

# FINAL REPORT FOR UNICEF

Evaluation of  
My Future is My Choice (MFMC)  
Peer Education Life Skills Programme in Namibia:  
Identifying Strengths, Weaknesses and Areas for Improvement

Project Leader: Dr Upjeet Chandan

HSRC Project Team: Elizabeth Cambanis, Prof. Arvin Bhana, Gerard Boyce, Dr.  
Mokhantso Makoae, Wanjiru Mukoma, and Sizwe Phakati

RFS Project Team: Erna Keulder, Lizl Stoman, David Amundjembo, Llewelyn Feris,  
Mathew Haufiku, Feris Joseph, Elicia Hangome, Veikko Iitembu, Elina Ngjilondo, Brenda  
Oarum, Immanuel Nghidengwa, Ottilie Sheehama, Petrus Skikongo, Joseph Theodor,  
Derik Vilas

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Contact Address:

Child, Youth, Family & Social Development Programme (HSRC)

Private Bag X07, Dalbridge 4014, South Africa

Upjeet Chandan: Phone - 031 242 5608 (w)

Fax - 031 242 5504

Email - [uchandan@hsrc.ac.za](mailto:uchandan@hsrc.ac.za) and [abhana@hsrc.ac.za](mailto:abhana@hsrc.ac.za)

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# TABLE OF CONTENTS

Acronyms.....	ii
Executive Summary .....	iii
Methodology .....	iii
Findings.....	iv
Recommendations.....	v
Chapter 1: Introduction .....	1
Work Assignment .....	1
Scope of Assignment.....	1
Structure of Report.....	1
Chapter 2: Background .....	3
The Situation of Young People in Namibia .....	3
Peer Education and Young People .....	12
My Future is My Choice (MFMC) Programme.....	20
Chapter 3: Methodology .....	26
Sample.....	26
Methods .....	26
Recruitment.....	28
Ethics approval .....	30
Translation .....	30
Data Analysis.....	30
Chapter 4: Findings .....	31
I. Perceived Impact of the MFMC Programme on MFMC Graduates.....	31
II. Perceived Impact of MFMC Programme on MFMC Facilitators.....	49
III. Assessment of Programme Impact and Content: Strengths and Weaknesses .....	55
IV. Assessment of Programme Delivery Mechanism: Strengths and Weaknesses.....	65
Chapter 5: Conclusions and Recommendations .....	83
Recommendations.....	84
Reference List .....	91
Appendices.....	105

## ACRONYMS

ABC	Abstain, Be faithful, Condomise
AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretrovirals
DHS	Demographic and Health Surveys
EMIS	Education Management Information Systems
FGD	Focus Group Discussion
GDP	Gross Domestic Product
HAMU	HIV/AIDS Management Unit
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
KAPB	Knowledge, Attitudes, Practices and Behaviour
MFMC	My Future is My Choice
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
RACE	Regional AIDS Committee for Education
REC	Research Ethics Committee
RFS	Research Facilitation Services
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
TOT	Trainer of Trainers
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing

## EXECUTIVE SUMMARY

The overall purpose of the research was to evaluate **My Future is My Choice** (MFMC), a national peer education HIV prevention life skills programme in Namibia, and to provide recommendations for improving and strengthening the programme. MFMC is an official extra-curricular life skills programme of the Ministry of Education at secondary and combined schools. It seeks to protect young people from HIV and other sexually transmitted infections, and to prevent unintended pregnancies.

As specified in the terms of reference, the specific objectives of the assignment were to:

1. Assess the impact and influence of MFMC on young people, both learners and peer facilitators;
2. Assess the programme delivery mechanism of the MFMC programme, including the quality and ability of facilitators and trainers to deliver the programme;
3. Identify and analyse MFMC programme strengths and weaknesses based on evaluation results;
4. Make realistic recommendations for improving the MFMC programme.

Key questions that the evaluation sought to address included:

- Is the MFMC programme effective in meeting its goals?
- Is the programme being implemented as intended?
- What impact has the programme had on the knowledge, skills, and behaviours of MFMC graduates and peer facilitators?
- What are the key obstacles to the effective implementation of the programme?
- What are the strengths and weaknesses of the programme?
- How do we revise the content and/or delivery mechanism?
- How do we improve the MFMC programme?

## METHODOLOGY

In order to answer the main questions proposed, a mixed-method approach that gathered qualitative and quantitative data was used. There was a strong emphasis on soliciting feedback not only from MFMC participants and peer facilitators, but also from stakeholders involved in overseeing the implementation of the programme, and monitoring and evaluation (M&E).

The evaluation used the following methods of primary data collection:

1. Questionnaires with learners who participated in the programme between 2006 and 2008;
2. Interviews with current MFMC peer facilitators, contact teachers, school Principals, RACE Coordinators, and the Trainer of Trainers;
3. Focus group discussions with MFMC graduates and MFMC peer facilitators;
4. Participant observation of MFMC training courses, both of facilitators and learners.

Data was collected in two phases, between July and October 2008, in six regions of Namibia. Phase I primarily involved collecting quantitative data that was used to inform and shape qualitative data collection in Phase II. The quantitative data helped to identify programme strengths and weaknesses that were probed in depth through qualitative data collection in Phase II.

## FINDINGS

The MFMC programme is broadly perceived by users, implementers and stakeholders, in a positive light and regarded as beneficial for MFMC participants, as well as for participating schools. Although there is room for improvement, the content and curriculum are considered useful and relevant to the lives of young people and the issues they face. That there is a uniform call from MFMC participants, MFMC facilitators, and stakeholders alike to expand MFMC to reach more young people speaks for the perceived benefits of the programme.

Commonly reported strengths identified by stakeholders, MFMC participants, and MFMC peer facilitators include that the MFMC programme:

- Creates awareness of HIV/AIDS, STIs, teenage pregnancy, and the dangers of risky sexual activity;
- Promotes abstinence;
- Teaches participants how to use condoms correctly;
- Provides information that some learners may not otherwise be exposed to, especially in rural areas;
- Teaches participants to care for people living with HIV/AIDS (PLWHA)
- Teaches participants important communication, decision-making and problem-solving skills;
- Enhances participants' self-esteem and self-confidence;
- Teaches participants how to resist peer pressure.

In addition, the programme reinforces and deepens what is learned in other classes, such as Life Skills and Science. The interactive participative methods empower young people not only to absorb the learning, but also to voice their opinions and to speak openly about sexuality and HIV/AIDS.

The qualitative data indicates that the MFMC programme has, for many participants and peer facilitators, enabled important, positive, and health-promoting changes. For example, MFMC graduates report, among other things, increased knowledge with regard to reproductive health and HIV/AIDS, the adoption of more protective sexual attitudes and practices, increased awareness of the effects of peer pressure, and increased awareness of the dangers of alcohol. Similarly, the qualitative data suggests that the MFMC programme has been an important, positive influence in the lives of peer facilitators. Through participation in the programme, they report various changes in their lives such as: becoming more knowledgeable about sex, reproduction, and HIV/AIDS; becoming more open and confident; becoming more accepting of HIV positive people; learning how to facilitate in front of a group and; engaging in less risky sexual and related behaviours. Indeed, many peer facilitators described the importance of these changes in terms of shifting their worldview and leading them to make better decisions and choices.

There are, however, various obstacles that compromise the effective delivery and implementation of the programme. Key obstacles include:

- Facilitators have limited knowledge and skills.
- High turnover of peer facilitator compromises programme continuity.
- The programme reaches only a small proportion of the target group.
- The programme is not integrated into the school curriculum.
- There is insufficient school buy-in, especially from Principals.

- There is poor communication between the MFMC programme office and the schools.
- There is uneven M&E and insufficient quality control.

In terms of the facilitator as the agent of delivery, the research indicates that, although the programme has improved peer facilitator capacity, there are still gaps in their knowledge. The programme requires a more skilled, committed, and better-compensated cadre of peer facilitators to effectively deliver the intervention. Related to the issue of facilitator capacity is high turnover among peer facilitators. The compensation that volunteer peer facilitators receive is often insufficient to retain them over time. This compromises programme continuity and the cultivation of a skilled cadre of peer facilitators over time.

In addition, the marginalisation of the MFMC programme in schools compromises its effectiveness. As an after school activity, it is easily sidelined by school staff (Principals and teachers) and made secondary to academic demands. Moreover, due to the timing of the programme, access is restricted to those who are able to stay after school and who do not have other commitments. The programme, therefore, does not necessarily reach those who need it most.

Lastly, another significant obstacle to the effective delivery of the MFMC programme is uneven M&E and insufficient quality control. M&E are often haphazard, so that it is difficult to determine what is happening in the classroom, or to ascertain whether the peer facilitator is delivering the intervention as intended.

## **RECOMMENDATIONS**

The quality and success of the MFMC programme depends on a skilled peer facilitator delivering the programme in a supportive, enabling school environment with clear accountability structures and a strong functioning M&E system. As the programme is currently being implemented, many of these critical ingredients are missing.

The recommendations that follow address many of the obstacles to effective implementation and also call for the expansion and institutionalisation of the MFMC programme. However, all issues of programme quality – i.e. training and retention of peer facilitators, M&E, and the revision of curriculum – must be resolved before efforts to expand and institutionalise the programme are undertaken.

### **RECOMMENDATION 1: INTRODUCE TARGETS FOR THE PROGRAMME AND ROUTINELY GATHER DATA**

Although the MFMC programme has clear goals and objectives, there are currently no internally-defined measurable targets against which to assess whether the programme is working towards its objectives. While external evaluations are important, as part of routine M&E, the programme should identify core indicators and targets against which to measure its performance, and routinely gather data for this purpose. In the context of HIV prevention, comprehensive knowledge about HIV transmission and prevention, the ability to identify symptoms of an STI, the demonstrated ability to use a condom, and the uptake of voluntary counselling and testing are examples of indicators that can be used to monitor programme performance.

### **RECOMMENDATION 2: MODERATE EXPECTATIONS ABOUT WHAT THE CURRICULUM CAN ACHIEVE**

There are limits to what a good peer education HIV prevention programme can achieve. The research evidence suggests that well-designed and well-implemented HIV peer education programmes can have positive impacts on young people's knowledge, attitudes, beliefs, and

perceived self-efficacy; behaviour, however, is much more difficult to change. Similarly, a recent *Lancet* article on behavioural strategies to reduce HIV argues that, while behavioural interventions are necessary to prevent HIV transmission, they are not, on their own, sufficient to reduce HIV transmission (Coates, Richter, & Caceres, 2008). It is recommended that expectations about what the MFMC programme can achieve be moderated. The programme should be seen as one important component of a more comprehensive HIV-prevention strategy among young people, which should include access to adolescent-friendly reproductive health services.

### **RECOMMENDATION 3: REVISE THE CURRICULUM TO ADDRESS GAPS AND WEAKNESSES**

The research indicates that, although the curriculum imparts useful and important information to participants about sex, reproduction, and HIV/AIDS, there are aspects and activities that require strengthening, revision, and/or greater emphasis. In some instances, such as the factual content on reproductive health and HIV transmission and prevention, greater emphasis needs to be placed on ensuring that participants leave the programme with comprehensive knowledge. In other areas, the curriculum should be revised to strengthen the key messages of the programme. For example, correct and consistent condom use is critical to HIV prevention. Conducting condom demonstrations just once during the course is not enough to ensure that all participants know how to use a condom correctly. It is therefore recommended that condom demonstrations be done more than once. In addition, the content of the MFMC curriculum should be updated to align with recent research in the field of HIV/AIDS and to address more directly the risks associated with intergenerational, transactional, and concurrent sex, as well as the protective effects of male circumcision. It is also recommended that the teaching of 'soft skills' (e.g. how to be assertive) be anchored within specific prevention strategies in order to maximise and focus on the key messages of the programme.

### **RECOMMENDATION 4: CREATE A PROFESSIONAL CADRE OF PEER FACILITATORS**

It is often assumed that peer education is an inexpensive HIV prevention strategy. However, the proper implementation of peer education programmes requires a significant investment of resources not only in terms of training, supporting, and supervising peer educators, but also in terms of providing them with the necessary resource materials and compensating them adequately for their involvement. The modest compensation and high turnover of peer facilitators make it difficult to develop a skilled and committed cadre of workers. In addition, although their training is useful, it is, in many ways, insufficient to the task of delivering the curriculum. Rather than having a large rotating cohort of peer facilitators who require continual recruitment and training because of high turnover rates, it is recommended that the facilitator role be formalised as a salaried position with job stability. This will not only attract a more skilled group of young people, but job security and a stable monthly income will provide incentives for peer facilitators and foster greater commitment.

### **RECOMMENDATION 5: MAKE THE PROGRAMME MANDATORY AND TARGET ALL GRADE 8 LEARNERS**

Under the current programme delivery model, a maximum of 66 learners per participating school per year can be accommodated by the MFMC programme. Only a small proportion of school learners, therefore, actually participate in the programme. In 2007, for example, only 8.2% of secondary and combined school students participated in the MFMC programme. By reaching only a small segment of the target population, the MFMC programme is missing an important opportunity to make a positive difference in the lives of more young people.



One way to ensure that all secondary school students receive the programme is to offer the programme to all Grade 8 learners, ideally before they become sexually active and begin experimenting with alcohol and drugs. It is better to target learners in mid-adolescence rather than late adolescence, before they adopt behaviours that might put them at risk of HIV infection and teenage pregnancy. By targeting young people when they are less likely to be sexually active, the programme also has the opportunity to help young people define themselves as sexual beings and agents and to establish healthy, protective behaviours and practices with regard to sex and HIV prevention.

### **RECOMMENDATION 6: INSTITUTIONALISE THE PROGRAMME AS PART OF THE SCHOOL CURRICULUM**

The timing and construction of the MFMC programme as an after-school activity is inherently problematic. It limits participation and school buy-in, and thus makes it easy for the programme to be made secondary to the academic curriculum or other activities. Given the critical importance of HIV prevention education in high prevalence countries, it is imperative that all young people have access to accurate and comprehensive information about how HIV is transmitted and prevented. Integrating the programme into the school curriculum would make it less likely to be sidelined by Principals, teachers, and learners. It would also indicate that the programme is supported, valued, and owned by the Ministry of Education as an integral part of young people's education.

### **RECOMMENDATION 7: STRENGTHEN THE MONITORING AND EVALUATION OF THE PROGRAMME TO ENSURE QUALITY**

Monitoring and evaluation of the programme is not operating effectively to ensure programme quality, and there is no accountability mechanism to ensure that M&E occurs as intended: M&E forms are sometimes, but not always, completed; Principals and contact teachers do not always understand their roles and responsibilities in monitoring and evaluating the course; and site visits by the MFMC programme office are sporadic and ad hoc rather than routinely scheduled. It is recommended that the M&E model of the MFMC programme be revised and strengthened and an accountability mechanism be adopted to ensure that these function to ensure programme quality.

### **RECOMMENDATION 8: ENGAGE PARENTS AS STAKEHOLDERS**

Parents and caregivers play an important role in shaping young people's sexual and reproductive behaviour. Indeed, current research indicates that parents, teachers, and friends are all important sources of influence and information about sexuality for young people. The greater the harmony between the various sources of influence in the lives of young people, regarding the importance of abstaining from sex and/or practising safe sex, the more likely that young people will be able to draw on protective resources and adopt protective behaviours. At present, there is no formalised mechanism through which the MFMC programme engages parents as stakeholders in the sexual and reproductive health and well-being of their children. This can routinely be done through the school board and parents' meetings. By explaining why the programme is important and some of the key strategies that the programme advocates there is a greater likelihood of achieving harmony and building partnerships among the various actors who influence young people in their sexual decision making.

# CHAPTER 1: INTRODUCTION

## WORK ASSIGNMENT

The overall purpose of the assignment is to evaluate My Future is My Choice (MFMC), a national peer education HIV prevention life skills programme in Namibia, and to provide recommendations for programme improvement and strengthening.

As specified in the terms of reference, the specific objectives of the assignment are to:

1. Assess the impact and influence of MFMC on young people, both learners and facilitators;
2. Assess the programme delivery mechanism, including the quality and ability of facilitators and trainers to deliver the programme;
3. Identify and analyse the programme strengths and weaknesses based upon evaluation results;
4. Make realistic recommendations for improving the programme.

## SCOPE OF ASSIGNMENT

Although the word 'impact' is used in the report, technically speaking, this evaluation is not an impact evaluation. Gathering baseline data prior to the implementation of an intervention, controlling for differences through the use of an experimental or quasi-experimental research design, and triangulating data is critical to being able to assess impact. Rather, this assessment is best described as *programme evaluation*, as it involves assessing programme fidelity (i.e. is the programme being implemented as intended?) as well as levels of satisfaction and perceptions of impact among various stakeholders, including learners, facilitators, school staff and officials, as well as the Trainer of Trainers. Given that the research design principally involves interviewing learners and facilitators who have already completed the programme, this study reports on and analyses participants' retrospective reflections on impact. Throughout this report the word 'impact' is used in the general sense of having an affect or influence.

Key questions that the evaluation seeks to address include:

- Is the MFMC programme effective in meeting its goals?
- Is the programme being implemented as intended?
- What impact has the programme had on the knowledge, skills, and behaviours of MFMC graduates and MFMC peer facilitators?
- What are key obstacles to the effective implementation of the programme?
- What are the strengths and weaknesses of the programme?
- How do we revise the content and/or delivery mechanism?
- How do we improve the MFMC programme?

## STRUCTURE OF REPORT

The report is structured according to the various objectives of the programme evaluation. The report begins (Chapter 2) with a critical examination of the empirical literature on the situation of adolescents in Namibia and also includes a discussion of the evidence for peer education/life skills programmes as a strategy to prevent HIV and promote adolescent reproductive health. Chapter 3 presents the research methodology. Chapter 4 reports on the main findings of the research in terms of programme impact on young people, both MFMC graduates and peer facilitators, and identifies

the strengths and weaknesses of the programme in terms of the programme content and programme delivery mechanism. Lastly, Chapter 5 synthesises all research findings and makes recommendations for improving and strengthening the MFMC programme.

## CHAPTER 2: BACKGROUND

This chapter examines the empirical literature on the situation of adolescents in Namibia. It covers a variety of issues relevant to the lives of young people in Namibia such as education and employment, as well as pressing health and social issues such as HIV/AIDS, teenage pregnancy, and substance abuse. The chapter also includes a detailed review of all relevant literature related to peer education and life skills programmes in general, and the MFMC peer education programme in Namibia in particular. Research evidence on the effectiveness of peer education and life skills programmes as a strategy for HIV/AIDS prevention and the promotion of reproductive health and adolescent sexuality has been given particular emphasis.

### THE SITUATION OF YOUNG PEOPLE IN NAMIBIA

Like other countries in Sub-Saharan Africa, Namibia is undergoing a youth demographic transition. The proportion of young people<sup>1</sup> in relation to the general population is growing and is expected to peak over the next twenty years, leading to a 'demographic bulge' in the youth population (World Bank, 2007). Already, Namibia's population is relatively young. An estimated 62% of the population are under the age of 24 (USAID, 2007). This demographic reality presents both tremendous opportunities and risks for the health, development, and well-being of children and youth in Namibia.

### EDUCATION

Educational access, progress, and achievement are some of the key indicators for assessing the development and well-being of young people. Prior to 1990, when Namibia gained its independence from South Africa, the education system was characterised by fragmentation across racial and ethnic lines, unequal access to education across all levels, and inefficiencies in terms of learner progress and achievement (Amukugo, 2002). The official language of instruction was Afrikaans.

Since independence and the ratification of the Namibian Constitution in 1990, the education sector in Namibia has undergone significant transformation. Separate, ethnically-based educational authorities have been integrated into a single unified educational system, and 10 years of education are now compulsory for all children, starting at age six. The official language of instruction has been changed to English.

Only 7% of the population, however, speak English as a first language (CIA World Fact Book, 2008). According to 2001 census figures, 48% of households speak Oshiwambo, 11% Damara, 11% Afrikaans, 10% RuKwangali and 8% Otjiherero (Government of the Republic of Namibia, 2007). As a result, at the primary school level, from Grade 1 to Grade 3, vernaculars are used as a medium of instruction; however, from Grade 4 onwards, English is the sole medium of instruction with the vernacular taught as a subject.

Overall, over the past few decades, there have been significant improvements in the education of the Namibian citizenry. Namibia is a signatory to the World Declaration on 'Education for All', and the government has pledged its commitment to providing universal basic education (Grades 1-12). In the general population, literacy<sup>2</sup> rates have steadily increased over the past few decades, from 57% in 1970 to 85% in 2004, and are particularly high among youth. In 2004, 91% of male and 93% of female youth aged 15-24 were reportedly literate (UNESCO, 2008). Such high literacy rates

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<sup>1</sup> As per the United Nations definition, 'young people' is defined as persons between the ages of 15-24.

<sup>2</sup> Literacy is defined as the ability to both read and write with understanding in any language (UNESCO, 2008).

may be too optimistic, however, as SACMEQ II data indicates that only 26% of learners reached a minimum level of mastery in reading literacy and only 8% reached the desirable level (cited in Wikan, 2008, p.10).

At the primary school level, school participation rates are relatively high and at all levels of education, females have higher enrolment rates than males. For 2007, gross and net enrolment ratios<sup>3</sup> for primary school were 117% and 92% respectively. Rates of school participation, however, drop significantly in secondary school, more so for boys than girls. In comparison, the gross and net enrolment ratios for secondary school were 66% and 53%, respectively (see EMIS 2007, Table 27).<sup>4</sup>

In primary and secondary school, dropout rates are high and a cause for concern. In 2004, the survival rate to Grade 5 was only 86%. Although a significant problem across all grades and regions, dropout rates are highest at Grade 10, with 38% of students leaving school at the end of Grade 10 (see EMIS 2007, Table 30). Many drop out because they fail Grade 10 examinations and simultaneously age out of the secondary school system.<sup>5</sup>

High dropout rates are also related to a number of socio-economic issues. Poverty plays a key role (National Planning Commission, 2004; SIDA, 2004; Wikan, 2008). Although there is a legal guarantee of free primary school education, (The Government of the Republic of Namibia, 1990) fees often continue to be charged (UNESCO, 2008) and there is no legal requirement for the provision of free secondary school education. Even when parents do not have to pay school fees, they have to pay for uniforms, transport and other school-related expenses (Terry, 2006). There are also costs associated with the distance of travel from more remote rural areas; long distances can serve as a disincentive for attendance.

Female dropouts are often the result of pregnancy (EMIS, 2007; Mufune, 2002; National Planning Commission, 2004; SIDA, 2004; United Nations Namibia, 2004). Also, young people often leave school to help support their family by joining the labour market. The HIV/AIDS pandemic also plays a role in high dropout rates as it affects teachers and their capacity to deliver quality education. Moreover, the sick are often cared for by young girls and boys who are increasingly expected to stay at home (National Planning Commission, 2004; United Nations Namibia, 2004). The language of instruction also affects dropout rates, as the preference for English over mother-tongue languages in the higher grades affects learners' ability to read and write and thus pass their exams (Wikan, 2008).

Further, of the small number of learners that write Grade 12 school-leaving exams, only a small proportion qualify for admission to higher education. In 2005, for example, of the 13 850 students who completed Grade 12 exams, only 2 840 qualified for University or Technikon admission (Mseyamwa, 2006). It is not surprising then that enrolment in tertiary education remains very low, with a gross enrolment ratio of 6% for males and 7% for females (UNESCO, 2008).

## **POVERTY AND UNEMPLOYMENT**

Namibia faces numerous social and economic challenges, including pervasive poverty, high unemployment, and marked socio-economic inequalities. Although classified as a middle-income country, wide social and economic disparities exist (National Planning Commission, 2004). Namibia has the highest Gini coefficient in the world (UNDP, 2008) with nearly 80% of the country's GDP being concentrated in 20% of the population (USAID, 2006 Over one third of the

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<sup>3</sup>The net enrolment ratio refers to children enrolled in school who are in the official school age group for a given level of schooling. In comparison, the gross enrolment ratio refers to enrolled children of all ages.

<sup>4</sup> The discrepancy between net and gross enrolment rates in both primary and secondary schools indicates that there is widespread overage enrolment at both the primary and secondary school level.

<sup>5</sup> Nolan van der Ross (UNICEF), personal communication, 28 October 2008

population (35%) lives on less than \$1 a day, and over half the population (56%) on less than \$2 a day<sup>6</sup>(UNDP, 2008).

Although the country is urbanising, 60% of the population still live in rural areas, where female-headed households and poverty are concentrated (Central Bureau of Statistics, 2004). The phenomenon of female-headed households can be largely attributed to the migrant labour system. Although there has been an increase in female migration since Namibia gained independence, labour migration remains statistically a male trend (Winterfeldt, 2002). On average, female-headed households are poorer than male-headed households, both reflecting and contributing to gender inequality. The 40% of female-headed households in Namibia account for only 29% of the total annual consumption as opposed to the 59% of male-headed households that account for 70% of total consumption (Central Bureau of Statistics, 2004).

Among the general population, unemployment is high at 34%,<sup>7</sup> and significantly higher among youth as 67% of 15-19 year olds and 59% of 20-24-year-olds are unemployed. A disproportionate number of male youth are economically active compared to female youth, as 64% of males are employed or working, compared to only 42% of females (Community Agency for Social Enquiry, 2007). Each year large numbers of young people, some of whom have completed their schooling and others who have not, enter the labour market with few prospects of finding paid employment. Importantly, unemployment is linked to low levels of education, as the majority of the unemployed (74%) have only primary or junior secondary education (Labour Resource and Research Institute, 2003).

In addition to the everyday challenges of poverty and unemployment, other pressing social issues confronting Namibian youth include alcohol abuse, teenage pregnancy and HIV/AIDS.

## **ALCOHOL USE/ABUSE**

Alcohol abuse is recognised as a widespread problem in Namibia and is associated with various social, economic, and health problems and risks. It is estimated that up to 90% of violent crimes in Namibia are alcohol-related (United Nations Namibia, 2004, p.44). Alcohol use and abuse among young people is of critical concern. Across Sub-Saharan Africa, there are indications that alcohol consumption is on the increase among children and young adults between 10-25 years of age (Odejide, 2006).

Early experimentation with alcohol is common among Namibian youth. One UNICEF (2006) study found that the median age at which Namibian youth (15-24) started drinking was 15 and that three out of 10 young people surveyed had already tried alcohol. The national Global Status Report on Alcohol 2004 reports that 11% of young men between 18 and 24 years old and 2% of young females between 18 and 24 years old are heavy episodic drinkers, consuming five or more standard drinks in one sitting at least once a week (WHO, 2004).

In the context of HIV prevention, alcohol use and abuse is considered a risk factor for HIV transmission (Mufune, 2003; LeBeau et al, 2001). For example, a UNICEF study (2006) found that drinking alcohol increased the probability of youth having taken one or more sexual risks by a factor of 3.5. Similarly, Parker & Connolly (2007) found that among those sampled, high levels of alcohol consumption were significantly related to HIV-related risk behaviours.

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<sup>6</sup> The \$1 a day benchmark is used as a measure of extreme poverty whereas the \$2 a day benchmark is a measure of moderate poverty. According to the Namibian National Planning Committee, the 35% of the population that lives below \$1 a day spend 80% of their total income on food (Integrated Regional Information Networks, 2007)

<sup>7</sup> It is higher among women (39%) than men (28%) and higher in rural (36%) as compared with urban areas (31%).

Although it is illegal to sell or serve alcohol to young people under the age of 18 in Namibia, the pervasiveness of home enterprises that sell alcohol (*shebeens*), and the acceptability of alcohol in social gatherings, means that alcohol is often easy for young people to obtain (Mufune, 2002).

## TEENAGE PREGNANCY

Although fertility rates are declining, Namibia has one of the highest birth rates in the world. Namibian women have on average 3.6 children; approximately 50% of them have their first child by the age 21.5 (DHS, 2006). Within this broader context, teenage pregnancy is high and, in recent years, has received much political attention. According to 2006 DHS data, one in seven young women aged 15-19 have already entered their childbearing years. Thirteen percent are already mothers, while 3% are pregnant with their first child. Young women in rural areas and those with no education are much more likely to be young mothers than their urban and educated counterparts. For example, young women with no education are 10 times more likely to have begun childrearing by age 19 than those who have completed secondary school.

Teenage motherhood comes with various risks and disadvantages for young women and their children. It necessarily entails the onset of sexual activity that is unprotected, placing the young mother at risk of HIV infection and also of passing the virus on to her unborn child if she is HIV positive. It often leads to interrupting or withdrawing from schooling, thus limiting their educational opportunities and their ability to compete in the formal labour market over the long term. Moreover, because marriage for both men and women comes at a relatively late age across all ages and education groups in Namibia<sup>8</sup>, most young mothers are single mothers, still financially and otherwise dependent on their relatives and family members. Lastly, because abortion is only legal in Namibia if a woman's life is at risk due to pregnancy or if she has been raped (and the case is being investigated), a legal abortion is not an option for most young women if the pregnancy is unplanned and unwanted.

## HIV AND AIDS

Sub-Saharan Africa (SSA) has been severely and disproportionately affected by the global HIV epidemic. With nearly two-thirds of all adults and children living with HIV and AIDS - approximately 25 million people - residing in sub-Saharan Africa, the region is classified as the worst affected by the epidemic (UNAIDS/WHO, 2006). In 2006 alone, it was estimated that 2.8 million people in SSA became infected with HIV (UNAIDS/WHO, 2006). Although in many countries in SSA, rates of new infection peaked in the late 1990s with overall HIV prevalence levelling off; in many Southern African countries prevalence rates are still exceptionally high. While there are indications that HIV prevention efforts are having significant positive effects in certain regions of Africa (World Bank, 2007; UNAIDS/WHO, 2007), it is indisputable that more needs to be done to prevent the spread of new infections.

In Namibia, similar to other countries with generalised epidemics, the main mode of HIV transmission is penetrative heterosexual sex among the general population. Within this context, adolescents and young people are particularly vulnerable to HIV and an important target of HIV prevention programmes. It is estimated that 50% of all new infections occur among young people aged 15-24. Adolescent girls, in particular, are at very high risk of being infected. In SSA, for example, more than two-thirds of newly infected 15-to-19 year olds are female (UNICEF/UNAIDS/WHO, 2002). Due to both biological and socio-economic factors, females are more susceptible to contracting HIV/AIDS than males. The disempowered status of women and girls in society often places females at greater risk, as they may have diminished power to practise safe sex and are sometimes victims of coercive sex and rape (Kopelman & Van Niekerk, 2005). A

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<sup>8</sup> The average age at first marriage among women and men aged 30-49 is 28.2 years of age for women and 35 years of age for men, respectively (DHS, 2006).

critical step in curbing the epidemic, therefore, is reducing the rate of new infections among young people, especially young women.

Although the HIV prevalence rate in Namibia is showing signs of decline, Namibia nonetheless remains one of the most seriously affected countries in the world. In 2007, the HIV prevalence rate among adults age 15 to 49 was estimated to be 15.3%, and it was estimated that 195 000 people, both adults and children, were living with HIV in 2007 (MOHSS 2008). 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), with antenatal prevalence rates as high as 40% in parts of the Caprivi strip, mother-to-child transmission is still a matter of serious concern (UNAIDS/WHO, 2006, pp. 13-14; The Government of Namibia MoHSS, 2008). Given that, by age 21, nearly 50% of young Namibia women will have had at least one child (DHS, 2006), preventing new infections among young women is an especially important prevention strategy for protecting the future generation.

Moreover, infection rates among young women are three times higher than that of young men and a cause for concern. Among young Namibian men aged 15-24, the rate of HIV infection is estimated at 4%, whereas for young women it is estimated to be 13% (The Government of Namibia MoHSS, 2008). The statistics are sobering and indicate that more must be done to prevent HIV transmission among young people.

## **SEXUAL BEHAVIOUR AND HIV RISK AMONG NAMIBIAN YOUTH**

This section reviews the literature on sexual behaviour of Namibian youth and their knowledge and awareness of HIV and AIDS. In the context of high HIV prevalence, early sexual debut, intergenerational sex, coercive sex, concurrent sexual partners, transactional sex, and inconsistent or incorrect condom use are all risk factors for HIV infection among young people (Harrison, Smit & Myer, 2000; Pettifor, Rees, Steffenson, Hlongwa-Madikizela & MacPhail, 2004). Promoting protective behaviours, such as delaying the onset of sexual activity, limiting sexual partnerships, as well as using condoms consistently and correctly is an important part of a broader HIV prevention strategy to minimise the risk of HIV infection among young people.

### **SEXUAL DEBUT**

According to the most recent DHS data, which is nationally representative, the average age of sexual debut for young Namibian women is 19 years, and for male youth is 17.7 years. Seven percent of young women aged 15-19 become sexually active by the age of 15 and 19% of young men aged 15-19 become sexually active by age 15 (DHS, 2006). Although this national data is indicative of broader trends, it also obscures important inter-regional differences and inflates the age of sexual debut for certain regions. For example, in Kavango, 19% of female youth (15-24) and 29% of male youth (15-24) had sexual intercourse before age 15.

Other studies, often limited to select regions, also show higher numbers and more alarming trends. Indeed, a UNICEF (2006) KAPB study surveying young people (15-24) in Kavango, Omaheke, and Ohangwena found that almost one third of young people sampled became sexually active by the age of 14. In addition, a recent study by NawaLife Trust surveying residents in Rundu, Walvis Bay, Keetmanshoop, and Oshakati suggests that the average age of sexual debut is becoming younger over time. Indeed, in their sample, 15-24 year-olds were more likely than respondents in older age groups to have had first sex at 15 years or younger; also, 37% of young men and 27% of young women had had their first sexual experience at 15 years or younger (Parker & Connolly, 2007).

In addition, among young people, male sexual debut is more likely to take place with a same-age partner, while female sexual debut is more likely to occur with an older partner (Schwarz, 2003). UNICEF (2006), for example, found that 42% of sexually active girls sampled had experienced sexual debut with an older partner – as much as 10 or more years older in some cases – in



comparison with only 17% of males. In high prevalence countries, intergenerational sex is especially problematic as youth with sexual partners 10 or more years older are considered to be at higher risk of infection because they are being exposed to a higher HIV prevalence age group (cf. Gregson et al, 2002).

## **MULTIPLE SEXUAL PARTNERS**

The mean number of total sexual partners for Namibian youth (aged 15-24) is 4.6 for young men and two for young women, with the mean number of sexual partners increasing with age. While male youth aged 15-19 have an average of 3.2 sexual partners, male youth aged 20-24 have an average of 5.6. Similarly, older female youth (20-24) have an average of 2.1 sexual partners while younger female youth (15-19) have an average of 1.7 (DHS, 2006).

As the data above indicates, the practice of multiple sexual partners is more of a male phenomenon than a female one. For example, according to 2006 DHS data, 3% of females (15-19) had had two or more partners in the previous 12 months, compared to 17% of males (15-19) who have had two or more partners. Other research suggests that these gender differences can be partly attributed to the social construction of masculinity in Namibia, where masculinity is associated with virility and having multiple sexual partners (Brown, Sorrell, Raffaelli, 2005; Mufune, 2003). Indeed, there seems to be little expectation among youth, particularly females, that their partners will be faithful, which creates certain kinds of risks for youth in relationships. For example, some youth report feeling less safe in a steady and allegedly faithful relationship than when having casual sex, as condom use in a steady relationship can be read as a sign of distrust (UNICEF Namibia, 2002). In addition, studies from other parts of Sub-Saharan Africa point to a different, more emotionally-tied, construction of faithfulness, where having a casual sexual partner in addition to a boyfriend/girlfriend is not necessarily regarded as being unfaithful (Thomsen, 2007). Thus, there appears to be numerous problems with the concept of 'faithfulness' as a means of HIV prevention, and the central message of 'faithfulness' that appears in the majority of HIV awareness campaigns is possibly doing more harm than good (Schwarz, 2003; UNICEF Namibia, 2002).

## **COERCIVE SEX**

Forced sex constitutes a significant problem for Namibian youth. Existing research suggests that as many as 10-15% of young people have been victims of coercive sex (Schwarz, 2003). Girls are particularly vulnerable. Twenty-four percent of girls surveyed as part of the UNICEF KAPB (2006) study reported being forced into their first sexual encounter. Clearly, such high reported rates of forced sex reflect a broader culture of violence against women and children. Although the data on domestic violence in Namibia is incomplete, available data suggests the normalisation of violence in sexual and romantic relationships. A study on domestic violence in Windhoek reported that 36% of ever-partnered women experienced physical or sexual violence from a partner (MoHSS 2003 in United Nations Namibia, 2004) In addition, according to DHS (2006) data, more than one third of women and over 40% of men agree that a husband is justified in beating his wife for reasons such as neglecting the children or going out without telling him. Moreover, nearly a quarter of men believe that if a woman refuses to have sex with her husband, he has the right to be angry and reprimand her. In terms of sexual violence, crime records from the Namibian police reveal a 28% increase in reported rape and attempted rape between 2000 and 2003 and it is estimated that approximately 40% of reported victims of sexual violence are children (United Nations Namibia, 2004, p. 43). High incidences of rape exacerbate the HIV/AIDS epidemic as the disparate power balances that characterise such an interaction do not allow for the negotiation of safer sex. Situations where boys experience forced sex at the hands of male perpetrators are particularly dangerous, as the anal-rectal area is easily torn during intercourse (Van Dyk, 2005), allowing for easier HIV transmission.

## TRANSACTIONAL AND INTERGENERATIONAL SEX

Transactional sex is seen to be common in Namibia, where girls obtain a 'sugar-daddy' and engage in sexual intercourse in exchange for gifts and commodities. According to Schwarz (2003), it is estimated that one in six young women have engaged in transactional sex. However, according to 2006 DHS data, only 1.5% of men surveyed (15-49) indicated that they have paid for sexual intercourse, suggesting that the phenomenon may not be as widespread as believed.

Problematically, DHS does not report on the number of women indicating that they have accepted money or commodities for sex.

In the context of transactional sex, unequal power balances mean that females are often less able to negotiate safer sex and less likely to leave risky relationships (Jewkes, Levin & Penn-Kekana, 2003; Mufune, 2002; Mufune, 2003; Tobias, 2001; Weiss, Whelan & Gupta, 2000), making young women particularly vulnerable to HIV/AIDS. However, young women themselves often buy into this discourse, as they expect money and material support in exchange for sexual relationships, and may seek to have their needs met elsewhere if their current partner cannot fulfil them.

Transactional sex is not necessarily poverty-driven; it may also reflect an attempt by young girls to obtain money for luxuries such as cell phones, clothing and cosmetics (LeBeau et al, 2001; Mufune, 2003).

Transactional sex is often intertwined with intergenerational sex, as it is older, working men who are more able to meet the socially-defined needs of young women. Soldiers, policemen, road-workers and government workers, in particular, are alluring due to their secure earnings (LeBeau et al., 2001). DHS data (2006) indicates that of those females (15-19) who had engaged in high-risk sex, 4% reported having had sexual intercourse with a man 10 or more years older. In the NawaLife Trust study, however, the numbers are much higher. Thirty-seven percent of Rundu females (15-24), 34% of Walvis Bay females (15-24), 23% of Keetmanshoop females (15-24) and 20% of Oshakati females (15-24) had a last sexual partner who was 10 or more years older than them (Parker & Connolly, 2007).

Such patterns of cross-generational sex are extremely dangerous as they amplify the risk of infection. Indeed, research indicates that for every year's increase in the age difference between partners, there is a 28% increase in the odds of having unprotected sex (UNAIDS, 2006). Reasons for such low rates of condom use include not only younger females' inability to negotiate condom use with a much older partner, but also the beliefs by some older males that they can be sexually rejuvenated by having unprotected sex with a young women, and that HIV/AIDS can be cured by their having unprotected sex with a virgin (Leclerc-Madlala, 2008).

## CONDOM USAGE AND PROTECTED SEX

Young adults who use condoms at first sex are more likely to sustain condom use later in life. Condom use at first sex serves as an indicator of reduced risk of exposure at the beginning of sexual activity (DHS, 2006). According to DHS (*ibid*) data, 64% of 15 to 19-year-old females and 53% of 15 to 19-year-old males used a condom at first sexual intercourse. Among 15-19-year-olds females who had had two or more partners in the previous year, 77% reported using a condom at last sex. Among 15-19-year-old males who had had two or more partners in the previous year, 84% reported using a condom at last sex. The NawaLife Trust study conducted in Rundu, Walvis Bay, Keetmanshoop and Oshakati also reports high rates of condom use, with the rate of condom use at last sex among youth (15-24) being 81% (Parker & Connolly, 2007).

Although existing data indicates that young people are using condoms, not enough is known about the extent of youths' condom knowledge; namely whether they know how to use a condom *correctly*. Studies often measure youths' perceived self-confidence to use condoms as a proxy for their condom ability; however, confidence to use condom does not necessarily translate into correct condom usage. UNICEF's (2006) study indicated that 74% of youth (15-24) believed that they knew how to use a condom. Schwarz's (2003) overview of the research conducted with

Namibia's youth also suggests high levels of confidence to use condoms among Namibian youth overall, with lower self-confidence in rural areas. However, it is important that more research is done on the youth's *actual* capability to use condoms.

In addition, the self-efficacy to use condoms and to prevent HIV may be negatively affected by certain beliefs that exist among youth. For example, Schwarz (2003) reports that 15-20% of youth do not believe that condoms prevent HIV. Among urban youth, 20-25% believe that condoms reduce sexual pleasure and 20-50% believe that the use of condoms in a relationship signifies distrust between partners. Youth report numerous obstacles to their use of condoms, including difficulty in accessing condoms, alcohol and drug abuse, disproportionate gender relations, sex for economic gain and knowledge-practice gaps (UNICEF Namibia, 2002). The use of condoms thus appears to be selective and inconsistent, varying from context to context (Schwarz, 2003). Importantly, additional research needs to be conducted to determine the consistency of condom use.

### **HIV/AIDS KNOWLEDGE AND AWARENESS**

Studies measuring HIV/AIDS-related knowledge and awareness among Namibian youth report mixed results. Two UN studies, for example, report high levels of HIV/AIDS knowledge among Namibian youth (15-24), with average scores on correct responses to questions on HIV/AIDS transmission and prevention ranging between 86% and 97% (United Nations Namibia, 2004; UNICEF, 2006). DHS data (2006), however, indicates lower levels of knowledge, as only 65% of females and 62% of males were said to have comprehensive knowledge about HIV/AIDS. However, knowledge levels were tabulated differently for each of the studies and are not directly comparable<sup>9</sup>.

Schwarz (2003) indicates a strong urban/rural divide in knowledge levels, with rural youth (particularly uneducated girls) still in need of basic information such as modes of transmission and prevention. DHS data (2006) reporting on a sample of the entire Namibian population indicates only slightly higher knowledge levels among the urban Namibian male population (70%) than among the rural male population (65%). Among the female population, however, urban Namibians have a greater level of HIV/AIDS knowledge (68%) than their rural counterparts (59%). These figures might suggest that the urban/rural divide in HIV/AIDS knowledge might not be as strong as originally proposed; however, this is impossible to know on the basis of available data. Schwarz (2003) also indicates that there is variation in knowledge levels with regards to age and school-going status, with older and out-of-school youth generally having higher knowledge levels. The UNICEF study (2006), however, found no differences in HIV/AIDS knowledge between younger and older youth.

According to Schwarz (2003) despite the fact that 80-90% of youth have knowledge about sexual and blood-to-blood transmission, there are significant gaps in specific HIV/AIDS knowledge. Knowledge about disease progression is very poor, as the relationship between HIV and AIDS is not understood. The 'window period' is also not understood and one in four young people believe that HIV is symptomatic. Between 10% and 20% of youth also have the misconceptions that HIV can only be contracted if they themselves are being unfaithful, as opposed to their partners being unfaithful, and that HIV can be prevented by contraceptives other than condoms. Schwarz (2003) also reports that a majority of youth, 80-90%, are aware that condoms offer protection against HIV/AIDS, but that misconceptions about HIV prevention also persist as youth do not understand the high level of reliability that condoms have, guessing down to about 60% safe. Among the

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<sup>9</sup> According to the DHS study, those defined as having 'comprehensive knowledge' could identify two ways of preventing HIV transmission and were also able to reject two common misconceptions about transmission in Namibia, namely that one can contract HIV by sharing food with an HIV+ person and also that one can contract HIV through a mosquito bite.

surveyed in-school youth (15-19) who participated in UNICEF's (2006) study, misconceptions also existed. Indeed although an estimated 85% knew about sexual and blood to blood transmission, 20% believed that HIV could be contracted by sharing cutlery with a PLWHA and 28% believed that HIV could be prevented by using contraceptives other than condoms.

Thus, despite overall high levels of HIV/AIDS knowledge, pockets of low knowledge exist which need to be addressed.

### **PERCEIVED SUSCEPTIBILITY**

The data suggests that Namibian youth are divided on the subject of their perceived susceptibility to contract HIV/AIDS. According to Schwarz (2003), about two thirds of youth believe that they are not at risk of contracting HIV. Youth reportedly believe that they are not at risk as they have adopted one of the three safer sexual behaviours - most often condom use or being faithful to one partner. A study that surveyed approximately 1500 respondents between 15-35 years of age found that 13% of young women (15-24) believe that they are not at risk because they themselves are faithful in their relationships (SIAPAC/SMA study cited in Schwarz, 2003). According to UNICEF (2006), more than one in five Namibian youth surveyed, reported feeling that they were not at risk to contract HIV. Some seem to have a false sense of security when it comes to their HIV risk. On the other hand, others seem to be overwhelmed by the threat of contracting HIV, and hold a fatalistic outlook. A 2003 RFS study (cited in Schwarz, 2003) reported that 40% of Windhoek youth (15-24) did not believe that their personal choices would make a difference regarding their risk of HIV infection.

A 2002 UNICEF Namibia qualitative study provides a more in-depth probe into issues surrounding young people's perceived level of HIV risk. Interviewees reported feeling very much at risk of contracting HIV, despite the fact that they were informed about the virus. This high level of perceived risk was related to very low levels of perceived self-efficacy. For example, many felt that they had no control over whether they contracted HIV/AIDS due to the unfaithfulness of their partners. They also felt unsafe because of alcohol use during their sexual encounters, which often resulted in unsafe sex. Girls, in particular, felt very powerless due to a perceived inability to negotiate condom usage with sexual partners. Research regarding the Namibian youth's perceived susceptibility to contract HIV thus yields mixed results. More research, particularly qualitative, needs to be carried out to better understand youth's perceived risk.

### **SOURCES OF HIV/AIDS KNOWLEDGE**

There is a paucity of research on the sources from which youth obtain HIV/AIDS information. Available research suggests that there are important rural/urban differences in one's exposure to HIV/AIDS sources. For urban youth, HIV/AIDS awareness campaigns comprise an important source of HIV information (Schwarz, 2003). A qualitative study conducted with 64 young people (17-26) in the rural, urban and peri-urban areas of Oshakati (UNICEF Namibia, 2002) also found that newspapers, radio and TV are seen as reliable sources of good quality information by urban youth. Interactive newspapers where young people can write in and get their questions answered are highly valued, but the posters, pamphlets and advertisements of many awareness campaigns are beginning to be seen by the urban youth as old and repetitive, and are criticised for not providing in-depth detail or ways of putting the hypothetical slogans into practice in the real world. Urban participants reported feeling comfortable talking to their friends about HIV/AIDS issues, but feared that the information gained is not accurate. Communication with parents about sex and HIV/AIDS seems to be getting slightly easier in urban areas, particularly between male youth and their fathers.

