facilitators' to young people. The peer facilitators are meant to be role models to the young people who take part in the programme. Facilitation is used as the method of teaching rather than didactic methods, and the role of the peer facilitator is to enable young people to make choices about health, particularly regarding sexual health and HIV prevention, and decisions about their lives rather than telling participants what to do (Ministry of Education, 2008:25).

According to the Facilitators' Manual of the Ministry of Education (2006:2), MFMC is directed towards youth still at school (Grades 8-12) and those out of school (15 to 25 years). The programme involves 20 hours of participatory training and activities. It is composed of 10 two-hour sessions which aim to inform participants on topics such as HIV transmission and prevention, reproductive and sexual health, pregnancy, how to use a condom and a femidom, communication skills, the practice of assertiveness, decision-making, and substance use/abuse. Although each session starts with an activity or game, different sessions have unique topics which teach knowledge and specific skills (Ministry of Education, 2006:2).

Up to now, MFMC has been the only recognised extra-curricular life skills programme targeting young people between the ages of 15 and 24 (grades 8 to 12) in Namibia. Over the past fourteen years of implementation, the programme has managed to reach approximately 200 0000 young people countrywide, reaching about 45 000 in the Oshana region in particular. During this period, young people were equipped with knowledge and skills to protect themselves against HIV infection and other STIs.

3.6 "My Future is My Choice" programme: Management and implementation

According to the Ministry of Education (2008:28), the HIV and AIDS Management Unit (HAMU) at the Ministry's head office is responsible for MFMC national coordination, data compilation and monitoring of MFMC implementation at the national level. It also

approves regional work plans and the budget. The Directors of Education at the regional level are accountable for MFMC implementation in the region, while Inspectors of Education are responsible for the programme implementation at the Circuit level and the school principal is responsible for the practical implementation of the programme in the school.

Furthermore, the Ministry of Education (2008:28) indicated that every education region must designate and appoint an HIV and AIDS focal person to provide technical guidance to the Regional AIDS Committee of Education (RACE) members and the MFMC Coordinator. He/she is also responsible for reporting on MFMC activities in the region to Regional AIDS Committee of Education (RACE) and the Regional Director and for supervising the MFMC Coordinator. The focal person is also responsible for coordinating the programme for all schools to implement, monitor and evaluate the HIV and AIDS programme; to advise management regarding programme implementation and progress; and to create a supportive and non-discriminatory environment in collaboration with Regional AIDS Committee of Education (RACE) members.

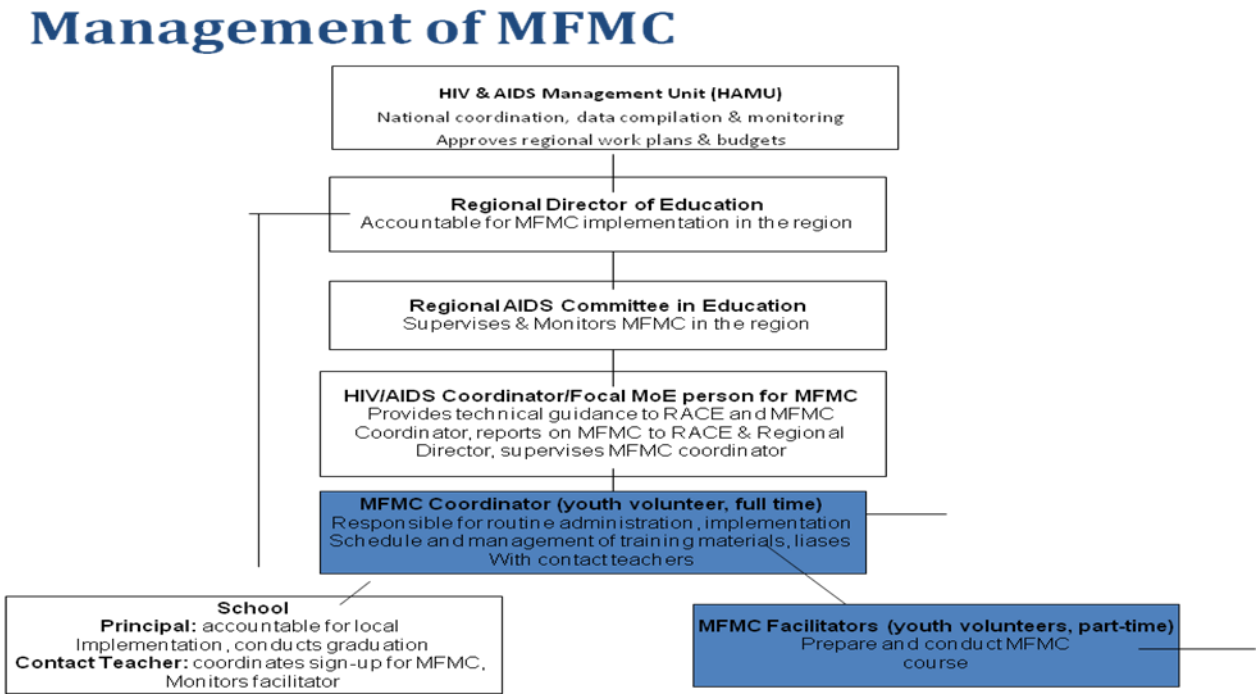

Figure. 3.1: Structure of MFMC programme

Source: MFMC Management Guide for RACE (2005) in the Ministry of Education, (2008:28).

According to the Ministry of Education (2008:28), the MFMC Coordinator is a youth volunteer employed full time and is responsible for routine administration, implementation schedule and management of the training materials as well as liaising with the Contact Teachers at schools. As noted earlier, this follows the 'peer' education principle where young people closer in age are regarded as better able to openly discuss issues of sexual health, relationships, STDs, HIV and AIDS and substance abuse. This does not mean that 'peer education' is the only intervention. Teachers, health workers and parents as credible and acknowledged sources of information must reinforce HIV-prevention information and risk-reduction skills. As 'gate keepers' teachers have an important role in challenging traditional norms which put young people at risk of HIV infection.

As principals are often busy, the MFMC initiative identified the need for contact teachers to be identified and kept informed by the facilitators of the progress of the MFMC train-

ing sessions in the school. The Ministry of Education (2002:3) further explained that this is a volunteer position, in support of the Ministry's intervention. It is assumed that the contact teacher is motivated and wants to assist so that MFMC is run effectively in the school and young people can obtain the information and skills they need to prevent HIV infection. Contact teachers are responsible for coordinating the signing-up by learners for MFMC and for monitoring the MFMC facilitators. Because the facilitators receive a cash incentive it is also very important that their performance be monitored by the school. It is therefore the responsibility of the contact teacher to check up on the facilitator at least four times in each 10-session course and be involved in the MFMC graduation activity.

According to the Ministry of Education (2002:3), MFMC is facilitated by secondary school graduates (Peer Facilitators/Educators). These graduates are selected, after interviews by a panel that usually consists of the school principal, the MFMC contact teacher and the MFMC coordinator of the school where the programme will be implemented. After the interviews are completed, the selected candidates are sent for 10 days of training on the basis of the MFMC Facilitators' Training Manual. Only after a successful completion of the course in which a candidate must achieve 70% as a total evaluation score, will he or she be appointed as peer facilitator. Once the course has been completed, they are sent back to schools and are expected to conduct at least four MFMC courses per year (taking between 12 and 20 weeks in total). Three of these courses of 10 sessions over 20 hours each, should be conducted with young people in the school and is to be done as an extramural afternoon activity.

The minimum requirements in recruiting a peer facilitator are stated as follows (Ministry of Education, 2008:27). The facilitator should:

- Be a young person (no older than 22 at inception)
- Have completed Grade 12
- Live in the area (town, village) where the course will be taught
- Have a desire to help young people and be a volunteer
- Be recommended by two community members

- Be proficient in English
- Have strong communication skills
- Be self-confident and assertive

The Ministry of Education (2003:12) stated that the content of HIV and AIDS education programmes should include the following:

1. Providing information regarding sexual and social behaviour, for the prevention of HIV transmission.
2. Teaching basic first-aid principles from an early age, including how to deal with bleeding and other necessary safety precautions.
3. Emphasizing the role of drugs, sexual abuse, violence and sexually transmitted diseases in the transmission of HIV, and empowering learners to deal with these situations.
4. Encouraging learners and students to make use of health care, counselling and support services offered by the health clinics, educational institutions, community service organizations and other organisations.
5. Teaching learners and students how to behave towards persons with HIV and AIDS, raising awareness about prejudice and stereotypes concerning HIV and AIDS.
6. Cultivating an enabling environment and a culture of non-discrimination towards persons with HIV and AIDS.
7. Providing information on appropriate prevention and avoidance measures. Such measures should include abstinence from sexual intercourse, the use of condoms, faithfulness to one's partner, obtaining prompt medical treatment for sexually transmitted diseases and tuberculosis, avoiding traumatic contact with blood, and the application of universal precautions and
8. Providing information on living positively with HIV and AIDS and on caring for family members who are living with HIV or AIDS.

3.7 Objectives of the "My Future is My Choice" programme

The following are the objectives of MFMC programme:

- To provide young people who are not having sexual intercourse with the skills to delay sexual intercourse;
- To prevent young people from becoming infected with HIV:
- To provide young people with facts about sexual health and behaviour, pregnancy and HIV and AIDS;
- To improve the communication and decision-making skills of young people;
- To provide young people with the information and skills required to face peer pressure.

MFMC course: Overview of topics and sessions

Session	Content
Session 1: **Getting Started**	➢ Group rules ➢ Building trust ➢ Puberty and changes in our body
Session 2: **Reproductive Health**	➢ Pregnancy and reproductive health ➢ Consequences of teen pregnancy ➢ Methods of contraception
Session 3: **HIV and AIDS: The Facts**	➢ HIV and STI transmission (including MTCT) ➢ Identifying high danger, low danger, no danger sexual activities ➢ Myths about HIV and AIDS (optional) ➢ Signs and symptoms of an STI
Session 4: **HIV and AIDS: Reducing the risks**	➢ Self-assessment of risk

	➢ ABC model of prevention and its limits ➢ Strategies of abstaining or delaying sex ➢ How to use a condom ➢ Negotiating the use of a condom (Optional)
Session 5: Facing HIV and AIDS	➢ Stigma and discrimination against PLWHA ➢ Voluntary Counselling and Testing ➢ Treatment and ARVs
Session 6: **Decision, Choices and Consequences**	➢ Decision making ➢ Decision making & risk taking ➢ Understanding who/what influence our decisions, parents, peers, teachers/school, media)
Session 7: **Communication**	➢ Different ways of communicating ➢ Practising Assertiveness ➢ Saying no ➢ Negotiating no (optional)
Session 8: **Values and Relationships**	➢ Identifying values ➢ Understanding gender roles in relationships ➢ Difference between a good and a bad relationship
Session: 9 **Alcohol and Drugs**	➢ Health and social risks of alcohol and drug abuse ➢ Attitudes towards drinking and drugs ➢ Saying no to alcohol and drugs under

	peer pressure
Session: 10 **Our Future**	➢ Commitment for behaviour change (pledges) ➢ Plan graduation ceremony and ongoing peer activities (with contact teacher)

Figure 3.2: MFMC course: Overview of sessions and topics

Source: Ministry of Education (2008:26).