Among rural participants in the UNICEF Namibia (2002) study, access to HIV/AIDS knowledge differed from that of the urban youth. Young participants in the rural areas reported having less access to sources of HIV/AIDS information than their urban counterparts. Their access to

awareness campaigns is often limited to clinics in the area. Rural youth also do not seem to talk to their peers about sex and/or HIV/AIDS, and communication with their parents about such issues is almost impossible, particularly for rural girls. Like their urban counterparts, rural youth, particularly females, are active information-seekers and attempt to gain information wherever possible. School-based HIV prevention programmes remain an extremely important source of HIV-related information for both urban and rural youth, although rates of enrolment may be lower in rural areas.

## **PEER EDUCATION AND YOUNG PEOPLE**

The following section reviews the literature on peer education and life skills programmes. It outlines core concepts, critically examines the research evidence, and identifies key programme components associated with best practice.

### **BACKGROUND AND RATIONALE**

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 (schools, universities, workplaces, churches, street settings, community halls) to promote various health-positive behaviours (stopping smoking, violence prevention, substance use, HIV prevention, etc). Compared with more individualised modes of health promotion and delivery, peer education programmes target the peer group as the unit of change and use an individual from the target group (i.e. 'peer educator' or 'peer facilitator') as the agent of change.

Although an established strategy in health promotion, peer education is nonetheless difficult to define with precision or clarity (Bastien, Flisher, Mathews, & Klepp, 2008). Defined variously as a process, methodology, communication channel, and tool (Adamchak, 2006, p. 5), the activities and strategies that fall within the ambit of peer education vary considerably depending on the programme, context, and target group. It is perhaps best understood as an 'umbrella term' and intervention modality (Shiner, 1999).

### **PEER EDUCATION AND HIV PREVENTION**

Over the past decade, peer education programmes have gained particular prominence within the context of adolescent sexual and reproductive health, in particular in HIV prevention. Generally speaking, the goal of such programming is to promote the development of knowledge, attitudes, beliefs, and skills that will enable young people to engage in healthy behaviours and improve their reproductive and sexual health outcomes – i.e. prevent unintended pregnancies, STIs and HIV.

Facilitated by peers of the same, or similar, age who come from similar backgrounds, HIV prevention peer education programmes recognise the important role peers play in influencing young people's behaviour. They reflect the premise that young people are more apt to alter their behaviour if the peers they trust and like advocate change. Evidence indicates that the peer group is a primary influence in the lives of adolescents, such that both risk-taking and non-risk taking behaviours are learned through peer relationships (Pearson & Michell, 2000).

In matters relating to sexuality, reproductive health and HIV, there is also the view that young people are more likely to speak openly, engage with and learn from peers than with authority figures like teachers or health workers (UNAIDS, 1999; Campbell, 2004). An alternative to professional-led models of HIV prevention, peer facilitators are meant to both teach and model desired behaviour. The working assumption is that the peer facilitator, as a role model, will reinforce learning and influence group norms through both the formal programme and informal interactions.

Although methods applied to youth peer education vary, such programmes often use interactive, participative techniques that seek to generate shared knowledge rather than didactic methods that

seek to impart knowledge (UNAIDS, 1999, Campbell, 2004). They generally unfold over a period of time and include information dissemination, skill building, and ideally, the renegotiation of peer norms.

In HIV prevention, peer education programmes are popular for various reasons. Commonly cited reasons include: peer programmes can reach young people at lower costs compared to professionally-trained and paid staff; they present opportunities for young people to gain work experience and develop professionally; they can reach those who are difficult to reach through conventional educational methods (Backett-Milburn & Wilson, 2000; Milburn, 1995; Turner & Shepherd, 1999).

While peer education as a health promotion strategy for young people is popular and generally viewed in positive terms, evidence of its effectiveness is mixed and not clearly established. Much of the literature on peer education is descriptive and anecdotal, and most peer education programmes have not been rigorously evaluated using experimental or quasi-experimental designs. Much of the evidence that is available is qualitative in nature, focused on process rather than outcomes (Orme & Storkey, 1999). Through a systematic review of more than 200 evaluations of peer education programmes for young people, Harden, Oakley and Oliver (2001) concluded that there was little support for the 'common sense assumptions' on which the peer education approach is based, or for its effectiveness when compared with other methods of health promotion. Mellanby, Rees and Tripp (2000) similarly found that, although there are indications that peer-led, school-based health education programmes can be at least as, if not more, effective than adult-led education, the evidence is not conclusive, due to the methodological and analytical limitations of studies. A randomised, controlled trial conducted by Borgia, Marinacci, Schifano and Perucci (2005) in Italy found that the only benefit of an HIV prevention peer-led programme was greater improvements in knowledge of HIV. There were no reported improvements in sexual behaviour (condom use or number of sexual partners) for either group. Also, rather than privileging one over the other, it may rather be that both adults and peers have an important role to play in effective school-based sex education, and more work needs to be done to identify which components are more appropriately delivered by adults, and which by peers (Mellanby, Newcombe, Rees & Tripp, 2001).

In addition, although the cost-effectiveness argument for peer education is attractive, its relative cost-effectiveness vis-à-vis other intervention strategies has not been tested. There are, for example, no rigorous comparisons of the cost-effectiveness of training peer facilitators versus other kinds of facilitators (teachers, health workers, etc). Moreover, when implemented properly, peer education "requires intensive planning, coordination, supervision, and resources" as well as careful budgeting and monitoring (Adamchak, 2006, p. 5).

Other critiques of peer education relate to its theoretical basis, or lack thereof. In their review of the literature, Turner and Shepherd (1999) argue that there is little reference to theory in the literature on peer education; peer education thus is "a method in search of a theory" rather than the application of theory to practice (p. 235). This is not to deny that various theories, such as Social Learning Theory (Bandura, 1986), the theory of participatory education (Freire, 1993), and Diffusion of Innovations Theory (Rogers, 1983) have been applied to peer education<sup>10</sup>, but to say that peer education has not been born of a strong theoretical base that would give credence to its effectiveness as a method.

That said, despite the limitations of the evidence, there is general agreement that peer education is a useful strategy in HIV prevention among young people. Criticism of peer education may in fact reflect poor implementation rather than peer education itself being inherently problematic (Swartz, 2003). In general, evaluations of peer education programmes promoting safer sexual behaviour and HIV prevention in sub-Saharan Africa and elsewhere provide some evidence that, if designed

and implemented properly, peer education can have positive impacts on young people's knowledge, attitudes, self-efficacy and, to a lesser extent, behaviour for both peer facilitators and their target peers (Aarons, Jenkins, Raine, El-Khorazaty et al, 2000; Aggleton & Campbell, 2000; Audrey, Cordall, Moore, Cohen et al, 2004; Bhana, 2007; Campbell, 2005; Campbell & MacPhail, 2002; Caron, Godin, Otis & Lambert, 2004; Jemott, Jemmott & Fong, 1998; Kelly, 2004; Klepp, Ndeki, Seha & Hannan et al., 1994; MacPhail & Campbell, 2001; Mellanby et al., 2000; Morrow, 1999; Ozer, Weinstein, Maslach & Siegel, 1997; Plummer, Wight, Wamoyi, Nyalali et al., 2007; Shuey, Babishangire, Omiat & Bagarukayo, 1999; Visser, 2007; UNICEF/UNAIDS/WHO, 2002; United Nations, 2003).

In her literature review on community-based peer education programmes targeting youth in lower income countries,<sup>11</sup> Eleanor Maticka-Tyndale concluded that peer-led interventions were effective in connecting young people to services and distributing HIV prevention resources. Broadly speaking, 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, use of condoms). However, changes in other aspects of sexual behaviour, particularly in terms of increasing abstinence were limited (Adamchak, 2006). More generally, a review of 11 evaluated school-based HIV prevention programmes for African youth (Gallant & Maticka-Tyndale, 2004) as well as a systematic review of school-based sexual health interventions in Sub-Saharan Africa (Paul-Ebhohimhen, Poobalan, and Van Teijlingen, 2008) reached similar conclusions. While programme effects often include statistically significant effects on knowledge and attitudes, behaviour is much more challenging and difficult to change.

This may be partly due to the problematic assumption that there is a linear relationship between knowledge, attitudes, and behaviour. Many HIV prevention campaigns are grounded in cognitive theories and premised on the assumption that an individual's sexual behaviour is the outcome of a rational decision-making process, such that increased HIV/AIDS knowledge enables a shift in attitudes which then leads to the adoption of safer sexual behaviour (Parker, 2004; Rompel, 2005). Indeed, the assumption that high HIV/AIDS knowledge necessarily translates into safer sexual behaviour has been reported as erroneous (Campbell, Foulis, Maimane & Sibiya, 2005; Eaton, Flisher & Aaro, 2003; Harrison, Smit & Myer, 2000; Hartell, 2005; Kelly, Parker, Oyosi, 2001; MacPhail & Campbell, 2001; Parker, 2004; Paul-Ebhohimhen et al., 2008; Rompel, 2005; Thomas, 2004; Van Zyl, 2003). While access to HIV/AIDS information is necessary and important, it is insufficient on its own to bring about behavioural risk reduction (Johnson, Carey, Marsh, Levin, Scott-Sheldon, 2003; Rompel, 2005).

Hartell (2005), for example, emphasises that behavioural interventions need to involve not only the dissemination of knowledge, but also the introduction of life skills. A meta-analysis of prevention interventions conducted by Johnson et al (2003) found that behavioural interventions that both supplement adolescents' existing HIV/AIDS knowledge and strengthen their skills for sexual discussion, sexual negotiation and condom use are more likely to reduce their risk of infection than other interventions. Similarly, a meta-analysis conducted by Schaalma, Kok, Abraham, Hospers, Klepp and Parcel (2002) found that effective school-based interventions were those that developed sexual communication and negotiation skills, that acknowledged the role of contextual factors in youth's sexual behaviour, and that worked to increase the personalisation of risk.

## **SCHOOL-BASED LIFE SKILLS PROGRAMMES**

As discussed above, life skills programming developed with the growing recognition that building knowledge alone is not an effective strategy for promoting risk-reduction behaviour (Campbell et al., 2005; Hartell, 2005; Parker, 2004). Rather it must be part of larger efforts to help young people develop the life skills necessary to put knowledge into practice and reduce their vulnerability to

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<sup>11</sup> Of the 34 studies that met the evaluation criteria, 19 of the programs were in Sub-Saharan Africa.

HIV. While peer education programmes often incorporate a life skills approach, it is important to note that some life skills programmes are adult- or teacher-, rather than peer-led.

Available research from other African countries shows that life skills programmes have few positive outcomes for adolescents of high school age. For example, an evaluation of a Ugandan life skills programme, which included basic HIV/AIDS information, role-play activities, and condom and negotiation skills, found no significant 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 concluded that the life skills programme in fact had very little effect (Kinsman, Nakiyingi, Carpenter, Quigley, Pool & Whitworth, 2001).

Similarly, an evaluation of South African life skills programmes at secondary schools showed that the programmes only had a positive effect on HIV/AIDS knowledge, but no positive effects on attitudes, self-efficacy or sexual behaviour. The study highlighted problems in the quality and consistency with which life skills programmes are implemented, as only those that had been *fully* implemented, demonstrated improvements with regard to sexual attitudes and feelings of social support. Furthermore, 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 (James, Reddy, Ruiter, McCualey, & van den Borne, 2006).

Life skills programmes with primary school learners, however, have had more positive effects. An evaluation of a Tanzanian life skills programme at primary school level showed the intervention group to have not only higher levels of HIV/AIDS knowledge than the control group, but also safer sexual norms and intentions (Klepp, Ndeki, Leshabari, Hannan et al., 1997). Furthermore, an evaluation of a Ugandan life skills programme at primary school level showed a significant decrease in sexual activity among the intervention group, with sexual activity in the control group remaining unchanged. The intervention group also had a significant decrease in the number of sexual partners, while the number of partners for the control group was unchanged (Shuey et al., 1999).

This is in line with research findings showing that interventions introduced at a younger age, before individuals begin to engage in high-risk behaviours, are more successful than those attempting to modify already established behaviours (Gaskins, Beard & Wang, 2002; Gillian, Eke, Aymer & O Neil, 2001; Maypole, Schonfeld, O'Hare, Showalter & Cicchetti, 1998).

Similar to other HIV prevention programmes for youth, the life skills paradigm is conceptualised within a rationalist framework where it is assumed that, if life skills regarding decision making and communication are taught, they can simply be applied to numerous different situations, thereby reducing one's risk of HIV infection. However, the *contexts* within which youth live can constrain their individual ability to have rational control over their actions, and the *context* within which the life skills programme is implemented can hamper its effectiveness. A lack of regard for these contextual constraints may explain why there is little evidentiary support for HIV/AIDS Life skills programmes, particularly in developing countries (Boler & Aggleton, 2004).

Such contextual factors include: the assumption that life skills teachers, used to didactic teaching methods, can simply and easily switch over to participatory methods with minimum training; the lack of buy-in from schools and teachers due to lack of ownership; school environments where the rights and opinions of learners are not taken seriously and where sexual harassment is tolerated or even encouraged; school environments characterised by poverty and a lack of facilities and resources (Boler & Aggleton, 2004).

Indeed, a review of the evidence of both peer education and life skills programmes indicates the need to pay greater attention to the broader social contexts in which young people live, which can hinder behaviour change and undermine well-intentioned programmes (Aggleton & Campbell, 2000; Bhana, 2007; Campbell & MacPhail, 2002; Campbell & Mzaidume, 2001; Loewenson, 2007;



Tawil, Verster & O' Reilly et al., 1995; Weiss, Whelan & Gupta, 2000;). Peer education life skills programmes do not unfold in a vacuum and, as Campbell (2004) illustrates, the social and school environments can be enabling or disabling. Without supportive, health-enabling environments, a well-designed programme can easily be undermined. Campbell et al. (2005) have identified three "interacting dimensions of context" that can undermine the likelihood of effective HIV prevention, namely: the symbolic context (i.e. the stigmatisation of youth sexuality, particularly female sexuality); the organisational/network context (differing strategies and messages of civil society, government, and the private sector at the local level); and the material-political context (poverty, unemployment, and crime). They cogently argue for the need to situate youth HIV prevention programmes within the broader context of youth and social development (p. 471).

## **BEST PROGRAMME PRACTICES**

Given the limitations of the research evidence, it is not possible to recommend any given model as a best practice model for peer education/life skills programming in HIV prevention among young people, or even to define what the critical elements are within the context of a comprehensive HIV strategy that will actually reduce HIV risk behaviour or incidence. Nevertheless, a review of the programmatic literature reveals general agreement on some of the key components of well-designed and implemented peer education programmes. These include:

### **NEEDS ASSESSMENT**

For peer education programmes to be successful, it is fundamental that the needs of the target population are identified. Needs analysis, baseline surveys and pilot studies can determine whether peer education would be an effective intervention strategy for a population and what the specific needs of the population are (Campbell, 2005; Population Council, 2000; UNICEF, 1999). In this way, a peer education programme can be tailor-made for the target population. To determine the needs of the target population, it is necessary to communicate with both the targeted population and other key stakeholders (Population Council, 2000; UNICEF, 1999). Furthermore, needs assessment should not merely take place prior to implementation; there should be constant evaluation and modification of the programme to ensure that the target groups' needs are being met. Analyses regarding cost-effectiveness are useful in determining whether implementation of a peer education programme is a more prudent investment than other interventions (UNICEF, 1999).

### **SUSTAINABILITY**

Because peer education generally relies on volunteers, it is often mistaken to be an inexpensive HIV prevention strategy. However, peer education is neither a cheap nor an easy option, as it requires great investment in order to adequately train, support and supervise peer educators, equip them with resource material, and compensate them for their involvement. Garnering financial resources is thus crucial for the sustainability of peer education programmes (Population Council, 2000; Walker & Avis, 1999).

Certain strategies have proven successful in bringing about greater programme sustainability. These include: partnering with health clinics and thus generating income from clinic fees and condom sales; creating community funds from the interest on small loans; profiting from the sale of comic books, t-shirts and so forth; integrating peer education programmes into the curricula of already-existing institutions, such as schools; providing empirical documentation of the programme's success to encourage continued funding from donors. Stakeholders such as Principals or even learners are not simply gatekeepers but also play a fundamental role in the success of the peer education programme. It is thus vital that the target population and important stakeholders are involved in the design of the programme even prior to implementation, to ensure their greater sense of ownership of the programme, and thus a greater buy-in from these parties. Stakeholders also need to be shown the various ways they can benefit from the peer education programme, in order to increase their support for it. Overall, peer education programmes need

short-, medium- and long-term strategies for sustainability (Population Council, 2000; UNICEF, 1999).

### **SELECTION AND RECRUITMENT OF PEER FACILITATORS**

The selection and recruitment of peer facilitators needs to be done carefully, as they are a crucial determinant in the quality and success of a peer education programme. The definition of, and selection process for, peer educators often differ from programme to programme. It is thus vitally important that clear definitions regarding the role of a peer facilitator are developed, together with clear criteria to guide the selection of peer facilitators (Population Council, 2000; UNICEF, 1999). By definition, peer facilitators should be selected from the target group, so that they are not only similar in age but also share a similar socio-economic background (Campbell, 2005; United Nations, 2003). The recruitment of peer educators should not simply be the prerogative of programme managers; the target population and important stakeholders should also be consulted (Campbell, 2005; Population Council, 2000; UNICEF, 1999). This would not only ensure their sense of ownership of the programme, but would increase the acceptability of peer facilitators in schools, communities and other targeted settings (Campbell, 2005; United Nations, 2003). It is important that facilitators have a full understanding of their role and the programme objectives, and that they are fully committed to programme goals (Adamchak, 2006).

### **TRAINING OF PEER FACILITATORS**

Peer facilitators need to be equipped not only with factual information to impart to learners, but also with specific methods to disseminate such knowledge. It is important that these methods do not take the form of didactic teaching, as the didactic method constructs learners as passive 'information-receivers' and fails to empower young people to take ownership and control over their sexual and reproductive behaviour (Bhana, 2007; Buthelezi et al., 2007; Campbell, 2005; Campbell & MacPhail, 2002; MacPhail & Campbell, 2001). Peer facilitators need to be trained through the use of role plays, story telling, songs, art, games, video documentaries and group work. They also need to be able to use these methods in their own programmes, as it is such methods that lead to critical thinking and the enhancement of learning (Bhana, 2007; Buthelezi et al., 2007; Campbell, 2003; Campbell, 2004; Campbell, 2005; Campbell & MacPhail, 2002; Freire, 1993; MacPhail & Campbell, 2001; Norris et al., 2007; Pattman & Cockerill, 2007; United Nations, 2003). Furthermore, high quality peer education training necessarily involves life skills training in planning, organisation, decision making, self-awareness, interpersonal and group communication skills, group management skills, and basic and counselling skills (Adamchak, 2006; United Nations, 2003; Walker & Avis, 1999). The peer facilitator needs to have the ability to model such skills as well as to cultivate them in learners (Campbell, 2004; Campbell & MacPhail, 2002; Freire, 1993, Walker & Avis, 1999). The facilitator needs to engage learners in problem-solving dialogue about behaviour change and the gender and socio-economic obstacles that hinder behaviour change. Facilitators should also have a prominent role in the designing of the training curriculum and materials. In terms of quality assurance, the facilitators' competency should be assessed once training has concluded (Population Council, 2000). In order to maintain a certain level of quality regarding facilitation, it is imperative that facilitators receive refresher training after a period of time (Population Council, 2000; United Nations, 2003).

### **RETENTION OF PEER FACILITATORS**

Due to the nature of peer education, the turnover of peer facilitators leads to the need for regular recruitment and training. While retention will always be limited because peer facilitators grow out of programmes and pursue other life goals, there are other reasons that they leave, including burnout, boredom, stress and inadequate compensation (Adamchak, 2006). Various strategies can be used to stem high facilitator turnover and enhance retention. These include:

## **Compensation**

It is essential to motivate peer facilitators through different forms of incentive, recognition or compensation (Campbell, 2005; Population Council, 2000; UNICEF/UNAIDS/WHO, 2002; United Nations, 2003). A modest honorarium paid to peer facilitators helps to build a sense of accountability and to maintain continuity. This is especially necessary for young people from low-income families, who may have financial responsibilities towards their families (Adamchak, 2006). In the light of the costs associated with dropouts and training, it can be difficult to determine which type of compensation would be most cost-effective. One option is a tier system, whereby the compensation given to a peer educator is determined by his/her level of responsibility, quality of performance and time contributed to the programme. However, for such compensation to be viewed as valuable by the peer educators, it is vital that it be based on context-specific standards and values (Population Council, 2000).

## **Social support and supervision**

In addition to material incentives, it is crucial that peer educators are given psychological and emotional support. Periodic individual and group sessions can help facilitators cope with stress and burnout, and thus prevent high turnover. Creating a social support network among peer facilitators can facilitate the exchange of ideas and experiences, thus allowing them to develop courage and wisdom from each other (Adamchak, 2006; Population Council, 2000). Support also takes the form of supervision that both monitors and motivates. This can be done by observing facilitators regularly in the field, as well as by holding meetings and providing them with feedback (Population Council, 2000; United Nations, 2003).

## **Sense of ownership of programme**

To improve retention rates, it is important not only to ensure a manageable scope of work, but also that the facilitators feel a sense of their responsibility and decision-making authority in the programme (Population Council, 2000). This can be accomplished by involving peer educators in programme design, implementation and evaluation, and by ensuring that peer educators have ongoing access to programme material, resources and updated information (Adamchak, 2006; Population Council, 2000). It has even been suggested that for a maximum ownership of the programme by facilitators and the community to be achieved, a plan needs to be implemented that gradually passes control and maintenance of the programme over to the facilitators and the community (Population Council, 2000).

## **Personal and professional development**

Research has shown that peer education programmes that include personal development opportunities for facilitators tend to be more successful. Similarly, as many peer facilitators are from disadvantaged communities and struggle to support themselves and their families, if the skills they acquire can enhance their financial independence, they are much more likely to remain in the programme (Population Council, 2000; United Nations, 2003).

## **Linkage with other programmes and services**

The absence of youth-friendly reproductive health services can compromise the impact of a peer education programme among young people (Aggleton & Campbell, 2000; Aggleton, Chalmers, Daniel & Warwick, 1996; Allen, 1991; Campbell, 2003; Campbell, 2004; Campbell & MacPhail, 2002; Campbell et al., 2005; Hughes, 1999; MacPhail & Campbell, 2001; Population Council, 2000; Tawil et al., 1995). In the context of HIV prevention, it is likely that peer education programmes will increase the demand for condoms, voluntary counselling and testing (VCT) services and treatment for sexually transmitted infections (STIs) (United Nations, 2003). Available research evidence indicates that, when young people learn how to use condoms, they should also have easy access to them. And when young people suspect that they have contracted STIs, they need access to clinics where they can receive counselling and treatment without being judged. When such services are

not easily accessible and confidentiality cannot be assured, young people are more likely to hide their infections until it is too late (United Nations, 2003, p. 34).

Linking HIV peer education programmes with other programmes and services has the potential to improve young people's sexual behaviour. Increasing awareness and training clinic staff to be sensitised to the needs and concerns of young people is one way to make health services more 'adolescent-friendly.' It has also been suggested that clinics could be more effective if peer facilitators were recruited to provide VCT services and condoms to clinic attendees (UNAIDS, 2003). There is also the option of linking peer education programmes to social marketing programmes, such as those of pharmacies and clinics in the community, to ensure easy access to condoms and youth-friendly services (Aggleton & Campbell, 2000; Campbell, 2001; Campbell, 2003; Campbell, 2004; Campbell, 2005; Campbell & MacPhail, 2002; MacPhail & Campbell, 2001; United Nations, 2003).

The integration of sexual health services with the efforts of other agencies has been effective in a number of developed countries. For example, improvements in adolescent sexual health in Norway, Greece and the Netherlands have been attributed not to a single factor, but to the combined improvements in condom supplies, sex education and laws. Also, in France, Switzerland and the Netherlands, interventions to prevent STIs and unplanned teen pregnancy were more successful when integrated (Aggleton & Campbell, 2000).

## **MONITORING AND EVALUATION OF PEER EDUCATION PROGRAMMES**

It is difficult to monitor and evaluate the impact of peer education programmes, as it is still not really known what mechanisms actually underlie their successes or failures (Campbell & MacPhail, 2002). Furthermore, programmes do not exist in isolation and it is thus difficult to attribute behaviour change to a programme, as opposed to contextual or environmental factors. Behaviour 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, a programme that results in increased knowledge does not necessarily have a significant impact on behaviour (Campbell, 2005). The fact that donors do not provide sufficient funds for evaluation of peer education programmes also acts as an obstacle to adequate monitoring of the programme (Population Council, 2000). Despite such challenges, it is imperative to find quality methods of evaluating and monitoring peer education programmes, as it is only through M&E activities that these programmes can be improved.

### **Monitoring**

Process evaluations are an important part of monitoring peer education programmes. They may include: field visits, activity reports, regular meetings, focus group discussions and qualitative surveys with young people and peer facilitators. It is through such monitoring activities that progress can be assessed and improvements can be made. There are limited instances where comprehensive methodologies are being used in order to assess the process of peer education programmes; this is often a result of the fact that little is known about the processes involved in such interventions, and that there is little evidence about their effectiveness. An exception exists in the case of Ghana and Thailand, where a social network analysis has been used to address process issues such as recruitment, supervision, retention, initiation and intensity of contacts, quality/accuracy of information, and referrals to other services (Population Council, 2000).

### **Evaluation**

Outcome evaluations also need to be conducted, and there is a real need for more longitudinal studies to be conducted in order to evaluate behavioural changes over longer periods of time (Population Council, 2000; UNICEF, 1999). There are limited instances where comprehensive and innovative methodologies are being used to assess peer education programmes. One such instance is in South Africa where the South African Training Network has designed a planning, M&E

framework used to track inputs, outputs, coverage and the behavioural and biomedical impact of peer education programmes. The framework has been applied to over 40 peer education projects in the region, enabling the documentation of process and impact indicators in the participating programmes.

## MY FUTURE IS MY CHOICE (MFMC) PROGRAMME

### DESCRIPTION

My Future is My Choice is one example of a peer education, life skills, HIV-prevention training programme. First piloted in 1996 in Namibia, the programme was scaled up in 1998 and has been in operation for 10 years. In 2003, it became an official extra-curricular life skills programme of the Ministry of Education at secondary and combined schools.

The MFMC programme seeks to equip young people with information and skills to improve their ability to make healthy choices and reduce high-risk behaviours. The focus of the programme is on protecting young people from HIV infection and sexually transmitted diseases, and preventing unintended pregnancies.

Premised on a peer education model, the intervention is delivered *by* young people – ‘peer facilitators’ – *to* young people. The peer facilitators are meant to be role models to the adolescents who participate in the programme. The style of teaching is facilitative rather than didactic in nature. The role of the peer facilitator is to empower participants to make healthy choices and decisions about their lives, particularly vis-à-vis their sexual health and HIV prevention, rather than telling young people what to do.

The programme targets both in-school (Grade 8 – 12) and out-of-school (15-25 years) youth and involves 20 hours of participatory training and activities. It is composed of 10 two-hour sessions that cover topics such as HIV transmission and prevention, reproductive and sexual health, pregnancy, how to use a condom and femidom, communication skills, practising assertiveness, decision making, and substance use/abuse. Each session starts with an activity or game; it then includes revision of the previous session, and has a new topic that imparts knowledge and teaches specific skills. Some activities are mandatory and others are optional. (See Figure 1 below for a detailed description of the curriculum)

Once they are trained and assigned to schools, facilitators are responsible for signing up a group of between 20-22 participants, with an equal gender split. In practice, more young women than young men sign up for the course. In addition, UNICEF recommends that 15-16 year olds and 17-18 year olds be separated into two different groups, as there is a greater likelihood that the older cohort will be sexually active, and safe sex messages will be more important than delaying the onset of sexual intercourse.

School-based sessions generally run over a three to five week period as an extra-curricular school activity. Community-based sessions for out-of-school youth are meant to be spread over a number of weekends. Each programme participant receives an MFMC workbook and those that attend all 10 sessions graduate and receive a certificate.<sup>12</sup> Upon completion of the programme, MFMC graduates are encouraged to continue with post-MFMC activities, such as creating AIDS awareness clubs, etc.

The rollout of the MFMC programme in schools is decentralised and planned at the regional level. In some regions, the MFMC programme is offered to all schools; in others, schools are selected on a more ad hoc basis, such as need, location, and interest of Principal/teachers.

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<sup>12</sup> In previous years, participants received a t-shirt upon completion of the programme. This incentive however was discontinued in 2007.

**Figure 1: MFMC Course: Overview of sessions and topics**

Session	Content
<b>Session 1: Getting Started</b>	Group rules Building trust Puberty and changes in our body
<b>Session 2: Reproductive Health</b>	Pregnancy and reproductive health Consequences of teen pregnancy Methods of contraception
<b>Session 3: HIV &amp; STIS: The Facts</b>	HIV and STI transmission (including MTCT) Identifying high danger, low danger, no danger sexual activities Myths about HIV/ AIDS ( <b>Optional</b> ) Signs and symptoms of an STI
<b>Session 4: HIV &amp; AIDS: Reducing the Risks</b>	Self-assessment of risk ABC model of prevention and its limits Strategies for abstaining or delaying sex How to use a condom Negotiating the use of a condom ( <b>Optional</b> )
<b>Session 5: Facing HIV and AIDS</b>	Stigma and discrimination against PLWHA Voluntary Counselling and Testing Treatment and ARVs
<b>Session 6: Decisions, Choices and Consequences</b>	Decision making Decision making & risk taking Understanding who/ what influence our decisions (parents, peers, teachers/school, media)
<b>Session 7: Communication</b>	Different ways of communicating Practising Assertiveness Saying no Negotiating no ( <b>Optional</b> )
<b>Session 8: Values and Relationships</b>	Identifying values Understanding gender roles in relationships Difference between a good and bad relationship
<b>Session 9: Alcohol and Drugs</b>	Health and social risks of alcohol and drug abuse Attitudes towards drinking and drugs Saying no to alcohol and drugs under peer pressure
<b>Session 10: Our Future</b>	Commitment for behaviour change (pledges) Plan graduation ceremony and ongoing peer activities (w/contact teacher)

Source: MFMC Management Guide for RACE, 2005

## **ROLE OF THE PEER FACILITATOR**

The quality of the peer facilitator, as the agent of intervention delivery, is the most critical aspect of the MFMC programme. Facilitators are recruited locally and selected by the school where the intervention will take place. Prospective facilitators are interviewed by a panel that generally includes the school Principal, the MFMC contact teacher, circuit inspector, and/or the MFMC Coordinator. Selected candidates are sent for a 10-day training course and are appointed as facilitators only on successful completion of the course. Candidates must achieve 70% of a total evaluation score.

Importantly, peer facilitators are volunteers rather than employees. They receive an incentive rather than a salary for their facilitation of the courses (approx N\$ 500 per course plus a transport allowance). A peer facilitator generally facilitates four courses per school year, three of which are school-based (learners) and one of which is community-based (out-of-school youth). Most facilitators earn approximately N\$2000 per year through the MFMC programme.

The minimum requirements in recruiting a peer facilitator are as follows. The facilitator should:

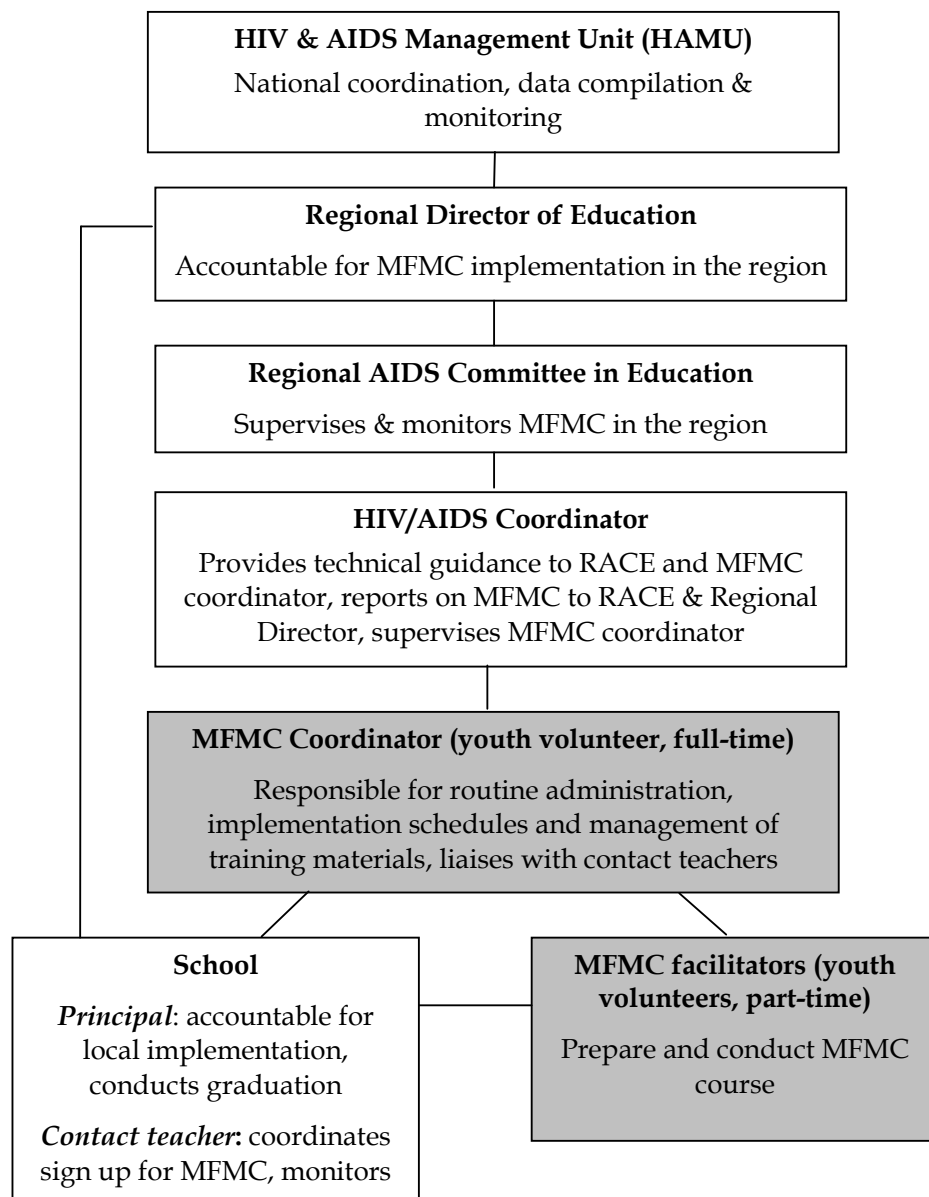
1. Be a young person (no older than 22 at inception);
2. Have completed Grade 12;
3. Live in the area (town, village) where the course will be taught;
4. Have a desire to help young people and to be a volunteer;
5. Be recommended by two community members;
6. Be proficient in English;
7. Have strong communication skills;
8. Be self-confident and assertive.

## **MFMC PROGRAMME MANAGEMENT STRUCTURE**

At a national level, the HIV& AIDS Management Unit (HAMU) of the Namibian Ministry of Education functions as the national secretariat of the MFMC programme. At the regional level, the responsibility for the implementation of the MFMC programme lies with the Regional AIDS Committees for Education (RACE), which is tasked with routine oversight and periodic evaluation of the programme. These roles and responsibilities are the sphere of the RACE Coordinator. Each region also has a MFMC Coordinator, also a volunteer position with a stipend, who reports directly to the RACE Coordinator and is responsible for routine administration of the programme and necessary documentation (i.e. course schedule, sign-up list, attendance records, evaluation of facilitators' forms, and course completion forms), the management and distribution of training materials, as well as liaising with contact teachers at participating schools.

Each participating school and Principal specifies a contact teacher for the MFMC programme. The role of the Principal is critical: s/he provides leadership for the overall implementation of the programme and ensures that the MFMC programme and other HIV activities are in the School Development Plan. The main responsibilities of the contact teacher are to coordinate the sign up of MFMC participants at the school and to monitor the day-to-day implementation of the programme and the performance of the facilitator. The contact teacher is required to attend at least one full session of the MFMC course, as well as the last session during which MFMC participants are meant to plan their graduation and follow-up activities to reach the broader school community. The organogram below details the MFMC management structure.

**Figure 2: MFMC Management Structure**



Source: MFMC Management Guide for RACE, 2005



## **PREVIOUS EVALUATION AND ASSESSMENT RESEARCH**

### **RANDOMISED, LONGITUDINAL STUDY (1998)**

Between 1996 and 1997, before the implementation of MFMC to scale, the programme was evaluated through a randomised, controlled longitudinal trial. The sample consisted of 515 youths (aged 15 -18) from 10 schools in the regions of Caprivi and Omasuti. In 1996/1997, the programme was in fact being co-facilitated by a volunteer teacher together with an out-of-school youth and consisted of 14, rather than 10, sessions. Youth were randomly assigned to either the intervention group where they would participate in the MFMC programme, or to the control group where they would only receive the intervention after the study was completed. HIV risk behaviours, intentions and perceptions were assessed in both groups at baseline, immediately post-intervention, at six months post-intervention and at 12 months post-intervention.

Results showed no differences in rates of condom use between control and intervention youths at baseline or at any of the follow-up periods. However, findings did show that of those youths who had not had sex at baseline, a higher percentage of intervention youths (17%) than control youths (9%) remained sexually inexperienced one year later. Additionally, the findings showed that of those youths who had not had sex at baseline, but who subsequently engaged in sexual intercourse, intervention youths were more likely than control youths to use a condom (18% compared to 10%) in the immediate post-intervention period. The study concluded that the MFMC intervention therefore reduces HIV risk behaviours among sexually inexperienced youth (Stanton, Li, Kahihuata, Fitzgerald et al., 1998).

It can, however, be argued that this conclusion exaggerates the capabilities of the MFMC programme; indeed, although higher rates of condom use were found among individuals from the intervention group, this significant difference is in fact only found in the immediate follow-up period. Importantly, there was no significant difference in condom use at the six-month follow-up period, and no difference at all in condom use for the 12-month follow-up period (85% condom use for both the control group and intervention group). This raises critical questions of how durable the effects of the intervention are, given that positive effects have only been found in the short-term. Furthermore, the delay of sexual debut by sexually inexperienced intervention youth was *only* significantly different from the control group at the 12-month follow-up period. One can argue that, if this delay was attributable to their participation in the MFMC programme, there would be a significant difference at all follow-up periods. The fact that the above conclusions were drawn on the basis of 16% of the original control sample, and 26% of the original intervention sample, suggests that the findings of the study are not sufficiently robust, as there were extremely high rates of attrition, resulting in small sample sizes and skewed data. Aside from this, other significant differences were also inconsistently represented (for example, the increased ability to discuss past sexual partners with a current partner). Despite these shortcomings, the MFMC programme was scaled up for implementation on a wider scale.

### **UNICEF / GRN (GOVERNMENT OF THE REPUBLIC OF NAMIBIA) ASSESSMENT (2002)**

The 2002 assessment of the MFMC programme attributed national implementation and scaling up of the programme to the 1998 evaluation. The objectives of the 2002 assessment differed greatly from those of the 1998 evaluation. The main objectives of the 2002 assessment were to review the implementation of the programme at the regional level, develop a plan for strengthening the coordination and implementation of the programme, and harmonise the links to national structures and existing mechanisms. This assessment was conducted through focus group discussions with multiple stakeholders (Principals, senior teachers, contact teachers, school counsellors, MFMC participants, MFMC peer facilitators, and various members of MFMC management). Eleven schools were visited in the four regions, namely Caprivi, Khomas, Omaheke, and Erongo, and 66 individuals participated in the focus group discussions.

The assessment found that there were numerous obstacles to the successful implementation of the programme in terms of logistics, school buy-in, and the ability of facilitators. In terms of logistical issues, key obstacles to effective implementation included: too few learners being reached; strained and distant relationships between the regional stakeholders and the school, and insufficient programme M&E. In terms of school buy-in, articulated challenges included insufficient responsibility being shouldered by the Principals, limited awareness of the MFMC programme by senior staff and school management, and the timing of the programme as an after-school activity, which contributed to uneven learner participation. Lastly, in terms of facilitator skill and capacity, key obstacles included: insufficient support received from Principals and school management by peer facilitators; limited skills and low commitment among peer facilitators; lack of continuity in the programme due to high peer facilitator turnover, and insufficient support given by facilitators to help participants implement post-MFMC graduation goals.

To address the implementation bottlenecks, the following recommendations, among others, were offered: ensure stronger, more formalised relationships between programme and school; allow schools to have a role in the selection and management of facilitators; assign facilitators to one or two schools on which they focus their work; review and revise training mechanisms, and provide facilitators with regular refresher training to ensure their quality implementation.

### **UNICEF/ AHHP (ADOLESCENT HIV PREVENTION PROGRAMME) ASSESSMENT (2004)**

In 2003, the Ministry of Basic Education, Sport and Culture (MBESC) declared MFMC an official extra-curricular activity to be offered at all secondary schools. From implementation in 1998 until 2003, MFMC reached 160 000 young people. The 2004 assessment was intended to evaluate the state of the MFMC programme from the viewpoint of the MFMC participants, the peer facilitators, the Master Trainers and the Senior Master Trainers from Khomas, Oshana, Omasuti, Kunene (North), Erongo (East and West), Omaheke and Hardap. Focus group discussions were used to evaluate the programme content and methodology, with the objective of reviewing the programme delivery mechanism and its relevance to HIV/ AIDS prevention for the youth.

Similarly to the 2002 assessment, the 2004 assessment identified numerous obstacles to the successful implementation of the programme, including: poor communication between the facilitators and the programme; high peer facilitator turnover; insufficient support for MFMC across various levels and stakeholders; insufficient M&E; limited skills among peer facilitators, and the need for refresher training for facilitators.

### **CONCLUSION**

In reviewing previous studies and assessments of the MFMC programme, it is clear that there is some evidence that the programme may contribute to reducing HIV-related risk behaviours among young people. There are, however, enduring concerns about how the programme has been, and is being, implemented. Obstacles to effective implementation identified in 2002 and 2004 assessments continue to be challenges faced by the programme in 2008, indicating that the recommendations from previous assessments have not been fully accepted and/or adopted.

## CHAPTER 3: METHODOLOGY

In order to answer the main questions proposed by the evaluation study, a mixed-method approach that gathered both qualitative and quantitative data was used. There was a strong emphasis on soliciting feedback not only from users, namely, MFMC participants and implementers, MFMC peer facilitators but also other stakeholders such as Principals, contact teachers, and RACE Coordinators.

The evaluation used the following methods of primary data collection:

- Questionnaires with learners who participated in the programme between 2006 and 2008
- Interviews with current MFMC peer facilitators, contact teachers, school Principals, RACE Coordinators, and the Trainer of Trainers
- Focus group discussions with MFMC graduates and MFMC peer facilitators
- Participant observation of MFMC training courses, of both facilitators and learners

Data was collected in two phases between July and October 2008 across six regions of Namibia. Phase I primarily involved collecting quantitative data that was used to inform and shape qualitative data collection in Phase II. The quantitative data provided information about the perceived impact of the programme on graduates and helped to identify programme strengths and weaknesses, which were probed in depth through qualitative data collection in Phase II.

In Phase I, data was collected in the regions of Kavango, Omaheke, Oshana, and Omusati. In Phase II, data was collected in the regions of Khomas, Hardap, Omaheke, and Oshana. Regions were selected in consultation with UNICEF Namibia and the Ministry of Education to reflect the diversity of the Namibian school-going population. A data collection matrix and all research instruments are included as part of Appendix A.

### SAMPLE

A convenience sample was used, meaning that the sample was purposeful rather than random. In terms of sample size, the research team worked towards, and achieved, the following targets:

1. 300 questionnaires with MFMC graduates
2. 12 semi-structured interviews with MFMC peer facilitators
3. 13 stakeholder interviews (four Principals, four contact teachers, four RACE Coordinators, one MFMC Trainer of Trainers)
4. Eight FGDs with MFMC graduates (n= 65)
5. Four FGDS with MFMC facilitators (n= 23)

Lastly, although the MFMC programme is also offered to out-of-school youth in community-based settings, due to the challenges of tracking and recruiting out-of-school youth, only MFMC participants who had completed the course in school were asked to participate.

### METHODS

#### MFMC PARTICIPANT QUESTIONNAIRES (PHASE I)

Learners who participated in the MFMC programme between 2006 and 2008 were asked to complete a questionnaire to assess the current state of their knowledge, attitudes, behaviours, and skills with regard to reproductive health and HIV/AIDS prevention. Knowledge was probed and assessed through recall of programme content. Skills uptake was assessed through condom

demonstrations. Behaviours and attitudes were assessed through questions on condom usage, HIV positive people, and the uptake of testing. The questionnaire also included questions on programme satisfaction and perceived impact. Both open-ended and Likert scale questions were included. As part of the questionnaire data collection, every other MFMC participant (n=150) was also asked to demonstrate the use of a male condom as a means of assessing their skill level. Only those graduates who had completed the activity on condom demonstrations during the MFMC course were evaluated.

Questions were developed in consultation with UNICEF Namibia and in part derived from a questionnaire designed for a previous KAPB (Knowledge, Attitudes, Practices, and Behaviour) study conducted by UNICEF (2006) in conjunction with RFS (Research Facilitation Services). The questionnaire was administered to both MFMC participants and non-participants. Although the 2006 data cannot be considered baseline, it was agreed that the previous KAPB data could provide a useful point of comparison for the data gathered in the present study. Given that the 2006 KAPB study included both MFMC participants and non-participants, for the present purposes only data from non-participants (in-school), aged 15-19, was analysed.

The questions were also developed and shaped in relation to the teachings and messages of the MFMC curriculum in order to assess to what extent MFMC participants had absorbed the content of the course, in terms of knowledge, attitudes, and skills.

Given that the questionnaire to assess knowledge, attitudes and behaviours was only administered to MFMC participants at one time point, after participation in the programme, the data was used to assess the extent to which participants' responses reflect understanding and absorption of the content and teachings of the curriculum and to identify strengths, weaknesses, and areas of programme improvement. The absence of relevant baseline data precluded the possibility of pre- and post-test comparative analysis.

### **PEER FACILITATOR SEMI-STRUCTURED INTERVIEWS (PHASE I)**

Interviews were conducted with MFMC peer facilitators to elicit their understanding and knowledge of the MFMC programme, the impact of the programme on their lives and on MFMC participants, and their role as peer facilitators. Questions of motivation and retention were also explored in addition to peer facilitators' assessment of programme quality, the usefulness of their training, as well as support and supervision received both at the schools and through the MFMC programme itself.

### **STAKEHOLDER INTERVIEWS (PHASE I AND II)**

School Principals, contact teachers, RACE Coordinators, and the Trainer of Trainers (TOT) were interviewed to better understand their involvement, perceptions, and support for the programme and to identify obstacles to implementation. Stakeholders were asked to assess programme quality, identify programme strengths and weaknesses, and make recommendations for improvement. Stakeholders were also asked about their experiences with peer facilitators and to what extent facilitators had the capacity to effectively deliver the intervention.

### **MFMC GRADUATE AND MFMC PEER FACILITATOR FOCUS GROUP DISCUSSIONS (PHASE II)**

In Phase II, focus group discussions were held with MFMC graduates and peer facilitators to obtain additional data on perceived programme impact, as well as to probe patterns that emerged in the preliminary analysis of questionnaire data to identify possible reasons for weaknesses in the programme and to explore ideas for improvement.

Once the questionnaire data had been analysed and gaps in information identified, focus group discussion questions were finalised collaboratively with UNICEF Namibia. The gaps in

information that were probed in follow-up focus group discussions related to attitudes towards alcohol and drug use, the ability to use a condom comfortably and to negotiate safe sex, as well as the low uptake of Voluntary Counselling and Testing (VCT).

In addition to probing the areas of programme weakness mentioned above, MFMC graduates were asked a variety of questions about the impact of the programme on their lives and their experiences of their respective MFMC facilitators and his/her capacity to deliver the curriculum. They were also asked about the relative usefulness of the various sessions and for suggestions to improve the programme.

As with MFMC graduates, areas of programme weakness identified in Phase I of the research were probed with peer facilitators. In addition, facilitators were asked about the perceived impact of the programme on learners who had participated in the programme, as well as the impact of the programme on their own knowledge, attitudes, and skills. Facilitators were also asked to describe how they implemented various components of the curriculum, such as the modules on condom demonstrations, VCT, and alcohol and drugs, and to reflect on the usefulness of their training and their ability to effectively deliver the course.

## **OBSERVATION OF TRAINING OF TRAINERS AND MFMC COURSE DELIVERY (PHASE I AND PHASE II)**

To assess fidelity of implementation, the research also included participant observation of MFMC training courses (one training of MFMC facilitators and one training of learners). Field notes were taken on the capacity of trainers and facilitators to deliver the content of the sessions and effectively manage both group processes and questions that emerged during the training sessions, including the delivery of the programme. In addition, an observation checklist (see Appendix A) was used to evaluate the trainer and facilitator in terms of their mastery of knowledge, organisation, presentation skills, and interactions with participants.

In terms of the observation of the training of new peer facilitators, five out of 10 days training were observed during which the trainers covered all 10 sessions of the MFMC programme. During the first half of the training session, expert trainers deliver the curriculum and during the second half facilitator trainees practise conducting the session. It was jointly decided by UNICEF Namibia, the HSRC and RFS that observations would be conducted on expert trainers delivering the curriculum, as it is meant to represent how the curriculum should be implemented in practice. It was also agreed that to evaluate and assess facilitator trainees during their initial training would not be useful as a measure of facilitator ability or skill.

Despite efforts to observe two 10 sessions trainings of MFMC learners, one by a female facilitator and one by a male facilitator, competing interests (examinations) at the schools made it possible only to observe 10 sessions with the female facilitator.

## **RECRUITMENT**

### **MFMC GRADUATES**

MFMC graduates who participated in the programme between 2006 and 2008 were recruited to participate in the research, with the assistance of contact teachers and Principals at participating schools. Schools were selected in consultation with the RACE Coordinators in each of the respective regions. In each phase, one urban and one rural school were selected per region. In total, MFMC graduates were recruited from 16 different schools in six provinces. For logistical reasons, and to minimise travel time and distance, schools selected in each region were situated no more than 100 kilometres apart. Only schools where the MFMC programme had been in operation since 2006 were selected. While this means that, in most schools, the MFMC programme would have been established for at least three years, it does not necessarily mean that it was consistently or

regularly offered at these schools during this time. In Phase II, focus group discussion participants were intentionally not recruited from schools where the questionnaire was administered, in order to expand the number of graduates participating in the study and to minimise contamination.

In terms of the questionnaire sample, the original intention was to sample 300 MFMC graduates who had completed all ten sessions of the course, with equal representation of male and female participants, participants from urban and rural schools, and participants who completed the programme in 2006 rather than 2007/2008. The rationale behind such a distribution in the sample was to assess whether there were any intra-group differences based on gender, place (urban/rural), or year of participation.

Although the research team was able to recruit 300 participants and achieved an equal split between urban and rural participants, there were slightly greater numbers of female participants (55%) than male participants (45%) in the final sample. In terms of the year participation 27% of the sample participated in the programme in 2006, 40% in 2007, and 33% in 2008 rather than the 50/50 split sought for 2006 and 2007/2008 graduates. The comparatively lower percentage of participants from 2006 may be related to them graduating or otherwise leaving school.

Recruitment for the MFMC graduates' focus group discussions was also done to approximate a 50% split between male and female, urban and rural and graduates completing the course between 2006/2007 and 2008. For each school, eight to nine graduates between the ages of 15 and 19 were recruited, and a total of 65 participated in the focus group discussions. While there were equal numbers of urban and rural participants, and near equal numbers of male and females participants (31 male and 34 female), the majority of focus group participants were graduates of the 2008 programme. Eight percent participated in the programme in 2006, 29% in 2007, and 68% in 2008.

## **MFMC PEER FACILITATORS**

Potential participants in the semi-structured interviews and focus group discussions were identified by obtaining a list of peer facilitators with two or more years' facilitation experience from RACE Coordinators of the respective regions. The rationale was that peer facilitators with two or more years' experience represent the 'average' MFMC peer facilitator.<sup>13</sup>

During recruitment, however, it became evident that there were a limited number of peer facilitators with two or more years' experience. In terms of the semi-structured interviews, two peer facilitators (one in Omaheke and one in Omusati) did not meet this recruitment criterion. Similarly, in recruiting participants for the focus group discussion in Phase II, it was not possible to identify enough peer facilitators with two or more years' experience. In such instances, a list of current peer facilitators of varying experience was provided by the RACE Coordinator. All peer facilitators who expressed interest in participating and who were available on the scheduled day for the FGD, were included. Of those who participated, nine had less than one year's experience, seven had 1-2 years' experience, and seven had two or more years' experience. In one region, however, only three of eight recruited peer facilitators actually showed up on the day of the FGD. In the other three regions, there were between six and seven participants in each FGD.

In addition, for both the semi-structured interviews and the focus group discussions, peer facilitators were recruited to realise an approximately equal number of male and female respondents. A total of 35 peer facilitators, 16 male and 19 female, ranging in age from 19-32, participated in the research. The mean age of MFMC peer facilitators who participated in the research was 23.

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<sup>13</sup> This information was provided by UNICEF Namibia during the finalisation of the research methodology (June 2008).

## **STAKEHOLDERS**

In each of the four regions sampled in Phase I, one Principal and one contact teacher were interviewed. Principals and contact teachers were recruited from the same schools as MFMC participants. A RACE Coordinator was interviewed in each of the four regions sampled in Phase II. There is only one RACE Coordinator per region. In terms of the Trainer of Trainer, the trainer with most experience with the MFMC curriculum and training of peer facilitators was invited to participate.

## **ETHICS APPROVAL**

This study was approved by the Research Ethics Committee of the Human Sciences Research Council (REC 1/14/05/08) in May 2008. Each adult participant (18 years or older) was required to sign an informed consent prior to interview. Both child consent and parental consent were required for all participants between the ages of 15-18 for participation in the study. All MFMC graduates who completed the questionnaires and participated in the FGDs received a 'Windows of Hope' journal. In addition, all FGD participants received a snack and cool drink, as well as a N\$100 stipend for their participation.

## **TRANSLATION**

All data was collected in English. However, the MFMC graduate questionnaire and parent consent forms were translated into Afrikaans and Oshivambu and back translated into English to verify accuracy of translation. In addition to English, Afrikaans and Oshivambu are two commonly spoken languages in the regions where data was collected. MFMC Graduate questionnaires were translated into local languages to assist fieldworkers during questionnaire administration, in case respondents had questions and required clarification in the local language. In addition, all fieldwork teams dispatched to the various regions contained fieldworkers and moderators fluent in the local languages.

## **DATA ANALYSIS**

Quantitative data was coded and analysed using SPSS (Statistical Package for the Social Sciences, version 16.0). Frequencies were calculated to determine the distribution of scores for each of the items, and Cronbach alphas were calculated for the scales to determine their reliability when used with the sample of Namibian youth. In addition, various tests of significance (i.e. correlational analysis, independent sample t-tests, one-way ANOVAS, and chi-squared tests) were conducted on the data to identify if there were any statistical differences based upon area (rural/urban), year of participation (2006/2007/2008), gender, and age.

Qualitative data gathered was coded and analysed using thematic content analysis to identify main themes and sub-themes.

## **CHAPTER 4: FINDINGS**

This chapter presents the main findings of the MFMC evaluation. It is divided into four sections. The first section reports on the findings of the KAPB questionnaire and the perceived impact of the programme on MFMC graduates. The second section examines the perceived impact of the programme on MFMC peer facilitators. The third section identifies programme strengths and weaknesses, from the perspective of programme impact and content, and the fourth section assesses the programme's strengths and weaknesses from the perspective of the programme delivery mechanism.

### **I. PERCEIVED IMPACT OF THE MFMC PROGRAMME ON MFMC GRADUATES**

#### **MFMC GRADUATE QUESTIONNAIRE DATA**

As a way of assessing the influence and absorption of the MFMC programme by participants, much of the questionnaire's content was developed in relation to the various sessions and modules of the MFMC curriculum. Comparing graduates' responses with curriculum content provides some indication of the degree to which MFMC participants have absorbed the key messages and skills of the programme.

Data on graduates' sexual history and behaviour was gathered to help identify patterns in sexual risk and protective behaviours.

Questionnaire data was gathered on the following:

- Sexual history and behaviour
- Knowledge of sexually transmitted infections (STIs)
- Knowledge of the consequences of teenage pregnancy
- Knowledge of HIV transmission and prevention
- Sources of knowledge about HIV/AIDS
- Satisfaction with the MFMC programme
- Personalisation of risk and intentions to practise safe sex
- Self-confidence to prevent HIV
- Attitudes toward people with HIV and AIDS
- Alcohol use
- Beliefs and attitudes about alcohol
- Beliefs about condoms and condom self-confidence
- Peer relationships and sexuality
- Gender relationships and power

It is important to emphasise that the questionnaire data only provides a 'snapshot' of MFMC graduates' knowledge, attitudes, practices, and behaviours at one particular time. The data helps to frame and guide the discussion and to identify key issues. It cannot be used as a measurement of change and results cannot be generalised to all MFMC graduates.



Various tests of significance were conducted on the questionnaire data to identify whether there were any statistical differences based upon area, year of participation, gender, and age. Importantly, few significant differences were found, suggesting a relatively homogenous sample. All data tables for the following section are included in Appendix B.

**Figure 3: Summary of demographic data**

<b>GRADUATE DEMOGRAPHIC AND HOUSEHOLD DETAILS OF THE SAMPLE</b>	
<b>Gender</b>	55% female and 45 % male.
<b>Year of participation</b>	27% participated in the programme in 2006, 40% in 2007 and 33% in 2008.
<b>Age</b>	Age range 15 to19 years. 52% between 15-16 years; 18% 17 years; 16% 18 years; 15% 19 years.
<b>Grade</b>	79% in Grades 8, 9, and 10, suggesting a sizable proportion of over-age learners for the grade level.
<b>Household composition</b>	76% living with at least one parent/caregiver.
<b>Birth parents</b>	42% indicated that at least one birth parent was dead. 57% of fathers were either dead or living elsewhere; 41% of mothers were either dead or living elsewhere. 8% reported that both parents were dead.
<b>Economic status</b>	The poverty Scale ( $\alpha = .83$ ) shows that the self-reported poverty experienced by the youth is low to moderate. Mean score on the poverty scale (0 – 25): 7.5. During the past year: 50% of graduates had gone without food at least once 53 % had gone without clean water at least once 55% had gone without medicine when sick at least once 61% had gone without electricity/wood/gas to cook food at least once 65% had gone without a household cash income at least once

## **GRADUATE SEXUAL BEHAVIOUR**

### **Relationship status**

Forty-eight percent of the sample reported having a boyfriend/girlfriend. A small percentage of respondents (7%) reported having more than one boyfriend/girlfriend, while 45% indicated that they were not in a relationship. Older respondents were more likely to be in a relationship ( $p = .021$ ) and those in relationships were much more likely to have had sex before. For example, of those who had a boyfriend/girlfriend, 72% had had sex, compared to 25% of those who did not have a boyfriend/girlfriend.

### **Ever had sex**

Of the total sample, 51% reported that they had already had sex and 49% that they had not. There was a significant relationship between having had sex and place as well as having had sex and gender. Rural youth were more sexually active than urban youth; 43% of urban youth had had sex compared to 59% of rural youth. Male respondents also reported greater sexual activity than females. Fifty-nine percent of males had had sex compared to 44% of females. Sexual activity is

also related to year of participation, as many more 2006 graduates (65%) were sexually active than either 2007 graduates (44%) or 2008 graduates (48%).

### **Sexual debut**

The mean age of sexual debut is 14.2, the mean age of male sexual debut being 13.5 and that of females 14.9 ( $p = .009$ ; see Table 2). Sixty-five percent of sexually active participants had a sexual debut at 15 years or younger (see Table 1). Younger sexually active participants also had a lower age of sexual debut than older participants; indeed, the mean age of sexual debut for 15-year-olds was 12.5, while the mean age of sexual debut for 19-year-olds was 15.8 ( $p = .000$ ; see Table 3). Lastly, sexual activity also increases with age, as 34% of 15-year-olds had had sex in comparison with 68% of 19-year-olds ( $p = .004$ )

### **Sex first time**

Of respondents who had had sex, the majority had their sexual debut with same age partners. Seventy-one percent reported that they had their sexual debut with someone of the same age, 3% with someone much older (10 or more years) than them, 14% with someone older (five or more years) than them. There is a significant relationship between the age of first partner and gender, with females (21%) more likely to have had sexual debut with older partners (five or more years). Similarly, 17% of male respondents indicated that their first partners were younger than them (as compared to 1% of females).

### **Number of sexual partners**

Since having had sex for the first time, 51% indicated that they had had only one sexual partner, 18% had had two, 13% three, and 8% four sexual partners. Nine percent indicated that they had had more than six sexual partners. There was a significant relationship between number of sexual partners and place. In general, rural youth were more likely to have had more sexual partners than urban youth and males were more likely to have had a greater number than females. For example, 67% of sexually active females had had only one partner compared to 34% of sexually active males, who had had only one partner.

### **Use of alcohol and condoms during sex**

Of sexually active youth, 80% reported that they never drink alcohol when they had sex, 77% that their partner never drinks alcohol during sex, and 73% reported that they always use a condom. Importantly, very few sexually active respondents said that they or their sexual partner always have alcohol to drink in the context of sexual relations. A small but important subset of sexually active respondents, however, indicated that they use condoms inconsistently, i.e. 'sometimes' (9%) or 'never' (18%) (see Table 4).

### **Risk behaviours**

From a provided list (see Table 5), sexually active youth were asked to select all the risk behaviours they had engaged in over the previous 12 months. The most commonly reported risk behaviours were having more than one sexual partner (32%), visiting a doctor or clinic for an STD (32%), sex with a partner "who I know cheats on me" (16%), unprotected sex with one or more partners (14%), and sex with "someone I did not know very well" (12%). Importantly, comparatively smaller percentages engaged in transactional sex of any kind (either on the paying or receiving end) or had sex with more than one person at the same time.

Moreover, 34% of sexually active youth reported that they had not engaged in any of the risk behaviours detailed above. Thirty percent reported that they had engaged in one sexually risky act, 19% in two, 7% in three, and 6% in four sexually risky acts. On the Sexual Risks Scale ( $\alpha = .69$ ), the mean score for those sexually active (possible range: 0-11) was 1.4, showing overall a low engagement in multiple sexual risks.

## **HIV testing**

Of all respondents, 29% (n=86) indicated that they had been tested for HIV. Of those tested, 87% went back for their results. There was a significant relationship between being tested for HIV and place. Interestingly, rural youth (34%) were more likely to be tested than urban youth (23%). There was also a significant difference in HIV testing with regard to gender. A higher number of females (34%) had been tested as opposed to males (22%). There was a significant relationship between HIV testing and age, as testing increases with age. Also, there is a very significant relationship between having been tested for HIV and being sexually active, as many more sexually active graduates had been tested for HIV (40%) than those who were not sexually active (17%).

## **KNOWLEDGE OF SEXUALLY TRANSMITTED INFECTIONS, PREGNANCY, AND HIV/AIDS.**

### **Knowledge of sexually transmitted infections**

Graduates were asked to name all the sexually transmitted infections that they had heard of. The majority of the sample (54%) correctly named three STIs, while 16% correctly named one, and 22% correctly named two STIs. Only 7% named four or more STIs, and less than 1% could not name a single STI. HIV/AIDS was the most frequently identified STI (24%), followed by syphilis (19%) and gonorrhoea (18%).

Graduates were also asked to name three symptoms that suggest a person may have a sexually transmitted infection. Knowledge of STI symptoms was extremely low, with 56% unable to name a single symptom. The most frequently identified symptoms of STIs were sores/bumps/ blisters near sex organs, anus or mouth (10%) followed by discharge from sex organs (7%).

### **Knowledge of the consequences of pregnancy**

To assess knowledge about the potential impacts of pregnancy on learners' lives, graduates were asked to list two negative things that might happen because of teenage pregnancy. The majority (63%) correctly named two consequences of teenage pregnancy; 30% were able to correctly identify one, while a small number (8%) were unable to correctly identify a single consequence.

The most commonly identified consequences of teenage pregnancy were: leaving school and being unable to complete one's education (32%), a lack of financial resources (14%), and the breakdown of social relationships, including family and community (9%). Of the sample, 6% mentioned suicide as a possible negative consequence of teenage pregnancy.

### **Knowledge of HIV transmission**

MFMC graduates were asked a variety of True/False questions about how HIV is transmitted (see Table 6). Graduates were also given the option of indicating that they 'don't know.' For each correct answer, graduates were given one point – the highest score being 9. Overall, the results below indicate high knowledge of HIV transmission. Nearly 60% of the sample scored 8 or 9, and the mean score was 7.6. Significant majorities correctly identified unprotected sex with an HIV positive person (93%) and being injected with a needle that has been used by an HIV positive person (92%) as sources of infection. Similarly, large majorities correctly identified how HIV is *not* transmitted, namely by sharing food (95%), touching the sweat of an HIV positive person (84%), and holding hands with an HIV positive person (97%).

However, there were particular points of confusion for some learners. Sizable minorities did not know that an HIV positive woman could transmit HIV to her unborn baby (22%), that they could not get infected if bitten by a mosquito that had bitten an HIV positive person (23%) or if they shared cutlery with someone who had HIV (26%). There is also a lack of clarity about whether you can get infected with HIV by someone putting a curse on you; 5% of learners answered the question incorrectly while an additional 27% did not know.

## **Knowledge of HIV prevention**

Similarly to the questions about HIV transmission, MFMC graduates were asked a variety of True/False/Don't Know questions about how a person can prevent being infected by HIV (see Table 7). For each correct answer, graduates were given one point – the highest score being 8. Overall, the results below indicate high knowledge of HIV prevention, although not as high as HIV transmission knowledge. The majority of learners (57%) received a score of either 6 or 7, and the mean score was 6.2.

Most learners correctly identified the ABC approach for preventing HIV: namely, not having sex at all (86%); having sex with only one partner who is not HIV positive (81%); and always using condoms with partners (91%). However, among sizable minorities, the data indicates confusion about the protective effects of other forms of contraception, such as birth control pills/injection (24% responded incorrectly or didn't know), having sex only with people who you know do not have HIV (34% responded incorrectly or didn't know), and withdrawal before ejaculation (33% responded incorrectly or didn't know). There was also some confusion about the protective effects of using condoms with sex workers, as 23% responded to the statement incorrectly and an additional 11% did not know that 'always using a condom when having sex with a sex worker' was protective. When this data is considered in light of the 91% of graduates who correctly identified always using condoms as a means of preventing infection, the variation in responses on the sex worker question suggests that the efficacy of condoms as a barrier method may be called into question by the category of the sexual partner.

## **SOURCES OF KNOWLEDGE ABOUT HIV/AIDS.**

### **Most useful information about HIV/AIDS**

Graduates were asked to name two places or people from whom/where they have received the most useful information about HIV/AIDS. The MFMC programme (29%) was most frequently cited as the top source of information on HIV/AIDS followed by teachers (21%), parents (13%) and school (8%). Interestingly, only 6% named peers/friends. Overall, learners' responses indicated that the school and people at the school (MFMC facilitator, teacher) provide an important source of information about HIV/AIDS for graduates.

### **Usefulness of information at school**

Graduates were given a list of school-based sources, both people and activities, of HIV/AIDS-related information and asked to rate the usefulness of each source of information along a scale ranging from 'not useful at all' to 'very useful' (see Table 8). The activities that large majorities of graduates found useful or very useful were the MFMC programme (93%), AIDS campaigns (85%), AIDS drama and plays (83%), discussions with peers/friends (78%) and life skills classes (77%). The only school activity that a large percentage of graduates found to be not useful at all/not useful as a source of HIV/AIDS information, was the school assembly.

In addition, MFMC graduates were asked to identify *all* the people who have spoken to them about sex and HIV and AIDS from a list (see Table 9). With regard to sex and other issues related to sex, the three most commonly reported persons were the MFMC peer facilitator (77%), friends (77%), and parents/caregivers (68%). Similarly, in terms people who spoke to graduates about HIV/AIDS, the three most often cited persons were the MFMC peer facilitator (80%), teachers (74%), and parents (72%). It is worth noting that, while the majority of learners had been spoken to by their friends about sex (77%), a smaller percentage had spoken to their friends about HIV/AIDS (58%). Also, given that the MFMC programme deals specifically with issues relating to sexuality and HIV/AIDS, it is surprising that more learners did not select the MFMC facilitator.

From the aforementioned list, learners indicated that the persons from whom they learned the most about sex were parents/caregivers (28%), MFMC peer facilitators (27%), and friends (27%). However, in terms of the persons from whom they have learned the most about HIV, the MFMC

facilitator was by far the most frequently cited person; indeed, 48 % selected the MFMC peer facilitator, 17 % selected parents or caregivers, 16 % selected teachers, and 8 % selected friends (see Table 10). In terms of the person who has had the most influence on respondents' attitudes and behaviours in relation to HIV, again the MFMC peer facilitator (30%) was most often mentioned followed by parents/caregivers (24 %) and friends (17%) (See Table 11).

### **MFMC PROGRAMME SATISFACTION AND PERCEIVED IMPACT**

MFMC graduates were asked to agree or disagree with a variety of statements about MFMC programme content, the role of the facilitator, and their perception of the impact of the MFMC programme on their lives (see Table 12). On the whole, graduates reported very positive experiences and perceptions of the programme with regard to the content, their MFMC facilitators, and the impact of the programme. Overall, the preponderance of graduates agreed/strongly agreed that the MFMC programme gives useful information about HIV/AIDS (92 %) and that the materials are easy to understand (89%) and interesting (84 %). However, responses to other questions suggest that the content requires improvement and refinement; 31 % agreed/strongly agreed that some of the materials were confusing and 34 % agreed/strongly agreed that some of the materials embarrassed them. Similarly in terms of peer facilitators, graduates' experiences were largely positive, but there was also some ambivalence; 88% liked their MFMC peer facilitator and 92% indicated that they learnt a lot from their facilitator. However, only 64 % of graduates agreed/strongly agreed that the MFMC was a positive role model to them during the course of the programme, while 18% percent disagreed/strongly disagreed with this statement, and an additional 18% were neutral.

In terms of the perceived impact of the programme in their lives, 93% agreed/strongly agreed that programme helped protect them from getting HIV/AIDS, 96% agreed/strongly agreed that the programme helped them to understand more about HIV/AIDS, and 86 % agreed/strongly agreed that the programme helped them accept people living with HIV.

In order to identify the most and least valuable components of the programme, graduates were asked three questions. They were asked to name the MFMC sessions that they remember, the most valuable things they learned during the programme and what they liked least about the programme. Graduates were able to give multiple responses for each of these questions. Therefore, the percentages below, unless otherwise indicated, refer to the percentage of all responses rather than the percentage of graduates responding.

The MFMC sessions most often mentioned were HIV/AIDS, including prevention (21%), Alcohol and Drug Use/Abuse (14%), Reproductive Health (11%), Pregnancy (10%), and How to Use a Condom (8 %). Graduates indicated that the most valuable things they learned during the programme were knowledge about HIV/AIDS, including prevention (31%), how to use a condom (11%), pregnancy (9%), alcohol and drug use/abuse (8%), caring for people living with HIV (8%), STIs (7 %), to abstain from sex (6%), and reproductive health (6%). Comments relating to communication, relationships, assertiveness, negotiation, decision-making, choices, and values were minimal.

In terms of what learners liked least about the programme, over half of graduates (51%) indicated either that they liked the programme or that there was 'nothing' that they liked least. In terms of what graduates did not like, the most common responses were talking about sexuality (11%), the format of the programme, namely the use of games, role plays, and the general exchange of ideas (6%), the facilitation style (5%), and the content on drug and alcohol use/abuse (4%).

### **ATTITUDES AND PRACTICES ABOUT SEX, RELATIONSHIPS, AND HIV/AIDS.**

The extent to which individuals see themselves at risk of contracting HIV is a central concept linked with risky sexual behaviour. For example, people who perceive themselves to be at high risk for contracting HIV are more likely to engage in safe sex practices (cf. Becker, 1974;

Rosenstock, 1974). For this reason, graduates were asked a variety of questions about their risk of getting infected. The first three questions in the scale (see Table 13) assess the personalisation of risk, while the remaining questions measure the intention to practise safe sex. There is also one question in the scale about the protective effects of male circumcision.

The responses to questions about the personalisation of risk suggest that graduates do see themselves as susceptible to contracting HIV; indeed, 80% disagreed/strongly disagreed with the statement 'people like me do not get HIV.' Similarly, 76% disagreed/strongly disagreed that 'I am very healthy, so my body can fight off an HIV infection' and 83 % disagreed/strongly disagreed that 'I am too young to get an HIV infection.' The mean score of graduates was 12.3 (range of 3 - 15), suggesting a high personalisation of risk. There was a slight difference between males and females, with female graduates having a slightly higher understanding of their risk ( $p = .053$ ). There was also a small significant negative relationship between age and perceived risk, such that the younger the respondent, the higher his/her understanding of risk.

With regard to the question about male circumcision, 70% of graduates disagreed/strongly disagreed with the statement, 'A male can reduce his chance of HIV infection by getting circumcised.' Although the MFMC curriculum does not expressly cover male circumcision as part of its content, learner responses reveal that most learners are unaware of the protective aspects of circumcision for men.

With regard to intentions to practise safe sex, the overall results were positive. The mean score was 24.8 (range of 6 - 30) indicating positive intentions to practise safe sex. For example, 90% of graduates agreed/strongly agreed that they will make sure a condom is used when they have sex, 76% agreed/strongly agreed that they will wait to have sex until they are older and ready, and 73% agreed/strongly agreed that they won't have sex with someone who refuses to use a condom. However, 23% disagreed/strongly disagreed with the statement that they would not have sex with someone who refused to use a condom, suggesting mixed intentions with regard to condom usage.

On the two questions regarding transactional sex, 89% disagreed/strongly disagreed that they would have sex with someone who agreed to pay their school fees, and 92% disagreed/strongly disagreed that they would have sex without a condom if someone offered to buy their family food. However, only 61% agreed/strongly agreed that they would not have sex with someone who they knew was having sex with someone else, while 30 % disagreed/strongly disagreed with the same statement, suggesting a fair degree of tolerance for concurrent sexual partnerships. There was a small significant, negative correlation between age and intentions to practise safer sex, such that the lower the age, the higher the positive intention.

### **SELF-CONFIDENCE TO PREVENT HIV**

In terms of self-confidence to prevent HIV, most graduates felt very sure or sure that they would refuse to have sex with someone they didn't know very well (71%), use a condom correctly if their partner wanted to (88%), convince a partner that he/she should use a condom (88%), ask a partner about his or her other sexual partners (74%), and make their partner go for an HIV test before having sex with them (88%). Smaller majorities felt sure that they could talk about safe sex with a casual partner (56%), that they could prevent a partner from having anal sex with them (54%), and that they could refuse sex with someone who was offering money as a gift (67 %) (See Table 14).

In addition, those who had had sex before were more certain that they could make a partner get an HIV test before sexual intercourse (93%) than those who had not had sex before (84%).

### **STIGMA**

In general, MFMC graduates responded with positive attitudes towards people with HIV and AIDS (see Table 15). For example, 95% indicated that they would care for an HIV positive family member, 87% disagreed with the statement that they would not buy food from an HIV positive

shopkeeper or food seller, 87% disagreed with the statement that HIV positive teachers should not teach, 90% disagreed with the statement that HIV positive children should not go to school, and 93% wouldn't mind being friends with an HIV positive person. However, only 67% would want other people to know if their family members were HIV positive and only 65% thought HIV positive people should be allowed to work in a restaurant/bar.

## **ALCOHOL USE**

Sixty-one percent of graduates reported having used alcohol, 33% reported drinking less than once a month, 28% once a month, and 19% once a week. The mean age in years of the first time graduates tried alcohol was 13.6; 74% of graduates who had drunk alcohol before, had their first sip at age 15 or younger (see Table 16) . Of graduates that use or have used alcohol, alcohol is most often obtained from parties (40%), friends (34 %), or through purchase (26%). A small percentage (6 %) indicated that they obtain alcohol from their parents.

## **BELIEFS AND ATTITUDES ABOUT ALCOHOL**

Substance use and abuse is considered a risk factor for HIV and is expressly addressed in the MFMC curriculum. Responses to a variety of statements regarding attitudes to alcohol use reflect a good understanding of how alcohol consumption can influence sexual behaviour (see Table 17). For example, 63% agreed/strongly agreed that it is more difficult to say no to sex after drinking, while 65% agreed/strongly agreed that it is more difficult to remember to use a condom after drinking. In addition, 68% agreed/strongly agreed that it was OK to be the only person in a group of friends not drinking. However, responses to more general questions about alcohol use, in particular the social contexts of alcohol use, indicate more varied responses; 49% strongly disagreed/disagreed that parties are no fun if there is no alcohol, while 44% strongly agreed/agreed. Also, 45% strongly agreed/agreed that drinking helps overcome shyness, while 40% disagreed/strongly disagreed. Forty-nine percent strongly disagreed/disagreed that drinking helps people cope with problem while 37 % agreed/strongly agreed.

## **BELIEFS ABOUT CONDOMS AND CONDOM SELF-EFFICACY**

Although the majority of graduates (76%) indicated that they are in favour of using condoms and indicated that they know how to use a condom correctly (75%), many graduates also have more ambivalent feelings about actually using them. Only 52% disagreed/strongly disagreed with the statement that they would not be embarrassed to put a condom on, while 32% agreed/strongly agreed that they would be embarrassed. Only slight majorities disagreed/strongly disagreed that condoms interfere with romance (54%) and that the smell and feel of condoms make them unpleasant to use (54%). In addition, 44% disagreed/strongly disagreed that condoms reduce sexual pleasure, while 22% of respondents were neutral, and 34% agreed/strongly agreed. In terms of talking about and negotiating condom use with a partner, 78% agreed/strongly agreed they would be able to discuss condom use with any partner, 69% agreed/strongly agreed that they would insist on using condoms with a new partner, and 80 % agreed/strongly agreed that they could easily convince their sexual partner to use a condom.

That said, only 57% disagreed/strongly disagreed that, if they suggested condom use with a partner, they might be rejected and only 63 % disagreed/strongly disagreed that if they were unsure about a partner's feelings they would not suggest using one, whereas 19% agreed/strongly agreed with the statement. There was a significant relationship between having had sex and the belief that one knows how to use a condom correctly; 82% of sexually active youth felt that they knew how to use a condom correctly, compared to 68 % of those who had not had sex before.

Overall, the data on condom usage suggests a good deal of ambivalence about using condoms and the ability to communicate and negotiate condom usage in a variety of contexts (see Table 18).

## **DEMONSTRATED ABILITY TO USE CONDOMS**

Although 76% of youth believed that they could use a condom correctly, their involvement in a condom demonstration showed that only 69% could correctly use one. There was a very significant relationship between the ability to use a condom and region, as 97 % of the Oshana graduates were able to demonstrate how to correctly use a condom, 76% of the Omasuti graduates, 63 % of the Kavango graduates and only 40 % of the Omaheke graduates. There was also a very significant relationship between ability to use a condom and school. Whereas 100% of the graduates from a combined school in Oshana could correctly demonstrate the use of a condom, only 17% of graduates from a senior secondary school in Omaheke could do so. Furthermore, there was a very significant relationship between the ability to use a condom and the year of participation in the MFMC programme, as 80% of the 2007 graduates could correctly demonstrate condom use, compared to 79 % of the 2006 graduates and only 47% of the 2008 graduates.

## **PEER NORMS, SEXUALITY, AND HIV PREVENTION**

In order to assess the influence of peer relationships and attitudes on respondents, particularly as they relate to issues of sexuality and HIV prevention, MFMC respondents were asked to respond to a variety of statements about their peers (see Table 19).

The first two statements in the scale probe the influence of peers and friends in general. Responses to these two statements suggest that, for slight majorities, being part of a peer group is not equated with doing the same things or agreeing about issues. Indeed, 55% strongly disagreed/disagreed that by doing the same things as their friends they feel part of a group and 52% agreed/strongly agreed that it is easy for them to disagree with their friends. Yet, for each of these statements, approximately 35% of respondents agreed/strongly agreed that by doing the same things as their friends they do feel part of a group and that it is not easy for them to disagree with their friends.

Over half the sample (52%) strongly disagreed/disagreed that their friends think it is OK for people their age to have sex, while only 36% agreed/strongly agreed that it is OK for people their age to have sex. Forty-three percent agreed/strongly agreed that most of their friends were having sex and 39% disagreed/strongly disagreed, suggesting that among MFMC respondents there is almost an exact split across the response scale vis-à-vis the sexual activity of friends. Among items in this scale, this is the only item where there is a strong significant relationship between respondents' responses and whether they are sexually active ( $p=.000$ ). Fifty-five percent of sexually active respondents said most of their friends were having sex compared with only 30 % of youth who are not sexually active who indicated that their friends were having sex.

In terms of HIV transmission and prevention, the responses to items in this scale suggest that peer relationships and attitudes are broadly supportive of respondents' efforts to engage in practices that prevent HIV. However, there is also diversity in responses, suggesting that peer norms around sexuality and HIV prevention are in flux and in the process of re-negotiation.

Overall, HIV is a topic of discussion among respondents and their peers; 75% of respondents agreed/strongly agreed that they discuss questions and feelings about HIV with friends. Fifty-six percent agreed/strongly agreed that friends would support their decision to avoid all sexual activities that would put them at any risk for HIV exposure, while 26% strongly disagreed/disagreed. Fifty-eight percent disagreed/strongly disagreed that to be sexually active proves one is a man, while 26% agreed/strongly agreed. Fifty-seven percent strongly disagreed/disagreed with the statement that friends would laugh at them if they tried to convince them to avoid sexual intercourse because they might get HIV, while 29% agreed/strongly agreed. Sixty-four percent disagreed/strongly disagreed that their friends would laugh at them if they tried to convince them to use condoms, while 24% agreed/strongly agreed. There is a small negative relationship between friends' attitudes and age, such that the lower the participant's age, the more protective their friends' attitudes toward sex are. Again, although the majority of



responses to the items discussed indicate peer attitudes that promote safe sex or abstinence, the data suggests there is considerable room to strengthen these norms among young people.

## **GENDER RELATIONSHIPS**

Overall, the responses to the statements on gender relationships and gender suggest the emergence of gender norms that promote equality in relationships (see Table 20). However, for some items there are sizable minorities that still adhere to gender norms that privilege boys as decision makers in romantic relationships and sexual encounters.

In terms of romantic relationships, most respondents did not think it is appropriate for either boys or girls to have many girlfriends/boyfriends; 91% disagreed/strongly disagreed that it is OK for a boy to have many girlfriends, while 92% disagreed/strongly disagreed that it was OK for a girl to have many boyfriends.

Although most respondents disagreed/strongly disagreed that if a boy says he loves a girl, she should not refuse sex (78%) and that if a boy gives a girl presents, she should not refuse sex (74%), responses as to who should make decisions about the terms of sexual engagement and condom use are more mixed. Sixty-five percent disagreed/strongly disagreed that boys should make decisions about condom use while 28% agreed/strongly agreed. Sixty-seven percent disagreed/strongly disagreed that it is the boy's decision to decide how and when to have sex, while 24% agreed/strongly agreed. Seventy-eight percent disagreed/strongly disagreed that if a boy wants sex, he has the right to get it. Also, 74% disagreed that if a girl suggested using condoms to a partner it would mean she didn't trust him, while 20% agreed/strongly agreed.

## **SUMMARY**

While the KAPB data cannot be used to attribute or ascertain programme impact, the data is suggestive, points in useful directions and helps identify areas for improvement. Firstly, in terms of the sexual behaviour and practices of MFMC graduates, although the average age of sexual debut is young (14.2), it suggests that most graduates surveyed had already become sexually active by the time they enrolled in the programme. Indeed 65% of sexually active graduates reported having had sex at 15 years of age or younger and 15% reported sexual debut between the ages of two and 10. Clearly, this is alarming. In addition, those who reported having a boyfriend or girlfriend were much more likely to have had sex, suggesting that efforts to encourage young people to delay sexual debut should also include strategies to delay romantic relationships altogether.

Although the average age of sexual debut is low, other data is more encouraging. When comparing KAPB 2006 non-participant data (n= 208) with the current data on MFMC graduates, in many ways the sample of MFMC graduates reported safer sexual practices. In terms of sexual risk taking, although sexually active young men in both samples reported taking more sexual risks than young women, non-participant males were 10 times more likely than non-participants females to have had sex with someone they did not know well, whereas male MFMC graduates were only twice more likely than female MFMC graduates to do so. In addition, a larger percentage of sexually active MFMC graduates, (34%), engaged in no sexually risky behaviour, compared with 23% of sexually active non-participants. In terms of transactional sex, very few MFMC graduates (2% of sexually active young women and 3% of sexually active young men) reported receiving money or gifts for sex. In contrast, 8% of sexually active female non-participants and 11% of sexually active male non-participants reported having engaged in transactional sex. Indeed, as a whole, MFMC graduates reported engaging in few high-risk sexual behaviours (See Appendix C for more detailed comparisons).

In terms of the uptake of VCT, although there is room for improvement among MFMC participants, 29% of MFMC participants went for VCT, compared to only 14% of non-participants. Similarly, another positive sign is that 32% of sexually active MFMC graduates reported having

visited a doctor to be tested for an STI, compared with only 17% of non-participants. Again, while this data cannot be used to attribute programme impact, looking at similar data from non-participants, provides a useful point of reference.

The quantitative data is also suggestive in terms of identifying areas of programme strength and weakness. Examining graduates' responses in relation to programme objectives and the content of the MFMC curriculum, it was asked to what extent participants had absorbed the main messages and skills taught by the MFMC programme. The graduate questionnaire data suggests the following areas of programme strength: graduate programme satisfaction and perceived impact; the usefulness of HIV/AIDS-related information delivered through the MFMC programme; MFMC graduates' personalisation of risk and intentions to practise safe sex or to abstain; as well as reported positive attitudes towards PLWHA. In terms of areas of weakness, the data suggests considerable room for improvement in graduates' knowledge of the consequences of pregnancy, knowledge of the symptoms of STIs, comprehensive knowledge of HIV transmission and prevention, demonstrated ability to use a condom, negotiating sex and condom usage, the uptake of voluntary counselling and testing, as well as alcohol use and attitudes towards alcohol use.

Areas of strengths and weaknesses are explored in greater detail. It is however useful to first examine and integrate the qualitative findings of perceived programme impact.

## **MFMC GRADUATE FOCUS GROUP DISCUSSION DATA**

While the quantitative data provides some indication of how the programme has influenced MFMC participants, without baseline data it is difficult to attribute positive or promising signs to the MFMC programme itself. With this limitation in mind, qualitative data was also gathered to assess the perceived impact of the MFMC programme on participants, as well as to probe more deeply into the patterns that emerged through analysis of the questionnaire data.

To assess what impact the MFMC programme has had on participant knowledge, attitudes, and behaviours, graduates were asked a variety of questions about the MFMC programme and what they had learned. These questions included:

1. Please tell us about the My Future is My Choice programme and why this programme is offered to learners?
2. What do you remember from the programme?
3. What do you think are the most important messages of the programme?
4. Was there anything that you learnt through the My Future is My Choice course that you did not know before?
5. Has the programme changed the way you think about things in general?
6. Has the programme changed your behaviour in any way?
7. Do you know of any learners who have changed their sexual behaviour because of this programme?

Despite the variation and specificity in graduates' responses, several important themes emerged through content analysis. Participants reported the following impacts:

1. Improved *knowledge* with regard to reproductive health, including HIV transmission and prevention
2. Changed *attitudes towards risky sexual practices* such as unprotected sex, multiple sexual partners, and sugar daddies
3. *More protective sexual practices* such as increased protected sex, fewer sexual partners, and less involvement with sugar daddies
4. Increased awareness of the *dangers of alcohol and drug* use in general and the link to sexual and other risk taking

5. Increased awareness of the *effects of peer pressure* and the importance of *choosing friends wisely*
6. Greater *acceptance and care* of people living with HIV/AIDS
7. Increased awareness of the importance of *good communication, respect, and love* in relationships
8. Increased awareness of the importance of *making the right choices for the future*.

Each of these reported impacts is discussed in greater detail below.

## RELEVANCE OF PROGRAMME

By and large, graduates' responses reflected good understanding of the MFMC programme and why it is offered to learners. Common responses included: to teach young people life skills, to help them cope, make good choices, and prepare for their future; to teach young people about the dangers of sex and how to protect themselves from HIV; and to help young people abstain from sexual relations. When asked what the most important messages of the programme were, the most common responses were how to prevent HIV and sexually transmitted infections, as well as unintended pregnancies – two of the key objectives of the MFMC programme.

Overall, it is clear from graduates' responses that the MFMC programme provides useful information about sex and HIV, especially in communities where there are taboos about talking directly to young people about sex. Although for some graduates, the MFMC programme reinforces or complements what they already know, for others, the programme creates awareness and provides important information that is not readily available elsewhere, in particular at home.

*The programme is there to educate the children about HIV and family planning and all those things. Because there are sometimes families that don't talk to children about HIV, sex and those things. Because they feel that it is not a thing to talk to children about. So the children only get a chance to learn about these things at school. It's a thing that they are not allowed to talk about in their traditions so most of the children here are not aware (Female graduate, Omaheke).*

The repeated use of the word "thing" in the above quote reinforces what the participant is in fact saying – that in some families to talk about sex and HIV is uncomfortable, uncommon, and often considered inappropriate.

Even where information about reproductive health and HIV is available, the way the programme is administered – through a participative, interactive style – adds a different dimension to the content. It not only reinforces and deepens learning gained through other course content, it is also fun, social, and empowers young people to voice their opinions and speak openly about what they think, what they know and what they have learned, without feeling embarrassed or ashamed.

*Sometimes My Future is My Choice also helps the children to find out more about HIV and AIDS, sex and pregnancies because in Natural Science and Life Skills we also learnt those things but you get ashamed to talk in the class so we understand it more in the My Future is My Choice class when we discuss (Female graduate, Hardap).*

*I know we do this at school. But MFMC is much more social and we can relate to it and we also talk about problems that people face at home and even at school and it kind of helps people to mature (Male graduate, Khomas).*

*Sometimes in our session we had a kind of news reporter that would explain what happened previously and basically explain what is going to happen today. We also played a few games, it was really interesting and fun and I think what I enjoyed mostly about the classes was we actually had a chance to stand up in front of other children and express ourself, without feeling ashamed (Female graduate, Hardap).*

*It is a fun way of teaching people about serious things. We get to give our opinions, not like at school when you cannot give your opinion. It is fun in a way (Male graduate, Khomas).*

## **IMPROVED KNOWLEDGE OF REPRODUCTIVE HEALTH AND HIV/AIDS**

It is clear that, although graduates begin the programme with some knowledge about reproduction, sexuality, and HIV, their knowledge is often limited, incomplete, and in some instances incorrect. For many graduates, the programme has cleared up important misconceptions about sex and HIV. When graduates were asked what they had learned through the programme that they did not know before, the range of responses included:

1. That an STI can be spread even if a condom is worn
2. How an STI is transmitted from one person to another
3. That a girl can get pregnant without penetration or ejaculation
4. That a girl can get pregnant during menstruation
5. That condoms are not 100% safe
6. That using two condoms at a time is not safer than using one condom
7. That HIV is real
8. That HIV can be transmitted through other means besides sexual intercourse (i.e. blood-to-blood, shared needles, mother-to-child)
9. That HIV can be sexually transmitted not only from man to woman, but from woman to man
10. That there is no cure for HIV
11. That you can get tested for HIV
12. How to correctly use a condom and a femidom

Indeed, the responses above serve as a caution not to overestimate what young people know.

In addition, when they were asked what young people can do to prevent HIV infection, learners in all the focus groups were able to articulate the ABC approach clearly and persuasively. "We are taught how to prevent ourselves from HIV and AIDS. We are taught how to use condoms – female condoms and male condoms. There is also the ABC method, which means Abstain, Be Faithful and Condomise – it is also sending out a message." (Female graduate, Oshana). Many respondents, particularly young women, spoke about the importance of abstaining from, or delaying, sex as a way of preventing HIV infection and pregnancy. A female participant from Hardap explained that the programme teaches two key lessons: "that we as young children should abstain from sex and if you are sexually active then you should use a condom."

## **MORE PROTECTIVE ATTITUDES AND BEHAVIOURS TOWARDS SEX**

Although some graduates were reticent to talk about the impact of the programme on their sexual behaviour, many reported adopting more protective sexual behaviours as a result of their changed attitudes and beliefs. For young men, these protective behaviours included secondary abstinence (abstaining from sex after having been sexually active), fewer sexual partners, increased condom use and less consumption of alcohol. One male graduate from Oshana admitted "I used to drink a lot and then I had a lot of sex. Alcohol used to make me feel happy. But I do not drink anymore and I do not have sex anymore." Similarly, others reported:

*One thing is that it is not very good to have two girlfriends, you must abstain. There is no need to have sex every time with too many girls (Male graduate, Hardap).*

*I used to have two girlfriends, but as I joined the MFMC programme I changed totally. . . I no longer have a girlfriend (Male graduate, Oshana).*

*Before I attended the My Future is My Choice programme I thought that by sleeping with women, no matter how many there were, I just thought that by sleeping with a lot of women and not using condoms one would still not contract the HIV virus. And after I attended the course I now know how dangerous it is to actually be involved with a lot of partners and that you should always use a condom at all times and by all means (Male graduate, Hardap).*

Interestingly, one participant articulated a shift in his sexual behaviour much more broadly. Prior to participation in the programme, he would sexually harass girls at school. Through conversations with his peer facilitator, however, he decided to give up this behaviour.