3.8 Oshana Region

Namibia is divided into 13 political regions and each region has its Directorate of Education. This study focused on schools in the Directorate of Education in Oshana, one of the thirteen regions of Namibia. The Third Medium Term Plan (2004-2009) of the Ministry of Health and Social Services (2004:145) recorded the Oshana Region as having a population of 161,916, with 69% of the population living in rural areas. This region has the second highest population density in the country concentrated around Oshakati, Ondangwa and Ongwediva. With University Campuses and a Vocational Training Centre, the Region also is an education hub for the wider areas. In spite of this, unemployment is high (41%). Forty percent (40%) of the population is under the age of fifteen and women head 54% of the households. The National Sentinel Survey of the Ministry of Health and Social Services (2002) Statistics cited in the Third Medium Term Plan (2004-2009) of the Ministry of Health and Social Services (2004:145) found that the HIV and AIDS prevalence in Oshana Region is 29%. The Region also has the highest number of children under the age of fifteen (20%), who have lost either one or both parents.

The Oshana Directorate of Education covers 135 schools of which eight are private schools. According to the summary of 15th school day statistics of the Ministry of Education (2010:1) there are 52 319 learners, making the Oshana region one of the largest regions with a high enrolment rate in the country. Schools are divided into five circuits and 22 clusters. The circuits are Oshakati, Eheke, Oluno, Onamutai and Ompundja Circuits.

Ompundja Circuit consists of 32 schools of which 20 are Primary schools, nine are Combined and three Secondary Schools.

The region is faced with numerous problems that hinder the provision of quality education. There are not enough classrooms and qualified teachers, with only 2003 teachers in the region, which is below the teacher-learner ratio.

Table 3.1: Summary of Oshana Education Region

No. Schools	No. Learners	No. Teachers	No. Circuits	No. Clusters
135	52319	2003	5	22

Source: Ministry of Education, (2010:1).

3.9 Summary and Conclusion

Namibia is ranked amongst the top 10 in the world and top five in sub-Saharan African countries most affected by HIV and AIDS. The education sector, like many other sectors, has not escaped the ravages of the HIV and AIDS epidemic. It is not only the fringes of the education system, but also, and more critically, the nerve centre of the system that is affected by HIV. The impact of HIV and AIDS on education may be classified as: the impact on the demand for education; the impact on the supply; and the impact on the quality of educational services. Sixty-two percent of the Namibian population is under the age of 24. This demographic reality presents both tremendous opportunities and risks for the health, development and wellbeing of children and youth in the country.

Factors contributing to the spread of HIV and AIDS amongst the young people in Namibia include gender inequity and inequality; poverty and unemployment; alcohol and drug abuse; and youth peer pressure.

“My Future is My Choice” (MFMC), an HIV intervention programme, was designed and implemented as an additional life skills programme focusing on HIV prevention, care, communication, support and health promotion in schools.

CHAPTER 4

RESEARCH METHODOLOGY APPLIED TO EVALUATE THE MFMC PROGRAMME

4.1 Introduction

This chapter presents the research methodology applied for the study. Here, the researcher investigated different aspects of the research process used in the study such as the research design, data collection and sampling techniques, data analysis, validity and reliability, as well as ethical issues. The study evaluated the implementation of "My Future is My Choice" programme. An evaluation research approach was used to assess the above-mentioned programme in terms of its relevance to the targeted group of young people. The study made use of two methods of data collection: less structured (focus group interviews), as well as the analysis of existing documentary sources (annual reports).

4.2 The research design

An implementation evaluation research design was chosen for the study in order to assess the effectiveness of the "My Future is My Choice" programme in giving HIV and AIDS information and training young people in the Ompundja Circuit, Oshana Directorate of Education, in northern Namibia, with the necessary skills to reduce the risk of exposure to HIV. This study used evaluation research as the investigation focused on content of the course materials and success of the "My Future is My Choice" programme implementation in addressing risk behaviours facing young people and assisting young people to pass through adolescence to adulthood without being infected. Werner (2010:1) has explained that evaluation research is a general term for research that focuses on determining what is happening social programmes with regard to the design, implementation, administration, operation, services and outcome of such programmes. This study evaluated the relevance of the curriculum content and how successfully the programme was being implemented.

In a well-known text on evaluation research, Rutman (1984:10) states that programme evaluation makes use of scientific methods to measure the implementation and outcomes of programmes to facilitate decision making.

According to Babbie and Mouton (2006:337), since the beginning of evaluation studies, many evaluations were contacted for various reasons such as shaping purposes of programme management, improvement and refinement, financial accountability, on public demand, to meet accreditation requirements, for purposes of quality assurance and control, and various other reasons.

As mentioned by Patton's cited in Babbie & Mouton (2006:339), the purpose of using evaluation research can be reduced to three reasons to judge of merit or worth of a programme, to improve programmes, and to generate knowledge. In the case of this study, evaluation research was used to measure the relevance of the programme, to help to improve our understanding of how the MFMC programme works and how young people see the programme in terms of changing their attitudes and sexual behaviours.

The researcher believed that this research design was going to provide the opportunity to clarify findings in order to maximise the validity of the results.

4.3 Research methodology

During the study, different research methodologies were used depending on the appropriateness of the phenomenon under study; focus group interviews and document analysis of reports on attendance were used.

According to McGinty and Mundy (2009:143) the advantage of using different methodologies for data collection such as focus group interviews and document analysis allows the broadening of understanding of the subject at hand. Based on the above-mentioned arguments, the document analysis method was applied with the focus group interview as the main method of data collection.

The main information was obtained through interviewing young people who had participated in the MFMC programme. The focus group interview allowed a broader understanding and an opportunity to clarify and expand upon the secondary data gathered through document analysis. During the focus group interviews, respondents were questioned in depth about their experience of the programme, knowledge and skills learned, and attitudes' regarding HIV and AIDS and the My Future is My Choice programme.

Different documents written about MFMC and other life skills programmes were analysed. These included the end-of-semester and annual reports such as attendance forms, course completion forms and facilitators' reports. The facilitator's report highlights the challenges faced during the implementation of the programme; in this report facilitators share their views about the programme, and what the participants enjoyed or learned. They also suggest ways of improvement to the MFMC coordinator. Apart from that, other impact studies and assessments done on MFMC were also analysed.

4.3.1 Target population

The target population of this study was the young people who enrolled in and graduated from the "My Future is My Choice" (MFMC) programme. These young people had considerable experience of and were quite familiar with the MFMC programme. The intended population focus of this research was the young people who graduated from the MFMC programme in the Ompundja Circuit of the Oshana Directorate of Education.

Ompundja was selected out of five circuits in the Oshana region. This circuit was selected because the schools that were selected for the study fall in that circuit. There were 12 schools in the circuit that were eligible for the study. Only four of the 12 schools participated in the study. The selection of four schools was based on the fact that they could be accessed by walking and using public transport.

4.3.2 Sample recruitment

The sample for this study was drawn from the population. In total, 20 young people from four schools, namely the Gabriel Taapopi Secondary School, Mweshipandeka Secondary School, Ekwafo Secondary School and Hashiyana Combined School were chosen to take part in the study. Convenience sampling was used to choose the schools because they were within walking distance from the researcher's home and he could reach them without using transport. Three of the schools selected for this study serve grades 11 to 12 learners and one serves grades 8 to 10 learners. All the schools serve the grades targeted by MFMC and all have implemented the programme.

The young people were randomly selected from all those who completed and graduated from the MFMC programme at each school. Each of the four schools selected were asked to identify twenty such young people. Upon the arrival of the researcher, these groups of young people were gathered in one class and the researcher asked them to write their names on a piece of paper. These pieces were put in a box and one student was asked to pick five names out of the box. This ensured that the researcher ended up with five participants from each school. If a learner whose name was picked did not want to participate in the study, another name had to be picked. This ensured that five participants were selected from each school.

The purpose of selecting young people who had completed and graduated from the MFMC programme to take part in the study was two-fold: they were expected to be information-rich with respect to the purpose of the study and it helped to increase the usefulness of the findings. Hence, young people with MFMC experience were selected for the focus group interview. This fitted in with McMillan and Schumacher (2006:319) as "[t]hese groups of young people seem to be information-rich. In other words, these young people were chosen because they are likely to be knowledgeable and informative about the phenomena the researcher is investigating". Having five young people per focus group was manageable and allowed them to speak freely, more especially on sensitive issues. However, "the purpose of the purposive sampling is not to represent a popu-

lation as it would be its purpose in quantitative research" (Gall, Gall & Borg, 2003:181). That is to say, the information gathered from this study will not be generalised.

4.4 Methods of collecting data

The main method of data collection for this study was the focus group interviews with young people. Kvale (1996), cited in Dawids (2004:65), described an "interview study as an inner change of views between people conversing a theme of mutual interest". Based on that idea, the researcher employed the focus group interview to get a "thick description" of the phenomena under study. In support of the focus group interview study, Sudman and Bradbum (1989:148) stated that open ended questions allow the respondents to answer in their own words and the researcher can explore a topic in depth and obtain quotable materials. Kvale (1996) in Dawids (2004:65) elaborated further by defining qualitative research interviews as attempts to understand the world from the subject's point of view, to unfold the meaning of people's experiences, to uncover their lived world prior to scientific explanations. The selection of focus group interviews as the main method of data collection for this study was influenced by the above statements concerning to experience an inner change of views, to obtain quotable materials and to understand the programme from the point of view of those who were involved.

4.4.1 Focus group interview

The choice of focus group interviews was influenced by several factors. Given the short period available for collecting information for the study, the focus group interview was preferred because it saves time and money, compared to other measures of collecting data (Babbie & Mouton, 2006:292). Babbie and Mouton further point out that the use of group interviews helps in finding information you would not otherwise be able to access. They regard focus groups as a useful research instrument because they allow people to get together and create meaning among themselves, rather than individually. The first focus group interview was conducted with a total of five learners per school from the four mentioned schools in Ompundja Circuit.

Morgan (1997) is cited in Babbie and Mouton (2006:292) as saying that it requires the researcher to be knowledgeable and very skilled to pull together and direct focus groups in order to observe a large amount of interaction on a topic in a limited period of time. Babbie and Mouton (2006:292) add that another benefit of focus group interview is that it provides direct evidence about similarities and differences in the participant's opinions and experiences as opposed to reaching such conclusions from post hoc analyses of separate statements from each interviewee.

These focus group interviews took one to two hours. During the group interview, young people were questioned in depth, about their knowledge, attitudes and worries regarding the MFMC. The questions were semi-structured in format in order to elicit responses on specific topics while allowing flexibility of the content under discussion, in regard to the subjects' various responses.

This method therefore was chosen to allow the informants to describe and explain what was meaningful or important to them in their own words, rather than being restricted to predetermined categories; informants thus could feel more relaxed and speak more candidly. Another important aspect of this method and the reason why it was considered appropriate for this study is that it allowed the interviewer to probe for more detail and to ensure that the informants were interpreting questions the way they were intended to be understood. In addition, the researcher had flexibility to use his knowledge, expertise, and interpersonal skills to explore interesting or unexpected ideas or themes raised by the informants.