*The programme changed me a lot. I was in a group of boys and when you go past a girl you just touch her, you don't care... Like touch on her private parts. I was everyday in the office because of it. Then after the programme when Richard<sup>14</sup> spoke to me I just dropped those things. It now motivates me to study and do well in my school (Male graduate, Khomas).*

Whereas young men spoke mostly about limiting sexual partners and the importance of using condoms, young women spoke about the impact of the programme more in terms of delaying sex or learning to select sexual partners more carefully. For example, a female graduate from Oshana reported: "The programme has changed the way I behave, I stick to my plan not to have sex before marriage because it can lead to being infected with STDs and it is not good. I better focus on my studies." In the context of having a sexual relationship, many graduates in fact spoke directly about the importance of knowing your partner's HIV status. According to a female participant from Oshana "I cannot just date any guy [now], especially when I don't know his HIV status and I can only date one guy." Although few young women themselves admitted to being involved with older men, one female graduate from Oshana explained how she decided not to have a sugar daddy once she began participating in the programme:

*I was drinking and dating a sugar daddy for financial needs but when I joined this programme I decided not to do it. Because I learnt the negative consequences that will affect my life.*

Other young women reported similar decisions by their friends as a result of participation in the programme.

*One of my friends used to go the sex shop with men. It was men that were much older than her. When she joined the programme, she got more information to take care of herself. She is no longer going around with sugar daddies anymore (Female graduate, Oshana).*

In addition, a number of graduates reported behaviour change in fellow MFMC graduates. For example, a female graduate from Khomas explained:

*I knew this girl. She was in Matric last year. We used to meet in the location and hanging out. She used to hang out with different boys. She got to a stage, she attended the MFMC course and she got valuable information on safe sex and so on. She learnt that having one partner is better than having many. I just noticed that she changed.*

Similarly, a female graduate from Oshana reported: "I had a friend who was always absent from school. She was always going to her boyfriend and having sex with him. Then she joined the MFMC and she changed. She does not stay with the boys anymore."

Importantly, the programme has also helped some young people to re-configure their priorities and shift their attention away from romantic and sexual relationships and onto their studies. A male graduate from Oshana explained, "On my side, I heard that to have a girlfriend it is not good when you are in school, and it is good for you to wait and study until you finish school and then you choose which one you want."

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<sup>14</sup> The facilitator's name has been changed to protect his identity.

Of course, the programme will not necessarily have a positive impact on all graduates or in the same ways. One female participant from Hardap told a story about a female friend who initially attended the MFMC programme with her, but later dropped out.

*We were always very close friends and we always used to hang together and attend any classes like My Future is My Choice and Stepping Stones. Later on she stopped attending the classes because she thought she was an adult and she thought that she knew everything. So then she went and tried the stuff like taking older men and so then she found out that she was pregnant, then she tried to commit suicide. I was trying to stop her but she didn't want to listen to what I was telling her but in the end she decided to not kill herself. So she gave birth to her baby and she dropped out of school. So I think these classes affect some of the kids but not all of them.*

Although there is no 'hard' data demonstrating that the MFMC programme is actually preventing HIV infection and teenage pregnancy, it is telling that when MFMC graduates were asked what would happen if the programme did not continue, the most common response was that young people would not receive needed information about HIV prevention, and HIV infection rates would go up. Thus, for the majority of graduates, there is clearly a strong perception that the programme is preventing HIV infection among young people.

### **INCREASED AWARENESS OF THE DANGERS OF ALCOHOL AND DRUG USE**

It is clear from graduates' responses that the module on drugs and alcohol provides young people with important information about the dangers of alcohol and drug use. Many, particularly boys, indicated that before they participated in the programme they used to drink, smoke, and socialise with friends at shebeens. They did not understand the dangers associated with alcohol and drug use, either in terms of their general health or the risk of HIV infection.

Graduates had largely positive associations with alcohol use before they entered the programme. They thought it was cool, that it would make them strong or clever, or that it would make them rich and popular. The majority didn't realise that drug and alcohol abuse could damage the brain over time. This important piece of information was an eye-opener for many graduates. Speaking specifically about the module on alcohol and drugs, the following graduates from Hardap described the impact of the module on their attitudes and thinking.

**Respondent (Male):** *Drugs are extremely dangerous if you get to inject them in your body, so at first I thought that it would be fun to experiment with it. But after finding out and hearing from the teacher about the effects of drugs on your body, I have now completely changed my opinion on it and I consider the fact that drugs could be extremely dangerous.*

**Respondent (Female):** *I also hear that it was fun to smoke. Most of the young children do it.*

**Moderator:** *And you yourself did you want to smoke?*

**Respondent (Female):** *Yes, at first I did want to because my sister smoked. But then I found out that you can actually damage your lungs and I looked at a few photos and it looked really disgusting, so then I realised that it was really not worth wasting your life for a few minutes of fun. And alcohol, some people even die because of it. I saw how it ruined families and most of the people's lives. You see it everyday, then I realised why should you drink alcohol because there is cool drink and even water, so why should we have alcohol?*

**Respondent (Male):** *When you are having alcohol and hanging out with the guys then you will just smoke dagga. People say that if you smoke dagga then you won't have any stress. But after attending the classes I learnt about the bad effects of it.*

**Respondent (Female):** *At first I was dating a guy that was smoking and I didn't think that I was a passive smoker. My teacher just told me that if you are dating someone who is smoking then you are a passive smoker. Then I was also trying to smoke because I can't look at him smoking and then I told him to stop smoking but he said that he was addicted to it. And I told*

*him that I could not look at him smoking and so I also started smoking because I am already a passive smoker. But then I thought that I would make my life shorter and I would destroy my life so I just stopped smoking and I understand that he is addicted to it so now I just leave it. I was trying to help him.*

Moreover, prior to participation in the programme, many graduates did not clearly understand the link between substance use/abuse, decision making, and other risk taking behaviours, such as unprotected sex and drunk driving.

*I learned that by using drugs like Mandrax and alcohol, you could use it on your own and the next thing you find yourself in a big problem. For example, you might do something that you didn't want to do. You will go and have unprotected sex. If you drive, you might also find yourself in a car accident (Male graduate, Oshana).*

*When you are drunk, you cannot control yourself. You might get a girl and have unprotected sex. Say for instance the girl has AIDS... Then you get infected over one night of having fun. I do not want that to happen to me (Male graduate, Khomas).*

Graduates also described how increased knowledge has shaped their attitudes towards drinking and drugs, which in turn has impacted on their behaviour.

*If there was no course then I would have just been drinking up to now because no one was saying that I shouldn't drink. I was also drinking with my friends, even my father was also drinking. But after I attended this course I even taught my father about the bad effects that alcohol and drugs can do to you. Even then my father also stopped all of these things (Male graduate, Omaheke).*

*To me it has changed my behaviour. I used to drink alcohol before I joined the MFMC programme. But now I stopped drinking alcohol because I learnt drinking alcohol is not good to our health and to our school work. And it also changed me not to use drugs and not to have sex and be good to others and not to have bad friends (Female graduate, Oshana).*

*I thought that alcohol and drugs would have no effect on you if you used it. But now I found out that it has a huge effect on you because you can get an STD just through one night. You go to a club and you drink, then you meet up with a woman and you don't even know her. She is drunk and you're drunk and then one thing leads to another and you have sex. Then the next day you don't remember anything and a few weeks later you develop sores on your private parts and then you find out one day that you have an STD (Male graduate, Hardap).*

While most graduates described a shift in thinking with regard to the dangers of alcohol and drug use, others also emphasised the importance of knowing one's limits and demonstrating self-control. In the words of one female participant from Hardap:

*We can't actually blame alcohol. Alcohol has a good side and a bad side, it just depends on you. If you have limits then I think alcohol won't destroy you that much. Before I thought the same. I thought alcohol would be cool and the guys and girls would say that this one is cool and they would want to hang out with her. But after the lessons I learnt that alcohol can be good and bad, if you have your limits it can be good, but if you don't then it is bad.*

## **GREATER ACCEPTANCE OF, AND CARE TOWARDS, PEOPLE LIVING WITH HIV/AIDS**

Another key reported impact the programme has had on graduates relates to de-stigmatisation and the normalisation of HIV. Many observed that one of the important lessons they learnt through the programme was to treat HIV positive people with care and respect and not to discriminate against them. According to a male participant from Oshana, "The most important messages from MFMC is like how to avoid stigmatisation, stigmatisation and discrimination. It helps us to avoid treating people differently despite their HIV status, gender, sex and race." And, as one female participant from Khomas put it, "A friend with HIV is still a friend."

Prior to participation in the programme, some graduates were scared of HIV positive people and avoided any contact altogether. A graduate from Omaheke explains: "I was afraid to visit a friend whose parents are HIV positive. So it really taught us that there is no difference between a person who is HIV positive and negative." Another graduate speaks of similar fears and how she was afraid to touch an HIV positive person's clothes or even be in the same room as him. Her comments below suggest that her fears related to a lack of understanding of how HIV is transmitted and that participation in the MFMC programme transformed the way she sees HIV positive people.

*Before I attended the classes I knew this person who was having this alcohol and he was really like depending on it. So we usually buy things from him but then he got very, very sick. One day I went to this . . . And when I saw the way he was I was really scared of him, the most things that scared me was the fact that I knew he was sick with the disease. So when my mother said I should wash the clothes and then I always thought that I would get the disease from the clothes or things like that . . . so at points I would refuse to go and visit him. I told my mother that I had homework and that I had to go to the school because I was scared to look at him or even be in the same room as him. So when he was very sick, just the thought of him getting the disease really scared me and I refused to stay with him. Even to just go and buy things at the store, I didn't want anything to do with him. It was scaring me that this person was positive, but then he passed away during that year so this year there was the My Future is My Choice classes, and I refused to enter these classes because I thought it was just a person talking about sex and those things. But this year I think it was because of this friend I had, she convinced me and she was talking about the classes so I joined. When I found out that the person with the disease, you can't get it from being in the same room as the person or washing their things, I really started to change in the way I see people with the disease. (Female graduate, Omaheke)*

Graduates learned not only that there was no need to avoid HIV positive people (from an infection point of view), but also the importance of demonstrating love and care for people living with HIV/AIDS. Two male graduates, for example, spoke about how their behaviour towards HIV positive people changed as a result of participating in the MFMC programme.

*At first I was always... Whenever I saw people with sores, I used to say that they are HIV positive. But now I know that you must not tease somebody else. You must help him, and give him love and care. (Male graduate, Khomas)*

*I also changed my behaviour. Before I joined MFMC programme, when I heard that someone is HIV positive I wouldn't have talked to her or come close to her and I called them bad names. I learnt that stigma and discrimination is not good. (Male graduate, Oshana)*

## **INCREASED AWARENESS OF THE EFFECTS OF PEER PRESSURE**

Graduates also report that they gained valuable information through the MFMC programme about how peer pressure and norms can influence their behaviour and encourage them to become involved in activities that put them at risk.

Many graduates indicated that they had learnt that it is important to choose your friends wisely, as the wrong friends can influence you to do bad things and can lead you into danger. "I learnt that there are good friend and bad friends. There are some friends who can tell you to do things that are not true and can lead you in danger. And there are friends who will tell you things that are right" (Male graduate, Oshana).

Related to learning how to distinguish between good friends and bad friends and making choices, is learning how to make your own decisions. "The important message I got from MFMC, and I think it is the most important, is the chapter on peer pressure, which says don't let anybody make decisions for you. Make your own decision" (Male graduate, Oshana).



Many graduates spoke of changing their peer networks through their participation in the programme, in conjunction with the cessation of risky behaviours such as drinking, drug use, and having boyfriends.

*When I was in Grade Eight, before I was attending these classes I was drinking. I couldn't control myself because I always felt like drinking alcohol. Just like enjoying yourself everyday. And the friends would wait for me to go and drink. But after I have seen that these friends and this alcohol will take me nowhere, so I decided to leave it all. I want to get at least Grade Ten and then I want to look for a job (Male graduate, Omaheke).*

*In the past, my friends were smoking and taking drugs. I will not stay with them anymore. I will just leave those friends. But I used to drink alcohol. But I do not do it anymore (Male graduate, Oshana).*

*I used to go with my friends to parties. All of them had boyfriends. I think they were still too young. But at that time I also had a boyfriend because they had boyfriends. But I do not have a boyfriend anymore. I have learnt that if you have the wrong friends you will end up in the wrong way. You will not do well at school. I am not friends with them anymore. They put me in the wrong way (Female graduate, Oshana).*

### **INCREASED AWARENESS OF THE IMPORTANCE OF GOOD COMMUNICATION, RESPECT, AND LOVE IN RELATIONSHIPS**

Another impact that MFMC graduates report is that the programme has helped them recognise the importance of good communication, respect and love in relationships. They have not only learnt that there are different kinds of communication (passive, aggressive and assertive), they have also learnt the importance of open communication and respect in all relationships, be they romantic or otherwise. Some indicate that the programme has helped them speak more openly with their parents about sex and HIV, and also to draw on their parents as potential guides and resources.

*Another topic is discussing sex with your parents, it is teaching us to be free and discuss things with our parents because in most cases we just get information from our friends, which are not always correct (Female graduate, Oshana).*

*It changed the way I think about my parents and even my boyfriend. I didn't know that it is good to discuss your relationship with your parents because it helps as your parents give you advice, which in most cases are always correct, and I think it is good for your parents to know things about you (Female graduate, Oshana).*

In terms of romantic relationships, for some MFMC graduates, it was the first time they learnt of the distinction between love and sex; indeed, that one can have a boyfriend or girlfriend and not have sex. According to a female graduate from Oshana, "I thought to have a boyfriend was kind of just having sex but I learnt that it is not like that." For others, it has emphasised the values of respect, equality and good communication as pillars of a good, healthy relationship.

*It added value between the relationships of two people. Now when you are dating someone, you respect the girl and you know that she also wants to be loved (Male graduate, Khomas).*

*It also taught us respect for one another and respecting opinions and also about giving each other chances. Usually it is the guy who is leading and who is making the decisions. But we were taught that when you are in the relationship it is a two-way story. You both have to contribute to it and you should talk to one another about the way you feel (Male graduate, Khomas).*

*The way you communicate to show that you love each other. Without communication then the relationship might not grow. So we should have communication (Male graduate, Omaheke).*

It is evident from the above comments that graduates have absorbed not only the more technical and factual information of the MFMC curriculum, but also what many may identify as the 'soft

skills' or valued-based components of the curriculum. While some may argue that it is difficult to teach values, it is apparent from the data that the values imparted through the curriculum have been absorbed by, and resonate with, young people.

### **INCREASED AWARENESS OF MAKING THE RIGHT CHOICES FOR THE FUTURE**

By definition, 'My Future is My Choice' seeks to help participants understand that they are active agents in their lives, that their future is their choice, and that the decisions and choices they make today as young adults can have a lasting impact on their future. Indeed, in the context of teenage pregnancy and high HIV prevalence, one act of unprotected sex can have lifelong implications. It is thus important that when talking about how the programme has influenced them, many graduates speak of a general shift in their attitude to life. For many graduates, the programme helped them understand the link between decisions and consequences and to take responsibility for their lives and futures. Indeed, developing the skills to make decisions, consider consequences, and weigh advantages and disadvantages, repeatedly surfaces as a skill gained through participation in the programme.

For some, it enabled very specific changes, such as prioritising their studies rather than romantic and sexual relationships. "It taught me to have a responsibility towards my life . . . now the MFMC has taught me to put my education before any other things" (Male graduate, Hardap). For others, the shift reflects a more long-term view of their lives, as a graduate from Hardap explained, "We [now] have a life for the future." This general attitudinal shift is important, because it reflects that participants understand that they cannot simply live for today but should also live for tomorrow, and that the future is, in part, of their own making.

### **SUMMARY**

The MFMC programme aims to ensure that youth have a sense of control and self-confidence over their lives, their health and their future. The focus group discussion data suggests that these goals appear to have been met in numerous ways. MFMC graduates report: increased knowledge with regard to reproductive health and HIV/AIDS; changed attitudes towards risky sexual practices, and the adoption of more protective sexual practices. They also reported increased awareness of: the effects of peer pressure; the dangers of alcohol; the importance of open communication with loved ones; the importance of making the right choices for the future, and greater acceptance of PLWHA. The qualitative data thus suggests that the MFMC programme has, for many graduates, enabled important, positive, and health promoting changes.

## **II. PERCEIVED IMPACT OF MFMC PROGRAMME ON MFMC FACILITATORS**

In addition to understanding the impact of the MFMC programme on participants, it is also important to unpack the influence of the programme in the lives of MFMC peer facilitators. Peer facilitators, as the primary change agents, play a critical role in delivering the intervention and promoting protective health behaviours. In fact, one of the working assumptions of many peer education programmes is that the peer educator serves as a role model<sup>15</sup> to his or her peers and becomes a change agent for participants' growth and behaviour change. Transformation of self is thus an important aspect of helping others transform.

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<sup>15</sup> Peer facilitators, in part, are selected on the basis of being role models in their communities and this is also emphasised as part of their training.

Indeed, apart from age differences, there are often few differences between peer facilitators and the young people they work with. It is remarkable how much commonality exists between the impacts reported by MFMC graduates and those reported by facilitators. Perhaps it is because the content of the curriculum is, in general, quite relevant to the lives of young people. In the words of one female peer facilitator from Khomas:

*For me, the programme itself, when you look at our manual and the participant's guide, it's something that you can use in your daily life. It is not just something that you go and do just there. Like for us facilitators, it's like I know the whole manual now. I know if it is session one I know I what I have to start with. So you apply it to the daily life, it helps you grow.*

It is clear from interviews and focus group discussions with peer facilitators that the MFMC programme has been important for facilitators' growth and development as young adults. For some facilitators, the programme seems to have been a wake-up call and has enabled the development of critical life skills to make better decisions.

*For me, before I joined this programme life was just a jol. I lived day by day. But now since joining the My Future is My Choice now I can clearly see and make differences between what is important. So I think by joining this programme I became the real D (Male peer facilitator, Khomas).*

When MFMC peer facilitators were asked how the programme had changed their lives, common responses included that they have:

1. Become more **knowledgeable about sexual and reproductive health**
2. Engage in **less risky sex** and related behaviours (penetrative unprotected sex, sex with multiple partners, sugar daddies)
3. Learned how to **resist peer pressure** and know the difference between good and bad friends
4. Become more **accepting of people** living with HIV and AIDS
5. Become **better communicators** and **more confident**
6. Developed **facilitation skills**
7. Become **role models**

## **INCREASED KNOWLEDGE ABOUT SEXUAL AND REPRODUCTIVE HEALTH**

Although some facilitators indicated that they knew a fair amount about HIV and reproductive health before they became peer facilitators, others gained important knowledge about HIV transmission and prevention, condom use, and reproductive health, and have learned to apply this knowledge to the benefit of others. One peer facilitator stated that it was only during the MFMC training course that she learnt how pregnancy worked. Other responses include:

*I gained a lot of knowledge, especially about STDs and condom use (Female peer facilitator, Oshana).*

*It changed me in a lot of ways, so many ways I wish I could be that big and tell the whole world . . . Like I didn't know about femidoms back then, I didn't know many things especially like HIV, ARVs... Everything! I learnt a lot and now I want to teach everybody (Female peer facilitator, Khomas).*

*I am helping myself in terms of...because at first when I didn't join to be a facilitator of the My Future is My Choice Programme I never knew how to use the condom and what the importance of having my values is and how to communicate with my partner. So I never knew that stuff, but since I joined My Future is My Choice as a facilitator, I at least know more about it (Male peer facilitator, Kavango).*

*I learned a lot about HIV AIDS, skills. I also benefit in knowing very well how to protect myself and other people from HIV AIDS. So what I really benefited in my future I gained a lot of informations [sic] about this epidemic disease (Female peer facilitator, Omasuti).*

*I learnt a lot about how to work with a lot of people, and how to prevent myself from getting HIV AIDS, and I also learnt how to solve problems such as if somebody comes to me and they have got a problem and I have to give them some advice (Female peer facilitator, Oshana).*

## **ENGAGE IN LESS RISKY BEHAVIOURS**

Some facilitators also spoke about how they have changed their behaviour through involvement with the MFMC programme. It is important to mention, however, that facilitators who participated in the semi-structured interviews were much more likely to talk about behaviour change than peer facilitators in the focus group discussions. This difference is most likely related to the more public nature of the focus group discussion and potential concerns about confidentiality among fellow participants, rather than real differences between the groups.

Reported behaviour changes among peer facilitators include: engaging in less risky sex, using condoms consistently, and giving up drinking and smoking. For many, changing peer networks and recognising the difference between good and bad friends was an integral aspect of changing behaviour.

*To be honest . . . I was a person who was really ignoring HIV and AIDS because we were five in a group. So it was like we used to even tease people if you find the other guys going and getting condoms or girls going for contraceptives. So we used to hang by the clinic and wait for them and tease them. But now when I started facilitating I realised what I was doing was really very wrong. . . . It [the programme] put me at a level that is so good where I am now because if I remember when I was at school it was something like... We used to smoke too much and we were drinking too much alcohol and that really effected us... For instance like we didn't even want to go study anymore, we went to school but what came in our minds is that we have to go out quickly so that we can go and drink and have fun out there (Male peer facilitator, Kavango).*

*The time I started with a presentation of My Future is My Choice programme I was having a lot of friends, and then later I have learnt to differentiate between good and bad friends. I have also learnt the consequences and danger of multiple sexual partners. I have also learnt how to limit alcohol, when enough is enough. . . . Yes, I found out that it is important [to make change] because when it comes to the friends that I used to have, we used to do things that I cannot mention here, and when I changed others were still going on and they found out that I stopped working with them and I don't do what we were doing anymore; and because I have joined the My Future is My Choice programme and I no longer wanted to have the boyfriend that I was having because they were just there to supply money and this was just like buying people (Female peer facilitator, Oshana).*

*Yes. That occurred firstly when I went to the workshop. I didn't know anything concerning HIV and AIDS. It changed my lifestyle and how to avoid penetrative sex. And normally people say that AIDS spreads from sexual penetration when we didn't use condoms. So when I came to my rural area, I had that message in my mind, that if I do any single mistake, AIDS is there waiting for me. So they changed my lifestyle (Male peer facilitator, Omasuti).*

For one peer facilitator, involvement in the programme helped him fight peer pressure and give up membership of a gang.

*For me it was the ability to fight peer pressure. I used to be a gang member we used to beat people. But then, when I started doing the programme, I realised that what I was doing was wrong. I made new friends and changed my ways. I stopped being a member of the gang. I told them that I must go and be an example to the kids who I teach the programme to. Later on the entire gang broke up (Male peer facilitator, Hardap).*

## **INCREASED ACCEPTANCE OF, AND RESPONSIBILITY TOWARDS, PEOPLE LIVING WITH HIV AND AIDS**

Another impact reported by some peer facilitators is an increased acceptance of people living with HIV and AIDS. The range of changes vary from no longer harassing people who are HIV and treating them with respect to knowing how to care and support a friend or family member who is living with HIV.

*Before I was a facilitator, I used to do bad things. I used to accuse people of things when I found out when they were HIV positive. Now, today, I know that I must treat everyone the same and I know what I did was bad (Male peer facilitator, Oshana).*

*My Future is My Choice Programme changed me a lot because now I know a lot of things that I never knew. It encourages me and gives me help. Because sometimes I had problems of my own, and then I used the information I learnt in the programme to help me solve it . . . It really helps me because I now know, for instance if I have a friend who is HIV infected... I don't have to run away from this person because this person needs my help and support (Female peer facilitator, Kavango).*

*Also the approach, your approach towards people with AIDS is really different. Because I had an uncle who was in the house who was...I used to fear this thing. I would see pictures lying around and I would say "Euh!" But then I had an uncle or people that you know that are tested HIV positive and my approach towards them is different, it is not... You are different from the others in the house because you know exactly what they need and you know how to treat them as well. You know how to make them smile and laugh. If you hadn't attended this programme you wouldn't have known about the session on counselling and how we should approach people living with AIDS and how we should treat them, you would be ignorant (Female peer facilitator, Khomas).*

## **IMPROVED COMMUNICATION AND CONFIDENCE**

The most common response among peer facilitators in terms of how the programme has impacted on their lives is that it has improved their ability to communicate; it has helped them overcome their shyness and enhanced their confidence.

In general, they have become more comfortable talking about themselves and their feelings and have also become more open and more comfortable talking about HIV and AIDS.

*If I had a problem, I was not the type of person who would tell you about it. But nowadays, I talk about my problems with people (Male peer facilitator, Hardap).*

*I learnt to communicate properly. I used to very passive. Nowadays I am more assertive. Nowadays I tell people what I feel. I used to be scared (Female peer facilitator, Oshana).*

*For myself I changed because I was a person who was not open with the others but now I am open and I can talk openly. First I wasn't open, but now I am so I changed (Female peer facilitator, Omaheke).*

*I was not a shy person at all, but it helps me in the sense of having discussions about HIV/AIDS and condom use with my family (Male peer facilitator, Khomas).*

*Yes, it was good [to make changes] because like for the partners, family and friends now you we are even more free in talking about HIV, and when I was not that free and I was not free to talk about HIV with others. Now wherever I am I can talk about HIV and AIDS (Female peer facilitator, Oshana).*

They are also more confident.

*I could never talk in front of people, not in front of children or even in front of adults. But now I am much better and I am actually quite good at it (Female peer facilitator, Oshana).*

*I am a shy person. When I was doing the training I was wondering whether I would be able to stand in front of the learners. I wanted to drop out but I just said let me go and try. I think I changed because now I can stand there and talk (Female peer facilitator, Omaheke).*

*I learnt how to communicate properly with people. I also learnt to be open. I am also not shy anymore, so I can stand in front of anyone and talk to them (Male peer facilitator, Hardap).*

In addition, the increased confidence has had a ripple effect in their lives. It has spilled over into other relationships and contexts.

*Previously I couldn't talk about a penis, a vagina because it is a taboo in our culture as a young person until you reach the age of 22 then you will be able to talk about those things. Even the parents themselves noticed an improvement in me, and then I started explaining to my parents that this is what I am doing. So it really changed everything in my life, now I can make wise decisions (Male peer facilitator, Khomas).*

*Let me just tell you that if I wasn't part of My Future is My Choice and I was sitting here right now, you wouldn't have heard a single word from me. I would have come in here and sat and then went out again. Especially sitting in front of a lot of people, like they are all looking at you. That was something that I would never do, but then I went to the training and then I came back and the first group that I had was a bit difficult but then I was like, okay there is something that I have to tell them. So I just got used to it. Now don't let me start or else I won't stop (Female peer facilitator, Khomas).*

## **DEVELOPED FACILITATION SKILLS**

Peer facilitators also indicated that through participation with the MFMC programme, they have gained important new skills that relate directly to their role as facilitators. In addition to becoming more open, better communicators, and more confident, they have also gained critical facilitation, presentation, and listening skills.

*Also you learn that in a group of five or six you find different characters and how to handle them. You can find that even if you are facilitating at one of the schools, some people are just concentrating somewhere there. You know if we are short tempered, they complain so you must try to control yourself (Male peer facilitator, Khomas).*

*I got new skills like some of the activeness, concentration, and ways of communicating. I was learning these skills (Male peer facilitator, Omaheke).*

*I learnt many things. Wisdom, communication and even to talk in front of the whole group of learners while the learners are just listening (Female peer facilitator, Omaheke).*

## **BECOME ROLE MODELS**

As the above data suggests, part of the motivation for changing behaviour has been the desire to protect oneself from HIV infection through the acquisition of information and skills. Other motivating factors include the recognition among most peer facilitator of themselves as role models to other young people, particularly MFMC participants.

*I changed my life, first I knew that I must respect myself, and then second I have to trust, and I have to be self-confident, to be confidential and tolerant and respect the people; because if I am the facilitator and I don't respect, nobody will respect me, I should lead by example. If I respect myself, then I respect them they will also respect me, but if I don't care no one will care. (Female peer facilitator, Omasuti).*

Most peer facilitators were able to articulate that one of the key characteristics of a good role model is to lead by example and to practise what you preach.

*You must live by example. What you teach must come back. The must see that what you teach is what you are doing. It is not good if you do not do what you teach, like if you drink and smoke and go to clubs. That is not good at all (Male peer facilitator, Omaheke).*

*A role model starts with what you say and how you say it and then you progress to what you do and how you do it. Because you never know who's imitating what you do (Male peer facilitator, Hardap).*

*To be a role model is someone who other people can see an example from. They can change just because of the thing that you are doing (Male peer facilitator, Khomas).*

During the focus group discussions, peer facilitators were asked to comment on the following vignette about a peer facilitator who transgresses boundaries and goes with MFMC participants to the *shebeen*.

*Eleaser is a male MFMC peer facilitator at the Kudu school in the Oshana region. He is a friendly person and knows most of the students there very well. He is also well acquainted with the School Principal and contact teacher. He is well respected by everybody. After the completion of a full MFMC session, Theopolina, Laina Bertha, and Melanky, who just graduated, decide to invite Eleaser for a drink to a shebeen to celebrate their graduation. As they are talking about different issues, Eleaser pushes the girls to drink more beers and makes some jokes about sex. Theopolina and Laina refuse to drink more, saying that alcohol is not appropriate and that Eleaser is acting against the principles he has been teaching them. Eleaser says what happens inside the school is different from real life. What's going on here? What's to your response to this situation?*

Importantly, all peer facilitators recognised the contradictions implicit in the vignette.

The overarching response was that the facilitator was not a good role model and should not be allowed to practise as a facilitator anymore.

*The facilitator is not serious, we were talking about role models and those kids are going to look if you do what you teach. And what we do and what we do at home affects our lives in general. The facilitator is teaching him things that are not right and he should no longer be allowed to be a facilitator (Male peer facilitator, Hardap).*

*The facilitator did not mean what he said in the class. It shows that he is a kind of person that does not take it seriously. In his mind he is not a peer facilitator, he is something else (Female peer facilitator, Oshana).*

*The facilitator has lost his vision (Female peer facilitator, Oshana).*

*I think he was not serious at all because he was using peer pressure. He taught them not to drink alcohol but then he was forcing them (Female peer facilitator, Omaheke).*

*I think Eleaser should be expelled from the programme because if he starts doing this then it means he will keep on doing it. Then later he might even propose his participants and so on (Female peer facilitator, Omaheke).*

Others even suggested that the participants could have been testing him and he clearly failed the test. Lastly, some suggested that if he really wanted to go to the *shebeen*, he should have gone on his own. "Even if he wanted to go out to a bar he shouldn't have taken his participants with him. He should have done it on his own maybe" (Female peer facilitator, Khomas).

## **SUMMARY**

There are many indications, based on interview and focus group data, that the MFMC programme has played an important role in the lives of peer facilitators. The MFMC programme has helped them develop their knowledge and skills both in terms of their growth as young people and in terms of delivering the curriculum. Through participation in the programme as peer facilitators,

they reported various important changes in their lives, such as: becoming more knowledgeable about sex, reproduction, and HIV/AIDS; becoming more open; becoming more accepting of HIV positive people, and engaging in less risky sexual and related behaviours. Indeed many peer facilitators described the importance of these changes in terms of shifting their worldview and leading them to make better decisions and choices. They also recognise the importance of 'walking the talk', realising that they cannot encourage young people to make healthier choices and decisions if they themselves are not transformed. That said, although the programme has enabled positive change for many peer facilitators, for others it is primarily a job, an income-generation strategy until other opportunities emerge. This is evident from other data gathered. While it is understandable that peer facilitators would leave the programme for better income and work opportunities, this dynamic nonetheless shapes the level of peer facilitator commitment to the work.

### **III. ASSESSMENT OF PROGRAMME IMPACT AND CONTENT: STRENGTHS AND WEAKNESSES**

The qualitative data on the perceived impact of the MFMC programme includes numerous examples of how the programme has positively influenced young people in terms of building their knowledge, shaping their attitudes, and developing their skills. There are many indications that the programme is working towards its goals.

Looking at the data as a whole, it is also evident that there is also considerable room for programme improvement. Looking primarily at the questionnaire data, areas of strength and weakness were identified based upon achievement against programme objectives and the content of the MFMC curriculum. The main guiding question was: to what extent have MFMC participants absorbed the main messages and skills taught by the MFMC programme? The qualitative data was used to triangulate and inform patterns suggested by the quantitative data, to probe for areas of weakness and to elicit ideas for programme improvement.

#### **AREAS OF STRENGTH**

Key areas of strength identified include:

1. Programme satisfaction and perceived impact
2. Importance of the MFMC programme as a source of HIV/AIDS-related knowledge for participants
3. Personalisation of risk and intentions to practise safe sex or abstain
4. Positive attitudes towards PLWHA

#### **PROGRAMME SATISFACTION AND IMPACT**

Both the quantitative and qualitative data indicate that respondents are broadly satisfied with the programme and report that it has had a positive impact on their lives. Overall, participants reported positive experiences and perceptions of the programme with regard to the MFMC content, materials, and peer facilitators.

For example, in terms of the quantitative data, large majorities agreed/strongly agreed that the MFMC programme gives useful information about HIV/AIDS (92%) and that the materials are easy to understand (89%) and interesting (84%). In terms of the perceived impact of the programme in their lives, 93% agreed/strongly agreed that the programme helped protect them from getting HIV/AIDS and 96% agreed/strongly agreed that the programme helped them to understand more about HIV/AIDS. The qualitative data on perceived impacts reported by MFMC participants reinforces the quantitative findings.



## **SOURCE OF HIV/AIDS-RELATED KNOWLEDGE**

In terms of the most useful information received about HIV/AIDS from any source (i.e. home, school, media campaigns, etc), the MFMC programme was most often cited as most useful. Teachers were the second most often cited, confirming the importance of school-based HIV/AIDS programmes and information for school-going young people.

In addition, in rating the usefulness of HIV/AIDS information at school, the MFMC programme was rated useful or very useful by 93% of graduates. In terms of the person from whom they have learned the most about HIV, the MFMC facilitator was by far the most frequently cited person. In terms of the person who has had the most influence on respondents' attitudes and behaviours in relation to HIV, again the MFMC peer facilitator was most often mentioned.

The importance of the MFMC programme and the MFMC facilitator as sources of knowledge and influence with regard to HIV/AIDS is reinforced by other data as well. When participants were asked which sessions they found most valuable, content relating to HIV (including prevention) was most often mentioned, followed by how to use a condom, pregnancy, and alcohol and drugs. As a whole, the data above highlights the importance of the MFMC programme as a source of information and influence in the lives of MFMC graduates with regard to sex and, particularly, HIV/AIDS.

## **PERSONALISATION OF RISK AND INTENTIONS TO PRACTISE SAFE SEX/ABSTAIN**

The quantitative data indicates that MFMC participants have, by and large, personalised the risk of HIV infection. They recognise that they are vulnerable to infection and large majorities indicated that they intend to practise safe sex. For example, 80% of respondents disagreed/strongly disagreed with the statement 'people like me do not get HIV', while 76% disagreed/strongly disagreed that 'I am very healthy, so my body can fight off an HIV infection' and 83% disagreed/strongly disagreed that 'I am too young to get an HIV infection.'

In addition, with regard to intentions to practise safe sex or abstain, the overall results are positive. For example, 90% of respondents agreed/strongly agreed that they will make sure a condom is used when they have sex, 76% agreed/strongly agreed that will wait to have sex until they are older and ready, and 73% agreed/strongly agreed that they won't have sex with someone who refuses to use a condom. In addition, in terms of transactional sex, 89% disagreed/strongly disagreed that they would have sex with someone who agreed to pay their school fees, and 92% disagreed/strongly disagreed that they would have sex without a condom if someone offered to buy their family food.

Similarly, the qualitative data indicates that the MFMC graduates understand the link between risky sexual and related practices (i.e. alcohol and drug use) and increased risk of HIV infection. While it is not possible, due to the lack of baseline data, to attribute the personalisation of risk data directly to the MFMC programme, that MFMC graduates have internalised the risk of infection is a promising sign. Moreover, the personalisation of risk is widely seen to be a precursor to engaging in less risky sex.

## **POSITIVE ATTITUDES TOWARDS PLWHA**

In terms of the quantitative data, MFMC participants reported positive and accepting attitudes towards people with HIV and AIDS. Large majorities (ranging between 87% and 95% on given items) had positive attitudes towards people living with HIV and AIDS, indicating for example that they would care for an HIV positive family member, buy food from an HIV positive shop seller, and be friends with an HIV positive person. In addition, 86% also agreed/strongly agreed that the programme had helped them accept people living with HIV. Similarly, the qualitative data indicates that one of the most important reported impacts of the programme has been increased understanding, acceptance and care towards PLWHA.

## AREAS OF WEAKNESS

Although there are many programme strengths, there also many areas of programme weakness that require strengthening. These include:

1. Knowledge of consequences of pregnancy
2. Knowledge of the symptoms of STIs
3. Knowledge of HIV transmission
4. Knowledge of HIV prevention
5. Demonstrated ability to use a condom
6. Negotiating sex and condom usage
7. Uptake of voluntary counselling and testing
8. Alcohol use and attitudes towards alcohol use.

Only some of the identified areas of weakness lent themselves to further probing through the follow-up focus group discussions. In terms of knowledge-related questions such as knowledge of consequences of pregnancy, of STIs, and of HIV transmission and prevention, the onus is on the programme and peer facilitator to make sure all the complexities of the content addressed in the curriculum are fully covered when delivering the course. Gaps in knowledge identified suggest that certain content is not being covered adequately and requires greater emphasis.

Other areas, especially those related to attitudes and skills, require additional probing to understand better the weaknesses identified and, where possible, suggest improvements. The main areas of weakness probed through focus group discussions included modules and activities on how to use a condom, negotiating sex and condom usage, the uptake of voluntary counselling and testing, and attitudes towards alcohol and drugs.

### LIMITED KNOWLEDGE OF CONSEQUENCES OF PREGNANCY

As part of the questionnaire data, when asked to list two negative consequences of teenage pregnancy, only 63% of MFMC graduates could correctly identify two consequences. Given that one of the key objectives of the programme is to prevent teenage pregnancy, a larger percentage should be able to identify the risks associated with pregnancy.

*Ideas for improvement:* Revisit the curriculum to identify better ways to help young people understand the implications of having a child in their teenage years and reinforce these messages through follow-up activities.

### LIMITED KNOWLEDGE OF SYMPTOMS OF STIS

Participants were asked to name as many STIs as they could and three symptoms that suggest a person may have an STI. Although the majority of the sample (54%) correctly named three STIs, knowledge of the symptoms of STIs was extremely low. More than half the sample (56%) could not correctly identify a single symptom of an STI. Given that having an STI is a risk factor for HIV infection, it is critical that most young people be able to identify the signs of an STI.

*Ideas for improvement:* Revisit the curriculum to identify better ways to impart information about the increased risks for HIV infection associated with having an STI, as well as the importance of being able to identify the signs of an STI.

### LIMITED KNOWLEDGE OF HIV TRANSMISSION

Although overall knowledge of HIV transmission was high, there were points of confusion for learners. For example, only 78% knew that a pregnant HIV positive woman could transmit the virus to her unborn child, suggesting that this aspect of the curriculum is not adequately covered.

There are also indications that more needs to be done to deconstruct myths associated with HIV/AIDS. Only 44% knew, for example, that you cannot get infected with HIV by someone putting a curse on you.

Given that the section that covers 'Myths about HIV' is an optional, rather than required, activity, it is not surprising that participants still carry many misconceptions about HIV transmission.

**Ideas for improvement:** Revisit the curriculum to identify better ways of conveying the risk of passing the HI virus to the child (in utero, during birth, and through breastfeeding) if the mother is HIV positive and make the section on myths about HIV mandatory, rather than optional.

#### LIMITED KNOWLEDGE OF HIV PREVENTION

Although a large majority of respondents (between 85-90% on given items) were able to identify the ABC approach for preventing HIV, there was confusion about the protective effects of other forms of contraception such as birth control pills and injections, and whether withdrawal before ejaculation can prevent HIV. Twenty-seven percent also thought that you could prevent getting infected with HIV by only having sex with people you know do not have HIV, while 7% did not know either way.

**Ideas for improvement:** In discussions about the different forms of contraception, place greater attention on the fact that the only method of contraception that prevents HIV is the consistent use of a barrier method (condom or femidom). Emphasise that it is not possible to know with certainty that a person is not HIV positive, even if you see test results, as the person could have had unprotected sex after being tested, and thereby be infected.

#### DEMONSTRATED ABILITY TO USE A CONDOM

Through condom demonstrations performed by 150 graduates, it was found that only 69% of graduates tested could correctly explain how to put a condom on a demonstration penis. Given that the correct and consistent use of a condom is critical for HIV prevention and that knowing how to use a condom is a prerequisite for correct and consistent condom use, the fact that 30% of graduates tested could not correctly demonstrate how to use a condom is inherently problematic.

Both MFMC graduates and peer facilitators were asked about their experiences with the condom demonstrations and whether doing condom demonstrations once during the course is enough. According to the manual, condom demonstrations are generally only done only once, although some peer facilitators said that they did repeat the demonstration if learners indicated that they needed more practice. Although MFMC peer facilitators had mixed responses as to whether the condom demonstrations should be repeated, some did argue that a once-off condom demonstration was not enough. For example, peer facilitators from Hardap had this to say:

**Respondent (Male):** *Personally, I do not think it is enough. Some learners come to me after the sessions and ask me to show them again. Then I show them. Then I tell them that I will arrange with the contact teacher and the Principal to do it again, and even ask them if the whole school cannot come and look. So then the kids did it in front of the whole school . . .*

**Respondent (Male):** *I also do not think once is enough. Some learners are confident. They will demonstrate it. But those that are shy will maybe not do it the first time, or they will be so shy that they will get it wrong. The more the practice, the easier it becomes.*

**Respondent (Male):** *Yes, I also do not think it's enough. I did not do it just once. Not everybody got a chance to do it the first time. So I did it again so that everyone could get a chance to practise.*

Among MFMC participants, the consensus was that doing the condom demonstration once was not enough. They indicated, rather, that young people need more practice. Although some participants enter the course with knowledge and experience of condom usage, it varies a great

deal. For some participants it will be the first time they have actually practised using a condom. In the excerpt below, MFMC graduates from Oshana describe why more practice is necessary.

**Respondent (Female):** *It is not enough and we need to have more practice. That way it will help the ones who are really attending the demonstrations. But those that only stay home maybe they will get inspired for just staying there while others are going. So for sure they will also come for the demonstration.*

**Moderator:** *Preferably how many times do you want it to be done?*

**Respondent (Female):** *Lots of times.*

**Respondent (Female):** *Three times or two times a month*

**Respondent (Male):** *It is not enough. Simply because by demonstrating the use of a condom only once, some people don't see it very well. So the people that make up a demonstration should select some of the people from the group to come to the front and demonstrate also.*

The above quote also indicates that in certain cases participants are not given the opportunity to practise condom demonstrations themselves. Condom demonstrations generally include the facilitator showing participants how to use the condom correctly on a demonstration penis and giving participants the opportunity to demonstrate it themselves; however, this is not always the case, and a number of graduates may leave the programme without knowing how to use a condom.

Overall, peer facilitators indicated that they were comfortable conducting the demonstrations and enjoy teaching the module to participants. For example, when asked how comfortable he was with condom demonstrations, a male peer facilitator from Hardap replied: "No problem. I always try to come down to their level and think of myself as a kid again. So when they show me how to do it, I tell them to show me they way they would show one of their friends. Then I just tell them where they went wrong and make sure they know how to do it". Peer facilitators from other regions also indicated high levels of comfort with the task.

Both peer facilitators and MFMC graduates however indicated that some participants are shy and uncomfortable with the activity at first. For example, when asked how her learners respond to the demonstration, a female peer facilitator from Omaheke replied:

*I always tell them before, like tomorrow you are going to do the condom demonstration and I tell them that it will include these topics. So through that when some of them hear condom demonstration then they are already excited because they want to see. They just want to see how you are doing it. Some of them, when you give them the condoms, some are very shy but the others are just laughing. You can see that some of them already have the information and others don't.*

Similarly, peer facilitators from Hardap said:

**Respondent (Male):** *Normally, it is a bit weird for the kids. I always try my best to make the environment very friendly. We normally laugh a lot. Then they become more comfortable.*

**Respondent (Male):** *With the female condom, kids are very uncomfortable. They normally do not know how to do it. But then I show them. Most of them normally know how to use a male condom.*

This discomfort may prevent learners from actively participating in the condom demonstration. Indeed, a female graduate from Oshana, when asked if fellow learners are comfortable doing condom demonstrations, replied "Only some of them. Others were too shy to do it." Thus, it is clear that if condom demonstrations are only conducted once during the course, some learners may not be given the chance to become comfortable with the idea, and may miss out on an important opportunity to learn how to use a condom correctly.

**Ideas for Improvement:** According to the MFMC manual, the condom demonstrations are meant to be conducted only once and the suggested time for the activity is 35 minutes. This includes demonstrations of both the male condom and the femidom. Given that knowing how to correctly use a barrier method is critical to effective HIV prevention, the programme should expand and develop its condom demonstration activities so that all participants complete the course knowing how to correctly and comfortably demonstrate the use of both a male condom and a femidom. All participants should have the opportunity to practise on the models and condom demonstrations should be done at least twice with any given group of participants.

## NEGOTIATING SEX AND CONDOM USAGE

Although the majority of respondents had pro-condom attitudes, responses to condom-related statements also indicated that young people have more ambivalent feelings about actually using them. For example, over 30% of respondents agreed that they would be embarrassed to put on a condom, only 64% agreed or strongly agreed that they would be able to discuss condom use with any partner, only 68% agreed or strongly agreed that they would insist on using condoms with a new partner, and only 63% disagreed or strongly disagreed that if they were unsure of their partner's feelings about using a condom, they would not suggest using one. This suggests that among some participants there is still discomfort with actually using condoms, communicating with a sexual partner about condom use, and negotiating condom use. Overall, the data suggests that much more attention needs to be paid to the interpersonal dynamics that shape how, when, and if condoms are used, to better integrate the obstacles to condom use within the curriculum.

In addition to knowing how to use a condom, it is also important for young people leaving the course to feel comfortable negotiating sex and condom usage. As discussed above, the quantitative data suggests mixed feelings about actually negotiating condom usage in various contexts.

As a way of assessing their negotiation skills, their self-confidence to say 'no' and their ability to communicate their needs, MFMC graduates were asked to respond to two different scenarios during focus group discussions. In the first scenario, participants were probed to assess their ability to refuse sex: 'Let's say your boyfriend or girlfriend wants to have sex and you don't want to. What would you say? What can you do?' In the second scenario, participants were asked to negotiate condom use. 'Let's say you are in a relationship and you decide to have sex. How would you ask your boyfriend or girlfriend to use a condom? What would you say? If he/she refused to use a condom, how might you try to convince them?'

Overwhelmingly, the responses indicated that participants had absorbed the importance of communicating clearly, saying no, and sticking to their decisions.

Both male and female participants indicated not only that they would feel comfortable saying no to sex, but also that they would feel confident that they could find someone else who would be willing to respect their needs.

*I would say maybe it is not the right time to have sex. And if he doesn't accept that then I will tell him that there is still another person who will accept me (Female graduate, Khomas).*

*If I say no to a boy and he does not want to accept my no then I will just walk away (Female graduate, Oshana).*

*I will tell him that I don't want to have sex and if he doesn't want to agree with me then I will let him go, as they said. Then I will just think that the only reason that he came to me was to have sex because if he really loved like he claimed then he would stay and respect my wishes (Female graduate, Hardap).*

*If my partner wanted sex and I refused and then she doesn't want to accept then I will just have to say sorry . . . Because she doesn't love me (Male graduate, Khomas).*

*If my girlfriend doesn't want to accept the fact that I don't want to have sex then I will tell her that if she wants to leave me, then she can leave me. But I will ask her to try and adjust her feelings to mine so that we are on the same thinking (Male graduate, Hardap).*

Both male and female participants also reported feeling confident in communicating their wish to use a condom during sex. For example, a female graduate from Khomas said, "I will tell him that he has to use a condom and if no condom, no sex." The female participants mentioned a number of means of negotiating condom use, such as educating their partner about HIV/AIDS and, in effect, showing him the importance of condom usage. A female graduate from Hardap explained: "I will tell him about HIV and AIDS because then he will know that the reason why I want to use a condom is because I am afraid of HIV/AIDS." Another means of negotiation mentioned was appealing to the caring and respectful side of one's partner. Another female graduate from Hardap reported that she would say, "Honey, we have been together for a long time now I think it is time to do it. But just to prevent us from both hurting ourselves we should use safety."

Like the female graduates, male graduates also reported feeling confident in ensuring that condoms are used during their sexual encounters. According to a male graduate from Hardap "I will tell her that if she doesn't want to use a condom after several attempts then I will tell her to go and look for another boyfriend." Again, education about HIV/AIDS was mentioned as a way of negotiating condom use. A male graduate from Khomas explained, "If we decided that we will have sex then I will tell her about the disadvantages of not using a condom." Male graduates also spoke of bringing attention to the consequences of their actions as a means of negotiating safer sex. For example, a male graduate from Khomas reported: "If she says that she will not use a condom, then I will tell her that we cannot have sex because I am not ready to be a father."

Overall, most MFMC graduates who participated in the focus group discussions indicated a high perceived self-confidence to engage in safer sexual practices, as they seemed confident in their ability to say no to sex and to ensure condom use when engaging in sexual intercourse. The data indicates that MFMC graduates clearly know the 'right' answers, as per the curriculum. Yet the question remains whether, in real-life circumstances, they will be able to put the behaviours they speak about into practice. Overall, their responses were very rational and de-contextualised and gave little consideration to the emotional aspects of sexuality and issues of desire. Sexual practices often defy reason; yet very few participants recognised that their own feelings and emotions may make it difficult to negotiate sex or condom use when faced with real situations.

In an effort to understand better how context and interpersonal dynamics shape condom usage, MFMC graduates were asked to describe situations in which young people were less likely to use condoms. Some indicated that condom use was less likely in steady relationships where you trust and love your partner and there is the assumption of monogamy. A female graduate from Oshana said condoms were less likely to be used "when you trust your partner. And also if you want the girl to be your girlfriend forever." A female graduate from Omaheke also mentioned that not using a condom is a way of "show[ing] each other love, to prove that you really love each other."

Conversely, others graduates said that condom use would be lower in casual relationships when sex is unplanned, and when there is no condom at hand, including at a party or where alcohol is being consumed. A female graduate from Oshana said that young people are less likely to use condoms "only when they are under the influence of alcohol and drugs." Similarly, a male graduate from Omaheke explained that when people are under the influence of alcohol "... they don't really have time to put on the condom; they just go for it." On the subject of casual partners, a male graduate from Khomas pointed out that "a one-night stand is never planned, it just happens. So you might not have a condom with you. With committed relationships you would have talked about it and planned for it."

Other contexts mentioned included contexts of transactional sex. For example, a male graduate from Khomas mentioned that "some girls will just allow the man not to use a condom because the man is supporting her by buying her special things." Condoms are also not used in situations

where young people fear rejection from their partner for wanting to use condoms. Indeed, a female graduate from Omaheke explained "... [if] this guy doesn't want to use a condom but you want to use a condom, then you can't speak up because . . . you can't say no because then the guy will leave you for somebody who is willing." It was also mentioned that sex without a condom is sometimes the result of wanting to have a baby in order to keep a boyfriend. For example, a female MFMC graduate from Hardap said: "...and most of the girls when they want to keep the man they think that the man won't leave her if she has a baby. So then she doesn't put a condom on and she sleeps with him without a condom, then he can impregnate her and she can have his baby. Then he will stay with her."

Furthermore, condoms are less likely to be used when they are not readily available (e.g. in rural areas). Indeed, the link between unprotected sex and the unavailability of condoms was spoken about in the Omaheke focus group:

*Moderator: Now when are you less likely to use condoms?*

*Respondent (Female): Like for instance the farms and those places, you find that some places there are not clinics and then you get into the bar, like when you enter the door there is this box of condoms. But at some places there are no clinics . . .*

*In addition also, for example when we talk about the farms...you are sometimes very far away from the town and sometimes when...Just in that area you know you meet a person and from there you are not having a condom with you. Like she said there are no clinics where you can go and get the condom and so in those situations, people are just doing sex because there is no choice for him. He doesn't have a condom and he wants to have sex and so he just does it.*

Condoms are also less likely to be used when there is a strong perception that they reduce pleasure. A male graduate from Omaheke explained, "some people are saying that it is better to make sex without using a condom because if you are using a condom then it doesn't feel like you are making sex. Because the condom loses the effect..." A male graduate from Oshana put it more succinctly: "some people say if you have sex with a condom it is just like you are eating a sweet wrapped."

**Ideas for Improvement:** At present, two critical negotiation activities are marked 'Optional' in the MFMC curriculum. These are 'How to Convince Your Partner to Use a Condom' (Session Four, Activity Six) and 'Practising Negotiating 'No' (Session Seven, Activity Two). Given the identified weakness in negotiation skills, these activities should be made mandatory. In addition, participants should role play different scenarios and obstacles to condom use. For example, how to handle a situation when both you and your partner (casual or committed) really want to have sex, but there is no condom at hand. In addition, the curriculum can also take a more positive approach to sexuality and include discussions about how sex with a condom can be made more pleasurable, even though some may experience condoms as reducing sexual pleasure. It would also be useful to discuss obstacles to consistently carrying condoms for participants who are sexually active, and to include actively problem solving around this topic as part of the module.

## **VOLUNTARY COUNSELLING AND TESTING**

Only 29% of respondents indicated that they had been tested for HIV. Of those tested, 87 % went back for their results. While sexually active youth (40%) were more likely to test than youth who were not sexually active (18%), it is still striking that so few young people decided to test.

In an effort to understand why so few MFMC graduates have actually gone for VCT, both MFMC facilitators and MFMC graduates were asked various questions about the VCT module.

Both MFMC facilitators and MFMC graduates were able to clearly articulate the importance and benefits of testing, namely knowing whether you are positive or negative and knowing how to take care of yourself. For example, if you are negative, how to stay negative, and if you are

positive, how to best take care of yourself, avoid re-infection, and elicit support. Overall, MFMC graduates demonstrated good recall of the VCT content.

MFMC peer facilitators indicated that one of the limitations of the VCT module is that it is primarily an informational session, with little interactive content. Although there is an optional role play activity associated with the module, whereby one partner tries to convince the other to go for an HIV test, much of the content is technical, some of which can be confusing to participants. A female peer facilitator from Khomas explained the challenges of teaching the VCT content.

*I think this session is a bit too technical. It is a bit difficult for the participants to understand because first of all they hear about ARVs and that is a whole lot of stuff that you have to tell them. You tell them about the anti-bodies, you tell them that they test the person's anti-bodies and then you find that there is a virus. So that is a bit difficult for them to grasp because it is something that they would never think. They have heard of condoms and now you are talking about ARVs and anti-bodies and they way HIV spreads and so it is real technical. So usually the activity doesn't require you to play games and whatever. You just explain a whole lot of stuff but it is really confusing and the time is only two hours and usually you only tell them what you know.*

Recognising the limitations in the manual and their own limited knowledge, some facilitators have been proactive, seeking additional information from New Start Centres in their areas. A facilitator from Hardap invited a VCT counsellor to present some of the information to participants.

*I am not really a trained counsellor. So one day I invited a person to the class. She was a clinic counsellor. She came to the session and she told us more about the counselling and testing process. So the only thing that I did was tell the kids the basics about VCT and then she gave them more detail. The kids were very interested in the topic. At the end she also urged those that were interested to go for testing. I hope that they will go.*

When we asked MFMC peer facilitators how they encouraged young people to be tested, most indicated that they either emphasise the benefits of testing or share their own experiences of being tested. Others, however, make it clear that testing is a sensitive issue and the decision to test is personal. A peer facilitator from Oshana explained:

*This session is very sensitive. It is not easy for someone to go for testing. I tell them about the pre- and post-test counselling. I explain that the pre-test counselling is done before the test and the post-test counselling is done after the test, when you get your result. I also tell them to be themselves; not to go for the test just because their friends are going. You must make the decision to go and you should be prepared to accept the result, whatever it is.*

Such sensitivity is understandable. When MFMC graduates were asked why more young people did not go for VCT, they indicated that the primary deterrent to getting tested was fear. Fears mentioned include: the fear of knowing their status; fear of rejection; fear of discrimination and stigma; fear of their parents knowing that they are sexually active; fear of being seen at clinics; and fear that they will be berated by clinic staff or that the counsellor will tell others. Aside from fear, young people may also feel that if they are not sexually active, it is unnecessary to test.

When MFMC graduates were asked what the programme could do to encourage young people to test, most suggestions centred on either inviting people from New Start Centre to offer VCT at the school or to organise a group to go for testing, either after the course or as part of it.

**Ideas for improvement:** It is clear from the data that the main obstacle to the uptake of VCT among young people is not a lack of knowledge of the benefits or importance of testing, but rather the fear of testing. The session content needs to address the fears associated with testing more directly, and to include more interactive activities. The programme should also consider formalising a link between the programme and local VCT centres, both in terms of providing additional information and of offering VCT services at school.



## ALCOHOL USE AND ATTITUDES TOWARDS ALCOHOL USE

In terms of alcohol and drug use, both the quantitative and qualitative data indicate that, although participants demonstrated a good understanding of how alcohol can impact on sexual decision making, many participants continue to see alcohol as a social lubricant. As indicated by the quantitative data, attitudes associated with the social contexts of alcohol were split. For example, 44% agreed or strongly agreed that parties are no fun without alcohol, and 45% agreed or strongly agreed that drinking overcomes shyness. The variation in responses to general attitudes to alcohol use, which the MFMC curriculum seeks specifically to examine and deconstruct, suggests that there is scope for the programme to work more effectively with participants, to promote healthier attitudes towards alcohol use.

In order to better understand the strengths and limitations of the alcohol and drug use module, MFMC peer facilitators were asked how they deliver the session and how/if the main messages resonate with MFMC participants. As it is currently constructed, the session on alcohol and drug use mostly emphasises the dangers and negative impacts of substance abuse and how it can damage the brain. This is indeed one of the main messages that peer facilitators reinforce when they deliver the session, and it is also one of the key messages absorbed by participants. Most peer facilitators indicated that they tell participants to stay away from alcohol entirely, and that alcohol and studies do not mix. The predominant message of the session on alcohol and drugs is to 'Say No.' Peer facilitators from Oshana explained how they encourage MFMC participants to stay away from alcohol:

***Respondent (Male):** I normally ask them a question. I ask them what benefits they get out of drinking. I tell them that it wastes your money and that it makes you do things you would not normally do. You can even get involved in crime. It is also dangerous. You can have unprotected sex. People forget to use a condom. They do not even know where they are if they wake up the next morning. I told them these things.*

***Respondent (Female):** I encourage them to be aware of the dangers of alcohol. I have to try and scare them by telling them a real story that happened so that they can know how dangerous it is.*

***Respondent (Female):** I just tell them that they are still at school and I tell them that alcohol and school work does not go together.*

***Respondent (Male):** I explain to them that alcohol affects them badly and I tell them about the problems...*

While the dangers of alcohol is clearly an important message, it is also true that many young people in Namibia begin experimenting with alcohol, in particular, at an early age and that there is strong peer pressure to drink, especially in the context of social occasions such as parties. Of MFMC participants surveyed as part of this study, 61% indicated that they had already tried alcohol, and the mean age of the first drink was 13.6. This is very young. The data also suggests that many young people first try alcohol before coming into contact with the MFMC programme.

When peer facilitators were told that the average age of first drink among 300 MFMC participants surveyed was between 13 -14 years of age, there was little surprise or shock. Rather, there was general agreement that the peer pressure to experiment with alcohol is very strong and that it is hard for young people to resist, especially since drinking is part of how young people socialise. A peer facilitator from Khomas explained:

*Generally they drink anyway at their age and they go and visit bars and they go clubbing. They know what alcohol is . . . They can know when to get them from the clubs . . .*

The alcohol use of young people is seen to be very much related to peer pressure. Indeed, a peer facilitator from Oshana stated:

*Many young kids try alcohol because of peer pressure. Sometimes they go out and tell their friends not to drink. Then the friends will tell them that they have never tasted it before and how*

*can they judge them. Sometimes the kids also do not believe you when you tell them that if you are under the influence of alcohol, you will do things that you normally would not do. Then they go and try the alcohol to see if what you were telling them is true.*

In addition, because alcohol use and abuse is common in Namibia, what participants learn through the curriculum does not always accord with their own experiences. For some participants, parental drinking is part of the problem. Two peer facilitators from Omaheke explained:

*Some learners say that at their homes their mothers are drinking. So they just grow up in a house where their mothers are drinking. So they will just drink because their parents are drinking and they are still alive so they think that they can drink until they reach the point of being addicted.*

*All you can do is give the information and then the learners have to choose for themselves. So if the learners see their father drinking or someone important drinking then they will think that it is not wrong. What I think is that parents should also be helping and should intervene.*

In some instances, parents also send their children out to buy alcohol for them.

While the curriculum clearly delineates the hazards of substance use, as well as the warning signs of addiction, there is little content that deals directly with the social and familial contexts of substance use in Namibia, how to recognise one's limits, or what it means to use alcohol responsibly.

**Ideas for improvement:** Although the curriculum does include an activity whereby participants examine their attitudes about drinking, there is otherwise very limited content on the social pressures on young people to drink and how the youth can effectively navigate social situations where alcohol is plentiful, including at home. There is thus considerable scope for the programme to work more effectively with participants to promote healthier attitudes towards alcohol use. In addition, although there is some content on the differences between use and abuse, there is no content on responsible drinking.

#### **IV. ASSESSMENT OF PROGRAMME DELIVERY MECHANISM: STRENGTHS AND WEAKNESSES**

In addition to assessing the influence of the programme on MFMC graduates and MFMC peer facilitators and identifying areas of strength and weakness, one of the key objectives of the evaluation was to assess the programme delivery mechanism.

As a way of providing feedback about programme quality and the programme delivery mechanism, all stakeholders – Principals, contact teachers, RACE Coordinators, and the Trainer of Trainers – as well all peer facilitators who participated in the semi-structured interviews, were asked to give the MFMC programme a mark from 1-10. Respondents were also asked to explain and justify the mark given.

Out of 25 responses, the average programme mark given was eight. The range was between four and 10, with the majority of marks (72 %) falling between eight and 10. The most common justifications for marks less than ten included:

1. The programme reaches only a small proportion of the target group.
2. The programme is not integrated into the school curriculum or system.
3. There is insufficient buy-in from schools, especially the Principals.
4. It is difficult to sustain programme continuity due to high peer facilitator turnover.
5. Facilitator knowledge and skills are limited.

6. There is poor communication between the MFMC programme office and the schools.

In addition, these programme weaknesses were also frequently mentioned as barriers compromising the effectiveness of the programme and limiting its potential impact. Tellingly, almost all comments related to implementation issues and how the programme is delivered, rather than to the programme content. In fact, few respondents spoke about the need to revise the curriculum itself.

## **I. QUALITY OF PROGRAMME DELIVERY**

### **STRENGTHS**

When asked about the strengths of the programme, there was consensus among stakeholders that, despite the limitations of the MFMC programme (discussed below), the programme brings various benefits to the school and the learners who participate. No one suggested that the programme should be discontinued, or that it was doing harm by talking to young people about sex and HIV. Rather, among Principals, contact teachers, and RACE Coordinators, the programme is broadly seen as having an important influence in building life skills among participants and in reducing teenage pregnancies.

Commonly reported strengths mentioned by stakeholders, MFMC participants, and MFMC peer facilitators alike include that the MFMC programme:

- Creates awareness of HIV/ AIDS, STIs, teenage pregnancy, and the dangers of risky sexual activity;
- Promotes abstinence;
- Teaches participants how to use condoms correctly;
- Provides information that some learners may not otherwise be exposed to, especially in rural areas;
- Resonates with real issues in young people's lives;
- Teaches participants to care for PLWHA;
- Teaches participants important communication, decision-making and problem-solving skills;
- Enhances participants' self-esteem and self-confidence;
- Teaches participants how to resist peer pressure;
- Supports participants who are already HIV positive to accept themselves and cope with stigma;
- Leads to observable positive behaviour change among participants.

Importantly, many stakeholders believe that the programme has led to safer sexual behaviour in the form of abstinence, increased condom use and fewer sexual partners.

Another frequently mentioned benefit and strength of the programme is that it reinforces what is learned in other classes such as Life Skills and Science.

There is however an important difference. Compared with other classes at school, the MFMC programme creates a space for open discussion and also helps young people learn to make moral distinctions between what is 'good' and 'bad.' A contact teacher from Kavango describes how the MFMC programme reinforces what is taught in other school subjects and enhances learning, not only for MFMC participants, but for teachers and other students as well.

*Some of the things they learn in the programme are also taught in school subjects. This is a good thing. Because now these learners who participate can help you when you are teaching the*

*subject. They sometimes take over and explain things in class. They are very helpful . . . The learners also teach the teachers things they may have learnt in the programme and in this way they also help with the subjects that are given at school. Also, it has really changed some of the learners. Some of them know how to say something is good or something is bad.*

Thus, knowledge learnt by participants is also shared with the school and the broader community. There is also a strong sense among stakeholders that the knowledge gained through the programme prepares young people for life outside of school, helps them learn to take responsibility, make informed choices and think about their future. A Principal from Kavango makes a clear link between learning life skills and a reduced likelihood of falling pregnant:

*Because they are taught how to handle their lives, there is less likely to be chances of early pregnancies at school . . . They are taught how to abstain and . . . there aren't a lot of pregnancies at schools; imagine close to 600 learners but there are only few, like last term, who dropped out due to pregnancy.*

According to a contact teacher from Omusati, the MFMC programme also helps participants mature: "You see those you have attended are really acting differently from those who don't have the information . . . it makes them to be grown up and understand the situation properly."

Besides the recognised benefits of the programme discussed above, another expressed strength of the programme is the communication and relationship between peer facilitators and the school. School staff and participants report broadly positive experiences with peer facilitators. In general, there is good and open communication among the various actors at the school. Similarly, peer facilitators also report good support from the school such as assistance with logistics (e.g. making photocopies, organising a venue), curriculum content, managing disruptive learners, and moral support. Although peer facilitators report good support from both Principals and contact teachers, contact teachers tend to be more 'hands-on', attending sessions and encouraging learners to communicate openly, while school Principals tend to oversee the process and are more 'hands-off.'

## **WEAKNESSES**

### **Limited reach of the programme**

One of most common programme weaknesses cited by MFMC participants, facilitators, and stakeholders is that the programme reaches far too few students. When respondents were asked how to improve the programme, the most consistent suggestion was to expand the reach of the programme to include more young people. At each school where the programme is being offered, a maximum of 66 students, from Grade 8 to Grade 12, can enrol per year under the current model. Indeed, as it stands now, the programme only reaches a small section of the target group.

One RACE Coordinators explained how the recruitment process currently works and how it could be improved to reach as many learners as possible:

*Yes per term you have 22 learners in that particular school and then for instance you have a school of 500 learners. In a year you will only reach about 66 learners, so it is a very small number. . . . What I would like to see done on the programme is for the programme to become part of the curriculum. Say for instance like other subjects that we have in school such as History, Geography, Mathematics and so forth. I would like this programme of MFMC to become a school subject, it can be a non-promotional subject but at the end you have at least everybody in the school. That is what I think should be done, in order to reach as many learners as possible.*

It addition, the MFMC programme primarily reaches those who self-select into the programme. Thus, it does not necessarily reach those who need it most or who could most benefit from the information and skill-building. Contact teachers assist with recruitment and may help identify participants who are for example 'at-risk'; however, this is subject to the personality and discretion of the contact teachers, rather than a formalised mechanism of recruitment. The implication of

limiting the programme to a select number of learners, as compared with the secondary school-going population as a whole, is that many young people who could benefit from the MFMC programme are not included.

### **Construction of the programme as an after-school, optional activity**

Another commonly cited barrier to the effective implementation of the MFMC programme is its lack of integration into the school curriculum system. Rather than being built into the timetable of the school, the programme is only offered as an optional, after-school activity. This means that only young people who are available after school and do not have other responsibilities can actually participate; indeed, in many instances, learners are already actively involved in other activities, such as sports and clubs. And in communities where learners have to travel a fair distance to go to the school, or have household or childcare responsibilities after school, the timing of the programme is inherently problematic. In addition to transportation issues, learner fatigue and hunger in the afternoons is another obstacle to participation.

A contact teacher from Omaheke explains how the lack of integration of the MFMC programme into the school curriculum places considerable pressure on the learners and contributes to dropouts and uneven participation among learners.

*The kids have to come back at three o'clock and some of them live a distance away. I think we are putting a lot of pressure on the kids. The kids are interested in the programme, especially if they know they are going to get a certificate and a t-shirt. It is just the time, they have to go back. And because of the distances, some of the kids have to drop out of the programme"*

Besides logistical issues, because the programme is neither compulsory nor examinable, participants do not always take it seriously. For the programme to be seen as significant, most peer facilitators and stakeholders have suggested that the programme be included in the curriculum. One Principal from Omaheke explains one way this could be done: "Maybe they should change the programme and make it compulsory to start at Grade 8 and then you move with the same learners to Grade 9 and then you have a syllabus that covers all grades." One teacher, also from Omaheke, even suggested that the course should be examinable: "The kids should write a test to pass the programme."

In addition, although the programme is meant to include an equal number of male and female participants, because of the voluntary nature of participation, young women are over-represented among MFMC participants. The high rate of dropouts is often a result of boys feeling uncomfortable within a group consisting mostly of girls. Other cited reasons for low male participation include involvement in after-school sports, low effort by the school to encourage them to join, a lack of interest, and a lack of male peer support for their involvement.

Lastly, academic demand on learner time is often greater in secondary school. Learners have to spend far more time than primary school learners on their school work, so after-school commitments can easily take a back seat. Because the MFMC programme is offered after school and does not carry the weight of a normal school subject, the programme, although valued by stakeholders, is also seen as peripheral or secondary to the academic programme. In the quote below, a male peer facilitator from Kavango explains how, during the delivery of the MFMC course, participants are sometimes pulled out of the course by teachers to study.

*But sometimes it gets difficult because the teachers come and say that the learners have to go and study, but if they go for study they are going to read books that will help them go to university but that kind of book will never give them their life. Here the teachers are encouraging them to go for studies, studies must be there but they must also try to think about this programme to be like first. Just the same way they put studies first.*

While it is not surprising that a programme offered as an optional, after-school activity would be seen as secondary to academic demands, it nonetheless contributes to uneven buy-in of the

programme at the school level. According to one RACE Coordinator, one of the key obstacles to the effective implementation of the programme is that it is not integrated into the school curriculum, but rather seen as a “little extra cherry on the top.” In fact, she argued that until the programme is run like a normal school subject, there will be little change.

*But I think that it {the MFMC programme} needs to be more of an aligned function of the Ministry, not to be seen as some little extra cherry on the top. Not to be seen if we have the time and the money then you will be allowed to get the teachers together for an orientation meeting or something. It should have the same status as an academic subject so that everybody will take it seriously.*

Indeed, because the programme does not have the “same status as an academic subject” it is more easily sidelined by the school. It is clear from interviews with RACE Coordinators and MFMC peer facilitators that some Principals and teachers do see the MFMC programme as a diversion from the real business of the school, namely academics. While this is understandable, as Principals and teachers need to meet targets with regard to learner performance, without sufficient buy-in, the effective implementation of the programme will be compromised.

In fact, according to one RACE Coordinator, one of the main obstacles to the effective implementation of the programme is buy-in from Principals:

*The whole of September I have been on field trips and we were trying to explain the importance of the programme. The barrier is the Principals. I don't see that they are buying into the idea or they haven't weighed the importance of this programme and what it can do to the learners.*

Although the Principal is the head of school and provides leadership for emphasising the importance of the MFMC programme at his/her school, without strong leadership on the part of the Ministry of Education according a higher status to the programme, it is likely that buy-in from schools will be uneven.

### **High turnover of peer facilitators**

Another significant barrier to the effective implementation of the programme is the high turnover of MFMC peer facilitators. It is important to remember that peer facilitators are volunteers, not employees. MFMC peer facilitators do not have a contract, benefits, or job security. They receive a stipend, rather than a salary, for their facilitation of the course (N\$ 500 per course + a transport allowance). Given the nature of their position as volunteers, peer facilitators are inherently a mobile, fluctuating population and new volunteers need to be trained on a regular basis. Three out of four RACE Coordinators spoke about the high turnover of peer facilitators due to the voluntary nature of the position and having to continually train new peer facilitators, as compromising programme quality. One RACE Coordinator explained:

*Because the moment that they get another job then they just leave the programme. Then you have to go back the next year and start from the beginning to train new facilitators for the region. I think that is a challenge for the region because we trained eight facilitators during May and one of them, he didn't even start with the programme and then he got a job.*

Also, although one of the responsibilities of the MFMC peer facilitators is to assist with post-MFMC activities, because they are paid upon completion of the course, there is little incentive for peer facilitators to continue their involvement with the school besides arranging for another course in the next school term. A Principal from Omusati explains the need for permanence from a peer facilitator to help build the programme at the school and provide necessary support to learners:

*Getting the facilitator to provide the needed support to the learners . . . because . . .in the term after the session you will no longer see that person or facilitator for a very long time, and looking at the number of teachers we have and they are involved in so many activities and the time is not there to really provide necessary support to the children . . . it can either be permanent or a person will be coming in every term which means when term comes to an end*

*and you have somebody to be there as long as the person is able to communicate and not where he stopped the last session*

While the stipend offered to peer facilitators as volunteers may be competitive or even higher than other youth service volunteer positions in Namibia, it is still insufficient to live on. Indeed, when the question of peer facilitator retention and attrition were probed through interviews, it became clear that the main reason why peer facilitators leave the programme is because the stipend is not considered adequate to live on. When facilitators find other work that provides a steady or better income, they tend to leave. A peer facilitator from Omaheke explained:

*It is the financial things. It is not satisfactory. Also, it hampers the way to progress as a peer facilitator. Let us say you plant a tree but you do not give it water. It is your tree, but you are not giving it anything to grow. You expect it to bear fruits, but how can it bear fruit if you do not feed it?*

Importantly, the desire for an improved income is related to the high cost of living in Namibia. In speaking about the importance of improving peer facilitator compensation, a peer facilitator from Kavango described the challenges of trying to survive on the MFMC stipend:

*Because the cost of petrol is also high, food, everything is also high. Now with the little amount we are getting, it's not enough. Yes, really it's not enough. And we are living with the unemployed parents also, that little amount of money is not enough.*

### **Uneven monitoring and evaluation (M&E)**

Another significant barrier to the effective implementation of the MFMC programme is uneven M&E. Although there is an existing M&E system in place, it is not functioning properly to ensure programme quality and implementation.

The MFMC programme is meant to be monitored at three levels – local, regional, and national. This evaluation has explored issues of M&E only at the local level. At the level of the school, the contact teacher and Principal are the key stakeholders responsible for monitoring the implementation of the MFMC training sessions by the peer facilitator. The key monitoring forms are the participant sign-up list, the course schedule, the attendance form, the course completion form, and the evaluation of facilitator form. Of these forms, the only one that aims to assess the quality of the programme, rather than that the programme is being implemented, is the evaluation of facilitators' forms.

There are many reasons why the M&E system that is currently in place is not serving its purpose as envisioned. These include: poor communication between the MFMC programme and the school; lack of knowledge and understanding on the part of Principals and contact teachers; and uneven completion of M&E forms.

One of the key problems is a lack of communication between the MFMC programme office (herein referred to as the Head Office) and the school. Half of the Principals and all of the contact teachers interviewed indicated that they had very little direct contact with either the RACE Coordinators or the MFMC Coordinators in their respective regions. Many also indicated that they had not received training on the MFMC programme or their roles and responsibilities. A Principal from Kavango explained how he only “happened” to receive training on the programme this year, although his involvement began last year. Prior to being briefed on the MFMC curriculum, it was difficult to fully understand the programme and actively be involved in its implementation.

*I only happened to get training this year and it is only this year now I can be able to help. I came here last year but there was no training given to us as Principals and therefore it was not easy for us to be involved that much because if you don't understand what's going on, you cannot fully participate.*

Similarly a contact teacher from Oshana indicated that she had limited understanding of the programme from a systemic and, to a lesser extent, content, point of view and the importance of an orientation workshop for clarification.

*I am not well informed about the whole programme . . . Why I am saying that I am not well-informed is because first of all I don't know who the head of the whole programme is. I have never attended any orientation workshop to know about this programme...from my understanding I don't think that the two ladies that came to conduct this session, I don't know whether they are well informed about the programme too because they are not employees of the RACE office. So I think the only way for me to be well-informed about this programme is for me to attend an orientation workshop . . . I really need a workshop on this, although I know most of the topics being a teacher but at least there are maybe some of the things I don't know.*

Without sufficient information and good communication between schools and the Head Office, both contact teachers and Principals have to take 'educated guesses' about their roles and responsibilities vis-à-vis the programme. When asked about her role and responsibilities with regard to the MFMC programme, a contact teacher from Omusati replied:

*I am not really sure about my responsibility, but I am doing what I think is my responsibility at school, just to make sure that many of our learners are not left out from this important information and also to see to it that our school has a facilitator, to come and talk to the children and educate them about this programme. I feel that I am responsible because sometimes I also have to go and look for the facilitator to come if she is not available*

The response to contact teachers and Principals who have communicated with their regional RACE Coordinators and MFMC Coordinators about the programme, has primarily been limited to once-off workshops or written correspondence. Clear and regular communication is important at all times, but especially when there are changes in the programme or facilitator. Such information, however, is not generally forthcoming. A Principal from Omusati explained why regular contact with the MFMC Coordinator is needed:

*We should be meeting regularly so that the MFMC Coordinator can give us assistance we need.... for example he must inform us when the programme is not going to be run at the school. Sometimes, you are just sitting and waiting for someone to show up to start the course but you end up not having anyone. Furthermore, they don't even make an effort to notify the school. It's like the programme does not even exist.*

A contact teacher from Omaheke raised similar concerns about the lack of contact with the Head office and the implications for the school. Often schools only receive a letter from the Head Office informing them that a peer facilitator will be arriving.

*Head Office of the region should think about strengthening the relationship between their offices, the facilitators and the contact teachers. We do not have that much contact. This is a problem because Head Office thinks that after they have trained the facilitators, they are settled. Then they send the facilitators to the school. But then I do not think this is enough, Regional Office should improve contact...The person comes to you and they tell you they are a facilitator. How do I know they are really a facilitator? They also don't always send a letter saying that they have been trained. They also do not have a nametag or identification.*

Such irregular and limited communication with Head Office inevitably has an impact on the degree to which M&E happen. If Principals and contact teachers, as the primary persons responsible for overseeing the programme at schools, have limited understanding of the programme, how can they effectively monitor and evaluate the programme?

Indeed, when Principals and teachers were asked about their role in the M&E the MFMC programme, little detailed information was offered. Contact teachers, and even some Principals, indicated that they do observe sessions of the MFMC programme as part of M&E, and that they fill out and sign forms brought to them by peer facilitators; however, their responses also indicate



very limited understandings of the role of the school, in particular the contact teacher, in monitoring the performance of the facilitator and the programme in general.

Completing the form is not simply an administrative function; it is critical to ensuring quality and that the peer facilitator is performing his/her role adequately. However, according to RACE Coordinators, getting school staff to regularly complete the reporting forms and return them to the MFMC office can be something of a challenge. Often, schools do not use reporting forms; when they are completed, sometimes they are not returned on time, or at all; In addition, those completing the forms sometimes do not understand how to complete them. One RACE Coordinator explained the challenges of getting schools to complete the reporting forms, return them, and complete them correctly.

*The reporting for me is also another barrier, I have to travel around with this form (and distribute to the school in person) . . . . Sometimes I send them through the mail. But then the return is late and sometime they are not returned. Like last term I had ten schools that did not return the reporting forms. . . Because if they don't return the reports there is no proof that the programme is running. So the best remedy for all this is to let the people to understand because the schools that I have visited so far have said that they did not understand the form and the completion of it. They said that they could not see the need of it but now they said that they were buying into the idea because they understand.*

If the forms are not being completed correctly, it is difficult to rely on them as accurate tools for M&E. One of the key challenges is a lack of training and orientation on how to use and complete the forms. Another RACE Coordinator explained how, although the programme office in her region recently trained contact teachers on the MFMC programme, the training itself omitted the administrative aspect of the contact teacher's role:

*On a formal basis we had an orientation course for contact teachers that was done by the UNICEF Consultant . . . As far as it went, I think that it was very good because it gave people a discussion forum and so on. But it didn't include the administrative side of the contact teacher's job, filling in forms and so on which I think was a bit of a lack. It should have included that and it should have gone more into what is actually expected of the contact teacher, not just to say that they have to monitor sessions but also to go more into more about how they should go about it and the use of all these forms that they are supposed to use and so on. So I think that could have been better, we have not done that this year for various reasons.*

While it is clear that MFMC coordinators and RACE Coordinators do conduct site visits to school, these visits are generally ad hoc, dependent on the needs of schools, and subject to the availability of the MFMC and RACE Coordinators, rather than systematic and formalised. One RACE Coordinator explained that she has played almost no role in M&E, while another explained that the limited access to a staff vehicle makes it difficult to conduct regular site visits.

Lastly, although peer facilitators indicate that they do receive support at the schools from Principals and contact teachers, direct supervision of the peer facilitator is nevertheless very limited and depends largely on the interest, commitment, and personality of the contact teacher. The primary person responsible for monitoring and evaluating the programme is the contact teacher. If the contact teacher does not fully understand his/her role and does not receive the necessary support and training, the M&E system can easily fall apart.

## **II. CAPACITY OF FACILITATORS**

### **STRENGTHS**

During the semi-structured interviews, peer facilitators were asked to describe the MFMC programme and their role as peer facilitators, and to assess to what extent they understood and could articulate the key objectives and content of the programme. Although peer facilitators' aptitude for, and mastery of, the content do vary, overall, peer facilitators have a good

understanding of the MFMC programme and the 10 sessions. They were able to explain the purpose and structure of the programme as well as speak in detail about the importance of given sessions. The quote below illustrates how, at a basic level, peer facilitators are able to explain the key goals of the programme and its content.

*My Future is My Choice is just a programme which aims to give young people knowledge or information and skills about this epidemic disease HIV/AIDS. We describe it also as a programme of ten sessions, where young people can gain information and skills about My Future is My Choice programme . . . The reason for My Future is My Choice I think is offered for the young people or whoever is included to fight against this epidemic disease and to protect themselves. . . . We have ten sessions as I said, the first is "Getting Started", second is "Reproductive Health", third is HIV/AIDS, fourth "Risk situations", fifth "Facing HIV", here we teach kids how to deal with HIV/AIDS or dealing with people who are infected; sixth "Decision Making", here we talk about how to make decisions, right decisions and how to cope with peer pressure. The seventh is "communications - whereby we deal with how to communicate with different people either young or old, we even talk about different ways to communicate with different people. And the bad ways to be avoided: aggressive and passive, Eighth "Relationships", - we talk about gender roles and relationships, Ninth "alcohol and drug abuse" - where we discuss how alcohol and drugs affects people's mind; Tenth "future" - here we make preparations and discuss about the graduation event. (Female peer facilitator, Omusati)*

In addition, peer facilitators also have a good understanding of their role as facilitators; namely, to provide information, facilitate activities, and guide learners. They are also clear that, while their role is to inform and advise, they cannot tell young people what to do. Most also understand the importance of being a good role model to participants, and value the programme for the difference it can make in the lives of young people.

## **WEAKNESSES**

### **Variations in ability to communicate in English**

Peer facilitators vary in their ability to express themselves in English. Some are able to communicate clearly and effectively in English, whereas for others it is apparent that English is not their first language. This comes across clearly in the interviews and focus group discussions with peer facilitators, as it is sometimes difficult to understand what the peer facilitator is actually saying. Although there are many different languages spoken in Namibia and English is the first language of only 7% of the population, English is nonetheless the medium of instruction at the secondary school level.

The implication is that if it is difficult for the interviewer to understand what the peer facilitator is trying to communicate, there is also a strong likelihood that the peer facilitator faces challenges in conveying the programme content and explaining concepts to MFMC participants in English, especially if questions or topics come up that are not directly included in the curriculum.

### **Limited knowledge and ability to answer questions**

Broadly speaking, the knowledge level of the MFMC peer facilitator is limited to what they learn through the initial MFMC training course and any refresher courses they attend thereafter. Although many peer facilitators do take the initiative as individuals to deepen their understanding of the content of the programme, it is nevertheless clear from the data that peer facilitators' knowledge levels are limited, rather than broad. Some learners ask questions that peer facilitators do not know the answers to, and in some cases learners themselves are more knowledgeable than the peer facilitators.

A Principal from Kavango, for example, explained how learners are sometimes more knowledgeable about certain topics as they may be studying these subjects in other classes, and how this can create problems:

*The one big weakness is that the facilitators although they are good facilitators. . . .How can I put it? The knowledge of that person should be broad like a teacher because the programme is normally being run by people who are not teachers. . . . I think proper workshops should be given to those people to help them have this knowledge. They must have proper classes given to them because I think after they are given a few workshops it will help to broaden their knowledge on the subject. Because you will find some of these learners are having these classes, whenever the facilitator is giving them a mistake they will know that this facilitator is not very knowledgeable and then it will create a small problem there because they know better as they have done these things . . . started in Grade 4 . . . these things of human anatomy. . . Some of these learners know and then they challenge the facilitator when the facilitator is not comfortable with the whole thing. There needs to be workshops to upgrade the knowledge of these people . . . It's very important.*

Some peer facilitators themselves indicated that they needed additional training to be able to respond more adequately to learners' questions, especially if they relate to scientific or technical content (e.g. human biology, reproduction, the science of HIV/AIDS etc). Many have called for additional and refresher trainings to meet the knowledge gap. One peer facilitator from Omusati explains the need for a longer training period and more workshops, as a way of improving the current training model and the knowledge levels of facilitators.

*They should make it longer. So that we can gain more knowledge. And again they must give us more workshops, even in the year we must meet even three times, so that we cannot forget. Some of things we forget. . . . This year we didn't meet and that is of the things to improve. They must give more workshops so that we understand the things better. And we must get enough knowledge.*

When peer facilitators were asked during focus group discussions how they handled participant questions they did not know the answer to, almost all peer facilitator responded that they either a) do some research and get back to participants or b) have participants themselves respond to the question, either through elicitation or by having participants do some research and report back to the group. The kinds of response to the question follow below:

*I have the learners write their questions on a sheet of paper and then put it in the question box. Then, if I do not know the answer, I do research and then the next day I give them answers (Peer facilitator, Hardap)*

*Sometimes you must throw the ball to them about the question. Ask them what they think about it and you can find that you can have good...and sound answers (Peer facilitator, Khomas)*

*We have a question box where the participants put their questions. I then give them feedback the next day (Peer facilitator, Oshana)*

*Really you don't have to lie to them and say something. If you don't know you just have to tell them that you don't know but you will try to find out more information on it. Instead of lying to the kids or making kids confused (Peer facilitator, Omaheke)*

That said, interviews with participants and stakeholders suggest that in some instances peer facilitators either respond to questions without the requisite knowledge or even avoid difficult questions altogether. In the quote below, one RACE Coordinator, in speaking about importance of recognising her own limits, explained that peer facilitators do not always know the limits to their knowledge:

*When I am telling people at a workshop for instance, when I am saying let's wait for tomorrow because then we have a session by the lady from Catholic Health Services who is a qualified nurse and who is working on a daily basis with things like prevention of mother to child*

*transmission and ARVs and so on. I tell them that they can ask her the questions rather because if I try to answer this is not my own field of expertise. I am not a medical doctor or nurse. I am a trainer so what I know is only what I have read in books or what I have got from the internet or what somebody else has told me. I do not have firsthand knowledge of these things and I do not have the whole scientific or medical background so I tell them that we should rather ask her. And then I find that somebody with Grade 12 is then answering, or is trying to answer similar questions later. I know where my limits are and I also know that different information comes with different levels of credibility or authority depending on the source. I would tread carefully there but a little bit of knowledge is a dangerous thing.*

When MFMC participants themselves were asked how peer facilitators responded to questions during focus groups, most indicated either that the peer facilitator was able to respond to all questions, elicit the answer from other participants, or look it up and return with the answer. Others, however, had different responses; for example, that their peer facilitator ignored questions he/she did not know the answer to or promised to answer the question in the future but never did, as suggested in the following interchange during a focus group discussion held in Hardap:

**Moderator:** *Now about the question, remember you said that you ask a question and then he ignores it? Was there ever a question asked by you people sitting here or any other participants who are not here today. Was there ever a question asked to the peer facilitator and he didn't know the answer? Did he ignore because he didn't want to talk to you or did he ignore because he didn't know?*

**Respondent (Female):** *He didn't know, because the minute I asked him then he ignored me, but then afterwards he came back to my question and answered me. But he didn't answer it in the form that I wanted it to be.*

**Moderator:** *So it was not clear to you?*

**Respondent (Female):** *Yes, it wasn't clear. It didn't fit the content of the question that I asked so I thought that he doesn't understand what I was trying to ask.*

**Moderator:** *I just want to know whether there was ever a question asked by any participant to the Facilitator and he couldn't answer it. I want to know how he handled that situation, what did he do?*

**Respondent (Male):** *There was one guy who asked where the HIV virus came from and then she said that she did not know yet but she will find out. But until today she didn't tell us.*

Similarly, another MFMC graduate from a rural school in Hardap explained that although her peer facilitator tried to answer all of the participants' questions, she sometimes struggled to get it right. "Sometimes she could answer but sometimes she couldn't but she just tried. . . . She tried to explain it, how she understands it. She tried to explain it like that but not really straight".

However, some of the difficulty in conveying content may be related to issues of confidence. When the Trainer of Trainer was asked to assess the capacity of the facilitators he had been training over the past eleven years, he felt strongly that their knowledge and skills levels were good, but that a lack of confidence might impair their ability to deliver the curriculum. This is more the case when delivering the curriculum to learners from top schools. In speaking about the capacity of the facilitator, he said:

*I always tell them that I can contribute 10% to their success as a peer facilitator, and the rest, the 90% will depend on them. There are many of them who do a really great job at delivering the programme, once they do it at schools. But then you get some, when in the training they do really well and they score very high. But once they go into the field and they face the reality, they lack the self-confidence to deliver the course successfully. So in terms of their knowledge there is nothing missing. You also find that they really want to do a good job and they want to give the programme successfully to participants, but they get put off by logistical problems and some of them get better opportunities. That is why I said, they should allow peer facilitators to*

*deliver the programmes at any school, and not just at the school where they are assigned to. Some of them do not want to go to the top schools where the students are challenging, and then they lose hope and do not do a good job.*

Lastly, it is important to note that there is no formalised mechanism for peer facilitators to seek additional information when participants ask them questions they do not know the answers to. They only receive the MFMC manual and participant guide as resource materials; if questions are asked that fall outside what is covered in the manuals, they are left to their own initiative – which they often exercise. Peer facilitators indicated a variety of sources where they seek additional information (e.g. Principal, contact teacher, Window of Hope teacher, MFMC Coordinator, VCT clinic). However, they carry out this process at their own discretion, rather than it being a formalised procedure within the programme. The lack of a formal mechanism means it is difficult to control for the quality of the information.

### **Limited ability to manage the class**

It is important to remember that the training offered to MFMC peer facilitators is limited. They do not study the programme content, as teachers-in-training do. Nor do they have in-service training or placements where they are able to test and develop their skills over time before being formally placed in the classroom. Much of what they learn is therefore learnt ‘on the job.’

When asked how to improve the skills of the peer facilitator, one contact teacher from Omaheke made the important point that facilitators need to be trained not only in content, but also in pedagogy and classroom management techniques.

*I think that when people are trained, they should not just be trained on the subject matter on what will be given, but also on how to transfer the information. They are not trained as teachers. You might find children that do not listen and who disturb the class. They might not know how to deal with these kids. But normally we choose, out of each grade, the well-behaved kids as the first group. I am not saying that it is not important for children who do not behave themselves, but we are trying to help them along.*

Peer facilitators also report challenges with dealing with disruptive students and teasing. In fact, the MFMC programme recently modified the order in which the 10 sessions are delivered because of teasing. The Trainer of Trainer explained why this decision was taken.

*. . . when it comes to sexual topics there is a lot of teasing. That is why we started to look at the importance of values. That Values should be the second session to be addressed because then there will be respect. With the manual it goes from one to ten but we have already started the process where we start with Session One followed by Values. Just to lay the foundation that people shouldn't laugh when we talk about sexual organs because you might offend the next person. So there are challenges when it comes to that because the boys will tease the girls or the girls will be shy to participate.*

Most peer facilitators indicated that they either used group rules as a way of keeping disruptive behaviour in check, sent the disruptive participant out of the classroom if it continued and/or asked the contact teacher to intervene. Nevertheless, in terms of establishing their own authority in the classroom and keeping the course moving, there is room for improving peer facilitators' skills. A peer facilitator from Kavango explained how she would like refresher training that addresses how to handle learners in different contexts:

*But one thing that is lacking is that they should do some refresher training too. . . it is very important. Sometimes we get stuck when working with the learners and think how can we handle this? It will help if they do some more training on how to handle the learners, for example: if the learner does this you can just do that . . .*

Lastly, with high peer facilitator turnover, there are limited opportunities to improve ability, or for peer facilitators to master MFMC content and the delivery of the course over time through practice.

### **III. TRAINING OF FACILITATORS**

Related to the question of whether peer facilitators are capable of effectively delivering the intervention, is whether their training adequately prepares them to carry out their work.

All prospective facilitators undergo 10 consecutive full days of training, during which time they are oriented to the programme and to their roles and responsibilities (including administrative) and are trained in all 10 sessions. During the first half of the training they are participants in the MFMC course and during the second half they practise implementing the course. At the end of the 10 days, participants' knowledge and skills are assessed through a variety of knowledge and facilitation tests. Only those facilitators who score 70% or higher and attend all ten days of the training (unless there is a medical excuse) qualify as peer facilitators.

#### **STRENGTHS**

When peer facilitators were asked about the quality of their training, the dominant response was that their training was useful and that they learnt important information from the trainers. They also reported that it helped to build their knowledge and skills, particularly in terms of standing up in front of a group of learners and speaking openly about sex and HIV.