4.4.2 Document analysis

The second method of collecting data for this study was the critical analysis of the course materials. McGinty and Mundy (2009:143) refer to information about a course coming through published documentation with the "focus [being] on the content of the course materials, pedagogical implementation, student involvement and interaction". Hence, an examination of relevant documents was conducted. The researcher undertook a critical

review of studies, consulted a number of documents on various impact and assessment studies and publications on the impact of HIV and AIDS programmes including the MFMC programme.

The researcher made use of documentary analysis of the various documents and available statistical data to collect the information used to arrive at conclusions, which added value to the research work. Since much information was available about the MFMC programme, the researcher concentrated on the more recent information covering 2007 up to 2010.

4.5 The research instrument

4.5.1 Interview guide

The choice of the interview as data collection method for this study was influenced by Mason (1996) who maintains that the legitimate way to generate data regarding social reality is to interact with people through talking, listening and gaining access to their versions and expressions.

In order to allow more constructive and comparative analysis of findings, the same interview guide was used for all groups. The researcher had a list of questions or issues (see Appendix A) which were explored in the course of an interview. Twenty-two questions were asked and were presented in a cluster of nine main categories, namely the profile of the respondents; perceived understanding of what MFMC is; perceived necessity of MFMC; perceived successes of MFMC in HIV prevention; perceived impact of MFMC on behaviour change; perceived impact of the MFMC programme on prevention of teenage pregnancy; perceived relevance of topics; the idea of closing the MFMC programme; and suggestions for ways to improve the MFMC programme. As clearly stated in Gall *et al*. (2003) as cited in Turner (2010:1), interviews are flexible the interviewee can move away from the question and go deeper into his own experience and meanings of his life without fear of being off the point. It allows the interviewee to share his opinion. A tape recorder was used during the interview (with permission of the group) and this allowed

the researcher to listen to the interviewee attentively without the need to interrupt and the need to have to write and listen at the same time. The format of the questions was not tightly structured.

4.5.2 Document analysis

At the end of each semester, facilitators are required to submit the following: sign-up, monitoring and evaluation forms, course schedule, attendance form and course completion forms. These forms are crucial to the MFMC Coordinator and the Education Officer (RACE Coordinator) for the payment of incentives to the MFMC facilitator. They are also important for record keeping and to ensure that the programme was implemented at the specific schools. Also important with regard to these documents is to find out how many young people registered in the programme, and if all ten sessions were completed as in the manual. These documents were selected for analysis. Impact studies and assessments conducted about MFMC were also analysed and some were compared with the findings from the focus group interview.

4.6 Data analysis and presentation

The results were interpreted according to the research question and objectives, research instruments and, in some cases; concepts from related studies were used. Information was grouped into categories according to type and each category was named after the common basic quality of the type of concept represented.

Many qualitative analytic strategies rely on a general approach referred by Thorne (2000:2) as “constant comparative analysis”. Data were therefore compared with all others that could be similar or different in order to conceptualise the possible relations between various types of data. In short, the researcher compared the data for similarities and differences in order to find relations within the data or findings.

4.7 Validity and Reliability

According to Messick (1989) as cited in Alasuutari, Bickman and Brannen (2008:221), validity is referred to as the accuracy of information and the reasonableness and warrantedness of data based on interpretations and to the adequacy and appropriateness of influence. For the study to be valid, the researcher endeavoured to ensure that personal influence did not interfere with the natural occurrence of the data.

The design of the interview guide was thoroughly discussed and tested by interviewing the colleagues who shadowed the learners before implementation. Very importantly, the researcher used the same interview guide for all the groups to ensure the reliability of the findings.

The same introduction to the interview was given to all the groups. Another means used to validate this study was the use of methodological triangulation; this involved checking data collected via the interview method with non-verbal information to confirm the interview testimony.

4.8 Ethical issues

In general, ethics deals with beliefs about what is right or wrong, proper or improper, good or bad (McMillan and Schumacher, 2006:142). Naturally, there is some degree of disagreement about how to define what is ethically correct in research. Ethics are important for researchers. Cohen and Manion (1994:347) remind us that at any stage during research issues relating to ethics could materialize. According to Alasuutari *et al.*, (2008:99), it is moral right to respect the autonomy and privacy of the people recruited for research participation. Before any data were collected, the researcher sought approval from the Permanent Secretary (see Appendix C) in the Ministry of Education to conduct research in the government schools.

In its most fundamental form, ethical research embodies the moral necessity of obtaining consent to participate in research that is informed, rational and voluntary. As part of the informed consent requirement, the prospective participants were provided with all information about the study. At the beginning of the research for this study, it was important that the informants were provided with an assurance of their anonymity and privacy during all stages of the interview. The researcher also took time to explain to the informants what would take place, especially with regard to using a tape recorder that could raise some concern with the informants.

That respect for persons is the most fundamental principle underlying research with human participants is affirmed by Dawids (2004:68), and it is important to obtain consent from all participants, while at the same time guaranteeing them confidentiality in dealing with the information that is gathered. Since some of the respondents were minors, under the age of 18, the researcher asked for permission from their contact teachers regarding their participation in the study. Before these young people join the MFMC programme, a contact teacher at the school has to seek the blessing or the consent of the parents or guardians of these young people. They have to complete a form of consent. Since parents had given consent to these young people to participate in MFMC, it was not found necessary to seek permission from the parents for participation in the study.

The learners who were the respondents in this study were assured of confidentiality and anonymity and were promised that their information would not be used for any reason other than the intended study.

4.9 Conclusion

An implementation evaluation study was conducted to assess the critical factors for successful implementation of MFMC programme. Focus group interviews and document analysis were used as data collection methods. Focus group interviews with young people comprised the main method of data collection. The target population of the study was the young people who enrolled and graduated from the MFMC programme in four

schools in the Ompundja Circuit of the Oshana Directorate of Education. A sample of twenty young people drawn from the population was chosen to take part in the study. Random sampling was used to select young people, while convenience sampling was used to choose the circuit and schools. An interview guide with semi-structured questions was used as a research instrument. Validity, reliability and ethical issues were considered before, during and after the study was conducted.

CHAPTER 5

PRESENTATION OF THE FINDINGS OF MFMC PROGRAMME

5.1 Introduction

This chapter presents findings of the study and information gathered from chapter 2 and 3. The study was conducted at four schools in the Ompundja Circuit of the Oshana Education Directorate in Namibia from 20 to 23 July 2010. This study was undertaken to assess the content and the success of the implementation of the "My Future is My Choice" programme among the young people, both those who are enrolled in as well as those who have been graduated from the programme. In order to establish the relevance of the content of the course materials and the success of the implementation of the MFMC programme, twenty young people were interviewed to elicit their views. The study looked at the knowledge and skills provided by MFMC to assist young people in dealing with teenage pregnancy, peer pressure and HIV infection.

The schools at which the study was conducted were: the Mweshipandeka High School, Gabriel Taapopi Secondary School, Hashiyana Combined School and Ekwafo Senior Secondary School. During the interviews, learners were placed into four groups consisting of five learners each. The names of those learners who were interviewed are withheld for purposes of confidentiality. Instead the schools at which the study took place were recorded as four separate groups: the learners interviewed at Ekwafo Senior Secondary School formed Group A, Group B was made up by learners from Mweshipandeka High School, Group C represented the Hashiyana Combined School and the Group D learners were from Gabriel Senior Secondary School.

5.2 Profile of the respondents

Twenty young people from three secondary schools and one combined school in the Ompundja Circuit under the Oshana Directorate of Education in northern Namibia were interviewed. The profile of the young people who were respondents in the study is presented in Table 5.1.

Table 5.1 Profile of the respondents

GENDER	AGE GROUPS					TOTAL
	16 years	17 years	18 years	19 years	20 years	
Male	2	3	2	1	1	9 (45%)
Female	3	4	4	0	0	11 (55%)

45% of the respondents were boys and 55% were girls. Although this presents a good figure of male participation in the study, participation in the programme by boys in general is very low. Table 5.1 also shows that male participants who participated in the programme are adults aged 19 to 20.

With regards to the question of which year they were involved in the MFMC programme, 30% of the respondents were repeating the programme after they have completed the programme at other schools, there is no limitation of how many times you can register for the programme, in some cases you find learners have more than three to four certificates of MFMC. 70% of the respondents were enrolled in for the first time.

5.3 Perceived understanding of what "My Future is My Choice" is

In order to find out in which way the young people perceived the "My Future is My Choice" programme as a necessary intervention, the following questions were posed: (1) according to your understanding, define for me what MFMC is. (2) What do you think is the aim of MFMC? With regard to the first request, respondents gave their opinions of the "My Future is My Choice" programme based on their understanding. One of the respondents from group A indicated that "My Future is My Choice" means that "my life is on my hand and depends on the decisions I am taking". This was supported by four other respondents who agreed that MFMC concerns the decisions they make; they believe that what they do today will influence their future. One of the respondents elaborated by saying that, "If you choose your future to be bright, so it will be". Two respondents from group B responded that MFMC is helping the young people to make

good choices for their future regarding teenage pregnancy and HIV and AIDS, it also made them aware of their rights. These answers indicate that the programme generally is perceived to be an empowerment programme, empowering young people to make the right decisions regarding various challenges facing them on a daily basis and protecting themselves against HIV infections.

Regarding the fourth question, respondents were also asked to identify the aims of the "My Future is My Choice" programme. About 85% of the respondents felt that the aims of the "My Future is My Choice" programme are to encourage and teach young people how to protect themselves against HIV and other challenges facing young people on a daily basis and how to overcome those challenges. One respondent from group D indicated that "It is helping us, the youth on decision making when it comes to HIV and other issues related to youth development". Some respondents from group A and C, felt that, the aims of "My Future is My Choice" are to provide young people with information on HIV and AIDS and enable them to make the right choices, and pave the way for the future generation to reach their dreams.

These answers indicate that the respondents are aware that MFMC is aimed at equipping them with knowledge and skills that will enable them to protect themselves against HIV infection. It also shows that they understand that the programme is preparing them to make right decisions.

5.4 Perceived necessity of "My Future My Choice" programme

In order to determine the need to attend MFMC by the young people, the following question was posed: (1) What did you learn from MFMC that was most valuable to you and why do you consider it important? All the respondents indicated that the programme was worth attending. Amongst what they have learned, fifteen of the respondents indicated that it was important to them to learn how HIV is transmitted, how to protect themselves and how to care for the people who are infected. One respondent- from group C indicated how valuable it had been to attend the programme by saying, "The programme

gave us the courage to face the future". "Prevention is better than cure". Although the above statement was supported by all the respondents, three respondents from group A also indicated that they had learned about making decisions on their own. Based on the answers provided, young people are indicating that the programme is necessary because it empowers them to handle problems that they may be facing in the future.

In the world today, teenagers face a lot of challenges. One of the respondents indicated that it was worth attending MFMC programme because "I learned how to choose good friends and handle peer pressure", while another respondent said it was worth attending MFMC because "we learned how to help those with low self-esteem [to] raise confidence and learn that HIV infected people are also as important as others in their communities". Regarding other reasons why it was worth attending MFMC, one respondent from group D indicated that she learned about the growing stages such as puberty and reproductive organs.

Furthermore, they explained that through the MFMC programme, they had learned valuable things such as the importance of circumcision and dangers of drugs and alcohol abuse. One respondent stated that "The abuses of alcohol are dangerous to our bodies and damage our brains".

Apart from the above-mentioned issues, five respondents indicated that they did not learn much in MFMC as many of the topics covered in the programme are the same as those that they studied in Biology. While the majority felt that MFMC had made them aware of things that face young people that they thought could not be prevented, they now are aware that anything can be prevented. Finally, two respondents mentioned that they had learned two things of main importance to their lives: though this is important, that respondent learned that a person can fall pregnant through oral sex, while the other respondent stated that "the most important thing I learned is about abstaining".

In general, many of the respondents mentioned that it was worth attending the MFMC programme as they learned about teenage pregnancy, peer pressure, abstinence, circum-

cision, HIV transmission, and the changes that occur in their bodies, as well as the danger of alcohol and drug abuse.

5.5 Perceived successes of "My Future My Choice" programme with regard to HIV prevention

In order to find out whether young people recognise the effectiveness of "My Future is My Choice" as an HIV prevention programme, the following questions were posed: (1) MFMC is a preventive programme. Do you think it has equipped you with relevant knowledge and skills to protect yourself from HIV infection? (2) Was there anything that you learnt through the MFMC course that you did not know before? If yes, what is it?

To the first question, all the respondents indicated that they had gained enough knowledge and skills on HIV prevention. In order to protect themselves against HIV infection, the respondents showed that they had learned about HIV prevention by using condoms for males and femidoms for females. Their responses are quoted verbatim. One of the respondents said that "the session on condoms involved condom demonstrations, we were shown how to use them correctly". They also indicated that they were taught the danger of using needles used by other people for injections, it is dangerous for HIV infection. One of the respondents in group C indicated that the programme equipped them with information on HIV transmission. She said, "For the first time I heard that HIV can be transmitted through breast feeding. The programme also taught us how an HIV-infected woman can prevent the unborn child from HIV infection".

They also indicated that they were taught that the best way for young people to respond to HIV infection is to abstain. One respondent in support of abstinence indicated that "this will help us to live [HIV] negative". In case they became infected, they learned not to put themselves down. One respondent in group B indicated that she learned about the Antiretroviral (ARV) treatment, which is another measure used by people who are infected in order to prolong their life. She also indicated that they were taught how to live positively if they were infected.

One of the respondents indicated that they were provided with information on the danger of alcohol consumption that can lead to irresponsible behaviour. While in agreement with that respondent, the other respondents from group A also indicated that they had learned about peer pressure and decision making.

Since MFMC is a prevention program, some of the respondents have indicated that they learned a lot about HIV prevention. One respondent in group C has this to say: "I have learned many things that I did not know before. One of the most important things I have learned is to prevent pregnancy with pills". The following response is from a respondent in group B: "Yes, I learned about pregnancy that it can happen whether you make sex standing or sleeping". There is a myth that withdrawal by the man when having sex (coitus interruptus) is a safe way to prevent unwanted pregnancy. In dismissing the myth, one respondent from group D had this to say: "From MFMC we learned that it is not safe, either to prevent pregnancy or STDs." Another respondent from group B said: "It was also important to learn that using condoms are not hundred percent safe either. We learned that pregnancy can come during the first time you have sex. In MFMC we also learned what is anal sex and second virginity." As a result of what they learned from the MFMC course, two of the respondents, one boy and one girl, indicated that they decided to drop their girlfriends/boyfriends.

Another respondent from group D indicated the effectiveness of the programme in the following words: "It was important to learn about dating and other ways of young people can do and not do when they are in a relationship. We were also taught how to behave as young people."

The following is a response from one respondent in group B: "I learned how to say no, not in terms of sex but on everything that I am not in agreement with. I was a soft person; very soft saying no is like turning people away from me. Really it was hard, with time I learned to say no." In support of a respondent in group B, she added that "MFMC

taught me to stand up for myself, if there is no one. The programme taught us to choose good friends and who to live with."

According to three respondents from group A and C, they learned that stigmatising and discriminating against infected people is not good as it ruins their lives and causes early death. This is what one of the respondents had to say: "This is to destroy someone's life instead of helping the person."

The responses that were provided by the respondents indicate that the programme is perceived to be effective in equipping the young people with knowledge and skills in the response to HIV infections. Apart from the preventive strategies learned through the MFMC programme, these young people also indicated that the programme provided them with the opportunity to learn to appreciate other people's differences, since people are created differently; they learned to look at life from a different perspective.

5.6 Perceived impact of "My Future My Choice" on behavioural change

To the question as to whether the programme changed the way they thought before enrolling for MFMC, many of the respondents agreed that the programme had changed them much. One of the learners who agreed that the programme had changed the way they behave, stated that, "Yes, I use[d] to think that people who look fresh are not HIV positive. People looking thin are HIV positive, through MFMC, we were taught not to judge people by looking, sometimes a person may look fresh but they might be infected."

One of the respondents in group C mentioned that the programme changed the way she thought about rape; she learned that it is important to report the rape immediately after it happened without changing clothing and also not to take a shower because evidence is shown when one did not take a shower.

One respondent in group C further stated that "I learned about withdrawal that it is dangerous. When young people think about sexual activities is like blowing a balloon and

that is it. It should be done with responsibility. When a person is infected, I learned that they need our love. They have life ahead of them. I thought that when you are infected you are nothing, you are just waiting to die."

According to one respondent in group B, the programme provided the young people with the opportunity to learn the difference between HIV and AIDS. Apart from the above, this is what one respondent in group D said about the programme "I learned how to be with my boy friend." Another respondent stated that MFMC has changed her: "I learned that sex is not love, you can love your partner without doing sex." One respondent indicated that, through joining the MFMC programme, he learned that apart from excitement one get from sex, there are also other problems such as unwanted pregnancy and sexually transmitted diseases. While another male respondent said that, as a result of attending MFMC, "I learned to love my girlfriend without doing sex and show her respect".

The respondents were further asked to explain how the MFMC programme changed their behaviours. One respondent in group B stated that, "Yes the programme has changed my behaviour; I was a rude and selfish person. I learned from my facilitator that being rude is not a good thing." Another respondent in group A stated that before joining MFMC programme, "To me, any one coughing in the class was having AIDS". "I was ignorant but now I have taken everything seriously". One respondent in group C stated that "before attending MFMC, I thought I knew many things surrounding HIV/AIDS, after attending the program I realized that I did not know much". One respondent in group B further stated that "I believed in other people (peer pressure), but now I changed, it built my self confidence". Another respondent from the same group said: "Yes, I use to feel shy when someone is laughing at me. From the programme I have learned to be self confident and able to choose good friends with good behaviours." One respondent in group C stated that "I learned to be open and behave like a mature person. I learned about the danger of the peer pressure and avoiding it".

In confirmation of the view that the programme has changed their behaviours, one of the respondents in group D stated that "we boys use to run after girls, but I realize that, that

will not take us anywhere, now I am concentrating on my study". Another male respondent indicated that "I learned the importance of open communication when I am with my girlfriends, not lying to her".

Four of the respondents indicated that they did have a negative attitude towards the MFMC programme, but since enrolling for MFMC courses, they realised that MFMC is a good programme. The programme has changed the behaviour of many of the respondents towards people living with HIV. This is what one of the respondents said: "Before joining MFMC, I fear to come closer with infected people, I thought they will infect me, but after attending MFMC, I learned that infected people need our love and to be cared for."

To the question of whether they changed their sexual behaviour after attending MFMC, about 90% of the respondents agreed that the programme had changed their behaviour. One respondent stated that "In the MFMC programme, I have learned the importance of keeping my virginity and waiting until I am ready to have sex". Two respondents indicated that they learned about friendship between boys and girls. "Now, I have concentrated on my education", was one response. Amongst others, they have also indicated that, having attended MFMC, they learned to control their feelings; to think of the consequences and effects of sex.

Four of the respondents indicated that they had ideas of having sex, but after they joined the programme, they learned that it is not a good thing. In the words of one respondent: "I used to think about sex when I see girls, but now I learned it is not a good thing." The other respondent further indicated that, "In the past, I used to do sex with my girlfriend without using the condom. The program taught us the advantages of using condoms all the time we have sex."

As a result of attending MFMC, this is what one of the respondents had to say: "I was dating one guy, but now I do not have interest in him. I learned that my life is in danger

due to HIV and unwanted pregnancies". One male respondent said: "I reduced the number of my girl friends and thinking to dump all of them".

The respondents were also asked if the MFMC programme could change young people's sexual behaviour. They thought that MFMC can do a lot to help young people change their sexual behaviour; those who cannot abstain, at least can learn how to protect themselves during sexual intercourse. One respondent replied: "Young people can learn about the importance of keeping their virginity and abstain from sex. It is a well know fact that more young people believe in sex and drinking. As a result, alcohol leads young people into unsafe sex." In order to help young people change their sexual behaviour, the respondents believe that establishing teenage clubs will keep young people out off the streets and prevent them engaging in high risk behaviour. Generally, the respondents shared the sentiment that most young people are ignorant when it comes to issues concerning HIV. They believe that teenage clubs should be made interesting, by addressing current issues affecting the youth.

Another suggestion that they offered to help young people to change their sexual behaviour is putting up billboards and posters in bars; when people come to buy beer, the message on posters will remind them of the danger of HIV and alcohol.

The last sentiment shared by all the groups concerned the lack of information, more especially regarding reaching out to the out-of-school youth. They thought the programme should be extended into the rural areas to educate youth about HIV prevention and the danger of teenage pregnancy.

5.7 Perceived impact of MFMC on prevention of teenage pregnancy

With regard to teenage pregnancy, the participants were asked to indicate what they have learned from MFMC regarding the prevention of teenage pregnancy. One respondent responded that, "In MFMC, I have learned about the danger of getting pregnant while at

school. You will end up dropping out of school and not finish your education." Another respondent from group A replied that "We are taught that the only 100 per cent way of avoiding teenage pregnancy is by abstaining". In most instances, the condom is emphasised as the preventive measure that can be used to avoid getting pregnant. According to another respondent from the same group, "[c]ondoms are not 100 per cent safe".

Another respondent from group D said: "We learned that teenage pregnancies are dangerous for young people. We girls were told to be careful with our boyfriends because sometimes they lie that they are using condoms, because they want to impregnate us."

In addition to the above statements, one respondent stated: "Teenage pregnancy might be accompanied by HIV infection, leaving school for breast feeding, affects your life at school and also in the community. Pregnancy damages young people. We learned that most of the girls falling pregnant in Namibia are young people, they need protection."

In brief, the respondents indicated that having attended the MFMC programme has changed the way they behave. They also believe that the programme is likely to transform many young people in changing their sexual behaviour.