Peer facilitators also reported positive experiences with the trainers and training modality; namely, experiencing the course first as a participant and then as a facilitator delivering the course. In the excerpt below, a female peer facilitator from Khomas describes the value of this learning modality and how she has drawn upon her initial training when delivering the course to MFMC participants:

*Usually in the training you get expert facilitators that know more than you know and they have been to different workshops and they are like consultants. . . . These people come with expert information and this is more influential for the participants. So when we hear information from the expert we really grasp it and take it home with you. The preparation of the presentations skills is because you actually get to do it, like during the session. In order for you to qualify as a facilitator you have to present and go through certain things and mostly you are making the activities. The training, you are making it. They tell you what to do but you are now the participant as well. So when you get into class you remember how it was done by the expert and that is what you copy. So basically you were not taught how to present but you basically do it yourself so you participated during the training sessions.*

#### **WEAKNESSES**

Although peer facilitators found the training useful, there is nonetheless a general consensus that they need more training. A once-off, 10 day training is insufficient to meet the demands of the work and the challenges that emerge with programme implementation. Although some peer facilitators have received refresher training, it varies considerably from region to region and is contingent on needs identified by the regional MFMC programme offices. There is no formalised schedule for refresher trainings; in one region there may be two refresher trainings in a year and in another there may be none.

In addition to the need for regular refresher trainings, other identified gaps in the training included a desire for more first-hand or expert knowledge, training in counselling skills, more reference and support materials, and more team-building to create a sense of community among peer facilitators.

## **More expert knowledge needed**

Although the trainers are skilled in the MFMC curriculum, they are not necessarily experts in the field of HIV/AIDS, either as researchers or practitioners. Peer facilitators expressed a desire to have opportunities to speak with, and learn from, doctors and nurses, VCT counsellors, and people who are HIV positive as a routine part of their training. In essence, they would like to learn from people who have first-hand experience, rather than simply gaining book knowledge. For example, a female peer facilitator from Omaheke explains the value of having a VCT counsellor talk to her and other peer facilitators about the VCT content in the manual: “The people, the part with the testing they have to ask a professional to do it. To come and talk about that part because he knows more, instead of us, who have never done it before. We are just doing what the book is directing us to do.” In a similar vein, a male peer facilitator spoke about the usefulness of speaking with someone who is HIV positive as a way of knowing that they are getting the right information from the right person: “I think for the training they should bring people who are infected so that for information, you are then asking the right person.” Expert or first hand-knowledge is thus seen to be an important complement to the knowledge presented in the training manual.

## **Additional materials, more resources needed**

As discussed in the previous section on facilitator capacity, there is background information that is not expressly covered in the manual, but may be necessary for the peer facilitator to perform effectively. There is no formalised mechanism for peer facilitators to follow when seeking additional information, nor are additional reference materials routinely provided.

Peer facilitators expressed the need for additional reference and support materials, especially in relation to the modules on reproductive health, voluntary counselling and testing, and ARVs. The section on the reproductive organs, for example, is challenging for peer facilitators who may not be able to draw with comfort or ease. Some indicated they would prefer the programme to develop a poster or other placards as a teaching aid, with the sexual organs already drawn. Some peer facilitators also mentioned that the female organ poster for the femidom demonstration had not been made widely available. In regard to VCT and ARVs, peer facilitators spoke about wanting more information on the science behind testing and ARVs, as well as some visual illustrations (i.e. pictures of what ARVs look like) that could be used as teaching tools.

## **Build facilitators’ counselling skills**

Because of their role, peer facilitators can easily find themselves in the position of needing to informally counsel MFMC participants and community members on various issues affecting their lives. While this is not part of their formal role and responsibilities, it is nonetheless a by-product of the creation of a communicative space where people feel comfortable to speak openly. During the peer facilitator interviews some indicated, for example, that they had become known in their communities as peer facilitators and were approached for information about HIV/AIDS, and how to access condoms and VCT. Although, in some instances, they are just approached for information, in other situations, basic counselling skills would have been helpful. A male peer facilitator from Khomas, for example, explained how a female MFMC participant who was being sexually abused by her father approached him for help:

*When we are facilitating some of the participants might come to you personally and then you must counsel them. But you didn't do it at the training because some people they say . . . Like when I was at one of the schools, one girl came to me and said that she wasn't going to go home now because if she went home now she said that her father would get her and he would want to sleep with her. And so we don't have those skills of counselling, so I think they must put counselling into the training.*

While it might not be possible to include counselling skills as part of peer facilitators’ training, it is likely that the curriculum will bring up sensitive or difficult issues in the lives of some

participants. Facilitators should be trained on how best to handle this possibility, as well as how to make the necessary referrals.

### **Space for team building and peer support**

Lastly, peer facilitators indicated that their training (initial or refresher) should include more opportunities for peer facilitators to build a sense of community and mutual support with one another. Although they do work in groups during the 10-day training, this does not necessarily include sharing experiences or team-building exercises. Peer support while they are delivering the curriculum is also important, as it gives peer facilitators an opportunity to discuss the challenges they face and to elicit feedback from their peers and trainers.

## **IV. OBSERVATIONS OF MFMC TRAINING SESSIONS – CASE STUDY**

As part of evaluating the effectiveness of the delivery mechanism, the research team observed one complete training session of the MFMC programme, as administered by an experienced MFMC peer facilitator, from beginning to end. Initially, the goal was to conduct observations of two MFMC peer facilitators, one male and one female. However, the team faced many challenges in arranging for the observations because of school exams and other scheduling hiccups. Within the stipulated timeframe of the research, therefore, only one 10-session observation was possible and completed.

The peer facilitator who was observed is a young woman in her late twenties. She has been working as a peer facilitator for the past three years. This case study illustrates how, without a strong M&E system and institutionalised quality control mechanisms, a good programme can easily go awry during implementation.

It was clear from the observations that the peer facilitator had many qualities and abilities that are necessary for a good facilitator. She is confident, dynamic, articulate, and knowledgeable. She speaks clearly, comfortably and openly and in a language young people can understand.

However, there were also numerous weaknesses observed during the implementation of the course that compromised the quality and effectiveness of programme delivery. For example, the peer facilitator:

1. Did not come prepared
2. Demonstrated a lack of commitment
3. Did not read participant cues (i.e. sleeping, not paying attention, group work dominated by a subset, hands raised, etc) and respond accordingly
4. Did not follow the curriculum and also misinformed participants
5. Presented information in a didactic way rather than engaging participants to come up with their own answers.

### **LACK OF PREPARATION**

Preparation is an important aspect of delivering the 10 sessions of the MFMC programme. This includes bringing the necessary supplies in order to facilitate the activities, as well as reviewing the information in advance. The facilitator generally did not come prepared. Although she did distribute participant booklets and pencils on the first day of the course and certificates on the last day, she did not generally prepare materials for given activities and never used a flip chart or Koki pens as aids or tools.

### **LACK OF COMMITMENT**

Although the peer facilitator was clearly knowledgeable about the content and could respond spontaneously to participants' questions, she generally read from the manual as a means of



delivering the course. Also, she often rushed through activities, which suggested that she was trying to finish the course as quickly as possible rather than allow the needs of the curriculum and participants to help set the pace of the activities.

The peer facilitator also did not facilitate one session at all and asked the MFMC Coordinator in the region to substitute for her. The reason given for her absence was that she was attending to a school assignment. In addition, the peer facilitator was distracted during most the sessions by continually checking her cell phone, and sending and receiving messages. As a result, she often did not read or respond to participant cues nor did she actively encourage participation. Even when learners were interested and engaged and would raise their hands, the peer facilitator often did not see them, as she was either busy reading from the manual or texting on her phone.

#### **DIVERGENCE FROM THE FACILITATOR’S MANUAL**

In addition to the peer facilitator often reading from the manual when delivering the course, she also skipped activities, condensed content, and did not follow the prescribed structure of the sessions.

For example, each session (except Session 1) is meant to include a revision of the previous session’s content. The peer facilitator skipped this activity altogether in all of the sessions. She also did not create a Question Box for participants, which is meant to be used throughout the programme as a way of encouraging participants to ask any questions without feeling embarrassed or scared.

She condensed the sessions in order to complete the programme as quickly as possible. The curriculum is meant to be delivered over the course of three to five weeks. In this instance, all 10 sessions were completed within two weeks. She was able to complete the course so quickly only by condensing sessions and skipping activities. Although each session is meant to be two hours, on three occasions the peer facilitator took two sessions (four contact hours) and condensed them into one (two contact hours).

A review of the content covered in the first half of the course (Session 1 to Session 5) on the following page reveals the wide gap between what was intended in the manual and what was actually delivered.

**Figure 4: Findings from observation of content coverage by peer facilitator**

<b>AS PER MANUAL</b>	<b>AS OBSERVED</b>
<p><b><u>DAY ONE</u></b>  <b><u>Session 1: Getting Started</u></b>  <b>Activity 1: Why are we here?</b>   <b>Activity 2: Our Group Rules</b>  <b>Activity 3: Trust Game</b>  <b>Activity 4: Puberty Quiz</b>   <b>Activity 5: How We Feel about the Changes in our Body</b>  <b>Activity 6: Lifeboat</b>  <b>Activity 7: Closing Circle</b></p>	<p>Asked participants to explain their reason for joining MFMC but never clearly explained the goals of the programme as per the manual.  Mentioned the titles of the various sessions but did not present the topic visually or explain why given topics were important  Done  Skipped  Done, but only broke participants into two groups – boys and girls – rather than four groups, even though there were 22 participants, and administered quiz like an exam and gave the correct answers rather than eliciting responses from participants.  Done  Done  Done, but no Question Box</p>
<p><b><u>DAY TWO</u></b>  <b><u>Session 2: Reproductive Health</u></b>  <b>Activity 1: Pregnancy Quiz</b>  <b>Activity 2: Review of Session 1</b>  <b>Activity 3: What is Reproductive</b></p>	<p>Done, but peer facilitator administered quiz like an exam and gave correct answers rather than eliciting responses from participants  Skipped</p>

<b>Health</b> <b>Activity 4: Consequences of Early Pregnancy</b> <b>Activity 5: Contraception Choices</b> <b>Activity 6: Closing Circle</b>	Done Done but flip chart paper was not used Partly done – PF read section “Background Information on Contraceptives” to participants Done
<u><b>DAY THREE</b></u> <b>Session 3: HIV and STI - The Facts</b> <b>Activity 1: Transmission Game</b> <b>Activity 2: Review of Session 2</b> <b>Activity 3: The Danger Game</b> <b>Activity 4: What do we know about HIV and AIDS</b>  <b>Activity 5: Transmission of HIV and STIs</b>  <b>Activity 6: Myths about HIV and AIDS (optional)</b> <b>Activity 7: Sexually Transmitted Infections</b> <b>Activity 8: Closing Circle</b>	Done Skipped Skipped Done but not per the manual. Peer facilitator read all the questions to participants and gave them the answers rather than eliciting answers from them. Partially done but also misinformed participant by saying that a baby cannot get infected with HIV in the womb, but only during birth and breastfeeding. Skipped Skipped Done
<u><b>DAY FOUR</b></u> <b>Session 4: HIV and AIDS: Reducing the Risks**</b> <b>Activity 1: Taking Risks - A Self-Assessment</b> <b>Activity 2: Review of Session 3</b> <b>Activity 3: Prevention - Realistic Options</b> <b>Activity 4: How to Delay</b> <b>Activity 5: How to Use a Condom</b>  <b>Activity 6: How to Convince Your Partner to Use a Condom</b>  <b>Session 5: Facing HIV and AIDS**</b> <b>Activity 1: AIDS Attacker Drama</b> <b>Activity 2: Review of Session 4</b> <b>Activity 3: AIDS among us</b>  <b>Activity 4: HIV Testing</b> <b>Activity 5: What if . . . ?</b>  <b>Activity 6: Closing Circle</b>	Done Skipped Done but did the activity with the whole group rather than dividing into male and female groups. Skipped Skipped because did not have not demonstration penis and condoms that day (done on Day Five). Skipped  Skipped Skipped Done but not all statements were read aloud and did not clearly follow the curriculum. Selectively done – asked some questions, but not all. Done but not as per the training manual. Participants were asked to imagine what it would feel like if they themselves were HIV positive rather than a friend or family member Skipped

### DIDACTIC TEACHING STYLE

As illustrated in the table above, the peer facilitator, in trying to complete the course quickly, strayed considerably from the content of the curriculum. In addition, the peer facilitator also strayed from the spirit of the MFMC programme, which is to actively encourage participants to engage with the material and collectively arrive at the answer. Although most of the MFMC

activities are constructed to be participative, the peer facilitator primarily used didactic techniques to impart the information. During the pregnancy quiz for example, the peer facilitator read out a series of statements and asked each group if the statement was true or false. Rather than elicit the correct answer from the participants through debate and discussion, the peer facilitator read the answer to the participants from the MFMC manual. This didactic approach for imparting information was used throughout delivery of the course.

Although the format of the programme lends itself to participation, the observation notes show that the peer facilitator did little to actually encourage participation and, in various ways, actually discouraged participation. The observation notes indicate a clear pattern of not engaging with participants. She also did not make attempts to encourage all participants to participate in cases when group work was dominated by a small subset of participants. The quote below from the observer's notes describes this recurring pattern:

*She did not encourage the participants to actively participate. At many times, she was just reading instead of paying attention to how the participants reacted. Even when they were playing, she did not do anything to keep them on the subject. At many points of the session she was just on her phone texting or doing something else and this destroyed the participants' morale. Lastly, participants were laying their heads on the tables but the Peer Facilitator only continued with those who looked interested. (Observer notes, 24 Sept 2008)*

## **MONITORING AND EVALUATION**

Lastly, it deserves mention that there was no contact teacher present during any of the sessions. The MFMC Coordinator, however, did observe half an hour of one session. It is not known whether the patterns or problems discussed above were also identified by the MFMC Coordinator during the observation.

## **CONCLUSION**

Importantly, this is a case study and the patterns identified herein cannot be used to draw broad conclusions about MFMC peer facilitators in general. However, such close and careful study of programme implementation draws attention to possible discrepancies between how the programme is meant to be delivered and how it is actually delivered. Without a strong M&E system, such discrepancies are easily missed. This case study also illustrates how difficult it is to control for quality under the current model.

## CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

Overall, it is apparent that the MFMC programme is perceived in a positive light by users, implementers and stakeholders, and regarded as beneficial for MFMC participants and participating schools. The content and curriculum, broadly speaking, are considered useful and relevant to the lives of young people and the issues that they face. The uniform call from MFMC participants, MFMC facilitators, and stakeholders alike to expand the programme to reach more young people speaks for the perceived benefits of the programme. Although there is no 'hard' data demonstrating that the programme is preventing HIV infection and teenage pregnancy, it is telling that when MFMC participants were asked what would happen if the programme did not continue, the most common response was that young people would not receive the needed information about HIV prevention, and infection rates would go up. In addition, there is a strong perception among stakeholders that the programme plays an important role in preventing teenage pregnancy among young people.

There is, however, room for improvement as there are many obstacles compromising the effective delivery and implementation of the programme. As currently implemented, the programme is not realising its potential. Indeed, because of implementation problems, it is hard to know if the limited impact of the programme is due to the programme content itself or to poor implementation.

In terms of the facilitator as the agent of delivery, there are two key inter-related obstacles. The first issue relates to the capacity of the facilitator. Although the programme has developed the capacity, knowledge and skills of peer facilitators, there are nevertheless many indications that gaps in their knowledge level persist, and that the programme requires a more skilled, committed, and better compensated cadre of peer facilitators to effectively deliver the intervention. While the training which facilitators receive does build their capacity, it is narrowly focused on the content of the curriculum. The implication is that their knowledge levels are often limited to what they are taught during the training, and facilitator ability to answer questions correctly is limited to content covered in the 10 sessions. In addition, facilitators do not generally receive additional reference or resource materials.

Related to the issue of facilitator capacity is high turnover among peer facilitators. They are essentially volunteers who receive a stipend for delivering the course, and the compensation they receive is insufficient to retain them over time. As a result, they are inherently transitory. When peer facilitators find formal employment or more lucrative income generating opportunities, they tend to leave. In addition, because there is such high turnover among peer facilitators, they have limited opportunities to build their skill levels and gain experience delivering the intervention.

Another significant obstacle to effective delivery is uneven M&E of the programme and insufficient quality control. As evidenced by the stakeholder data, as well as by observations of the MFMC training course, M&E often occur haphazardly, and Principals and contact teachers, who are responsible for overseeing the programme at the school level, are not always clear about their roles and responsibilities. Poor communication between the MFMC programme and the school contributes to this lack of understanding. The implication is that it is difficult to ascertain what is happening in the classroom, and whether the peer facilitator is delivering the intervention as intended. It is also difficult to detect errors and to identify areas of improvement as a part of ongoing programme assessment. The observations of the MFMC curriculum being delivered to participants by a peer facilitator illustrate how, with the existing M&E system, it is easy for a peer facilitator to diverge significantly from the course content and intention, without anyone knowing the difference.

Lastly, the marginalisation of the programme as an add-on, rather than an integral component of the school curriculum, compromises its effectiveness. As has been noted above, because it is an

after-school activity, it is easily sidelined by school staff and made secondary to academic demands.

In sum, the quality and success of the MFMC programme depend on a skilled peer facilitator delivering the programme in a supportive, enabling school environment with clear accountability structures and a strong, functioning M&E system. As the programme is currently being implemented, many of these critical ingredients are missing.

The recommendations that follow address many of these gaps and also call for the expansion and institutionalisation of the MFMC programme. However, all issues of programme quality -- training and retention of peer facilitators, M&E, and the revision of curriculum -- must be resolved before efforts to expand and institutionalise the programme are undertaken. It is suggested that the recommendations be phased according to short-, medium-, and long-term goals.

## **RECOMMENDATIONS**

### **RECOMMENDATION 1: INTRODUCE TARGETS FOR THE PROGRAMME AND ROUTINELY GATHER DATA**

Although the MFMC programme has clear goals and objectives, there are no internally-defined measurable targets against which to assess whether the programme is working towards its objectives. While periodic, external evaluations are important, as part of routine M&E, the programme should identify core targets against which to measure its performance, and then gather data for this purpose.

As it stands, the programme seeks to achieve many different objectives. For the purpose of ongoing assessment and evaluation, however, it is important to identify four or five key issues on which the programme seeks to focus its efforts. In the context of HIV prevention, comprehensive knowledge about HIV transmission and prevention, the ability to identify the symptoms of an STI, the demonstrated ability to use a condom, and the uptake of voluntary counselling and testing are examples of indicators that could be routinely used to monitor programme performance. In regard to teenage pregnancy, the ability of participants to identify the negative consequences of teenage pregnancy, and the rate of teenage pregnancy at participating schools, could be used as key indicators.

Examples of programme targets include:

1. 90% of participants should be able to identify three modes of transmission (sexual intercourse, blood-to-blood, MTCT).
2. 90% of participants should be able to identify at least three ways of preventing HIV infection.
3. 90% of participants should be able to identify three symptoms of an STI.
4. 90% of participants should be able to correctly demonstrate the use of a condom.
5. 90% of participants should be able to identify two possible consequences of unprotected sex.
6. 90% of participants should be able to identify two possible consequences of teenage pregnancy.
7. 60% of participants should go for VCT and know their HIV status.

In addition, there is currently no routine collection of data to assess whether participants have absorbed key content of the course. The development of programme targets and routine data collection for this purpose could simultaneously serve the purpose of assessing participants' absorption of course material.

## **RECOMMENDATION 2: MODERATE EXPECTATIONS ABOUT WHAT THE CURRICULUM CAN ACHIEVE**

There are limits to what a good peer education HIV prevention programme can achieve. As discussed in the literature review in Chapter 2, the evidence for peer education as a method of health promotion is mixed and not yet clearly established. In relation to HIV prevention, the research evidence suggests that well-designed and well-implemented HIV peer education programmes can have positive impacts on young people's knowledge, attitudes, beliefs, and perceived self-efficacy; behaviour, however, is much more difficult to change.

In this vein, a recent *Lancet* article on behavioural strategies to reduce HIV argues that, while behavioural interventions are necessary to prevent HIV transmission, they are not, on their own, sufficient to reduce HIV transmission. One of the key limitations of behavioural strategies is that they often privilege the individual as the primary unit of change, with little engagement with the contextual and structural factors that shape sexual behaviour. The article argues for a comprehensive and integrated approach to HIV prevention, with behavioural strategies being one important component of a comprehensive HIV prevention strategy that includes both structural and biomedical interventions (Coates, Richter, & Caceres, 2008).

Given the current evidence, it would be unreasonable to expect the MFMC programme to achieve what most other school-based HIV prevention peer education programmes, or other behavioural interventions for that matter, have not. It thus makes sense to moderate expectations about what the MFMC programme can achieve and to also see the programme as one important component of a broader HIV prevention strategy among young people, which should include access to 'adolescent friendly' reproductive health services. While it is understandable that behavioural change is often used as the main outcome measure of programme effectiveness, it may nonetheless be overly ambitious. Although knowledge and skills are not enough to prevent HIV transmission, they are necessary. Rather than measuring the effectiveness of the MFMC programme primarily through measurements of behavioural change, it is more realistic for the programme to measure the acquisition of knowledge and skills.

## **RECOMMENDATION 3: REVISE THE CURRICULUM TO ADDRESS GAPS AND WEAKNESSES**

The research indicates that although the curriculum imparts useful and important information to participants about sex, reproduction, and HIV/AIDS, there are aspects and activities that require strengthening, revision, and/or greater emphasis. In some instances, such as the factual content on reproductive health and HIV transmission and prevention, greater emphasis needs to be placed on ensuring that participants leave the programme with a thorough knowledge of the issues. The content itself does not necessarily need to be revised; rather, some mechanism needs to be instituted to ensure that peer facilitators comprehensively cover all topics addressed in each session.

In other areas, the curriculum should be revised to strengthen the key messages of the programme. For example, correct and consistent condom use is critical to HIV prevention. Conducting condom demonstrations only once during the course is not enough to ensure that all participants know how to correctly use a condom. It is therefore recommended that condom demonstrations be done more than once during the course.

Similarly, in terms of consistent condom use, greater attention needs to be given to the obstacles to consistent condom use among young people, as well as to methods of actively problem solving and role playing around these key barriers.

In addition, the content of the MFMC curriculum should be updated to align with recent research in the field of HIV/AIDS and to address more directly the risks associated with intergenerational, transactional, and concurrent sex, as well as the protective effects of male circumcision.

Lastly, while it is clear from the qualitative data that participants find the 'soft skills' -how to communicate effectively, how to be assertive, knowing one's values - valuable, it also makes sense to anchor these skills within specific prevention strategies, such as maintaining abstinence, consistent condom use, and getting tested, in order to emphasise and focus on the key messages of the programme. This will create additional opportunities to reinforce the main messages, while also teaching useful life skills.

See Appendix D for a more detailed outline of suggested curriculum revisions.

#### **RECOMMENDATION 4: CREATE A PROFESSIONAL CADRE OF PEER FACILITATORS**

It is often assumed that peer education is an inexpensive HIV prevention strategy. However, the proper implementation of peer education programmes requires a significant investment of resources, not only in terms of training, supporting, and supervising peer educators, but also in terms of providing them with the necessary resource materials and compensating them adequately for their involvement. The current model of MFMC peer facilitators as a volunteer corps is clearly not working. Although their training is useful, it is, in many ways, insufficient for the task of delivering the curriculum. In addition, the lack of standardised refresher trainings across all regions at regular intervals, and of an institutionalised assessment mechanism to identify gaps in peer facilitator skills and knowledge, means that efforts to enhance the capacity of peer facilitators are left to the discretion of the regional offices. This creates unevenness in the quality of facilitators and their facilitation skills. Moreover, the modest compensation and high turnover of peer facilitators also makes it difficult to develop a skilled and committed cadre of workers. Under the current model, there are few incentives besides a modest stipend, and the desire to make a contribution, to retain peer facilitators.

In addition, although a popular method of health promotion, there is little evidence to support the assumption that peer education is more effective than professional or adult-led models of education. It is also arguable whether MFMC peer facilitators are really peers. For example, of the 35 peer facilitators who participated in the current research, the age range was between 19 and 32 years of age, with the mean age being 23 years of age. In contrast, the age range of MFMC participants, at least in schools, was between 15 and 19 years of age.

That said, it is clear from the data that the active participation of young people, both as facilitators and participants, is an important component of the MFMC programme. Compared with other school classes, the programme creates a different kind of learning space where young people can speak openly, express their thoughts and opinions, and engage with the material in an interactive, participative style. The learning space created by the MFMC programme differs from the more didactic approach of other school classes, where the teacher is clearly the authority figure.

One alternative to having a transitory cadre of volunteer peer facilitators is to professionalise the work of the peer facilitator. Rather than having a large cohort of peer facilitators, who deliver only four MFMC courses per annum and require continual recruitment and training because of high turnover rates, it is recommended that the facilitator position be made into a formalised, salaried position with job security. This will not only attract a more skilled group of young people, but job security and a stable monthly income will provide an incentive for the facilitators and foster greater commitment. Regular trainings and close supervision will be important to ensure that facilitators have the requisite knowledge and skills to deliver the curriculum effectively and correctly. It is recommended that each region have a cadre of permanent peer facilitators who travel between schools. While the needs of regions will differ, it is recommended that peer facilitators be assigned at the circuit level to minimise travel time between schools. The number of peer facilitators per circuit will depend on the needs and size of the school population.

Another alternative is to train teachers themselves to deliver the curriculum, and to eliminate the peer facilitator role altogether. However, it is likely that this would place additional pressure on teachers and the school system, and could compromise teacher buy-in. It can also be challenging for a teacher trained in didactic methodologies to switch to more participative techniques, where knowledge is generated collectively rather than imparted. Lastly, it may create role confusion for both the teacher and the student. In fact, research evidence on life skills programming, for example, indicates that these are some of the key barriers to the effective implementation of teacher-led life skills programmes (Boler & Aggleton, 2004).

### **RECOMMENDATION 5: MAKE THE PROGRAMME MANDATORY AND TARGET ALL GRADE 8 LEARNERS**

Under the present programme delivery model, a maximum of 66 learners per participating school per year can be accommodated by the MFMC programme. Access to the programme is thus inherently limited and restricted so that only a small proportion of school learners actually participate in the programme. For example, it is estimated that, in 2007, only 8.2% of secondary and combined school students participated in the MFMC programme. This is a very small percentage of the target population. Because the programme is optional, the programme may not be reaching those who need it most. Girls, for example, are more likely than boys to enrol for the programme. In 2006, for example, 60% of the 18 913 learners who participated in the MFMC programme at school were female.<sup>16</sup> Yet we know from existing evidence on youth sexuality in Namibia that young men are more likely to be sexually active than young women, and also that they are more likely than young women to engage in sexually risky behaviours. Clearly, young men need information and skills building as much as young women do.

Given that a high HIV prevalence in Namibia, and that an estimated 50% of new infections in Sub-Saharan Africa, occur among young people aged 18-24, the MFMC programme, by reaching only a small percentage of young people, is missing an important opportunity to make a positive difference in the lives of more young people. Although there are multiple sources of information – such as media campaigns – about HIV in Namibia, it is clear that the MFMC programme provides young people, especially those in rural areas, with useful and valuable information that should be given to all, rather than only to a small subset. In addition, by only reaching a small number of learners, it is more difficult to reach critical mass and to shift peer and cultural norms to a broader level. Indeed, in order to see prevalence rates among young people decline, large numbers of young people who are potentially at risk of contracting HIV would need to change their behaviour in significant ways and to maintain these changes over time (cf. Coates, Richter, & Caceres, 2008).

One way to ensure that all secondary school students receive the programme is to uniformly offer the programme to all Grade 8 learners, ideally before they become sexually active and begin experimenting with alcohol and drugs. In our sample of 300 MFMC graduates, approximately 50% reported being sexually active, with the average age of sexual debut being 14.2. Importantly, sexual activity only increases with age. In addition, in terms of alcohol use, 61% reported having tried alcohol, with the average age of alcohol debut being 13.6.

Although these numbers are not representative of all MFMC participants, or young people in general, they are telling and suggest that it is better to target learners in mid-adolescence rather than late adolescence: that is, before the onset of behaviours that may put them at risk of HIV infection and pregnancy. Indeed the research evidence indicates that interventions introduced at a younger age, before individuals begin engaging in high risk behaviours, are more successful than those attempting to modify already established behaviours (Gaskins et al 2002; Gillian et al, 2001; Maypole et al, 1998). It is easier, for example, to help young people maintain abstinence than to convince them to practise secondary abstinence once they have become sexually active. Lastly, by

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<sup>16</sup> Data on MFMC participation by year and gender was provided by UNICEF Namibia (November 2008).



targeting young people when they are less likely to be sexually active, the MFMC programme has the opportunity to help them to define themselves as sexual beings and agents and to establish healthy, protective behaviours and practices with regard to HIV prevention, behaviours that can extend over their lifetime.

Further, in theory, MFMC facilitators are meant to hold separate courses for younger (15-16 year olds) and older (17-19 year olds) youth; however, in practice courses contain a mixture of learners of various ages from Grade 8 to Grade 12. In terms of sexuality education, the developmental needs of a 15-year-old are different from those of a 19-year-old. The messaging, although similar, will have different emphases, as an 18-year-old is much more likely to be sexually active than a 15-year-old. By targeting all learners in a school at Grade 8, participants would be able to absorb the content of the programme with peers at a similar developmental stage. If all peers are targeted, there is also a greater likelihood of shifting peer norms relating to sexuality and HIV prevention.

That said, before expanding the programme to all Grade 8 learners, it is critical that the quality of the programme first be improved in the light of the identified weaknesses and the recommendations of the research. The programme should only be scaled up once the curriculum has been revised and tested and all existing gaps in M&E, as well as the quality of the peer facilitators, have been adequately resolved.

## **RECOMMENDATION 6: INSTITUTIONALISE THE PROGRAMME AS PART OF THE SCHOOL CURRICULUM**

The timing and construction of the MFMC programme as an after-school activity is inherently problematic. It limits participation and school buy-in, and thus makes it easy for the programme to be sidelined and made secondary to the academic curriculum or other after school activities. Given the critical importance of HIV prevention education in high prevalence countries, it is imperative that all young people have access to accurate and comprehensive information about how HIV is transmitted and prevented, and which behaviours can put them at risk of infection or, alternatively, protect them. By integrating the programme into the school curriculum and building it into the school timetable, the programme is less likely to be sidelined by Principals, teachers, and learners. It would indicate that the programme is supported, valued, and owned by the Ministry of Education as an integral part of young people's education. It would also indicate that HIV prevention education is not an afterthought, but is a critical component of promoting the health and well-being of young Namibians.

There are different ways in which the programme could be integrated into the school curriculum. One option is to offer the 10-session MFMC course as a distinct class, taught by a permanent MFMC facilitator. Although an attractive option, from both a resource and logistical point of view, it would actually be difficult to institutionalise the programme as such, as there are a limited number of school periods in the school day as well as a limited amount of school resources (i.e. available classrooms and related supplies). It would also create an additional cost burden on the Ministry of Education in terms of financing the programme.

Another more realistic option is to mainstream the MFMC curriculum into other carrier subjects such as Biology, Life Science, and Life Skills, and perhaps even Religious and Moral Education. The more technical, scientific, and factual content on reproductive health, HIV transmission, ARVs and HIV testing, for example, lends itself to a more didactic teaching style and can easily be taught by a teacher and integrated into either Biology or Life Sciences. The research indicates that the more technical content is also more challenging for peer facilitators to master and deliver, as their knowledge levels are largely limited to what they learn during their 10 day training course.

In terms of the life skills components of the MFMC curriculum – such as how to use a condom, how to negotiate condom usage, how to communicate, and how to be assertive – these sessions and modules could easily be integrated into existing Life Skills classes, which are already part of

the school timetable. It is recommended that the MFMC peer facilitator deliver the life skills content of the MFMC curriculum through the Life Skills class, in collaboration with the Life Skills teacher. It is also recommended that the Life Skills teacher be trained in the MFMC curriculum.

Because life skills programming is still very new to Namibia, and there are many indications that the Life Skills curriculum is not being implemented as intended, it is important, in the short and medium term, that the MFMC facilitator be the primary person responsible for delivering the life skills components of the MFMC curriculum. For example, in the context of Life Skills, there is a lack of continuity in terms of teaching. Teachers rotate in and out of the role, so teachers who received training in Life Skills in Year 1 may not be responsible for teaching Life Skills in Year 2. In addition, because of limited training funds, not all teachers who teach the class received formalised or standardised life skills training. This contributes to uneven teacher buy-in and varying levels of comfort with the content and pedagogy of Life Skills classes.<sup>17</sup>

It is therefore recommended that, until there is greater standardisation of the implementation of Life Skills classes in Namibia and training in participative teaching methodologies is institutionalised as part of teacher training, an MFMC facilitator should be retained to deliver these modules. In the long term, as the teacher becomes more comfortable with, and well trained in, the participative methodology of the MFMC programme, these particular sessions could be absorbed into Life Skills itself. In the long term, therefore, there may be no need for a MFMC facilitator, as distinct from a Life Skills teacher, to deliver the MFMC curriculum.

See Appendix E for a detailed estimation of the costs associated with the adoption of the recommendations to institutionalise the programme and to offer it to all Grade 8 learners. Costs are estimated for both creating a professional cadre of peer facilitators as opposed to the current model of volunteer peer facilitators.

## **RECOMMENDATION 7: STRENGTHEN THE MONITORING AND EVALUATION OF THE PROGRAMME TO ENSURE QUALITY**

The research clearly indicates that the current M&E of the MFMC programme is not operating effectively to ensure programme quality. In fact, most current M&E forms record whether the programme is taking place, rather than if a quality programme is being offered. In addition, although many peer facilitators indicate that they do receive support from the school Principals and contact teachers where they deliver the programme, the regional MFMC offices provide very little direct supervision and support to peer facilitators, apart from assistance with practical issues such as disbursing transportation allowances, stipends, and course materials. An example of direct supervision and support would be regular supervision meetings between the peer facilitators and a representative from the MFMC office, to discuss programme implementation and any challenges that the peer facilitator may be facing. This could be done either individually or through group supervision sessions.

In terms of monitoring and evaluating the actual MFMC course, there is currently no accountability mechanism to ensure that M&E occur as intended. M&E forms are sometimes, but not always, completed, Principals and contact teachers do not always understand their roles and responsibilities, site visits by the MFMC programme office are sporadic and ad hoc rather than routinely scheduled. In some instances, the programme office only knows a course has been implemented after it is completed. As the M&E system is currently operating, there is too much room for error and lapses in quality.

It is recommended that the M&E model of the MFMC programme be revised and strengthened, and an accountability mechanism be adopted to ensure that M&E functions ensure programme

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<sup>17</sup> David Sampson, NIED (National Institute for Educational Development), personal communication, 27 November 2008 and Isma Fourie, NIED, email communication, 1 December 2008.

quality. In order to ensure accountability for regular reporting, it is imperative that Principals and contact teachers be trained to better understand their roles and responsibilities in monitoring, evaluating, and reporting. In addition, the programme should ensure that reporting forms are standardised across the various regions so that all regions are collecting the same kind of M&E data.

One of the benefits of having MFMC facilitators deliver the life skills components of the course through Life Skills classes is that the Life Skills teacher could function as the contact teacher currently does, but in a more involved and active way. By working in partnership with the peer facilitator and being trained in the curriculum as peer facilitators are, the Life Skills teacher would be present for all of the sessions delivered by the peer facilitator, and would be able to monitor and evaluate the performance of the peer facilitator and ensure that the programme is being implemented as intended. However, it must be noted that the only way that a teacher can effectively evaluate the peer facilitators is if s/he understands the learning objectives of the given modules, as well as the content, and if s/he has been trained, in similar fashion to the peer facilitator, on how the curriculum is to be delivered.

### **RECOMMENDATION 8: ENGAGE PARENTS AS STAKEHOLDERS**

Family environment, parental attitudes and parental support play an important role in shaping young people's sexual and reproductive behaviour (Aggleton & Campbell, 2000). Indeed, a review of international research indicates that youth who have open communication with their parents about sex are more likely to engage in safer sexual practices (Cheesebrough, Ingham & Massey, 1999). Moreover, there are also indications that parental communication moderates the relationship between youth's perceptions of peer norms and their sexual behaviour. A lack of communication with parents about sex may also lead to adolescents being more influenced by peers and by peer norms around sexuality (Whitaker & Miller, 2000).

Indeed, the current research indicates that parents, teachers, and friends are all important sources of influence and information about sexuality for young people. The greater the harmony between the various sources of influence in the lives of young people, regarding the importance of abstaining from sex and/or practising safe sex, the more likely that young people will be able to draw on protective resources and adopt protective behaviours.

As it stands now, there is no formalised mechanism through which the MFMC programme engages parents as stakeholders in the sexual and reproductive health and well-being of their children. Although parental consent is required for participation, and although stakeholders reported relatively little resistance from parents with respect to the programme, much more can be done to actively engage parental support and involvement. This can routinely be done through the school board and parent meetings where school authorities, in conjunction with the MFMC peer facilitator, can present an overview of the course to parents, as well as the key messages it promotes. This will create an opportunity to address parental concerns and questions and also dispel common concerns voiced about sex education programmes, namely that they promote sex. By explaining why the programme is important and some of the key strategies that the programme advocates, there is a greater likelihood of achieving harmony and building partnerships among the various actors who influence young people in their sexual decision making.

## REFERENCE LIST

- Aarons, S. J., Jenkins, R., Raine, T. R., El-Khorazaty, M. N., Clark, M. C., & Wingrove, B. (2000). Working with young people: towards an agenda for sexual health. *Journal of Adolescent Health, 15*, 283-296.
- Adamchak, S. E. (2006). *Youth education in reproductive health and HIV/AIDS*. Vancouver: Family Health International.
- Aggleton, P., Chalmers, H., Daniel, S., & Warwick, I. (1996). *Promoting young people's sexual health*. London: Health Education Authority.
- Aggleton, P. & Campbell, C. (2000). Working with young people towards an agenda for sexual health. *Sexual and Relationship Therapy, 15*, 283-296.
- Agha, S. & Van Rossem, R. (2004). Impact of a school-based peer sexual health intervention on normative beliefs, risk perceptions, and sexual behaviour of Zambian adolescents. *Journal of Adolescent Health, 34*, 441-452.
- Allen, I. (1991). *Family planning and pregnancy counselling projects for young people*. London: Policy Studies Institute.
- Ankomah, A. (1998). Condom use in sexual exchange relationships among young single adults in Ghana. *AIDS Education and Prevention, 10*, 303-316.
- Audrey, S., Cordall, K., Moore, L., Cohen, D., & Campbell, R. (2004). The development and implementation of a peer-led intervention to prevent smoking among secondary school students using their established social networks. *Health Education Journal, 63*, 266-284.
- Auerbach, J. D., Hayes, R. J., & Kandathil, S. M. (2006). *Overview of effective and promising interventions to prevent HIV infection* (Rep. No. 938). Geneva, Switzerland: World Health Organization.
- Backett-Milburn, K. & Wilson, S. (2000). Understanding peer education: insights from a process evaluation. *Health Education Research, 15*, 85-96.
- Bastien, S., Flisher, A., Mathews, C., & Klepp, K. (2008). Peer education for adolescent reproductive health: An effective method for programme delivery. In K. Klepp, A. Flisher, & S. Kaaya (Eds.), *Promoting adolescent sexual and reproductive health in East and Southern Africa* (pp.185-213). Cape Town: HSRC Press.
- Becker, M.H. (1974). The Health Belief Model and personal health behaviour. *Health Education Monographs, 2* (4), 324-508.
- Bertrand, T. B., O'Reilly, K., Denison, J., Anhang, R., & Sweat, M. (2006). Systematic review of the effectiveness of mass communication programmes to change HIV/AIDS-related behaviours in developing countries. *Health Education Research, 21*, 567-597.
- Bhana, A., Petersen, I., Mason, A., Mahintsho, Z., Bell, C., & McKay, M. (2004). Children and youth at risk: adaptation and pilot study of the CHAMP (Amaqhawe) programme in South Africa. *African Journal of AIDS Research, 3*, 33-41.
- Bhana, A. (2007). The price of innocence: teenagers, gender, childhood sexuality, HIV and AIDS in early schooling. *International Journal of Inclusive Education, 11*, 431-444.
- Boler, T. & Aggleton, P. (2004). *HIV/AIDS and education*. London: Save the Children & Action Aid International.

- Borgia, P., Marinacci, C., Schifano, P., & Perucci, C. A. (2005). Is peer education the best approach for HIV prevention in schools? Findings from a randomised controlled trial. *Journal of Adolescent Health, 36*, 508-516.
- Brady, M., Bruce, J., & Chong, E. (2003). *Selected DHS Data on 10-14-year-olds*. Paper presented at the Population Association of America, May 2003. Retrieved from the Population Council website: [http://www.popcouncil.org/pdfs/gfdreports/annexes/annex\\_namibia.pdf](http://www.popcouncil.org/pdfs/gfdreports/annexes/annex_namibia.pdf)
- Brown, J., Sorrell, J., & Raffaelli, M. (2005). An exploratory study of constructions of masculinity, sexuality and HIV/AIDS in Namibia, Southern Africa. *Culture, Health & Sexuality, 7*, 585-598.
- Buthezezi, T., Mitchell, C., Moletsane, R., De Lange, N., Taylor, M., & Stuart, J. (2007). Youth voices about sex and AIDS: implications for life-skills education through the 'Learning Together' Project in KwaZulu-Natal, South Africa. *International Journal of Inclusive Education, 11*, 445-459.
- Campbell, C. & Mzaidume, Z. (2001). Grassroots participation, peer education, and HIV prevention by sex workers in South Africa. *American Journal of Public Health, 91*, 1978-1986.
- Campbell, C. & MacPhail, C. (2002). Peer education, gender and the development of critical consciousness: participatory HIV prevention by South African youth. *Social Science and Medicine, 55*, 331-345.
- Campbell, C. (2003). Condoms are good but I hate those things: sexuality and HIV-transmission among young people. In *'Letting Them Die' Why HIV/AIDS intervention programmes fail* (pp. 121-131). Bloomington, Indiana: Indiana University Press.
- Campbell, C. (2003). Facilitating community-led peer education among Summertown youth. In *'Letting them die': Why HIV/AIDS intervention programmes fail* (pp. 132-148). Bloomington Indiana: Indiana University Press.
- Campbell, C. & Lubben, F. (2003). The Provision of a health-promoting environment for HIV/AIDS education: The case of Namibian senior secondary schools. *International Journal of Educational Development, 23*, 529-542.
- Campbell, C. (2004). Creating environments that support peer education: experiences from HIV/AIDS prevention in SA. *Health Education, 104*, 197-200.
- Campbell, C., Foulis, C. A., Maimane, S., & Sibiyi, Z. (2005). The impact of social environments on the effectiveness of youth HIV prevention: A South African case study. *AIDS Care, 17*, 471-478.
- Campbell, C. (2005). Using peer education projects to prevent HIV and AIDS in young people. *Nursing Standard, 20*, 50-55.
- Caron, F., Godin, G., Otis, J., & Lambert, L. (2004). Evaluation of a theoretically based AIDS/STD peer education program on postponing sexual intercourse and on condom use among adolescents attending high school. *Health Education Research, 19*, 185-197.
- Central Bureau of Statistics (2001). Namibia 2001 population and housing census: Census indicators, 2001 and 1991. Retrieved July 3, 2008 from [http://www.npc.gov.na/census/census\\_indicators.htm](http://www.npc.gov.na/census/census_indicators.htm)
- Central Bureau of Statistics: National Planning Commission. (2004). *Namibia Household Income and Expenditure Survey 2003/2004 Preliminary Report*. Windhoek: Central Bureau of Statistics.
- Cheesebrough, S., Ingham, R. & Massey, D. (1999). A review of the international evidence on preventing and reducing teenage conceptions: The United States, Canada, Australia and New Zealand. London: Health Education Authority.
- Chigali, G. (2006). *Assessment of the factors associated with HIV risk behaviours amongst women in Livingstone, Southern Province, Zambia*. (Master's thesis, University of the Western Cape, 2006).

Retrieved from

[http://etd.uwc.ac.za/usrfiles/modules/etd/docs/etd\\_gen8Srv25Nme4\\_6263\\_1189600891.pdf](http://etd.uwc.ac.za/usrfiles/modules/etd/docs/etd_gen8Srv25Nme4_6263_1189600891.pdf)

Chin, J. (2005). *Exploring gender, reducing HIV/AIDS: A training design for peer facilitators of UNICEF Namibia's "My Future is My Choice" programme*. (Master's thesis, University of Massachusetts, 2005).

CIA World FactBook (2008). *Namibia*. Retrieved July 7 from

<http://www.cia.gov/library/publications/the-world-factbook/geos/wa.html>.

Cleland, J., Ingham, R., & Stone, N. (2006). Asking young people about sexual and reproductive behaviours: Introduction to illustrative core instruments. UNDP, UNFPA, WHO, World Bank and the Special Programme of Research, Development and Research Training in Human Reproduction.

Coates, T., Richter, L., & Caceres, C. (2008). Behavioural strategies to reduce HIV transmission: how to make them work better. *The Lancet*, 372 (9639), 669-684.

Community Agency for Social Enquiry (CASE) (2007). The situation of youth in the Southern African development community, an overview of SADC countries. Retrieved on July 17 from [http://www.ydn.org.za/publications/yes/finalexecreport.htm#\\_Toc53811296](http://www.ydn.org.za/publications/yes/finalexecreport.htm#_Toc53811296).

DATA (2008). *The DATA Report 2008*. Washington: ONE

Delius, P. & Glaser, C. (2002). Sexual socialisation in historical perspective. *African Studies*, 61, 27-54.

Devereux, S. (2001). *IDS social pensions in Namibia and South Africa*. Brighton: Institute of Development Studies.

Eaton, L., Flisher, A., & Aaro, L. (2003). Unsafe sexual behaviour in South African youth. *Social Science and Medicine*, 56, 149-165.

Ebreo, A., Feist-Price, S., Siewe, Y., & Zimmerman, R. (2002). Effects of peer education on the peer educators in a school-based HIV prevention programme: Where should peer education research go from here? *Health Education & Behaviour*, 29, 411-423.

Edwards, L. (2004). *HIV/AIDS Poverty and Patriarchy: A Gendered Perspective*. Windhoek: Nara Training Centre.

Education Management Information Systems (EMIS) (2007) EMIS Education Statistics 2007. Namibia: Ministry of Education.

European Institute of Japanese studies (2008). *Economic and social data rankings-Namibia*. Retrieved July 17 from <http://dataranking.com/country.cgi?LG=e&CO=154> [On-line].

Fairweather, I. (2006). Heritage, identity and youth in post-colonial Namibia. *Journal of South African Studies*, 32, 719-736.

Family Health International (2005). *Participatory Assessment of Reproductive Health/HIV Prevention Needs of Young People in Namibia, 2003*. (Final Report) Namibia: Family Health International.

Family Health International & YouthNet (2006). *Assessing the quality of youth peer education programmes*. (Report). New York: United Nations Populations Fund.

Fitzgerald, A., Stanton, B., Terreri, N., Shipena, H., Li, X., Kahihuata, J. et al. (1999). Use of Western-based HIV risk reduction interventions targeting adolescents in an African setting. *Journal of Adolescent Health*, 25, 52-61.

Freire, P. (1993). *Education for Critical Consciousness*. New York: Continuum.

Fuller, B. & Van Zyl, D. (2006). *Silently starving: A new form of famine among small scale farming households affected by the HIV epidemic?* (NEPRU Working Paper No.17). Windhoek: The Namibian Economic Policy Research Unit.

- Gallant, M. & Maticka-Tyndale, E. (2004). School-based HIV prevention programmes for African youth. *Social Science and Medicine*, 58, 1337-1351.
- Gaomab, M. (2008). Youth empowerment- economic imperative/rationale. Paper presented at the Karas Youth Economic Empowerment Seminar April 2004. Retrieved from The South African Regional Poverty Network website:  
[http://www.sarpn.org.za/documents/d0001900/Youth\\_empowerment\\_Apr2004.pdf](http://www.sarpn.org.za/documents/d0001900/Youth_empowerment_Apr2004.pdf)
- Gaskins, S. W., Beard, S. R., & Wang, M. Q. (2002). An HIV/AIDS education programme for children in grades K-5. *Journal of HIV/AIDS Prevention and Education for Adolescents and Children*, 5, 31.
- Gilliam, G. A., Eke, A., Aymer, F., & O'Neil, C. (2001). Developing a theory-based, culturally sensitive intervention for adolescents: The Antigua School Project. In B.A. Dicks (Ed.), *HIV/AIDS and children in the English speaking Caribbean* (pp. 105-126). New York: Haworth Press.
- Goel, N., Kaur, N., Singh, S., Singh, G., & Kaur, P. (1999). Explorative 'KABP' study on AIDS among nursing professionals. *Indian Journal of Preventive & Social Medicine* 30 (2), 79-84.
- Gregson, S., Nyamukapa, C. A., Garnett, G. P., Mason, P. R., Zhuwau, T., Carael, M. et al. (2002). Sexual mixing patterns and sex differentials in teenage exposure to HIV infection in rural Zimbabwe. *The Lancet*, 339, 1896-1903.
- GRN & UNICEF (2002). *Youth health and development programme "My Future is My Choice" life-skills intervention implementation assessment*. Windhoek: GRN/UNICEF.
- Harden, A., Oakley, A., & Oliver, S. (2001). Peer delivered health promotion for young people: A systematic review of different study designs. *Health Education Journal*, 60, 339-353.
- Harrison, A., Smit, J., & Myer, L. (2000). Prevention of HIV/AIDS in South Africa: a review of behaviour change interventions, evidence and options for the future. *South African Journal of Science*, 96, 285-290.
- Hartell, C. (2005). HIV/AIDS in South Africa: A review of sexual behaviour among adolescents. *Adolescence*, 40, 171-181.
- Hayden, J. & Otaala, B. (2005). Very young children affected and infected by HIV/AIDS: How are they living? A case study in Namibia. *International Journal of Early Childhood*, 37, 11-19.
- Hayden, J. (2008). Beyond the gender differential: Very young children coping with HIV/AIDS. *Children and Society*, 20, 153-166.
- HIV InSite. (2008). *Sub Saharan Africa*. Retrieved July 28 2008 from  
<http://hivinsite.ucsf.edu/global?page=cr09-00-00>
- Huebler, F. (2008). International Education Statistics: Primary school gross and net enrolment. Retrieved on July 20 from <http://huebler.blogspot.com/2005/04/primaryschool-gross-and-net.html>
- Hughes, K. (1999). *Young people's experiences of relationships, sex and early parenthood: qualitative research*. London: Health Education Authority.
- Hunter, S. (2003). *Who cares? Aid in Africa*. New York: Palgrave Macmillan.
- Integrated Regional Information Networks. (2007). *Namibia: Humanitarian Country Profile*. Retrieved August 3 from  
<http://www.irinnews.org/country.aspx?CountryCode=NA&RegionCode=SAF>
- Irwin, A., Millen, J., & Fallows, D. (2003). Myth 2: dangerous behaviour. In A. Irwin, J. Millen, & D. Fallows (Eds.), *Global AIDS: Myths and facts* (pp. 19-39). London: South End Press.

- James, S., Reddy, P., Ruiter, R. A. C., McCauley, A., & van den Borne, B. (2006). The impact of an HIV and AIDS life- skills programme on secondary school students in KwaZulu-Natal, South Africa. *AIDS Education and Prevention*, 18, 281-294.
- Jemmott, J. B., Jemmott, S. L., & Fong, G. T. (1998). Abstinence and safer sex HIV risk-reduction interventions for African American adolescents. *Journal American Medical Association*, 279, 1529-1536.
- Jewkes, R., Levin, J., & Penn-Kekana, L. (2003). Gender inequalities, intimate partner violence and HIV preventive practices: findings of a South African cross-sectional study. *Social Science and Medicine*, 56, 125-134.
- Jewkes, R., Nduna, M., Levin, J., Jama, N., Dunkle, K., Puren, A. et al. (2008). Impact of stepping stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial. *BMJ*, 337, 1-11.
- Johnson, B., Carey, M., Marsh, K., Levin, K., & Scott-Sheldon, L. (2003). Interventions to reduce sexual risk for HIV in Adolescents, 1985-2000. *Arch Pediatr Adolesc Med*, 157, 381-388.
- Kelly, J. A. (2004). Popular opinion leaders and HIV prevention peer education: resolving discrepant findings and implications for the development of effective community programmes. *AIDS Care*, 16, 139-150.
- Kelly, K., Parker, W., & Oyosi, S. (2001). *Pathways to action: HIV/AIDS prevention, children and young people in South Africa (A literature review)*. (Report). Cape Town: Centre for Aids Development Research and Evaluation.
- Kinsler, J., Sneed, C., Morisky, D., & Ang, A. (2004). Evaluation of a school-based intervention for HIV/AIDS prevention among Belizean adolescents. *Health Education Research*, 19, 730-738.
- Kinsman, J., Nakiyingi, J., Carpenter, L., Quigley, M., Pool, R., & Whitworth, J. (2001). Evaluation of a comprehensive school-based AIDS education programme in rural Masaka, Uganda. *Health Education Research*, 16, 85-100.
- Kirby, D., Laris, B., & Roller, L. (2005). *Impact of sex and HIV education programs on sexual behaviours of youth in developing and developed countries*. North Carolina: Family Health International.
- Klepp, K., Ndeki, S. S., Seha, A. M., Hannan, P., Lyimo, B., Msuya, M. H. et al. (1994). AIDS education for primary school children in Tanzania: An evaluation study. *AIDS*, 8, 1157-1162.
- Klepp, K., Ndeki, S., Leshabari, M., Hannan, P., & Lyimo, B. (1997). AIDS education in Tanzania: Promoting risk reduction among primary school children. *American Journal of Public Health*, 87, 1931-1936.
- Klepp, K., Flisher, A. J., & Kaaya, S. F. (2008). *Promoting Adolescent Sexual and Reproductive Health in East and Southern Africa*. Cape Town: HSRC Press.
- Kopelman, L. & Van Niekerk, A. (2005). Moral and social complexities of AIDS in Africa. In L. Kopelman & A. Van Niekerk (Eds.), *Ethics and AIDS in Africa* (pp. 71-83). Claremont: David Philip Publishers.
- Labour Resource and Research Institute (2000). *The Namibian Labour Market at a Glance*. Retrieved on September 12 2008 from <http://www.larri.com.na/papers/Namibian%20labour%20market%20at%20a%20glance.doc>
- Labour Resource and Research Institute & Global Policy Network (2003). *Namibia: Labour market and socio economic indicators*. (Report). Windhoek: LaRRI and GPN.
- LeBeau, D., Fox, T., Becker, H., & Mufune, P. (2001). Agencies and structures facilitating the transmission of HIV/AIDS in Northern Namibia. *Society in Transition*, 32, 56-68.



- LeBeau, D. & Gordon, R. (2002). *Challenges for anthropology in the 'African Renaissance' A Southern African Contribution*. Windhoek: University of Namibia Press.
- Leclerc-Madlala, S. (2008). Sugar daddies and HIV: is it really about money, money, money? *HSRC Review*, 6, 11-12.
- Loewensen, R. (2007). Learning from diverse contexts: equity and inclusion in the responses to AIDS. *AIDS Care*, 52, 1613-1627.
- Lugalla, J., Emmelin, M., Mutembei, A., Sima, M., Kwesigabo, G., Killewo, J. et al. (2004). Social, cultural and sexual behavioural determinants of observed decline in HIV infection trends: lessons from the Kagera Region, Tanzania. *Social Science and Medicine*, 59, 185-198.
- MacPhail, C. & Campbell, C. (1999). Evaluating HIV/STD interventions in developing countries: do current indicators do justice to advances in intervention approaches? *South African Journal of Psychology*, 29, 149-165.
- MacPhail, C. & Campbell, C. (2001). 'I think condoms are good but, aai, I hate those things': condom use among adolescents and young people in a Southern African township. *Social Science and Medicine*, 52, 1613-1627.
- Maurer, L. & Kelly, M. (2005). Lessons learned and global partnerships: Stories of sexual and reproductive health from Namibia. *American Journal of Sexuality Education*, 1, 39-50.
- Maypole, J. S., Schonfeld, D. J., O'Hare, L. L., Showalter, D. R., & Cicchetti, D. V. (1998). Perceptions of vulnerability and fears of AIDS: A survey of elementary school children. *Journal of HIV/AIDS Prevention and Education for Adolescents and Children*, 2, 107-128.
- McCourt, W. & Awases, M. (2007). Addressing the human resources crisis: a case study of the Namibian health service. *Human Resources for Health*, 5 (1), 1-13.
- Mellanby, A., Rees, J., & Tripp, J. (2000). Peer-led and adult-led school health education: a critical review of available comparative research. *Health Education Research*, 15, 533-545.
- Mellanby, A., Newcombe, R., Rees, J., & Tripp, J. (2001). A comparative study of peer-led and adult-led school sex education. *Health Education Research*, 16, 481-492.
- Merakou, K. & Kourea-Kremastinou, J. (2003). Peer education in HIV prevention: an evaluation in schools. *European Journal of Public Health*, 16, 128-132.
- Milburn, K. (1995). A critical review of peer education with young people with special reference to sexual health. *Health Education Research*, 10, 407-420.
- Ministry of Health and Social Services (MOHSS), Republic of Namibia (2008). Estimates and projections of the impact of HIV/AIDS in Namibia. Windhoek, Namibia.
- Moore, S. & Rosenthal, D. (1993). Social Influences on adolescent sexuality. In S. Moore and D Rosenthal (Eds.) *Sexuality in Adolescence*, (pp. 63-80). London, New York: Routledge.
- Morrow, V. (1999). Conceptualising social capital in relation to the health and well-being of children and young people: A critical review. *Sociological Review*, 47, 744-765.
- Mseyamwa, N (2006, October 23). No Wonder Our Pass Rate is So Poor. *Mail & Guardian*. Retrieved August 14 from <http://www.mg.co.za/article/20061023namibianteachers-forced-to-look-for-other-jobs>
- Mufune, P. (2003). Changing patterns of sexuality in Northern Namibia: Implications for the transmission of HIV/AIDS. *Culture, Health & Sexuality*, 5, 425-438.
- Mufune, P. (2005). Myths about condoms and HIV/AIDS in rural northern Namibia. *International Social Science Journal*, 57, 675-686.

- Mufune, P. (2008). Stakeholders' perceptions and attitudes towards sexual and reproductive health education in Namibia. *Sex Education, 8*, 145-157.
- Muhato, W. (2003). *Gender assessment Namibia country strategic plan: 2004-2010*. (Report). Nairobi: USAID, REDSO and ESA.
- National Planning Commission Namibia. (2002). *Country Report*. Windhoek: National Planning Commission.
- National Planning Commission (2004). *Namibia 2004 Millennium Development Goals*. Windhoek: National Planning Commission.
- Norris, G., Mbokazi, T., Rorke, F., Goba, S., & Mitchell, C. (2007). Where do we start? Using collage to explore very young adolescents' knowledge about HIV and AIDS in four senior primary classrooms in KwaZulu Natal. *International Journal of Inclusive Education, 11*, 481-499.
- Obot, I. S. (2006). Alcohol use and related problems in Sub-Saharan Africa. *African Journal of Drugs and Alcohol Studies, 5*, 17-26.
- Odejide, O. A. (2006). Alcohol policies in Africa. *African Journal of Drugs and Alcohol Studies, 5*, 28-39.
- Oppong, J. & Kalipeni, E. (2004). Perceptions and misperceptions of AIDS in Africa. In E. Kalipeni, S. Craddock, J. Oppong, & J. Ghosh (Eds.), *HIV and AIDS in Africa: Beyond epidemiology* (pp.47-57). Oxford: Blackwell Publishing.
- Orme, J. & Starkey, F. (1999). Peer drug education: The way forward? *Health Education, 1*, 8-16.
- Ozer, E. J., Weinstein, R. S., Maslach, C., & Siegel, D. (1997). Adolescent AIDS prevention in context: the impact of peer educator qualities and classroom environments on intervention efficacy. *American Journal of Community Psychology, 25*, 289-323.
- Parker, W. (2004). *Rethinking conceptual approaches to behaviour change: The importance of context*. Johannesburg: Centre for AIDS Development, Research and Evaluation (CADRE).
- Parker, W. & Connolly, C. (2007). *HIV/AIDS Strategic Information Report: a mid-term household analysis of Residents in Rundu*. Windhoek: NawaLife Trust.
- Pattman, R. & Cockerill, M. (2007). Christian women and men from Durban: peer sex educators in the making. *International Journal of Inclusive Education, 11*, 501-517.
- Paul-Ebhohimhen, V., Poobalan, A., & Van Teijlingen, E. (2008). Systematic review of effectiveness of school-based sexual health interventions in Sub-Saharan Africa. *BMC Public Health, 8* (4), 1-13.
- Pearson Education (2005). *Measuring global poverty*. Retrieved August 1 2008 from <http://www.infoplease.com/ipa/A0908762.html>
- Pearson, M. & Michell, L. (2000). Smoke rings: social network analysis of friendship groups, smoking and drug-taking. *Drugs: Education, Prevention and Policy, 7*, 21-37.
- Peltzer, K. & Promtussananon, S. (2003). Evaluation of Soul City and mass media life skills education among junior secondary school learners in South Africa. *Social Behaviour and Personality, 31*, 825-834.
- Pettifor, A. E., Rees, H. V., Steffenson, A., Hlongwa-Madikizela, L., & MacPhail, C. (2004). *HIV and sexual behaviour among young South Africans: a national survey of 15-24 year olds*. (Report). Johannesburg: University of the Witwatersrand, Reproductive Health Research Unit.
- Plummer, M. L., Wight, D., Wamoyi, J., Nyalali, K., Ingall, T., Mshana, G. et al. (2007). Are schools a good setting for adolescent sexual health promotion in rural Africa? A qualitative assessment from Tanzania. *Health Education Research, 22*, 500-512.

- Population Council (1992). *Facts about adolescents from the demographic and health survey: statistical tables for program planning*. Retrieved July 24 2008 from <http://www.popcouncil.org/gfd/gfddhs.html>
- Population Council (1993). Namibia 1992: Results from the Demographic and Health Survey. *Studies in Family Planning*, 24(6), 382-386.
- Population Council (2000). *Peer education and HIV/AIDS: Past experiences, future directions*. (Horizons Final Report). Washington: Populations Council.
- Population Reference Bureau (2006). *The world's youth 2006 data sheet*. (Report). Washington: Population Reference Bureau.
- Powers, J. & Tiffany, J. (2006). Engaging youth in participatory research and evaluation. *Journal of Public Health Practice and Management, Suppl*, S79-S87.
- Reddy, P. & James, S. (2005). *Programming for HIV Prevention in South African schools: A report on programme implementation*. (Horizons Final Report). Washington: Population Council.
- Regmi, P., Subedi, K., & Lamsal, G. (2004). Baseline survey among adolescent students on adolescent reproductive health, HIV/AIDS/STD and sexual behaviours in Kathmandu, Nepal. Paper presented at the XV International AIDS Conference, 11-16 July, 2004.
- Robin, L., Dittus, P., Whitaker, D., Crosby, R., Ethier, K., Mezoff, J. et al. (2004). Behavioural interventions to reduce incidence of HIV, STD, and pregnancy among adolescents: A decade in review. *Journal of Adolescent Health*, 34, 3-26.
- Rogers, E. M. (1983). *Diffusion of Innovations*. (3rd ed.). New York: Free Press.
- Rompel, M. (2005). *Financing HIV/AIDS prevention through social health insurance: A cross-cutting issue for public health in developing countries*. (Report). Berlin: GTZ Systems of Social Protection & The Federal Ministry for Economic Co-operation and Development .
- Rosenstock, I (1974). Historical origins of the Health Belief Model. *Health Education Monographs*, 2 (4), 328-335.
- Sapiano, A., Nelson, T., Sohaba, N., & Esu-Williams, E. (2008). *Dare to be Different: enhancing life-skills education for HIV prevention in South African schools* Washington: Population Council.
- Schaalma, H., Kok, G., Abraham, C., Hospers, H., Klepp, K., & Parcel, G. (2002). HIV Education for young people: Intervention effectiveness, programme development and future research. *Prospects*, 32, 187-206.
- Schwarz, B. (2003). *Young Namibians and HIV/AIDS: A baseline study for UNICEF Namibia's adolescent HIV prevention programme*. Windhoek: UNICEF Namibia.
- Schwarz, B. (2004). *Managing 'Take Control': an assessment of the Namibian HIV & AIDS media campaign and its coordination*. Windhoek: Ministry of Information and Broadcasting and UNICEF Namibia.
- Shiner, M. (1999). Defining peer education. *Journal of Adolescence*, 22, 555-556.
- Shuey, D., Babishangire, B., Omiat, S., & Bagarukayo, H. (1999). Increased sexual abstinence among in-school adolescents as a result of school health education in Soroti district, Uganda. *Health Education Research*, 14, 411-419.
- Simbayi, L., Chauveau, J., & Shisana, O. (2004). Behavioural responses of South African youth to the HIV/AIDS epidemic: a nationwide survey. *AIDS Care*, 16, 605-618.
- Soul City Institute. (2008). *About Desert Soul: Namibian health communication environment*. Retrieved July 23 2008 from <http://soulcity.org.za/programmes/beyondsouth-africa/namibia>.

- Stanton, B., Li, X., Kahihuata, J., Fitzgerald, A., Neumbo, S., Kanduuombe, G. et al. (1998). Increased protected sex and abstinence among Namibian youth following a HIV risk-reduction intervention: a randomised, longitudinal study. *AIDS*, 12, 2473-2480.
- Stanton, B., Fitzgerald, A., Li, X., Shipena, H., Ricardo, I., Galbraith, J. et al. (1999). HIV risk behaviours, intentions, and perceptions among Namibian youth as assessed by a theory-based questionnaire. *AIDS Education and Prevention*, 11, 132-150.
- Strange, V., Forrest, S., & Oakley, A. (2002). Peer-led sex education-characteristics of peer educators and their perceptions of the impact on them of participation in a peer education programme. *Health Education Research*, 17, 327-337.
- Strange, V., Forrest, S., & Oakley, A. (2002). What influences peer-led sex education in the classroom? A view from the peer educators. *Health Education Research*, 17, 339-349.
- Swartz, S. (2003). The developmental basis for adolescent peer education. Unpublished paper. Retrieved July 28 2008 from <http://www.theyouthinstitute.org/>
- Swedish International Development Cooperation Agency (Sida). (2004). *Country Analysis 2003: Namibia*. Stockholm: Swedish International Development Cooperation Agency.
- Tawil, O., Verster, A., & O' Reilly, K. (1995). Enabling approaches for HIV/AIDS promotion: Can we modify the environment and reduce the risk? *AIDS*, 9, 1299-1306.
- Terry, E. (2006). *The need for a coordinated approach to facilitate access to education: A key finding of the research into child labour in Namibia*. Paper presented at the RECLISA Southern African regional child labour conference, 4-6 July 2006. Retrieved from the International Labour Organisation website: <http://www.ilo.org/>
- The Communication Initiative Network. (2007). 'Take Control' campaign- Namibia. Retrieved August 1 2008 from <http://www.comminit.com/en/node/125980/print>
- The Communication Initiative Network (2008). 'Desert Soul' project. Retrieved August 1 2008 from <http://www.comminit.com/en/node/130355/print>
- The Government of Namibia (1990). *The Constitution of the Republic of Namibia* (Article 20). Retrieved July 20 2008 from <http://www.orusovo.com/namcon/>
- The Government of Namibia Ministry of Health and Social Services (MoHSS) (2001). *Social marketing of condoms for HIV/AIDS prevention and family planning -NASOMA*. (Report on rapid assessment related to HIV/AIDS and condom use). Windhoek: GRN MoHSS, GmbH/MSI and UNICEF
- The Government of Namibia Ministry of Education (MoE) (2005). *Directorate of national examinations and assessments*. Retrieved July 21 2008 from <http://www.mec.gov.na/ministryOfEducation/dneaHeadOfficeD.htm>
- The Government of Namibia Ministry of Health and Social Services (MoHSS) (2005). *Follow up to the Declaration of commitment on HIV/AIDS (UNGASS)*. (Namibia Country Report). Windhoek: GRN MoHSS
- The Government of Namibia Ministry of Education (MoE) (2006). *Annual Report for the financial year 2005-2006*. Windhoek: GRN MoE.
- The Government of Namibia Ministry of Health and Social Services (MoHSS) (2007). *United Nations General Assembly Special Session (UNGASS)*. (Namibia Country Report). Windhoek: GRN MoHSS
- The Government of Namibia (2007). *Languages spoken in Namibia*. Retrieved August 13 2008 from <http://209.88.21.55/opencms/grnnet/AboutNamibia/population/languages.html>

- The Government of Namibia Ministry of Education (MoE) (2008). *Ministry of Education*. Retrieved August 12 2008 from [http://www.op.gov.na/Decade\\_peace/b\\_edu.htm](http://www.op.gov.na/Decade_peace/b_edu.htm)
- The Government of Namibia Ministry of Health and Social Services (MoHSS) (2008). *Namibia 2006-07 Demographic and Health Survey Key Findings*. Maryland: MoHSS and Macro International.
- The Government of Namibia Ministry of Health and Social Services (MoHSS) (2008). *Namibia Demographic and Health Survey 2006/07*. Windhoek: MoHSS.
- The Namibian Economist. (2008). "Be there to care": new 'Take Control' theme. Retrieved July 23 from <http://www.economist.com.na/content/view/630/33/>
- The World Bank (2007). *HIV/AIDS Regional Update: Africa*. Retrieved July 13 2008 from <http://web.worldbank.org/>
- Thomas, K. (2004). A better life for some: the LoveLife campaign and HIV/AIDS in South Africa. *Agenda*, 62, 29-32.
- Thomsen, S. C. (2007). *Tell Me More! Children's rights and sexuality in the context of HIV/AIDS in Africa*. Stockholm: Save the Children Sweden and The Swedish Association for Sexuality Education.
- Tobias, B. (2001). A descriptive study of the cultural mores and beliefs toward HIV/AIDS in Swaziland, Southern Africa. *International Journal for the Advancement in Counselling*, 23, 99-113.
- Turner, G. & Shepherd, J. (1999). A method in search of a theory: peer education and health promotion. *Health Education Research*, 14, 235-247.
- UNAIDS (1999). *Peer education and HIV/AIDS: Concepts, uses and challenges*. (UNAIDS best practice collection). Geneva: UNAIDS, Horizons/Population Council, FHI, Jamaican Ministry of Health, USAID and PATH.
- UNAIDS (2002). *Join the fight against AIDS in Namibia*. Geneva: UNAIDS.
- UNAIDS, UNFPA & UNIFEM. (2004). *Women and HIV/AIDS*. Geneva: UNAIDS.
- UNAIDS & World Health Organization. (2007). *AIDS epidemic update 2007*. Geneva: UNAIDS and WHO.
- UNAIDS & World Health Organization. (2008). *Sub Saharan Africa: AIDS epidemic update, regional summary*. Geneva: UNAIDS and WHO.
- UNAIDS & World Health Organization (2008). *Fact Sheet Sub-Saharan Africa*. Geneva: UNAIDS and WHO.
- UNAIDS & World Health Organization (2008). *AIDS epidemic update 2008*. Geneva: UNAIDS and WHO.
- UNAIDS & World Health Organization. (2006). *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections*. Geneva: UNAIDS and WHO.
- \UNAIDS & World Health Organization. (2006). *AIDS Epidemic Update 2006*. Geneva: UNAIDS and WHO.
- UNdata (2007). *Share of youth unemployed in youth population*. Retrieved September 12 2008 from <http://data.un.org/Data.aspx?d=GenderStat&f=inID%3A128>
- United Nations Development Programme. (2007). *Trends in human development and human poverty in Namibia*. (Background paper to the Namibia Human Development Report). Windhoek: UNDP.
- United Nations Development Programme. (2008). *Namibia: The human development index-going beyond income*. Retrieved July 13 2008 from [http://hdrstats.undp.org/countries/data\\_sheets/cty\\_ds\\_NAM.html](http://hdrstats.undp.org/countries/data_sheets/cty_ds_NAM.html)

- United Nations Development Programme. (2008). *Human development report 2007/08*. United Kingdom: Palgrave-Macmillan.
- UNESCO (2000). The EFA 2000 assessment: Country reports Namibia. Retrieved July 28 2008 from [http://www.unesco.org/education/wef/countryreports/namibia/rapport\\_2.html](http://www.unesco.org/education/wef/countryreports/namibia/rapport_2.html)
- UNESCO. (2008). *Education for all: Global monitoring report*. Paris: UNESCO
- UNICEF (2006). *HIV and AIDS knowledge, attitudes, practices and behaviour (KAPB) study in Namibia*. (Report on key findings). Windhoek: UNICEF Namibia and RFS.
- UNICEF (2008). *Namibia statistics*. Retrieved July 17 2008 from [http://www.unicef.org/infobycountry/namibia\\_statistics.html?q=printme](http://www.unicef.org/infobycountry/namibia_statistics.html?q=printme)
- UNICEF Namibia (2002). *Young people in northern Namibia: Assessing communication around HIV prevention*. (Final report on discussion group sessions) Oshikati Namibia: UNICEF Namibia.
- UNICEF/Adolescent HIV Prevention Programme (AHPP). (2004). *Mid-year assessment 'My Future is My Choice'* (Report on Major Findings and Recommendations). Windhoek: UNICEF/AHPP.
- UNICEF/Government of the Republic of Namibia (2002). *Youth health and development programme "My Future is My Choice" life- skills intervention implementation assessment*. Windhoek: UNICEF/GRN.
- UNICEF, UNAIDS & WHO (2002). *Young People and HIV/AIDS: Opportunity in Crisis*. New York: UNICEF
- United Nations (2003). *Young people: partners in HIV and AIDS prevention*. New York: United Nations.
- United Nations (2005). *Draft country programme document for Namibia*: Executive Board of the United Nations Development Programme and The United Nations Population Fund.
- United Nations Namibia (2004). *Common Country Assessment 2004*. Windhoek: GRN and the United Nations System in Namibia.
- United Nations Population Fund (2005). *Training of trainers manual: Youth peer education toolkit*. Retrieved October 11 2008 from <http://www.fhi.org/>
- USAID (2006). *Namibia overview*. Retrieved July 8 2008 from <http://www.usaid.gov/na/overview2.htm>
- USAID (2007). *USAID country health statistical report, Namibia*. Washington: USAID.
- USAID (2008). Latin America and the Caribbean: poverty data. Retrieved August 4 2008 from [http://gesdb.usaid.gov/lac/technotes\\_poverty.html](http://gesdb.usaid.gov/lac/technotes_poverty.html)
- Usdin, S., Scheepers, E., Goldstein, S., & Japhet, G. (2005). Achieving social change on gender-based violence: A report on the impact evaluation of Soul City's fourth series. *Social Science and Medicine*, 61, 2434-2445.
- Van Dyk, A. (2005). Fundamental facts about HIV/AIDS. In A. Van Dyk (Ed.), *HIV/AIDS care and counselling: A multidisciplinary approach* (pp 1-61). Cape Town: Pearson Education.
- Van Teijlingen, E., Pooblan, A., & Paul-Ebhohimhen, V. (2008). A systematic review of school-based sexual health interventions to prevent STI/HIV in sub-Saharan Africa. *BMC Public Health*, 8 (4), 1-13.
- Van Zyl, D. (2003). *An overview of HIV-related research in Namibia since independence*. Windhoek: Institute for Public Policy Research.
- Visser, M. J. (2007). HIV/AIDS prevention through per education and support in secondary schools in South Africa. *Journal of Social Aspects of HIV/AIDS*, 4, 678-694.

- Walker, A. W. & Avis, M. (1999). Common reasons why peer education fails. *Journal of Adolescence*, 22, 573-577.
- Walker, D., Gutierrez, J. P., Torres, P., & Bertozzi, M. (2006). HIV prevention in Mexican schools: prospective randomised evaluation of interventions. *BMJ*, 332, 1189-1194.
- Ward, C. L., Van der Heijden, I. J., Mukoma, W., Phakati, S., Mhlambi, T., Pheiffer, J. et al. (2008). *South Africa's peer education programmes: Mapping outcomes and assessment*. (Final report). Pretoria: UNICEF and the Department of Health.
- Weiss, E., Whelan, D., & Gupta, G. (2000). Gender, sexuality and HIV: making a difference in the lives of young women in developing countries. *Sexual and Relationship Therapy*, 15, 233-245.
- WHO & Department of Mental Health and Substance Abuse (2004). *Global Status Report on Alcohol 2004*. Geneva: WHO.
- WHO (2006). *Preventing HIV/AIDS in young people*. (WHO technical report series No. 938). Geneva: WHO, UNAIDS, UNFPA and UNICEF.
- Wikan, G. (2008). *Challenges in the primary education in Namibia*. (Report No.7). Hedmark, Norway: Hedmark University College.
- Winterfeldt, V. (2002). Labour migration in Namibia. In V. Winterfeldt, Fox, T., & Mufune, P. (Eds.), *Namibia, society, sociology* (pp. 39-74). Windhoek: University of Namibia Press.
- Whitaker, D.J. & Miller, K.S. (2000). Parent-adolescent discussions about sex and condoms: Impact on peer influences of sexual risk behaviour. *Journal of Adolescent Research*, 15 (2), 251-273.
- Wood, K. & Jewkes, R. (2005). 'Dangerous' love: reflections on violence among Xhosa township youth. In A. Cornwall (Ed.), *Readings in gender in Africa* (pp. 317-336). Bloomington: Indiana University Press.
- World Bank (2007). *World Development Report 2007: Development and the next generation*. Washington: World Bank.
- World Bank (2007). *Education at a Glance: Namibia*. Retrieved August 11 2008 from [http://siteresources.worldbank.org/INTNAMIBIA/Resources/NAM-Educ\\_at\\_a\\_Glance.pdf](http://siteresources.worldbank.org/INTNAMIBIA/Resources/NAM-Educ_at_a_Glance.pdf)
- World Health Organization (2005). *Namibia*. Retrieved July 18 from <http://www.who.int/countries/nam/en/>
- Youth Development Network (2008). *Namibia*. Retrieved July 23 2008 from <http://ydn.org.za>
- Zere, E., Mandlhate, C., Mbeeli, T., Shangula, K., Mutirua, K., & Kapenambili, W. (2007). Equity in health care in Namibia: developing a needs-based resource allocation formula using Principal components analysis. *International Journal for Equity in Health*, 6 (3), 1-7.

## **APPENDICES**



APPENDIX A: DATA COLLECTION MATRIX AND RESEARCH INSTRUMENTS

DATA COLLECTION MATRIX

METHOD	PHASE	KAVANGO	OMUSATI	OMAHEKE	OSHANA	KHOMAS	HARDAP	TOTAL NUMBER
MFMC Graduate Questionnaires	I	75	75	75	75			300
Peer Facilitator Interviews	I	3	3	3	3			12
Stakeholder Interviews	I, II	2 1 principal 1 teacher	2 1 principal 1 teacher	3 1 principal 1 teacher 1 RACE coordinator	3 1 principal 1 teacher 1 RACE Coordinator	2 1 RACE Coordinator 1 Trainer	1 1 RACE Coordinator	13
FGDs with MFMC Graduates	II			2	2	2	2	8 (n = 65)
FGDs with MFMC Facilitators	II			1	1	1	1	4 (n = 23)
Observation - Course to learners (10 days of training)	II					1 facilitator		1
Observation - Training of new peer facilitators	I				1			1

**MY FUTURE IS MY CHOICE  
YOUTH SURVEY  
LEARNERS AGED 15 TO 19 AT SCHOOLS  
27 JUNE 2008**

Dear Learner

UNICEF and the Namibian Ministry of Education have asked us to find out what you think about the My Future is My Choice (MFMC) peer education life skills programme. We would like you to help us by answering this questionnaire. Please be as honest as possible. Your answers are confidential and anonymous and will not be shown to anyone.

**DO NOT PUT YOUR NAME ON THIS PAPER**

INSTRUCTIONS: Please mark your answers like this:

EXAMPLE: What is your favourite colour? (Circle one answer)

Blue	1
Red	2
Green	3
Yellow	4

**Q1 Case Number (OFFICE USE ONLY)**

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**Q2 Region (OFFICE USE ONLY)**

Kavango	1
Omaheke	2
Oshana	3
Omusati	4

**Q3 Urban/Rural (OFFICE USE ONLY)**

Urban	1
Rural	2

**Q4 Name of School (OFFICE USE ONLY)**

--	--

**Q5 Name of interviewer and supervisor (OFFICE USE ONLY)**

--	--

**Q6 Name of coding clerk (OFFICE USE ONLY)**

--	--

**Q7 Did you complete 10 sessions of *My Future is My Choice*?**

Yes	1	IF YES CONTINUE
No	2	IF NO DISCONTINUE INTERVIEW

**Q8 During which year did you participate in *My Future is My Choice*?**

2006	1
2007	2
2008	3

**SECTION ONE: BIOGRAPHICAL AND HOUSEHOLD DETAILS**

*In this first section, we would like to know more about you and other members of your family and household.*

**Q9 Are you male or female?**

Male	1
Female	2

**Q10 How old are you now?**

--	--

**Q11 Which grade are you in now?**

Grade	
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**Q12 Which of the following people live in your home? (More than one answer can be circled)**

One parent or caregiver	1
Both parents or caregivers	2
Brothers and/or sisters	3
One or both grandparents	4
Other family members	5
Others (tenants; friends etc)	6
IF OTHER, please specify:	

**Q13 Tell us about your birth parents (Circle all the applicable answers)**

Relation	Alive and staying in your household	Alive, but not staying in your household	He/she is dead
a) Father	1	2	3
b) Mother	1	2	3

Q14 Over the past year, how often, if ever, have you or anyone in your family gone without:	Never	Just once or twice	A few times	Many times	Always	Don't know
a) Enough food to eat?	0	1	2	3	4	9
b) Enough clean water for home use?	0	1	2	3	4	9
c) Medicines or medical treatment?	0	1	2	3	4	9
d) Enough electricity/wood/gas to cook your food?	0	1	2	3	4	9
e) A cash income	0	1	2	3	4	9

**SECTION TWO: KNOWLEDGE OF PREGNANCY, SEXUALLY TRANSMITTED DISEASES (STDs) AND HIV/AIDS**

*In this section, we would like to find out how much you know about pregnancy, STDs, and HIV/AIDS.*

Q15 Which diseases have you heard of that can be transmitted sexually? Please name as many as you can.	
a)	
b)	
c)	
d)	
e)	
f)	
g)	
h)	

Q16 Name three (3) symptoms that suggest a person may have a sexually transmitted disease.	
a)	
b)	
c)	

Q17 List two negative things that might happen because of teenage pregnancy.	
a)	
b)	

Q18 Decide whether you think each statement is either true or not true. Circle the appropriate response. <i>"A person can get infected with HIV by ..."</i>	True	Not true	Don't know
a) Having unprotected sex with an HIV positive person	1	2	3
b) Being injected with a needle which has already been used by an HIV positive person	1	2	3
c) Sharing food with an HIV positive person	1	2	3
d) Being bitten by a mosquito who has bitten an HIV positive person before	1	2	3
e) A pregnant woman who is HIV positive can transmit HIV to her unborn baby	1	2	3
f) Touching the sweat of an HIV positive person	1	2	3
g) Holding hands with an HIV positive person	1	2	3
h) Sharing knives/forks/spoons with someone who has HIV	1	2	3
i) Somebody putting a curse on you to give you HIV	1	2	3

Q19 It is well known that sex is one of the primary ways that HIV is transmitted. Decide whether you think each statement is either true or not true. Circle the appropriate response. <i>"A person can prevent getting HIV by ..."</i>	True	Not true	Don't know
a) Not having sex at all	1	2	3
b) Having sex with only one partner who is not HIV positive	1	2	3
c) Using traditional medicine to prevent HIV from spreading from one person to another	1	2	3
d) Using the birth control pill or an injection, and not condoms	1	2	3
e) Always using condoms with partners	1	2	3
f) Always using a condom when having sex with a sex worker	1	2	3
g) Having sex only with people who you know do not have HIV	1	2	3
h) Withdrawing before ejaculating when having sex	1	2	3

**SECTION THREE: SOURCES OF KNOWLEDGE ABOUT HIV/AIDS**

*In this section, we would like to know more about where and from whom you have learned about HIV/AIDS*

<b>Q20 From whom/where have you received the most useful information about HIV and AIDS? Name two.</b>	
a)	
b)	

**Q21 If you have received information about HIV/AIDS from any of the following activities or people AT SCHOOL, please tell us how useful this information was for you. If you have not participated in one or more of the activities below, please leave the answer blank.**

	Not useful at all	Not useful	Some where in-between	Useful	Very useful
a) Life skills classes	1	2	3	4	5
b) Other classes	1	2	3	4	5
c) MFMC programme	1	2	3	4	5
d) AIDS drama/ play	1	2	3	4	5
e) School assembly	1	2	3	4	5
f) Discussions with teachers outside class	1	2	3	4	5
g) Discussions with peers/friends	1	2	3	4	5
h) AIDS campaign e.g. red ribbon campaign; AIDS day or AIDS awareness week	1	2	3	4	5

<b>Q22 Which of the following people have talked to you about: (Circle all that apply)</b>	<b>Sex and other issues related to sex</b>	<b>HIV/AIDS</b>
a) Parent/Caregiver	1	2
b) Other family member	1	2
c) Friends	1	2
d) Teacher	1	2
e) Counsellor	1	2
f) MFMC peer facilitator	1	2
g) Pastor, church member, or other person related to my church	1	2
h) Other	1	2

<b>From the list above in Q22, please specify the identifying letter e.g. a); b); or c) etc. Select only one response per question.</b>	
Q23 From whom have you learnt the most about sex?	
Q24 From whom have you learnt the most about HIV/ AIDS?	
Q25 Who has had the most influence on your attitudes and behaviour in relation to HIV?	

**SECTION FOUR: MFMC PROGRAMME**

*Now we are going to ask you a few questions about your participation in the MFMC programme at your school.*

<b>Q26 How strongly do you agree or disagree with these statements about the MFMC programme at your school?</b>	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Neutral</b>	<b>Agree</b>	<b>Strongly Agree</b>
a) The MFMC materials gives useful information about HIV/ AIDS	1	2	3	4	5
b) The MFMC materials on HIV/ AIDS are easy to understand	1	2	3	4	5
c) There is not enough information for my age group	1	2	3	4	5
d) I find some of the materials confusing	1	2	3	4	5
e) Some of the materials embarrass me	1	2	3	4	5
f) The MFMC materials on HIV/ AIDS are interesting	1	2	3	4	5
g) I liked my MFMC peer facilitator	1	2	3	4	5
h) I learned a lot from my MFMC peer facilitator	1	2	3	4	5
i) During the MFMC programme, the peer facilitator was a positive role model to me	1	2	3	4	5
j) The MFMC programme at my school helped me to protect myself from getting HIV/ AIDS	1	2	3	4	5
k) The MFMC programme helped me to understand more about HIV/ AIDS.	1	2	3	4	5
l) The MFMC programme helped me to accept people living with HIV/ AIDS.	1	2	3	4	5

<b>Q27 Please name the MFMC sessions that you remember.</b>	

<b>Q28 What was the most valuable thing you learned during the MFMC programme?</b>	

<b>Q29 What did you like least about the programme?</b>	

**SECTION FIVE: ATTITUDES AND PRACTICE**

*Now we would like to find out whether you agree or disagree with the following statements about sex, relationships, and HIV/ AIDS.*

<b>Q30 These statements are about the risk of getting infected with HIV. Do you agree or disagree ...</b>	<b>Strongly disagree</b>	<b>Disagree</b>	<b>Neutral</b>	<b>Agree</b>	<b>Strongly agree</b>
a) People like me do not get HIV	1	2	3	4	5
b) I am very healthy, so my body can fight off an HIV infection	1	2	3	4	5
c) A male can reduce his chance of HIV infection by getting circumcised (having the foreskin of the penis removed)	1	2	3	4	5
d) I am too young to get an HIV infection	1	2	3	4	5
e) I will make sure a condom is used when I have sex	1	2	3	4	5
f) I will wait to have sex until I am older and ready	1	2	3	4	5



g) I would not have sex with someone who refuses to use a condom	1	2	3	4	5
h) I would not have sex with someone who I know is also having sex with another person within the same period	1	2	3	4	5
i) I would have sex with someone if they agreed to pay my school fees	1	2	3	4	5
j) If someone offered to buy my family food, I would have sex with him/her without a condom	1	2	3	4	5

<b>Q31 Do you think you will be able to do the following things, in order to have safe sex?</b>	<b>Not sure at all</b>	<b>Not sure</b>	<b>Don't know</b>	<b>Sure</b>	<b>Very sure</b>
a) Talk about safe sex with a casual partner	1	2	3	4	5
b) Refuse to have sex with someone you don't know very well	1	2	3	4	5
c) Use a condom correctly if your partner wanted to	1	2	3	4	5
d) Convince a partner that he/she should use a condom	1	2	3	4	5
e) Prevent a partner from having anal sex with you	1	2	3	4	5
f) Ask a partner about his/her other sexual partners	1	2	3	4	5
g) Refuse sex with someone who is offering money or a gift	1	2	3	4	5
h) Make sure that your partner goes for an HIV test before having sex with you	1	2	3	4	5

<b>Q32 These statements are about your attitudes toward people with HIV and AIDS. Circle your response.</b>	<b>Yes</b>	<b>No</b>
a) I would care for a member of our family with HIV or an AIDS-related disease	1	2
b) I would not buy food that has been touched from a shopkeeper or food seller with HIV or AIDS- related disease	1	2
c) A teacher who has HIV but is not sick should be allowed to continue teaching in school	1	2
d) I would not want anyone to know if a member of our family becomes infected with HIV	1	2
e) HIV positive people should not be allowed to work in a restaurant or bar that serves food to people	1	2
f) Children suffering from AIDS- related diseases should be kept out of school	1	2
g) I do not want to be friends with somebody who has AIDS	1	2

**SECTION SIX: SEXUAL BEHAVIOUR**

Now we are going to talk about sexual behaviour. Remember you can be honest.

Nobody will know what you filled in.

**Q33 Do you have a girlfriend/boyfriend at the moment?**

Yes I have a girlfriend/boyfriend	1
Yes I have more than one girlfriend/boyfriend	2
No I am not in a relationship at the moment	3

**Q34 Have you ever had sex?**

Yes	1	IF YES, CONTINUE WITH Q35
No	2	IF NO, GO TO Q40

**Q35 If yes, how old were you the first time you had sex?**

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**Q36 Thinking about the person that you had sex with the first time, was he or she...**

Much older than you (10 years or more)	1
Older than you (5 years or more)	2
About the same age as you	3
Younger than you	4
Much younger than you	5

**Q37 How many different sexual partners have you had since you started having sex?**

1 person	1
2 people	2
3 people	3
4 people	4
5 people	5
6 or more people	6

**Q38 When you do have sex, how often?**

	Never	Sometimes	Always
a) Do you have alcohol to drink?	1	2	3
b) Does your partner have alcohol to drink?	1	2	3
c) Do you or your partner use a condom?	1	2	3

<b>Q39 Which of the following have you done in the past twelve months? (Circle all answers that apply) "I have/had ..."</b>	
More than one sexual partner	1
Unprotected sex with one or more partners	2
Sex with a partner who I know cheats on me	3
Sex with someone who is much older than me (10 years or more)	4
Sex with someone I did not know well	5
Sex with someone who paid me or gave me a gift to do so	6
Paid someone to have sex with me	7
Sex with more than one person at the same time	8
Visited a doctor or clinic to be tested for a sexually transmitted disease (STD)	9
Showed signs of a sexually transmitted disease (STD)	10
Anal sex with one or more partners	11
None of the above	12

<b>Q40 Have you ever been tested for HIV?</b>		
Yes	1	IF YES, CONTINUE WITH Q41
No	2	IF NO, GO TO Q43

<b>Q41 Did you go back for your results?</b>		
Yes	1	IF YES, GO TO Q43
No	2	IF NO, CONTINUE WITH Q42

**Q42 If you did not go back for your results, why not?**

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<b>Q43 Which of the following health services and facilities are available in the area you live in? "A Place where..."</b>	<b>Yes, and I use it</b>	<b>Yes, but I don't use it</b>	<b>No, it's not available</b>	<b>Don't know</b>
a) One can get tested for STD's or HIV	1	2	3	88
b) I can get condoms for free	1	2	3	88
c) I can buy condoms	1	2	3	88
d) A health facility for medical services	1	2	3	88

#### **SECTION SEVEN: ALCOHOL USE**

*Now we are going to discuss alcohol use.*

<b>Q44 Have you ever used alcohol?</b>		
Yes	1	IF YES, GO TO Q45
No	2	IF NO, GO TO Q48

<b>Q45 How often do you drink alcohol?</b>	
Daily	1
2-6 times a week	2
Once a week	3
2-3 times a month	4
Once a month	5
Less than once a month	6

**Q46 How old were you (in years) the first time you drank alcohol?**

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<b>Q47 Where do you usually get your alcohol? (More than one answer can be circled)</b>	
At parties	1
From friends	2
From my parents	3
I buy my own	4
Other (please specify)	5

<b>Q48 For each of the statements below, circle whether you agree or disagree:</b>	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Neutral</b>	<b>Agree</b>	<b>Strongly Agree</b>
a) Parties are no fun if there isn't any alcohol	1	2	3	4	5
b) It is often more difficult for people to say "no" to sex after drinking alcohol	1	2	3	4	5
c) Drinking helps overcome shyness	1	2	3	4	5
d) Drinking helps people cope with problems	1	2	3	4	5
e) It is often more difficult for people to remember to use a condom after drinking alcohol	1	2	3	4	5
f) It's okay to be the only person in a group of friends who chooses not to drink alcohol	1	2	3	4	5

## **SECTION EIGHT: CONDOMS**

*Now we are going to discuss condoms.*

<b>Q49 For each of the statements below, circle whether you agree or disagree:</b>	<b>Strongly disagree</b>	<b>Disagree</b>	<b>Neutral</b>	<b>Agree</b>	<b>Strongly agree</b>
a) Generally, I am in favour of using condoms	1	2	3	4	5
b) Condoms interfere with romance	1	2	3	4	5

c) The smell and touch of condoms make them unpleasant to use	1	2	3	4	5
d) Condoms reduce sexual pleasure	1	2	3	4	5
e) I know how to use a condom correctly	1	2	3	4	5
f) I would be able to discuss condom use with any partner	1	2	3	4	5
g) I would insist on using condoms with a new partner	1	2	3	4	5
h) I would feel embarrassed to put a condom on myself or my partner	1	2	3	4	5
i) If I would suggest using a condom to a partner, they might reject me	1	2	3	4	5
j) If I were unsure of my partner's feelings about using a condom, I would not suggest using one	1	2	3	4	5
k) I could easily convince my sexual partner to use a condom	1	2	3	4	5

**SECTION NINE: PEERS**

*Now we are going to ask you a few questions about your friends and relationships between boyfriends and girlfriends.*

<b>Q50 For each statement, circle whether you agree or disagree:</b>	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Neutral</b>	<b>Agree</b>	<b>Strongly Agree</b>
a) By doing the same things as my friends, I feel part of a group	1	2	3	4	5
b) It is easy for me to disagree with my friends.	1	2	3	4	5
c) Most of my friends think it is okay for people my age to have sex	1	2	3	4	5
d) Most of my friends are having sex	1	2	3	4	5
e) My friends would support my decision to avoid all sexual activities that would put me at any risk for HIV exposure	1	2	3	4	5
f) My friends and I discuss our questions and feelings about HIV transmission	1	2	3	4	5
g) My friends would agree that to be sexually active proves one is a man	1	2	3	4	5
h) My friends would laugh if I tried to convince them to avoid sexual intercourse because they might get HIV	1	2	3	4	5
i) My friends would laugh if I tried to convince them to use condoms during sexual intercourse	1	2	3	4	5

<b>Q51 For each of the statements below, circle whether you agree or disagree:</b>	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Neutral</b>	<b>Agree</b>	<b>Strongly Agree</b>
a) I think it is okay for a boy to have many girlfriends	1	2	3	4	5
b) I think it is okay for a girl to have many boyfriends	1	2	3	4	5
c) If a boy says he loves a girl, she should not refuse sex	1	2	3	4	5
d) If a boy gives a girl presents, she should not refuse sex	1	2	3	4	5
e) Boys should make decisions about whether to use a condom or not	1	2	3	4	5
f) In a relationship, it is up to the boy to decide when, where and how to have sex	1	2	3	4	5
g) If a boy wants sex, he has the right to get it	1	2	3	4	5
h) If a girl suggested using condoms to her partner, it would mean she didn't trust him.	1	2	3	4	5

**THANK YOU VERY MUCH FOR FILLING IN THIS QUESTIONNAIRE.**

**MFMC CONDOM DEMONSTRATION  
INTERVIEWER RATING FORM**

Q1 During which year did you participate in *My Future is My Choice*?