5.8 Perceived relevance of topics

In order to determine the relevance of the topics covered in the MFMC course, the following five questions were posed: (1) Which sessions did you find most and least useful? (2) Looking at MFMC content, which ones do you think are not relevant for your age group and why? (3) Apart from those topics covered in the MFMC programme, what other topics would you recommend being included in MFMC? (4) What do you like and dislike about the MFMC programme? (5) Amongst the materials covered by the programme, which one did you or did you not understand well and why?

The responses to these questions are tabled below. The respondents were presented with 10 topics covered by the programme and asked to indicate topics that were most and least useful to them. The numbers in tables represent the numbers of respondents who found the particular topic most and least useful.

Table 5.2 Perceived relevance of topics

Topics	**Most useful**	**Least useful**
Getting started	19	1
Reproductive Health	16	4
HIV and AIDS: The Facts	20	0
HIV and AIDS: Reducing the Risks	14	6
Facing HIV and AIDS	16	4
Decisions, Choices and Consequences	17	3
Communication	13	7
Values and Relationships	18	2
Alcohol and Drugs	12	8
Our Future	17	3

Learners studying science subjects indicated that some topics in the MFMC course repeated what they had studied in Biology.

In general, the respondents indicated that most of the topics covered in the MFMC programme were relevant. However, a few topics were identified as not being relevant; two respondents felt that the topic on relationships was not relevant as many youngsters are not that interested in relationships. This appears to contradict the finding that many young people see this topic as important. Learning how to take pills in order to prevent pregnancy was not supported by most of the participants; they regarded it as encouraging young people to have sex because they know they are protected from pregnancy. Three of the respondents thought that the emphasis on the use of condoms was not good; the emphasis should be on abstinence as one can only then be one hundred percent safe.

Backing this argument, one of them stated: “You know that young people like to practise, when you demonstrate condoms in front of them they will go and try.” This argument was received with mixed feelings. Some respondents felt it was good to learn about contraceptives, whilst others felt it was not good since it motivates young people to go and have sex or experiment with what they have learned.

With the fourth question, the researcher was interested to know what the respondents liked and disliked about the MFMC programme. To the first question, one respondent answered: “We like this programme, because it provides us with the platform to share ideas. It taught us how to handle life, respect and taking control about our life”. Another respondent replied: “I like the topic on wet dreams.” Yet another learner said: “I find everything interesting and educational.” They also mentioned that they met new friends through the MFMC programme.

With regard to what was disliked, one respondent said: “What I do not like is a person who come to join the programme but not interested in the program. They come to disturb us.” The other respondent stated that “the time is too long, it should be reduced to one hour instead of two hours”. In contrast to that, another respondent stated that “the time is too short”. One learner felt that “the programme should be introduced at the beginning of each term and not implemented during examinations”. She further stated that “some topics are touching and make me uncomfortable. The topic on menstrual cycle is not good as some boys laugh at girls, if that is presented by a male facilitator, it is even worse to girls”.

The responses clearly show that there is a need for improvement when it comes to the implementation of the MFMC programme. Seven of the respondents indicated that they were not comfortable with the time allocated to the sessions, it is very long. While, some respondents show that they were not comfortable with some topics as indicated in Table: 5.2 under the least useful topics.

In addition, to determine the relevance of topics covered in the MFMC course, respondents were asked to indicate the topics that were not clear to them during MFMC implementation. This question was received with a mixed response; some topics that were clear to the one group were difficult for another group. Some groups mentioned that they did not understand the topic on decision making very well as there were many confusing things. Some groups responded that they understood almost all the topics very well. The topics on the effect of drugs and alcohol were mentioned as not being clear for most of the groups. They felt that they need to be taught in more detail.

The participants were also asked to mention topics that were clear during the programme's implementation. Topics on contraceptives and reproductive systems were understood well. Apart from the above-mentioned topics, everything was reported as enjoyable, especially the games.

5.9 The idea of closing the MFMC programme

In order to obtain the respondents feelings' about the MFMC programme, they were presented with the idea of ending the programme. The respondents felt that the programme should be continued to save the nation. They mentioned that the programme is helpful as it supplements the information learned in the classroom and raises awareness about HIV for young people. One of the respondents said: "Ending the programme will create a big problem. MFMC is making a difference in the life of young people." Another respondent, from group C, also responded: "It taught the weak people to stand up and break the chain. Not to continue with MFMC will affect most of the youth, will not get information, our siblings will miss this important information."

The respondents felt that the programme had given them much information that they did not have in the past. They also believe that, if the MFMC programme is discontinued, birth and death rates will be high as people will not use preventive measures. One respondent stated that "more people will be infected and this will result in low productivity". A respondent also projected that "in five years to come if MFMC stopped, there will

be chaos in the country since there will be no one to teach the young ones, if parents are already afraid to talk to their children on the issue of menstruation". In brief, the participants felt that the programme should continue because many youth will miss this important information which is necessary for their development.

5.10 Suggestions for ways of improving the MFMC programme

In order to determine the opinions of the learners on how to improve the MFMC programme, the following question was posed: (1) If you would be asked to change the MFMC programme and make it better, what would you add or change? They felt the programme should be introduced well to attract the attention of the majority of young people, both boys and girls. A proper introduction would make learners feel comfortable and encourage boys to take part. They also felt that it is vital to use video shows on HIV transmission. Apart from emphasising the importance of contraceptives such as condoms and pills, they felt that it would also be fair to discuss the disadvantages of contraceptives.

The following is what one respondent had to say: "The programme should have a lot of fun." Since the programme is informative and important for young people, they felt that it should be rolled out into the communities, to reach out to the youth who are out of school and that graduates from the MFMC programme should go into the community to help the orphans and vulnerable children.

Some respondents voiced the opinion that the programme should be changed and made compulsory, or changed into a subject, or by some other means increase the number of young people attending. One respondents stated that "[p]articipants should be allowed to participate/use any languages during the discussion", while another respondent stated: "Increase the centres where young people meet and discuss information related to HIV/AIDS." One respondent felt that there should be a one-minute presentation on TV to announce holiday programmes about MFMC. The following is what one respondent would do if asked to change the programme: "I will add more hours for the session."

Another suggestion was: “I would rather add the topic of encouragement, how to live positive and not be ignorant.” Owing to the limited intake of MFMC participants, one respondent said, “I will make it open to all the people who want to join.” Another respondent stated “I will add quizzes and more games”, while yet another one would make it “[m]ore entertaining, graduates should go and share information in the villages”. One of those who felt that showing how to use contraceptives encourages the youth to practise stated that she would “[r]emove the topic of contraceptives”.

The respondents felt that the following topics should be added to the programme: friendship, addressing the issues of peer pressure, self-esteem and confidence. Another respondent stated that “[t]he topic on woman abuse is important and needs to be addressed in the programme”. Some participants felt that the programme should include topics on life after school and study tips, while some felt that topics on sexually transmitted diseases (STDs) is not well covered; more information is needed. Whilst the programme gave much time to the advantages of using condoms and other contraceptives, one respondent indicated that she felt “the disadvantages of the contraceptives should also be covered”.

In addition, as these young people were growing up they also wanted to know about life after having been infected with HIV or becoming pregnant, with regard to the effects of HIV. One female respondent stated that “soon we will be mother and topics on breast feeding by infected mothers will be relevant”.

In general, there was a feeling among the respondents that there is a need to redesign the programme in order to cater for the needs of the participants. They indicated a need to include video shows, to obtain information about the effects of using contraceptives, and for including more quizzes and games to add more fun to the MFMC programme.

5.11 Document analysis

As mentioned earlier, the main method used for data collection in this study was the focus group interviews with the young people. Document analysis comprised the second method of data collection. Various papers on the implementation of HIV and AIDS-prevention programmes were consulted. The findings are presented below under the following topics: perception of the MFMC programme, teenage pregnancy, behaviour changes and condom use.

5.11.1 Perception of MFMC

The report presented by Akoulouze *et al.,* (2001:21) stated that "the MFMC programme is a hit among the school-going children". The report further indicated that most school children enjoyed MFMC sessions much more than they enjoy the formal subjects in which HIV and AIDS are included. The report pointed out that the attendance in MFMC programmes was reported as very high. This suggested that MFMC sessions were a "never miss" phenomenon. As the sessions are informal, children have an opportunity to discuss issues of sexuality, friendship and diseases as well as emotional issues. This is seen as the strongest element of the programme. According to Akoulouze, MFMC is seen as an "effective carrier of information on HIV and AIDS, as more than three-quarters of the respondents indicated that it has helped them change their behavioural patterns and attitudes towards HIV and AIDS".

In addition, the same report by Akoulouze *et al.,* (2001) indicated that high attendance of peer education programmes was also noted in Tanzania, despite the fact that the programme was offered during lunch breaks. The reasons for the popularity of HIV and AIDS programmes among school children ranges from simple exposure to facts about the epidemic to claims of setting in motion the process of behavioural change among children. This shows that providing HIV and AIDS education to young people is both desirable and relevant. It may also reflect the suitability and quality of material used to impart knowledge and information about the epidemic. In short, the MFMC programme

is an effective vehicle for creating awareness and knowledge about the epidemic and its impact among the young people in Namibia.

5.11.2 Teenage pregnancy

Though there is no teenage pregnancy reported among the program participants between 2007 and 2010, the problem of teenage pregnancy among schoolgirls is of major concern in many countries including Namibia. Teenage pregnancy has been cited as a constraint in the elimination of gender disparities in education and in the achievement of the Millennium Development Goals of universal primary education and gender equality in education by 2015. “In a continent where the adage ‘when you educate a woman you educate a nation’ holds so true, the repercussions of girls dropping out of school due to pregnancy cannot be underestimated” (Hubbard, 2008:2). The same document indicated that 1 465 learners dropped out of school due to pregnancy. Despite limited research, it is clear that teenage pregnancy and family demands impact female learners. Indeed, if not for this, the percentage of female learners in Grade 10 (16 years old) and above could be two percent to three percent higher.

The Minister of Health and Social Service, Dr Richard Kamwi, in Smit (2011:1) has also pointed out that “the HIV epidemic has had a disproportionate impact on girls and women with 60% of those living with HIV being females”. It is particularly disconcerting that 76% of young people living with HIV are young women; the adolescent pregnancy rate in Namibia furthermore is estimated at 15,4% and as many as one in five pregnant women who are attending ante-natal clinics are HIV positive.

Information from Namibia Demographic and Health Surveys 1992, 2000 and 2006 cited in Hubbard (2008:2) indicate that Namibian women continue to give birth at fairly young ages. Although the incidence of teenage pregnancies has stabilised, there is still a lack of support and a continued negative attitude towards girls who fall pregnant.

5.11.3 Behavioural change

As with other HIV prevention programmes, one of the main goals of MFMC is to change the attitudes of young people towards people living with HIV. As a result, changes in attitude are viewed as an important goal in many AIDS prevention programmes and intentions to engage in low-risk behaviours are often taken as a sufficient indicator of subsequent behaviours. It is reported that attitudes towards people living with HIV and AIDS had changed in all programmes where this was measured.

Behavioural change includes communication with others (especially potential sexual partners) about HIV and AIDS; delays in onset of sexual activity; abstinence; reduction in number of partners; and use of condoms. Increased communication with others about HIV and AIDS is considered an important first step towards prevention, since such communication exposes youth to information and encourages a dialogue about risk options. Clearly communication was the easiest behaviour to change. All programmes that evaluated communication found an increase in communicating with peers and even with boyfriends and girlfriends, and specifically about sexual risks.

The evaluation of the Ugandan Primary school programme by Shuey *et al.,* (1999) and the Namibian intervention programme by Stanton *et al.,* (1998) both cited by Gallant and Maticka-Tyndale (2004:1347) "produced significant, desirable improvement reports of sexual initiation and number of sexual partners. Stanton reported that the Namibian intervention did produce conditional results, girls who were virgins at the beginning of the programme were less likely to have initiated sex by the time of the evaluation 12 months later".

5.11.4 Condom use

The change in attitudes toward abstinence and condoms and intentions to abstain or to use a condom were inconsistent. Attitudes towards condom use were not improved as a result of the programme in the three studies where they were measured, although the intention to use condoms was higher, although short-lived.

Self-efficacy in abstaining from sex and/or using condoms was examined in two evaluations by Gallant &Maticka-Tyndale (2004), the South African and Namibian programmes; both showed positive results.

According to Harvey *et al.*, (2000), cited in Gallant & Maticka-Tyndale (2004:1347), indicated that four studies evaluated increase in condom use in Uganda, Tanzania, Namibia and South Africa. The evaluation of the South African programme indicated that this was the only one that resulted in an increase in the proportion of students who reported ever using a condom. Gallant & Maticka-Tyndale (2004:1347), further indicated that the Namibian programme produced "an immediate increase in reported condom use by boys who became sexually active after the programme started (i.e., pre-programme virgins)". However, this gain was lost by the time of the six-month evaluation. After correcting for errors in the interpretation of results, an evaluation by Fawole *et al.*, (1999), in Gallant and Maticka-Tyndale (2004:1347), showed no improvement in condom use. This finding suggests a negative effect of the Namibian population as many people will become infected by HIV.

5.12 Conclusion

Twenty young people from four schools in the Ompundja Circuit of the Oshana Directorate of Education in Northern Namibia were interviewed. The following main topics were explored during the interviews: perceived understanding of MFMC, perceived success of MFMC on HIV prevention, perceived impact of MFMC on behavioural change, impact of MFMC on prevention of teenage pregnancy, perceived relevance of topics and suggestions for ways of improving the MFMC programme.

In addition to the focus group interviews, various documents were analysed and the following topics were covered: perception of MFMC, teenage pregnancy, behavioural change and condom use.

Despite the few challenges observed in the implementation of the programme concerning the duration and relevance of some topics, there was high interest among the young people participating in the programme. MFMC is a popular programme and is believed to have equipped young people with skills and knowledge to be able to protect themselves against HIV infection.

CHAPTER 6

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter contains a discussion of the findings of the study. Amongst other topics included are the perceived understanding of the MFM programme, perceived necessity of the programme, successes of the MFMC on HIV prevention, perceived impact of the MFMC on behavioural change and prevention on teenage pregnancy will be discussed. The findings are compared to the literature on peer education and programme implementation as reviewed in Chapter 2. The chapter ends with the recommendations and conclusions drawn from the findings on how to improve the programme.

6.2 Perceived understanding of the "My Future Is My Choice" programme

In general, the respondents were clear about the purposes of the "My Future Is My Choice" (MFMC) programme. As in the report presented by Akoulouze *et al.*, (2001:21), the findings of this study have revealed sufficient evidence that generally the respondents were well informed about the programme. MFMC is popular amongst young people in schools. This is supported by the statements made by some of the respondents that the programme had empowered them, and enabled them to make right choices on issues facing them as young people, such as issues of HIV and alcohol and drug abuse. As part of the MFMC programme to provide young people with the necessary skills to face the future, graduates commented that the programme equipped them with knowledge and skills to make good decisions about their future.

The findings are in agreement with the theory of participatory education by Freire (1970), in Mead (2010:3), which explains that programmes run by peers are crucial to influence behavioural change in young people. These findings have proved that the programme is both popular and is an effective HIV intervention for young people in the education sector.

However, some of the respondents felt that the programme needs to be introduced better in order to attract more young people, especially boys. MFMC was designed to be gender balanced, with eleven boys (50%) and eleven girls (50%) attending. However, it has emerged from the document analysis (course completion form) that about 90% of the participants in the programme are girls.

The impression of the MFMC programme on the recipients is crucial. If young people are aware of the benefits of the programme, they will be attracted and what they learn will not be forgotten once it is meaningfully understood.

6.3 Perceived necessity for the MFMC programme

The study revealed that the respondents are of the opinion that the MFMC programme is necessary. As in the report by Stanton *et al*. (1998) cited in Akoulouze *et al*, (2001:21), the "MFMC programme is a hit among the school-going children. The programme is popular because of the fact that through the programme, they were equipped with knowledge and skills such as condom use and caring about people who are infected and affected by HIV. Apart from condom use, they also reported that they were provided with information on HIV transmission which is necessary for young people to know". This finding is supported by Kirby *et al.* (2008:2), who stated that "learning about sex and HIV before young people start sexual activity reduces their risk of contracting HIV". Education is playing a major role in HIV prevention among young people. Kirby *et al.*, (2008:2) agreed that HIV education programmes such as school-based HIV and AIDS education can reach many young people with information about HIV before they become sexually active or begin to experiment with psychoactive substances such as alcohol and illicit drugs to equip them with skills to protect themselves.

The MFMC programme is described by the respondents to have played an important role by providing information on circumcision and the danger of drugs and alcohol abuse. Circumcision has recently emerged as one of the preventive measures in reducing HIV infection, while alcohol and drug abuse is listed among the highest risk behaviours. Addressing these risks has prepared young people to go through adolescence into adulthood.

It is believed that behavioural patterns established by the MFMC programme can have long-lasting positive effects on the future health and wellbeing of young people.

The MFMC programme also played an important role in addressing the issues of peer pressure. As indicated by respondents, many of them learned how to choose good friends. Peer pressure causes problems for many young people and encourages them to engage in risky behaviour such as alcohol and drug abuse.

Apart from the above-mentioned issues, there were some respondents who were not satisfied with the contents of the MFMC programme; they indicated that many of the topics covered in the programme are the same as those that they studied in Biology, a school subject. They also felt that many of the topics covered in the programme were not essential. The AVERT report stated that "effective HIV education encompasses both scientific and social aspects of HIV and AIDS". Knowledge of the basics of HIV and AIDS is important for understanding how the virus is passed on and how it affects the body, however, AIDS education must not focus on medical and biological facts only, but also on the real life situations of young people to provide them with adequate AIDS awareness. "Developing life skills and discussing matters such as relationships, sexuality and drug use are fundamental to HIV education" (AVERT 2010:5).

It is argued that knowing how the HI Virus reproduces will not assist a young person to negotiate condom use, for instance.

Based on the above statements, the conclusion can be drawn that there was a lack of consultation when the programme was designed. The suggestions from the respondents regarding the improvement of the programme, suggest that, prior for any programme implementation targeting the young people, it is necessary that they are consulted to have inputs on issues concern them. In the study by Mead (2010:3), it is argued that peer education, if the programme is designed and implemented properly, can have positive impacts on young people's knowledge, attitudes and self-efficacy. Furthermore, The report by AVERT (2010:6) added that talking to the young people themselves is the best way to

start when designing HIV education for young people. "Allowing learners to ask questions and encouraging their input will enable young people to express what they want from their HIV education".

Though many of the respondents praised and supported the MFMC programme, it is important that the content of the programme is revisited and the gaps identified such as making the programme mandatory and including new topics (women abuse, effects of contraception), addressed in order to make it more responsive to the young people's needs.

6.4 Perceived successes of the MFMC programme on HIV prevention

The study found that young people who had enrolled and graduated from the MFMC programme were impacted positively. It is reported that the behaviour of sexually experienced young people changed in that they reduced the number of their sexual partners. Those who did not stop sexual activity reported an increased use of condoms. Though it is hard to measure the behaviour, this revelation by the respondents indicated that the programme has been successful, more especially in that it delivered skills relevant to HIV risk reduction.

These findings of the successes of MFMC as an intervention programme in the education sector are in agreement with the review of school-based HIV intervention conducted by UNFPA (2011:3) which revealed that curriculum-based interventions incorporating key characteristics and led by adults presented the strongest evidence of effectiveness and showed positive results through changed behaviour. Specifically, these types of interventions found that school-based sex education and HIV education reduce sexual risk behaviours; increase knowledge; increase skills; and develop positive attitudes towards changing HIV-risk behaviour.

Irrespective of the fact that MFMC is led by young people, the results of the study are in agreement with the above statement in having revealed that many of the respondents

decided to delay sexual intercourse until they have finished their education or otherwise wait until they are ready to have sex. The findings from this study are different from the findings of Klepp *et al.*, (1997) who, in their evaluation study of the life skills programme in Tanzania, found that life skills programmes had no significant effect on secondary school adolescents.

Abstinence is the most important thing the programme has addressed and this is relevant to young people. This preventive measure is the only protection which is regarded as one hundred percent safe. Although it is mentioned in the course manual of the programme, the young people felt that it was not covered well enough. In addition, the programme equipped young people with information on modes of HIV transmission, such as unprotected sexual intercourse, breastfeeding, needles/injections and others. In general, the study agrees with recommendations by Klepp *et al.* (1997) that programmes need to pay greater attention to the broader social context in which young people live. Although, the respondents indicated that MFMC tried to address issues facing young people, they felt that there is a link to some of the issues facing them on a daily basis, such as crime and women and child abuse, which should therefore be addressed by the programme.

Having been part of the “My Future is My Choice” programme, the respondents reported themselves as having become equipped with comprehensive and correct information which included knowledge about ways of preventing HIV infection and teenage pregnancy, and being able to dismiss major misconceptions about HIV. Equipping young people with basic HIV and AIDS education enables them protect themselves against becoming infected. Young people usually are more vulnerable to sexually transmitted infections and to HIV infection resulting from drug use/abuse. Obtaining appropriate information and skills motivates them to avoid behaviours that carry risk.

It also emerged from the discussion with respondents that they learned about stigma and discrimination of people affected and infected by HIV and AIDS in the programme. MFMC helped them to understand the importance of fighting stigma and discrimination of people living with HIV. This has been reported as crucial in the fight against HIV

worldwide. The fear of being stigmatised often makes people reluctant to be tested for HIV and other STIs. Studies have shown that "somebody who is not aware of their HIV infection is more likely to pass the virus on to others". MFMC as an education programme is reported to help prevent this by halting stigma and discrimination before they have an opportunity to grow. This is in disagreement with the findings of the evaluation study on Ugandan life skill programmes conducted by Kinsman *et al.* (2001:96) which found no significant difference between the intervention group and the control group with regard to most of the measured outcomes.

6.5 Perceived impact of the MFMC on behavioural change

Respondents have reported that MFMC programme has provided young people with an opportunity to learn about the basics of HIV and the difference between HIV and AIDS. Most young people thought that sex is for fun. After joining MFMC they learned that some of the results of unprotected sexual activity is pregnancy and sexually transmitted diseases. Some respondents indicated that they had previously had a negative attitude to the MFMC programme, but since having enrolled for the MFMC course, they have realised that MFMC is a good programme, it provides information that some young people may not otherwise be exposed to such as how to use condom correctly and care for people living with HIV and AIDS. In general, MFMC creates awareness of HIV and AIDS, STIs, teenage pregnancy and the danger of alcohol and risk sexual activities.

Concerning the question whether they changed their sexual behaviour after attending MFMC, in general, the respondents agreed that the programme had influenced their behaviour. MFMC equipped young people with information on the importance of keeping their virginity and waiting until they are ready to have sex. Some respondents indicated that they were thinking about having sex, but after they had joined the programme, they learned that it is not a good thing. As a result of attending MFMC, some young people decided to end their relationships.

In many cultures around the world young people are denied an opportunity to learn about life saving information, because adults see the information to be too 'adult' for young people. This kind of thinking hampers the prevention of HIV infection, as it is important for young people to get to know about HIV and how it is transmitted before they are exposed to situations that carry a risk of HIV infection.

Like the findings of the review by Gallant and Miticka-Tyndale (2004:1347) of eleven evaluated school-based HIV prevention programmes for African Youth, as well as of a systematic review by Paul-Ebhohimhen *et al.* (2008) of schools-based sexual health interventions in Sub-Saharan Africa. "My Future is My Choice" in Namibia has played an important role in changing the behaviour of those young people who enrolled for the programme. Although behaviour is much more challenging and difficult to change, the programme succeeded in changing the respondents' perception of HIV infected people. MFMC has equipped young people with the skills of caring for and supporting infected people. Apart from gaining knowledge about HIV infection, they have also changed their perception of rape which has become a major social problem in most of societies.

As in the findings reported by Gallant and Maticka-Tyndale (2004), the participants in the programme believe that the MFMC programme can change young people's sexual behaviour; those who cannot abstain, at least can learn how to protect themselves during sexual intercourse such as using condoms. As in another evaluation study on behavioural change by Akoulouze *et al.*, (2001), this study revealed increased communication between sexual partners. This is considered important, since communication exposes youth to information and encourages them to be aware of risk options such as unprotected sex. Engaging in discussions on sexual issues indicates that young people feel free to ask and discuss taboo subjects without fear of being judged or labelled. These findings are similar to those found by the Ministry of Education (2008:4) which noted that young people are open to speak, engage with and learn from peers rather than from teachers when it comes to issues relating to HIV and sexuality.

It is a well-known fact that increasing numbers of young people engage in sex and drinking. As a result, alcohol leads young people into unsafe sex. The respondents suggested that clubs for teenagers would keep young people off the streets and prevent them engaging in high risk behaviour. Most of the respondents shared the sentiment that many young people are ignorant when it comes to issues concerning HIV. They believe that teenage clubs should be made interesting places, and address current issues affecting the youth.

Something else that was suggested to help young people to change their sexual behaviour concerned putting up billboards and posters in bars to remind young people who come to buy beer of the dangers of HIV and alcohol.

A final view shared by all the groups concerned the lack of information, more especially with regard to out-of-school youth. The respondents thought the programme should be extended and implemented in the rural areas to educate youth concerning HIV prevention and the danger of teenage pregnancy.

6.6 Perceived impact of the MFMC programme on the prevention of teen age pregnancy

With regard to teenage pregnancy, the respondents reported that they had been equipped with skills for the prevention of unwanted pregnancy. The programme addressed the danger of young girls becoming pregnant while they are still at school. It was emphasised that the only hundred percent safe way to avoid teenage pregnancy is by abstaining. Although this programme is reported to have had an impact on the prevention of pregnancy among teenage girls, the study by the World Health Organization (2003) indicated that the prevalence of HIV infection in Namibia was high among young people at 17.4% and 17.9% respectively. Official statistics for pregnancy-related school drop-outs in Namibia for 2007 show that a total of 1 465 left school for this reason (Hubbard, 2008:2).

In most instances, the condom is emphasised as the main preventive measure that can be used to avoid teenage pregnancies.

According to Kirby, Laris and Rolleri (2008:2), "pregnancy is a major cause of school dropout for girls in many countries". Sex and relationship education could therefore reduce girls' chances of unwanted pregnancies or sexually transmitted infection, including HIV. This would increase their chances of completing their schooling.

MFMC, however, has not addressed the disadvantages of using contraceptives such as pills and loops. Having read the programme manual, the researcher tends to agree with most of the respondents that, while it is important to address the issue of teenage pregnancy and HIV prevention, it is equally important to inform young people about the dangers of using contraceptives such as weight gain or loss and decreased libido, issues concerning the effect of using the contraceptive pill when they grow up, and HIV and breastfeeding.

Teenage pregnancy was part of the programme content, but many young people who participated in this study felt that this topic was not covered comprehensively. Though they were educated concerning the danger of teenage pregnancy, these young people will be without the knowledge and skills to handle the situation in the case of an unwanted pregnancy.

6.7 Perceived relevance of topics

In general, respondents indicated that most of the topics covered in the MFMC programme were relevant. MFMC covers ten topics in ten sessions. Like other intervention programmes, MFMC has also received criticism from the respondents who were interviewed during the study. They mentioned that some topics were not presented clearly to the participants, and some topics were irrelevant for some age groups.

According to the respondents, only a few topics were identified as not relevant; a topic on relationships was identified as not being relevant, since respondents felt that some young people are not that interested in having a relationship. Learning how to take pills in order to prevent pregnancy was not supported by the majority of the respondents; they saw it as encouraging young people to engage in sex because they know they are protect-

ed from pregnancy. Some of these responses were influenced by the personal values and religious beliefs such as staying single and faithfulness of the respondents.

Some of the respondents thought that emphasis on the use of condoms was not good; the emphasis should be put on abstinence as the only hundred percent safe method of HIV prevention. This question was accepted with mixed feelings; some respondents felt it was good to learn about contraceptives, while the others felt it was not good since it motivates young people to have sex or experiment with what they learned. In general, this has been debated for a long time; opinion is divided between education providers who take an abstinence-only approach to sex education and those who advocate a more comprehensive approach. It is important that HIV prevention programmes provide comprehensive information that educates about the importance of condom use as well as promoting delayed sexual activity.

Regardless of the contradictions amongst the participants about what they considered to be relevant, most have indicated that they like the programme. MFMC has provided young people with an opportunity to share ideas with their peers.

Despite the fact that some topics were seen as irrelevant, many respondents commented that the MFMC programme should not be stopped. The respondents felt that the programme should continue "to save the nation". It was indicated that the programme is helpful in supplementing the information learned in the classroom and in raising awareness about HIV among young people. The respondents felt that the programme has taught them much that they did not know before. They also believed that, if the MFMC programme were to be discontinued, birth and death rates would be high, as people would not use preventive measures.

In general, the MFMC programme was found to be successful in terms of changing young people's sexual behaviour and increasing knowledge, and some interventions were able to decrease risk behaviour associated with sexual activity, such as reducing the number of sexual partners and increasing condom use.

6.8 Suggestions for improving the MFMC programme

Though the programme implementation was found to be successful, respondents have suggested ways to improve the programme. Most of the respondents felt that the programme could attract more young people, if it is introduced properly and through asking the young people for input concerning what they want to learn. A proper introduction and participation in the programme design may encourage boys to participate. The information obtained from the course completion forms submitted at the Directorate of Education at the end of each semester revealed that few boys join the program.

Apart from offering theory on HIV transmission, video shows were recommended as the best tool to promote the message on HIV transmission. Also emerging from the discussion was the issue of time. Some of the respondents indicated that the time allocated to the session was too short.

Instead of emphasising the importance of contraceptives such as condoms and contraceptive pills, respondents felt that it would also be fair to discuss the disadvantages of contraceptives. Since the programme is informative and important for young people, they felt that the programme should be extended into communities to reach out to the youth who are out of school and that graduates from MFMC should visit the community to help the orphan and vulnerable children. Offering AIDS education at school is a principal method of reaching large numbers of young people, while the "My Future is My Choice" programme reaches 22 young people per term only and 66 in three terms if no one drops out of the programme. In order to ensure that all young people are reached with basic HIV and AIDS education, respondents proposed that the programme should reach out to young people outside the school. AVERT (2010:3) has pointed out that the young people in school have more advantages from receiving further information about HIV and AIDS from other sources which can add to what they learn in school and reinforce it. The AVERT study further regarded peer education as a "particularly effective way of target-

ing difficult to reach groups, such as young people who do not attend school, with important AIDS education".

Further opinions voiced by the participants included that the programme should be changed and made compulsory or changed into a subject, or otherwise increase the intake. Some respondents suggested adding the following elements to the programme: increasing the hours allocated to the sessions; including topics on encouragement and living positively; and adding more quizzes and games. According to Mead (2010:4) "games, art competitions and role plays help people to see things from a new perspective without being told what to think or do". Some young people's personal values and religious beliefs led to a feeling that the topic on contraceptives is not relevant and could be removed from the course manual. This study further found that using media such as the radio, newspapers and television is a powerful way of reaching large numbers of young people with HIV and AIDS information and prevention messages. However, it is difficult to measure the extent to which media-based AIDS education reaches young people, and the effect that it has. The respondents also showed concern about the venue used for MFMC sessions. In agreements with the respondents, AVERT (2010:5) has suggested that "AIDS education classes can be constructed to involve quizzes, games or drama for example and can still be very effective learning sessions".

Based on the above suggestions, it is clear that there is a need of revisiting the implementation strategies of MFMC programme to be relevant to the needs of the participants.

6.9 Recommendations

Even though the MFMC programme is perceived as having been successful in equipping young people with knowledge and skills to help protect themselves against HIV infection, it is deemed important to make the following recommendations:

- The programme is perceived to have contributed immensely in the prevention of HIV infection amongst young people. Despite success in changing young peoples' behaviour, the number is still limited to a maximum of twenty-two partici-

pants per term. Increasing the intake or integrating MFMC with the school curriculum will help to reach more young people.

- The findings derived from the documentary analysis indicate that some girls become pregnant as early as in grade 6. It is recommended that MFMC be implemented for earlier grades to prevent further unwanted teenage pregnancies and the possibility of sexually transmitted infections (STIs).
- Though MFMC materials are perceived to be relevant for tackling young people's concerns, there is a need to include video shows to make them interesting and to address current issues such as the abuse of women and living with HIV in the programme. The participation of stakeholders in designing and implementing the programme is therefore suggested as crucial. Young people who are the beneficiaries of the MFMC programme need to be consulted from time to time to hear their concerns about the progress of the programme.
- Peer facilitators need to be equipped with adequate knowledge of HIV and AIDS. Increasing the time for facilitator training and the screening of facilitators should be considered. It is believed that some young people drop out the programme due to the inability of facilitators to make the participation in the programme more interesting and attractive. Hence, facilitators need to be equipped with skills necessary to work with peers.
- The Abstain, Be Faithful and Condomise (ABC) prevention methods has proved to be effective according to some studies, but though it is part of MFMC prevention strategies, none of the respondents mentioned it. It is recommended that greater emphasis be placed on the ABC methods. Amongst many methods of HIV prevention, these methods are proven to be the best for young people, more especially those in the school going age. Not only they prevent HIV but also unplanned teenage pregnancy and sexually transmitted diseases
- From the respondent's opinions regarding improving the programme, it would seem that the sessions are too long. Since the programme is implemented in the afternoon and many of them have other responsibilities at home and are sometimes hungry, it is suggested that the sessions should be limited to one hour and the number of days for presenting the programme increased from 10 to 20 days.

- There is a great need for clear guidelines on MFMC programme implementation to facilitate and monitoring the facilitators and establishing whether the programme is implemented as intended. Though, there is a manual guide for the facilitators, different schools are implementing the programme differently. Schools are having various days and time for implementation, which makes it difficult for monitoring. There is need for a uniformity of the programme implementation.
- In order to determine the impact of MFMC on the prevention of teenage pregnancy, it is recommended that a further study is done to determine the number of young women who participated in the MFMC programme and yet fell pregnant. Though, one of the purpose of MFMC is to prevent teenage pregnancy, no study was done to determine the impact of the programme in reducing teenage pregnancy.
- As part of the promotion of healthy in schools, schools should focus on influencing health related behaviours: knowledge, beliefs, skills, attitudes and support.

6.10 Conclusion

The purpose of the "My Future is My Choice" programme is to impart knowledge and skills to help protect young people from getting infected with HIV and sexually transmitted infections (STIs). In general, the responses obtained from the study indicated that the programme is beneficial to young people. The respondents have reported different changes in their lives after attending MFMC programme, their knowledge about reproduction, sex, HIV and AIDS were enhanced. Challenges that need immediate attention involve the number of participants, a review of topics and the time allocated to the implementation of the programme.

As seen from the young people's responses, there is a need to reconsider the design and implementation of the programme to see whether it could be made compulsory or be integrated with the school curriculum, instead of being limited to a maximum of twenty-

two participants per session. This is a clear indication that the program is perceived as important in the lives of young people.

Though some topics were regarded as important, topics on contraception were received with mixed feelings by the young people who participated in this study. There was a feeling, however, that topics dealing with the abuse of women and the effects of contraceptives should be included in the programme. Varying opinions on some topics were influenced by the personal values and religious beliefs of the young people. The respondents demonstrated sound knowledge of HIV and AIDS. They were able to explain the difference between HIV and AIDS as well as being able to describe the modes of HIV transmission.

Another important concern addressed by the study concerned the relevance of the skills learned in the MFMC programme; different skills mentioned included the use of male and female condoms. Young people were able to identify the factors that influence behaviour, such as peer pressure, alcohol and drug abuse.

The following problems were encountered with regard to the implementation of the programme: a lack of facilities such as video shows; the irrelevance of some materials, too long sessions and the limited number of participants. Finally, graduates wanted to be tasked to go and educate out-of-school youth whom they regarded as being at high risk of HIV infection.

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Appendix A: Interview guide (Focus Group Interview)

Dear Students

My name is Nespect Salom, a student at the University of Stellenbosch, South Africa. I am studying for the Master of Public Administration degree and am particularly interested in carrying out a study on "How does the "My Future is My Choice" programme impart HIV/AIDS information and equip young people with necessary skills to assist in reducing the risks of becoming infected in Ompundja Circuit, Oshana Directorate of Education?" I do believe that learners are very important and have a lot of information to share as far as My Future is My Choice is concerned. The information obtained from the learners is very important, because this can play a major role in addressing the challenges faced by young people with regard to the MFMC programme. I would like to ask you questions to answer and please be honest as well as feel free to answer any question you wish and to ask questions whenever you need clarification. All data collected for this study become the property of the researcher. The information you give will be treated confidentially, will be anonymous and will not be shown to anyone.

1. Background information

   (a) Gender.....

   (b) Age .....

2. Which years were you involved in the MFMC programme?

3. According to your understanding, define for me what is MFMC?

4. What do you think is the aim of MFMC?

5. What did you learn from the programme that was most valuable to you? And why do you consider it important?

6. MFMC is a preventive programme; do you think it has equipped you with relevant knowledge and skills to prevent yourself from acquiring HIV infections?

7. Was there anything that you learned through the MFMC course that you did not know before? If yes, what is it?

8. Has the programme changed the way you think about things in general? If yes, give examples of the way you thought about specific things before you attended the course compared to the way you thought about these things after attending the course?

9. Has the programme changed your behaviour in anyway? If yes, please give me examples of how you behaved before you attended the course compared to the way you behave now, after attending the course.

10. How did MFMC programme change your sexual behaviour?

11. What do you think the programme can do to help young people change their sexual behaviour?

12. What did you learn from MFMC regarding teenage pregnancy?

13. Which sessions did you find most useful?

14. Which sessions did you find least useful?

15. Looking at MFMC content, which ones do you think is not relevant for your age group and why?

16. Apart from those topics covered in the MFMC programme, what other topics would you recommend to be included in MFMC?

17. What do you like about and did not like about the MFMC programme?

18. What did you enjoy least about the programme?

19. Amongst the materials covered by the programme, which one do you not understand well and why?

20. Amongst the materials covered by MFMC, which one do you understand well and why?

21. There is an idea to not to continue MFMC in the future; what would happen if the MFMC programme didn't continue?

22. If you would be asked to change MFMC programme and make it better, what would you add or change?

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

Appendix B: Letter to the Ministry of Education

P.O. Box 80042
Ongwediva
Namibia

21 June 2010

The Permanent Secretary
Ministry of Education
Private Bag 13186
Windhoek
Namibia

Dear Mr. A. Iukena

SUBJECT: PERMISSION TO CONDUCT RESEARCH IN GOVERNMENT SCHOOLS IN OSHANA REGION

My name is Salom Nespect, an employee of the Ministry of Education, Oshana region. As a Regional AIDS Committee for Education (RACE) Coordinator, I am responsible for HIV and AIDS implementation programs in the Directorate. I am currently doing a Master Degree in Public Administration with the University of Stellenbosch, South Africa. The title of the research project is 'an outcome evaluation study of My Future is My Choice HIV/AIDS Education Program in Oshana Directorate of Education". To conclude my study, I am requesting permission to conduct my research in government schools.

The findings of this study can be used by the Oshana Directorate to improve the implementation of My Future is My Choice program.

As a researcher, I undertake to guarantee that all information collected will be strictly used for the purpose of the research and the identity of all participants will be kept confidential as their names and any other identification information will not be required for the study.

Attached is my letter of proof of registration with the University of Stellenbosch.

I trust that you will consider my request favourably.

Should you have any further questions, please contact me at (0812224183) or (065-230057).

065-230035

Thanking you advance.

Yours faithfully

Nespect Eutty Salom

P.2 Ongwediva Teachers Resour 230035 01 Jul 10 17:28

Appendix C: Permission letter from the Ministry of Education

FROM :DIRECTORATE - POA FAX NO. :061 2933922 Jul. 07 2010 10:08AM P1

Mr. Salom
Please, indicate schools that will be part of your study.

REPUBLIC OF NAMIBIA

Received 8/07/10 **MINISTRY OF EDUCATION**

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

Private Bag 13186
Windhoek
NAMIBIA

2 July 2010

File: 11/2/1

MINISTRY OF EDUCATION 07 JUL 2010 REGIONAL OFFICE OSHANA

Mr Nespect Butty Salom
P. O. Box 80042
ONGWEDIVA

Dear Mr Salom

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN SOME SCHOOLS IN OSHANA EDUCATION REGION

Your letter dated 2 July 2010 requesting permission to conduct a research in some schools in Oshana Education Region, has reference.

Kindly be informed that the Ministry does not have any objection to your request to carry out a research project in Oshana Education Region.

Nevertheless, you are advised to contact the Regional Education Office for permission to carry out your study in the schools. As it may be impossible to visit all the schools in the region, you are therefore advised to identify specifically certain schools you intend to visit. This will enable the Regional Office to communicate to them for necessary arrangements.

Kindly take also note that your research activities should not interfere with the normal school programmes.

By copy of this letter the regional director is made aware of your request.

Yours faithfully,

MINISTRY OF EDUCATION Office of the Permanent Secretary 06 JUL 2010 Private Bag 13186 Windhoek Namibia

N Ilukena
PERMANENT SECRETARY

cc: Regional Director: Oshana Education Region

Appendix D: Permission letter from the Directorate of Education: Oshana

letter a permission

REPUBLIC OF NAMIBIA

OSHANA REGIONAL COUNCIL

DIRECTORATE OF EDUCATION
Aspiring to Excellence in Education for All

Tel: 065 - 229800
Fax: 065 - 229834
E-mail: dutte@iway.na
Enquiries: Dutte N. Shinyemba
Ref:

Private Bag 5518
Oshakati, Namibia

Mr. Nespect B S alom
Ongwediva Teachers' Resource Centre

22 July 2010

RE: Request for permission to conduct research in schools in Oshana Education Region

This serves to inform you that permission is granted to you to conduct research at the following schools:

1) Hashiyana Combined School
2) Ekwafo SS
3) Gabriel Taapopi SS
4) Mweshipandeka SS

Please be informed that your presence in the school should not disrupt teaching and learning activities.

Thank you for your understanding.

Shinyemba 22/07/10
Mrs. Dutte N. Shinyemba
Regional Director

OSHANA REGIONAL COUNCIL
OFFICE OF THE DIRECTOR OF EDUCATION
2010 -07- 22
P/Bag 5518, Oshakati
REPUBLIC OF NAMIBIA

Appendix E: Letter from the University of Stellenbosch

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot • your knowledge partner

Date of issue: 30 Mar 2010

PROOF OF REGISTRATION

This is to certify that

NESPECT SALOM

Date of birth : 13/10/1974

Identity no : 7410130000005

Student number: **15569918-2009**

is registered as a student at this University for the academic year 2010.

Degree/diploma/certificate programme:
MPA (ITE) (FULL TIME)
(Public and Development Management)

Date commenced with programme: **Febr 2010**

Minimum formal duration of programme: **1.0 Years**

Date of termination of studies (if applicable): **None**

This document is issued without alterations of any kind. As far as present students are concerned this only applies until the date of the certificate.

Mrs R Moore
FOR DEPUTY REGISTRAR

UNIVERSITEIT VAN STELLENBOSCH
SKOOL VIR OPENBARE BESTUUR
30 MAR 2010
SCHOOL OF PUBLIC MANAGEMENT
UNIVERSITY OF STELLENBOSCH

Navrae / Enquiries: Mrs R Moore Tel.: (021) 918 4409 Verw./Ref.:
Universiteitskantoor * University Offices
Privaat Sak / Private Bag X1 * Matieland * 7602 * Suid-Afrika / South Africa
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