2006	1
2007	2
2008	3

Q2 During the *My Future is My Choice* Programme, one of the topics covered is how to use a condom. Did your peer facilitator show you and other MFMC participants how to use a male condom?

Yes	1
No	2

**INSTRUCTIONS TO INTERVIEWER**

IF RESPONDENT ANSWERS YES TO Q1, PROCEED TO QUESTION 2

IF RESPONDENT ANSWERS NO TO Q1, STOP.

Q3 Ask the respondent to demonstrate how to put a male condom on.

Did the respondent?

a) Squeeze the tip of the condom before putting the condom on the wooden penis?

Yes	1
No	2

b) Roll the condom down onto the wooden penis?

Yes	1
No	2

**INSTRUCTIONS TO INTERVIEWER:**

**IF THE RESPONSES TO BOTH 3A AND 3B ARE "YES," THEN THE RESPONDENT HAS CORRECTLY DEMONSTRATED THE USE OF A CONDOM.**

**IF THE RESPONSES TO EITHER 3A OR 3B IS "NO," THEN THE RESPONDENT HAS NOT CORRECTLY DEMONSTRATED THE USE OF A CONDOM.**

Q4 Did the respondent correctly demonstrate how to use a male condom?

Yes	1
No	2

## MFMC GRADUATE FOCUS GROUP DISCUSSION QUESTIONS

- 1) Please tell us about the My Future is My Choice programme and why this programme is offered to learners?
- 2) What do you remember from the programme?
- 3) What do you think are the most important messages of the programme?
- 4) Was there anything that you learnt through the My Future is My Choice course that you did not know before?
- 5) Has the programme changed the way you think about things in general? If yes, please give us 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.
- 6) Has the programme changed your behaviour in any way? If yes, please give us examples of how you behaved before you attended the course compared to the way you behave now, after attending the course.
- 7) Do you know of any learners who have changed their sexual behaviour because of this programme? Please tell us a story or give us an example of this.
- 8) What are some of the negative things that can happen because of teenage pregnancy? You can mention negative things that can happen to the girl, to the boy and to the baby.
- 9) Let's talk about how young people can protect themselves from getting HIV? Here we are also referring to young people who are in sexual relationships.
- 10a) Not all learners or young people are sexually active. What helps young people wait to have sex for the first time?
- 10b) Are these things you've mentioned the same for boys and girls?
- 11a) What do you think prevents or gets in the way of young people waiting to have sex?
- 11b) Are these things you've mentioned the same for boys and girls?
- 12a) It seems that for those young people that are having sex, sometimes they use condoms and sometimes they don't. What gets in the way of young people always using condoms - every time they have sex?
- 12b) In which circumstances or situations are young people more likely to use condoms?
- 12c) When are they less likely to use condoms?
  - Do young people know how to use condoms?
  - Has the MFMC Peer Facilitator done the condom demonstrations with your group?
  - Do young people feel comfortable to use a condom?
  - Do you think doing the condom demonstration once is enough, or would it be better to have more practice with this?
- 13) Let's say your boyfriend or girlfriend wants to have sex and you don't want to, what would you say? What can you do?



14) Let's say you are in a relationship and you decide to have sex. How would you ask your boyfriend or girlfriend to use a condom? What would you say? If he/she refused to use a condom, how might you try to convince them?

15a) Now we'd like to change gears a bit and talk about what you liked and didn't like about the programme and the My Future is My Choice peer facilitator. What qualities do you think a good peer facilitator has or should have? I am going to write all the qualities you mention on a blank poster.

15b) We're now going to ask each of you to tell us a bit about your facilitator, when you participated in the programme. Did he or she have any of these qualities? Which ones? Can you give us some examples or tell us a story where you could see that he or she had these qualities? Maybe you can tell us about a particular conversation that you had or the way the facilitator taught the course.

15c) Was your facilitator someone you admired or looked up to?

15d) Was there anything you didn't like about your facilitator?

15e) Was there ever a question asked by you or another participant that the facilitator could not answer? Can you tell us what happened, how did the facilitator handle the situation?

16a) What did you enjoy least about the programme?

16b) Did any of the material covered by the facilitator confuse you or make you feel uncomfortable?

17) Which sessions did you find most useful? Least useful?

18a) We'd like to talk a bit more about the session on counselling and testing for HIV. What do you remember from the session on HIV testing?

18b) Why do you think testing is important?

18c) Why do you think more young people are not going for testing?

18d) Is there anything the programme can do to help young people get tested?

19) What would happen if the MFMC programme didn't continue?

20) If we asked you to make the programme better, what would you add or change?

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

## MFMC PEER FACILITATOR INTERVIEW QUESTIONS

- 1) Please tell us about the MFMC programme and why it was initiated.
- 2) Please describe the programme content. What topics are covered in this programme?
- 3) Do you think that the topics and activities that are covered in the MFMC programme satisfy the needs of the young people that you work with? Please tell us how it does or does not meet their needs.
- 4) Why did you become a MFMC Peer Facilitator?
- 5) What do you like about your work?
- 6) What do you not like about your work?
- 7) What do you do as a Peer Facilitator?
  - What is your role in the school?
  - And in the community?
- 8) Please tell me about the place where you hold the MFMC programme at the school.
  - What does the room look like?
  - Is it comfortable?
  - Is it big enough?
  - Is the environment quiet enough for you to have the session?
  - Are you sometimes interrupted by non-participants during the sessions
- 9) If you were to give the MFMC programme a mark out of 10, (1 being the lowest and 10 being the highest), what mark would you give this programme?
  - Why would you give the programme this mark?
- 10) Are there incentives (any form of encouragement) to support your professional growth and development?
  - Why do you feel this way?
  - If yes, can you give me examples of such incentives?
- 11) Please tell us about your training.
  - What are the most useful things that you remember about the training?
  - Were there things you would like to see improve when it comes to the training?
  - If yes, can you give us some suggestions on the things that can be improved?
- 12) Do you receive support at the school?
  - Why do you feel this way?
  - If yes, who supports you? How are you being supported?

- 13) Do you receive support from the MFMC Coordinator in this region?
- Why do you feel this way?
  - If yes, who supports you? How are you being supported?
  - What are the most useful things that they are supporting you with?
  - Is there anything that can be improved with regards to this support?
  - If no, what type of support do you need that you are not getting at the moment?
- 14) Are you involved in any monitoring and evaluation of the MFMC programme?
- If no, why are you not involved with this?
  - If yes, please tell me about your involvement. What are you doing? What type of information do you get to evaluate and monitor the course? Who is in charge of getting this information? Do you help in any way to get this information? How do you get the information: do you complete certain forms?
- 15) Through being a MFMC Peer Facilitator, have you made any changes in your life?
- If no, why have you not made any changes? Do you think it is important to make changes is your own life? Why do you feel this way?
  - If yes, please give some examples of how you have made changes in your own life? Do you think it is important to make changes in your own life? Why do you think so?
- 16) Why do you think do some MFMC Peer Facilitators remain in the programme? And why do you think do some leave?

## MFMC PEER FACILITATOR FOCUS GROUP DISCUSSION QUESTIONS

- 1) What kind of impact do you think the MFMC programme can have on the lives of young people?
- 2) What kind of impact do you think the programme actually has on the lives of learners who participate?
- 3) Do you know of any learners who have changed their behaviour because of this programme? Tell us about it.
- 4a) Have you experienced problems with participants dropping out of the programme?
- 4b) Why do you think some young people sign up and then drop out?
- 4c) How can we resolve this issue?
- 4d) Tell us about the things you do to keep young people in the programme, to keep them interested and involved?
- 5a) Who does condom demonstrations at the schools? *Probe reasons for not doing it at schools if no.*
- 5b) Tell us about your experience of doing condom demonstrations at the school. Describe how it happens.
- 5c) How do learners respond to the demonstration?
- 5d) What is your role in the activity?
- 5e) How comfortable you are with the activity?
- 5f) If learners are embarrassed by the activity, how do you handle it? Give us some examples from your experience.
- 5g) Have any of the school staff or parents ever complained about the condom demonstrations?
- 5h) Is doing the condom demonstration once during the course enough? Do learners get enough practice?
- 6a) Tell us about the session on Voluntary Counselling and Testing.
- 6b) Why is it important to get tested?
- 6c) What activities do you do around testing?
- 6d) How do you encourage young people to get tested?

7a) We know that during the teenage years, many young people experiment with alcohol and drugs, and that's part of why the MFMC programme has a module on it. As part of this study, we recently surveyed 300 MFMC participants and found that over half the group had already tried alcohol. Of this group, the average age when participants first tried alcohol was between 13 and 14 years of age, and almost 20% also said that they drink once a week. What do you think of this? Is this similar or different from your experience working with young people? Why do you think learners are drinking at such a young age?

7b) Why is it important for young people to avoid using alcohol and drugs?

7c) How do you encourage young people to stay away from alcohol and drugs? What do you do as a peer facilitator?

7d) How do you respond to learners who think it is okay to drink? What about those who say they only drink in moderation?

7e) Let's say three girls from your MFMC course are planning to go to party on the weekend. You overhear them talking about the party while you're waiting for other participants to arrive. They are giggling, excited, talking about what they will wear and all the cute boys that will be there. You know there will probably be alcohol at the party. You have already done the session on alcohol and drugs with them. What would you say to the girls? How would you encourage them to handle themselves at the party where there is alcohol and there are boys who they like?

8a) Let's talk about being a role model. What are characteristics of a good role model?

8b) Are there people in the community or at the school that have these characteristics? Tell us about them.

8c) Do you see yourself as having these characteristics? Explain why/why not.

9a) Now we're going to talk about how your personal experience of the programme. Has the programme changed the way you think about things, in any way? Please tell us about this.

9b) Have you changed your behaviour in any way because of what you learned through the programme? Please tell us about this.

10) Have you gained any new skills by working as a facilitator? Please explain.

11a) Think back on your training as peer facilitator. Now that you have taught the programme to young people, tell us how well you think the training prepared you to be a facilitator – to get up in front of young people, to talk about sex and HIV, to encourage them to talk and think about these and other issues. What was useful about the training, what has helped you in this work? Explain.

11b) No training is perfect. What was missing from the training? Now that you are working with young people, what kind of training should have been included that wasn't?

11c) If you were to design a refresher course for peer facilitators, what would it include?

15a) Let's talk about the sessions now. We'd like to know how comfortable you are with each of the sessions. This means your comfort and confidence level with the content and your ability to run the sessions and activities. So you would give a 1 to the session that you are most comfortable and a 10 to the session you are least comfortable with. Let's take a few minutes to think about and rank them (hand out paper so they can do it). We'll do this individually first and then as a group. Then we'll talk about why.

15b) Tell us about the challenges you face with the sessions that you've indicated you are less comfortable with.

16) What do you do if a participant asks you a question and you don't know the answer? How do you handle it? Give us an example from your own experience.

17) We know that sometimes participants can be disruptive to the sessions and even sometimes tease other participants, or perhaps even you. What do you do when this happens? Please give us an example from your own experience.

18) Now I'm going to give you a situation that may occur when you are implementing a session with participants.

Let's say you're doing the session on values and relationships. The group has finished the activity on identifying key values. Everyone is relaxed and having a good time. The top three values mentioned are 1) getting an education 2) getting a good job and 3) being healthy. The group talks about why these are important and everyone agrees these are important to them. The next activity is for boys and girls to work in small groups and identify what they look for in boyfriend or girlfriend. The boy's group comes back with the following list: a girl that is respectable, beautiful, and sexy. The girl's group lists: a boy that is handsome, who has a car, and who has money.

What's going on here? What do you think is happening? How would facilitate the discussion next?

19). Here's another story.

Eleaser is a male MFMC peer facilitator at the Kudu school in the Oshana region. He is friendly person and knows most of the students there very well. He is also well acquainted with the school principal and contact teacher. He is well respected by everybody. After the completion of a full MFMC session, Theopolina, Laina Bertha, and Melanky, who just graduated, decide to invite Eleaser for a drink to a shebeen to celebrate their graduation. As they are talking about different issues, Eleaser pushes the girls to drink more beers and makes some jokes about sex. Theopolina and Laina refuse to drink more, saying that alcohol is not appropriate and that Eleaser is acting against the principles he has been teaching them. Eleaser says what happens inside the school is different from real life.

What's going on here? What's to your response to this situation?

20) Is there anything you would like to talk about that we didn't cover?

## STAKEHOLDER INTERVIEW GUIDE

### FOR ALL STAKEHOLDERS (Principals, Contact Teacher, RACE Coordinator, and the Trainer of Trainers)

- 1) Please explain your understanding of the MFMC programme?
  - What is the programme about?
  - Why is this programme offered at schools?
  - What are the aims of this programme?
- 2) How are you involved in the MFMC programme?
  - What are your responsibilities and duties?
- 3) What do you see as the strengths of the programme?
- 4) What do you see as the weaknesses of the programme?
- 5) How could the programme be improved?
- 6) If you were to give the MFMC programme a mark out of 10, (1 being the lowest & 10 being the highest), what mark would you give this programme?
  - Why would you give the programme this mark?
- 7) What do you see as the main barriers or problems to successful running of the programme?
- 8) Please tell us about your experience and dealings or communication with the MFMC Peer Facilitators.
  - Are they to give the programme successfully?
  - Do you have suggestions on how they can be helped or supported to be better facilitators?

#### **A) FOR PRINCIPALS ONLY:**

- 9) Is your school collecting information about the MFMC programme?
- 10) Do you meet with RACE Coordinator in this region?
  - If no, why do you not meet? Do you think it is important to meet? Why do you feel this way?
  - If yes, how often do you meet? How do you meet (telephonically, personally)? What do you discuss in these meetings? Do you think it is important to meet? Why do you feel this way?
- 11) Do you meet with the MFMC Coordinators?
  - If no, why do you not meet? Do you think it is important to meet? Why do you feel this way?

- If yes, how often do you meet? How do you meet (telephonically, personally)? What do you discuss in these meetings? Do you think it is important to meet? Why do you feel this way?

12) Do you meet with MFMC Contact Teacher to discuss progress of the programme?

- If no, why do you not meet? Do you think it is important to meet? Why do you feel this way?
- If yes, how often do you meet? How do you meet (telephonically, personally)? What do you discuss in these meetings? Do you think it is important to meet? Why do you feel this way?

13) Have you encountered any opposition or resistance from parents about MFMC programme?

- If no, why do you think this has not happened?
- If yes, please tell us about it.

14) Do you think that the participants who are involved in the MFMC programme are the most vulnerable or at risk in your school? Please tell us why you feel this way.

***B) FOR CONTACT TEACHERS ONLY:***

9) Is your school collecting information about the MFMC programme?

10) Do you meet with RACE Coordinator in this region?

- If no, why do you not meet? Do you think it is important to meet? Why do you feel this way?
- If yes, how often do you meet? How do you meet (telephonically, personally)? What do you discuss in these meetings? Do you think it is important to meet? Why do you feel this way?

11) Do you meet with the MFMC Coordinators?

- If no, why do you not meet? Do you think it is important to meet? Why do you feel this way?
- If yes, how often do you meet? How do you meet (telephonically, personally)? What do you discuss in these meetings? Do you think it is important to meet? Why do you feel this way?

12) Have you observed any of the MFMC sessions?

- If no, why not? Do you think it is important to observe the sessions? Why do you feel this way?
- If yes, how often do you observe these sessions? What are your thoughts on the sessions that you have observed? Do you think it is important to observe these sessions? Why do you feel this way?

13) Do learners talk to you about MFMC?

- If no, why do you think this is the case?
- If yes, what are they saying to you about MFMC?



14) Do parents talk to you about MFMC?

- If no, why do you think this is the case?
- If yes, what are they saying to you about MFMC?

**C) FOR RACE COORDINATORS ONLY**

9) Do you meet with the School Principals?

- If no, why do you not meet? Do you think it is important to meet? Why do you feel this way?
- If yes, how often do you meet? How do you meet (telephonically, personally)? What do you discuss in these meetings? Do you think it is important to meet? Why do you feel this way?

10) Do you meet with the Contact Teachers?

- If no, why do you not meet? Do you think it is important to meet? Why do you feel this way?
- If yes, how often do you meet? How do you meet (telephonically, personally)? What do you discuss in these meetings? Do you think it is important to meet? Why do you feel this way?

11) Do you meet with the MFMC Coordinators?

- If no, why do you not meet? Do you think it is important to meet? Why do you feel this way?
- If yes, how often do you meet? How do you meet (telephonically, personally)? What do you discuss in these meetings? Do you think it is important to meet? Why do you feel this way?

12) Do you meet with the MFMC Peer Facilitators?

- If no, why do you not meet? Do you think it is important to meet? Why do you feel this way?
- If yes, how often do you meet? How do you meet (telephonically, personally)? What do you discuss in these meetings? Do you think it is important to meet? Why do you feel this way?

13) Are you monitoring the programme through field visits?

- If no, why not? Do you think it is important to do this? Why do you feel this way?
- If yes, how often do you do this? What are your thoughts about these field visits? Do you think it is important to have field visits? Why do you feel this way?

## MFMC TRAINING OBSERVATION WORKSHEET

ID Code \_\_\_\_\_

Session # \_\_\_\_\_

Date \_\_\_\_\_

Observer \_\_\_\_\_

### Directions:

Respond to each statement using the following scale:

Poor	Fair	Good	Excellent
1	2	3	4

Circle the number that best represents your response. For any rating of Poor (1) or Fair (2), provide details in the comments section below each session. Also, use the comment space to provide any other additional feedback or suggestions.

Content Organization	Poor	Fair	Good	Excellent
1. Clearly stated the objectives of the session	1	2	3	4
2. Followed the MFMC curriculum as per the training manual	1	2	3	4
3. Paced session appropriately	1	2	3	4
4. Reviewed content of previous session	1	2	3	4
5. Summarized main messages of session	1	2	3	4
6. Communicated main messages clearly and effectively	1	2	3	4
7. Came prepared with activity-related materials (flip chart, koki pen, etc)	1	2	3	4
8. Effectively used instructional tools and materials to support session organization	1	2	3	4

### Comments:

Presentation	Poor	Fair	Good	Excellent
9. Projected voice to be easily heard	1	2	3	4
10. Used tone to vary emphasis	1	2	3	4
11. Maintained eye contact with students	1	2	3	4
12. Used language participants could understand	1	2	3	4
13. Listened to student questions and comments	1	2	3	4
14. Conveyed session content enthusiastically	1	2	3	4
15. Restated important ideas at appropriate times	1	2	3	4
16. Presented examples to clarify points	1	2	3	4
17. Was friendly	1	2	3	4
18. Made the learners feel comfortable and at ease	1	2	3	4

**Comments:**

<b>Facilitator-Participant Interactions</b>	<b>Fair</b>	<b>Poor</b>	<b>Good</b>	<b>Excellent</b>
19. Encouraged participant questions	1	2	3	4
20. Encouraged participants to actively participate	1	2	3	4
21. Encouraged both boys and girls to participate equally	1	2	3	4
22. Maintained participant attention	1	2	3	4
23. Responded to nonverbal cues of participant interest, boredom, or confusion	1	2	3	4
24. Encouraged participants to answer questions that arose	1	2	3	4
25. Asked probing questions when participant answers were incomplete	1	2	3	4
26. Restated questions and answers for emphasis and clarification	1	2	3	4

**Comments:**

<b>Content Knowledge and Relevance</b>	<b>Poor</b>	<b>Fair</b>	<b>Good</b>	<b>Excellent</b>
27. Demonstrated command of subject matter	1	2	3	4
28. Presented material appropriate to student knowledge & background	1	2	3	4
29. Made distinctions between fact & myth	1	2	3	4
30. Responded accurately to participant questions	1	2	3	4
31. Presented material relevant to given session	1	2	3	4
32. Effectively used activities to impart knowledge	1	2	3	4
33. Effectively used activities to help participants generate knowledge	1	2	3	4
34. Effectively corrected participants' misconceptions	1	2	3	4
35. Effectively used activities to make the link between the content of the session and the realities of participants' lives	1	2	3	4

**Comments:**

36. What overall impressions do you think participants left this session with in terms of content or style?

37. What were the key messages that were emphasised during the session?

38. How did the facilitator encourage the participants to actively participate?

39. What worked well? Why? (especially activities)

40. What didn't work well? Why? (especially activities)

41. What were the facilitator's main strengths as demonstrated in this observation?

42. What suggestions do you have for improving upon this facilitator's skills?

## APPENDIX B: MFMC GRADUATE QUESTIONNAIRE DATA TABLES

**Table 1**

*Frequencies on 'Age of Sexual Debut'*

If you have had sex before, how old were you the first time you had sex ...

	Frequency (%)	Cumulative %
2 years old	1 (0.7%)	0.7%
5 years old	2 (1.4%)	2.1%
6 years old	3 (2.1%)	4.2%
7 years old	2 (1.4%)	5.6%
8 years old	1 (0.7%)	6.2%
9 years old	2 (1.4%)	7.6%
10 years old	11 (7.6%)	15.3%
11 years old	5 (3.5%)	18.8%
12 years old	4 (2.8%)	21.5%
13 years old	11 (7.6%)	29.2%
14 years old	20 (13.9%)	43.1%
15 years old	31 (21.5%)	64.6%
16 years old	24 (16.7%)	81.2%
17 years old	11 (7.6%)	88.9%
18 years old	8 (5.6%)	94.4%
19 years old	5 (3.5%)	97.9%
20 years old	3 (2.1%)	100%

**Table 2***Mean Age of Sexual Debut by the Demographic 'Gender/Sex'*

Gender/sex	Sexual debut
Male	13.5
Female	14.9

Significant difference between means at  $p < .01$  level ( $p = .009$ )**Table 3***Mean Age of Sexual Debut by the Demographic 'Age'*

Age	Mean age of sexual debut
15 years old	12.5
16 years old	13.8
17 years old	13.8
18 years old	14.9
19 years old	15.8

Significant difference between means at  $p < .01$  level ( $p = .000$ )**Table 4***Frequencies on 'Use of Alcohol and Condoms during Sex'*

When you have sex, how often...			
	Never	Sometimes	Always
Do you have alcohol to drink?	122 (80.3%)	25 (16.4%)	5 (3.3%)
Does your partner have alcohol to drink?	117 (77%)	32 (21.1%)	3 (2%)
Do you & your partner use a condom?	28 (19.4%)	13 (8.6%)	111 (73%)

**Table 5***Frequencies on 'Risk Behaviours of Sexually Active Participants'*

---

Which of the following have you done in the past 12 months?

I have/had...	Frequency (%)
More than one sexual partner	49 (32%)
Unprotected sex with one or more partners	22 (14%)
Sex with a partner who I know cheats on me	24 (16%)
Sex with someone who is much older than me (10 years or more)	14 (9%)
Sex with someone I did not know well	18 (12%)
Sex with someone who paid me or gave me a gift to do so	7 (5%)
Paid someone to have sex with me	4 (3%)
Sex with more than one person at the same time	10 (7%)
Visited a doctor or clinic to be tested for a Sexually Transmitted Disease (STD)	49 (32%)
Showed signs of a Sexually Transmitted Disease	9 (6%)
Anal sex with one or more partners	6 (4%)
None of the above	1 (34%)

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**Table 6***Frequencies on 'Knowledge of HIV Transmission'*


---

A person can get infected by HIV by...

	True	Not true	Don't know
Having unprotected sex with an HIV positive person	279 (93%)	15 (5%)	6 (2%)
Being injected with a needle which has already been used by an HIV positive person	275 (91.7%)	17 (5.7%)	8 (2.7%)
Sharing food with an HIV positive person	12 (4%)	286 (95.3%)	2 (0.7%)
Being bitten by a mosquito who has bitten an HIV positive person before	46 (15.3%)	231 (77%)	23 (7.7%)
A pregnant woman who is HIV positive can transmit HIV to her unborn baby	235 (78.3%)	46 (15.3%)	19 (6.3%)
Touching the sweat of an HIV positive person	17 (5.7%)	252 (84%)	31(10.3%)
Holding hands with an HIV positive person	4 (1.3%)	292 (97.3%)	4 (1.3%)
Sharing knives/forks/spoons with someone who has HIV	51 (17%)	221 (73.7%)	28 (9.3%)
Somebody putting a curse on you to give you HIV	14 (4.7%)	206 (68.7%)	80(26.7%)

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**Table 7***Frequencies on 'Knowledge of HIV Prevention'*

A person can prevent getting HIV by...	True	Not true	Don't know
Not having sex at all	257 (85.7%)	39 (13%)	4 (1.3%)
Having sex with only one partner who is not HIV positive	242 (80.7%)	40 (13.3%)	18 (6%)
Using traditional medicine to prevent HIV from spreading from one person to another	5 (1.7%)	262 (87.3%)	33 (11%)
Using the birth control pill or an injection, and not condoms	42 (14%)	229 (76.3%)	29 (9.7%)
Always using condoms with partners	272 (90.7%)	20 (6.7%)	8 (2.7%)
Always using a condom when having sex with a sex worker	196 (65.3%)	70 (23.3%)	34(11.3%)
Having sex with only people who you know do not have HIV	81 (27%)	197 (65.7%)	22 (7.3%)
Withdrawing before ejaculating when having sex	38 (12.7%)	202 (67.3%)	60 (20%)

**Table 8***Frequencies on 'Usefulness of HIV/AIDS Information through School Curriculum or Activities'*

	Not useful at all/ not useful	Somewhere in between	Useful/ very useful
Life skills classes	27 (9.7%)	37 (13.3%)	215 (77%)
Other classes	37 (14.2%)	69 (26.5%)	154 (59.2%)
MFMC programme	7 (2.5%)	13 (4.6%)	262 (92.9%)
AIDS drama/play	10 (3.8%)	34 (12.8%)	221 (83.4%)
School assembly	92 (41.2%)	48 (21.5%)	83 (37.2%)
Discussions with teachers outside class	56 (18.7%)	56 (18.7%)	124 (41.4%)
Discussions with peers/ friends	18 (6.3%)	45 (15.8%)	221 (77.8%)
AIDS campaigns	25 (9.4%)	17 (6.3%)	226 (84.4%)

**Table 9***Frequencies on 'People whom Learners have talked to about Sex and HIV/AIDS'*

	Sex and related issues	HIV/AIDS
Parent/caregiver	205 (68.3%)	217 (72.3%)
Other family member	179 (59.7%)	163 (54.3%)
Friends	231 (77%)	173 (57.7%)
Teacher	165 (55%)	223 (74.3%)
Counsellor	98 (32.7%)	137 (45.7%)
MFMC peer facilitator	229 (76.3%)	239 (79.7%)
Pastor/ church member/ other person from church	103 (34.3%)	154 (51.3%)
Other	137 (45.7%)	154 (51.3%)

**Table 10***Frequencies on 'Persons from whom Learners Learnt the Most about Sex and HIV/AIDS'*

	Sex and related issues	HIV/ AIDS
Parent/caregiver	82 (28.3%)	50 (17.2%)
Other family member	19 (6.6%)	19 (6.5%)
Friends	77 (26.6%)	24 (8.2%)
Teacher	25 (8.6%)	47 (16.2%)
Counsellor	4 (1.4%)	6 (2.1%)
MFMC peer facilitator	79 (27.2%)	140 (48.1%)
Pastor/ church member/ other person from church	2 (0.7%)	3 (1%)
Other	2 (0.7%)	2 (0.7%)

**Table 11***Frequencies on 'Persons who had the Most Influence on Learners' Attitudes and Behaviours Related to HIV'*

Parent/caregiver	70 (24.4%)
Other family member	21 (7.3%)
Friends	48 (16.7%)
Teacher	30 (10.5%)
Counsellor	14 (4.9%)
MFMC peer facilitator	85 (29.6%)
Pastor/ church member/ other person from church	7 (2.4%)
Other	12 (4.2%)

**Table 12***Frequencies on 'MFMC Programme Satisfaction'*

	Strongly disagree/ disagree	Neutral	Strongly agree/ agree
The MFMC materials give useful information about HIV	11 (3.7%)	12 (4%)	277 (92.3%)
The MFMC materials on HIV/AIDS are easy to understand	13 (4.3%)	21 (7%)	266 (88.6%)
There is not enough information for my age group	169 (56.4%)	48 (16%)	83 (27.7%)
I find some of the materials confusing	146 (48.6%)	60 (20%)	94 (31.3%)
Some of the materials embarrass me	148 (49.3%)	49 (16.3%)	103 (34.3%)
The MFMC materials on HIV/AIDS are interesting	30 (10%)	17 (5.7%)	253 (84.3%)
I liked my MFMC peer facilitator	8 (2.7%)	28 (9.3%)	264 (88%)
I learned a lot from my MFMC peer facilitator	7 (2.3%)	17 (5.7%)	276 (92%)
During the MFMC programme, the peer facilitator was a positive role model to me	54 (18%)	53 (17.7%)	193 (64.3%)
The MFMC programme at my school helped me to protect myself from getting HIV/AIDS	11 (3.7%)	10 (3.3%)	279 (93%)
The MFMC programme helped me to understand more about HIV/AIDS	4 (1.3%)	8 (2.7%)	288 (96%)
The MFMC programme helped me to accept people living with HIV/AIDS	26 (8.6%)	15 (5%)	259 (86.3%)

**Table 13***Frequencies on 'Personalisation of Risk and Intentions to Practice Safer Sex'*

	Strongly disagree/ disagree	Neutral	Strongly agree/ agree
People like me do not get HIV	239 (79.6%)	17 (5.7%)	44 (14.7%)
I am very healthy, so my body can fight off an HIV infection	229 (76.3%)	23 (7.7%)	48 (16%)
I am too young to get an HIV infection	247 (82.4%)	17 (5.7%)	36 (12%)
A male can reduce his chances of HIV infection by getting circumcised (having the foreskin of the penis removed)	210 (70%)	49 (16.3%)	41 (13.7%)
I will make sure a condom is used when I have sex	18 (6%)	11 (3.7%)	271 (90.3%)
I will wait to have sex until I am older and ready	40 (13.3%)	33 (11%)	227 (75.7%)
I would not have sex with someone who refuses to use a condom	70 (23.3%)	11 (3.7%)	219 (73%)
I would not have sex with someone who I know is also having sex with another person within the same period	89 (29.6%)	28 (9.3%)	183 (61%)
I would have sex with someone if they agreed to pay my school fees	267 (89%)	11 (3.7%)	22 (7.3%)
If someone offered to buy my family food, I would have sex with him/her without a condom	276 (92%)	4 (1.3%)	20 (6.7%)

**Table 14***Frequencies on 'Self-efficacy to negotiate and Refuse Sex'*

Do you think you will be able to do the following things, in order to have safe sex?

	Not sure/ not sure at all	Don't know	Sure/ very sure
Talk about safe sex with a casual partner	97 (32.3%)	34 (11.3%)	169 (56.3%)
Refuse to have sex with someone you don't know very well	72 (24%)	15 (5%)	213 (71%)
Use a condom correctly if your partner wanted to	25 (8.3%)	11 (3.7%)	264 (88%)
Convince a partner that s/he should use a condom	24 (8%)	13 (4.3%)	263 (87.6%)
Prevent a partner from having anal sex with you	97 (32.3%)	40 (13.3%)	163 (54.3%)
Ask a partner about his/her other sexual partners	62 (20.7%)	17 (5.7%)	221 (73.7%)
Refuse sex with someone who is offering money or a gift	86 (28.7%)	14 (4.7%)	200 (66.7%)
Make sure that your partner goes for an HIV test before having sex with you	29 (9.7%)	7 (2.3%)	264 (88%)

**Table 15***Frequencies on 'Stigma and HIV/AIDS'*

	Yes	No
I would care for a member of our family with HIV or an AIDS-related disease	284 (94.7%)	16 (5.3%)
I would not buy food that has been touched from a shopkeeper or food-seller with HIV or an AIDS-related disease	40 (13.3%)	260 (86.7%)
A teacher who has HIV but is not sick should be allowed to continue teaching in school	262 (87.3%)	38 (12.7%)
I would not want anyone to know if a member of our family becomes infected with HIV	100 (33.3%)	200 (66.7%)
HIV positive people should not be allowed to work in a restaurant or bar that serves food to people	105 (35%)	195 (65%)
Children suffering from AIDS-related diseases should be kept out of school	30 (10%)	270 (90%)
I do not want to be friends with somebody who has AIDS	22 (7.3%)	278 (92.7%)

**Table 16***Frequencies on 'Age of First Alcohol'*

If you have drunk alcohol before, how old were you the first time you drank alcohol ...

	Frequency (%)	Cumulative %
1 year old	1 (0.6%)	0.6%
3 years old	2 (1.1%)	1.7%
5 years old	1 (0.6%)	2.3%
6 years old	1 (0.6%)	2.9%
8 years old	3 (1.7%)	4.6%
9 years old	5 (2.9%)	7.4%
10 years old	16 (9.1%)	16.6%
11 years old	5 (2.9%)	19.4%
12 years old	20 (11.4%)	30.9%
13 years old	19 (10.9%)	41.7%
14 years old	21 (12%)	53.7%
15 years old	36 (20.6%)	74.3%
16 years old	22 (12.6%)	86.9 %
17 years old	10 (5.7%)	92.6%
18 years old	10 (5.7%)	98.3%
19 years old	2 (1.1%)	99.4%
20 years old	1 (0.6%)	100%



**Table 17***Frequencies on 'Beliefs and Attitudes toward Alcohol Use'*

	Strongly disagree/ disagree	Neutral	Strongly agree/ agree
Parties are no fun if there isn't any alcohol	146 (48.7%)	22 (7.3%)	132 (44%)
It is often more difficult for people say "no" to sex after drinking alcohol	74 (24.7%)	37 (12.3%)	189 (63%)
Drinking helps overcome shyness	119 (39.7%)	47 (15.7%)	134 (44.7%)
Drinking helps people cope with problems	146 (48.7%)	42 (14%)	112 (37.3%)
It is often more difficult for people to remember to use a condom after drinking alcohol	80 (26.7%)	24 (8%)	196 (65.3%)
It's okay to be the only person in a group of friends who chooses not to drink alcohol	67 (22.3%)	30 (10%)	203 (67.7%)

**Table 18***Frequencies on 'Beliefs about Condoms and Condom Self-efficacy'*

	Strongly disagree/ disagree	Neutral	Strongly agree/ agree
Generally, I am in favour of using condoms	46 (15.3%)	25 (8.3%)	229 (76.3%)
Condoms interfere with romance	162 (54%)	70 (23.3%)	68 (22.6%)
The smell and touch of condoms makes them unpleasant to use	161 (53.6%)	66 (22%)	73 (24.3%)
Condoms reduce sexual pleasure	132 (44%)	66 (22%)	102 (34%)
I know how to use a condom correctly	44 (14.6%)	31 (10.3%)	225 (75%)
I would be able to discuss condom use with any partner	39 (13%)	28 (9.3%)	233 (77.6%)
I would insist on using condoms with a new partner	52 (17.3%)	42 (14%)	206 (68.6%)
I would feel embarrassed to put a condom on myself or my partner	156 (52%)	47 (15.7%)	97 (32.4%)
If I would suggest using a condom to my partner, they might reject me	171 (57%)	57 (19%)	72 (24%)
If I were unsure of my partner's feelings about using a condom, I wouldn't suggest using one	190 (63.4%)	53 (17.7%)	57 (19%)
I could easily convince my sexual partner to use a condom	29 (9.6%)	30 (10%)	241 (80.4%)

**Table 19***Frequencies on 'Peer Norms, Sexuality and HIV Prevention''*

	Strongly disagree/ disagree	Neutral	Strongly agree/ agree
By doing the same things as my friends, I feel part of a group	166 (55.3%)	28 (9.3%)	106 (35.4%)
It is easy for me to disagree with my friends	104 (34.7%)	39 (13%)	157 (52.3%)
Most of my friends think it is okay for people my age to have sex	155 (51.6%)	37 (12.3%)	108 (36%)
Most of my friends are having sex	117 (39%)	54 (18%)	129 (43%)
My friends would support my decision to avoid all sexual activities that would put me at any risk for HIV exposure	77 (25.7%)	54 (18%)	169 (56.3%)
My friends and I discuss our questions and feelings about HIV transmission	39 (13%)	36 (12%)	225 (75%)
My friends would agree that to be sexually active proves one is a man	175 (58.3%)	48 (16%)	77 (25.6%)
My friends would laugh if I tried to convince them to avoid sexual intercourse because they might get HIV	170 (56.7%)	42 (14%)	88 (29.3%)
My friends would laugh if I tried to convince them to use condoms during sexual intercourse	193 (64.3%)	36 (12%)	71 (23.6%)

**Table 20***Frequencies on 'Gender Relationships'*

	Strongly disagree/ disagree	Neutral	Strongly agree/ agree
I think it is okay for a boy to have many girlfriends	272 (90.7%)	12 (4%)	16 (5.3%)
I think it is okay for a girl to have many boyfriends	277 (92.3%)	15 (5%)	8 (2.7%)
If a boy says he loves a girl, she should not refuse sex	233 (77.7%)	24 (8%)	43 (14.3%)
If a boy gives a girl presents, she should not refuse sex	223 (74.3%)	27 (9%)	50 (16.7%)
Boys should make decisions about whether to use a condom or not	195 (65%)	22 (7.3%)	83 (27.7%)
In a relationship, it is up to the boy decide when, where & how to have sex	200 (66.7%)	27 (9%)	73 (24.3%)
If a boy wants sex, he has the right to get it	233 (77.7%)	22 (7.3%)	45 (15%)
If a girl suggested using condoms to her partner, it would mean she didn't trust him	221 (73.6%)	18 (6%)	61 (20.4%)

## APPENDIX C: YOUNG PEOPLE (15-24) AND HIV/ AIDS IN NAMIBIA

Source: Adapted from UNICEF Namibia 'DATASHEET: Young People 15-24 and HIV/AIDS' (October 2007)

Indicators	KAPB 2006 15-19 year olds Non-participants	DHS 2006 15-24 year olds	MFMC 2008 15-19 year olds MFMC Participants
<b>Sexual debut of young Namibians</b>	<ul style="list-style-type: none"> <li>• 39.4% of sexually active became sexually active by age 14.</li> <li>• Average age of sexual debut was 14 years for young men and 15.5 years for young women.</li> <li>• 34.1% of young people sampled had previously had sex, including 44.7% of men and 23.8% of women.</li> <li>• 16% of young women were forced into their first sexual encounter.</li> <li>• The majority (66.2%) of respondents had their first sexual encounter with someone of the same age. Females (28%) were more likely to have had a first sexual encounter with someone older than themselves than males (15.2%)</li> </ul>	<p><b>Young women:</b></p> <ul style="list-style-type: none"> <li>• 6.6% of young women ages 20-24 became sexually active by age 15 and just under half (43.8%) were sexually active by age of 18.</li> <li>• 7.4% of young women ages 15-19 became sexually active by age 15.</li> <li>• 7% of young women 15-24 became sexually active by age 15, and average age of sexual debut for young women is 19 years.</li> </ul> <p><b>Young men:</b></p> <ul style="list-style-type: none"> <li>• 16.6% of young men ages 20-24 became sexually active by age 15 and over half (58.4%) were sexually active by the age of 18.</li> <li>• 19.2% of young men ages 15-19 became sexually active by age 15.</li> <li>• 18.1% of young men 15-24 became sexually active by age 15, and average age of sexual debut for young men is 17.7 years.</li> </ul>	<ul style="list-style-type: none"> <li>• 43% of sexually active became sexually active by age 14.</li> <li>• Average age of sexual debut was 13.5 years for young men and 15 for young women</li> <li>• 50.7% of young people sampled had previously had sex, including 59% of males and 44% of females</li> <li>• No data on forced sex but 15% of sexually active report age of sexual debut between 2-10 which may be indicative of forced sex</li> <li>• The majority (71.1%) of respondents had their first sexual encounter with someone of the same age. Females (22.2%) were more likely to have had a first sexual encounter with someone older than themselves than males (13%)</li> </ul>

Indicators	KAPB 2006 15-19 year olds Non-participants	DHS 2006 15-24 year olds	MFMC 2008 15-19 year olds MFMC Participants
<b>Knowledge of HIV/AIDS among young people...</b>	<p><b>Young women:</b></p> <ul style="list-style-type: none"> <li>• 78.1% of young women knew that risk of HIV/AIDS can be reduced by using condoms with a new partner.</li> <li>• 84.8% of young women knew that risk of HIV/AIDS can be reduced by limiting sexual intercourse to one partner.</li> <li>• 68.6% of young women knew that risk of HIV/AIDS can be reduced by using condoms and limiting sexual intercourse to one partner.</li> <li>• 85.7% of young women knew that risk of HIV/AIDS can be reduced by abstaining from sexual intercourse.</li> </ul> <p><b>Young men:</b></p> <ul style="list-style-type: none"> <li>• 82.5% of young men knew that risk of HIV/AIDS can be reduced by using condoms with a new partner.</li> <li>• 85.4% of young men knew that risk of HIV/AIDS can be reduced by limiting sexual intercourse to one partner.</li> <li>• 72.8 % of young men knew that risk of HIV/AIDS can be reduced by using condoms and limiting sexual intercourse to one partner.</li> </ul>	<p><b>Young women:</b></p> <ul style="list-style-type: none"> <li>• 83.4% of young women knew that risk of HIV/AIDS can be reduced by using condoms.</li> <li>• 88.1% of young women knew that risk of HIV/AIDS can be reduced by limiting sexual intercourse to one partner.</li> <li>• 78.5% of young women knew that risk of HIV/AIDS can be reduced by using condoms and limiting sexual intercourse to one partner.</li> <li>• 82.6% of young women knew that risk of HIV/AIDS can be reduced by abstaining from sexual intercourse.</li> </ul> <p><b>Young men:</b></p> <ul style="list-style-type: none"> <li>• 98.8% of young men have heard of AIDS.</li> <li>• 86.4% of young men knew that risk of HIV/AIDS can be reduced by using condoms.</li> <li>• 90.9% of young men knew that the risk of HIV/AIDS can be reduced by limiting sexual intercourse to one partner.</li> </ul>	<p><b>Young women:</b></p> <ul style="list-style-type: none"> <li>• 92.2% of young women knew that risk of HIV/AIDS can be reduced by using condoms with partners.</li> <li>• 75.3% of young women knew that risk of HIV/AIDS can be reduced by limiting sexual intercourse to one partner.</li> <li>• 72.3% of young women knew that risk of HIV/AIDS can be reduced by using condoms and limiting sexual intercourse to one partner.</li> <li>• 82.5% of young women knew that risk of HIV/AIDS can be reduced by abstaining from sexual intercourse.</li> </ul> <p><b>Young men:</b></p> <ul style="list-style-type: none"> <li>• 88.8% of young men knew that risk of HIV/AIDS can be reduced by using condoms with partners.</li> <li>• 87.3% of young men knew that risk of HIV/AIDS can be reduced by limiting sexual intercourse to one partner.</li> <li>• 80.6% of young men knew that risk of HIV/AIDS can be reduced by using condoms and limiting sexual intercourse to one partner.</li> </ul>

Indicators	KAPB 2006 15-19 year olds Non-participants	DHS 2006 15-24 year olds	MFMC 2008 15-19 year olds MFMC Participants
<b>Knowledge of HIV/AIDS among young people contd...</b>	<ul style="list-style-type: none"> <li>• 88.3% of young men knew that risk of HIV/AIDS can be reduced by abstaining from sexual intercourse.</li> </ul>	<ul style="list-style-type: none"> <li>• 81.3% of young men knew that risk of HIV/AIDS can be reduced by using condoms and limiting sexual intercourse to one partner.</li> <li>• 85.7% of young men knew that risk of HIV/AIDS can be reduced by abstaining from sexual intercourse.</li> </ul>	<ul style="list-style-type: none"> <li>• 89.6% of young men knew that risk of HIV/AIDS can be reduced by abstaining from sexual intercourse.</li> </ul>
<b>Condom use at last sex among young people...</b>	<ul style="list-style-type: none"> <li>• 58.7% of young men reported condom use at last sex.</li> <li>• 88% of young women reported condom use at last sex.</li> </ul>	No comparable data	<p>No data for condom use at last sex but:</p> <ul style="list-style-type: none"> <li>• 11.4% of young men reported that they sometimes use condoms during sex while 67.1% said they always use condoms during sex</li> <li>• 5.5% of young women reported that they sometimes use condoms during sex while 79.5% said they always use condoms during sex.</li> </ul>
<b>Higher risk sex among young people...</b>	<ul style="list-style-type: none"> <li>• Sexually active young men reported taking more sexual risks than women and are 10 times more likely to have sex with someone they don't know well.</li> <li>• Young women face greatest risk by having sex with a male partner who is unfaithful, and by having multiple partners.</li> <li>• 22.5% of sexually active youth had engaged in no sexually risky activity.</li> <li>• 33.8% of sexually active had more than one sexual partner in year.</li> </ul>	<p><b>Young women:</b></p> <ul style="list-style-type: none"> <li>• 64.2% of young women reported using a condom at last higher risk sex.</li> <li>• 51.6% of young women reported consistent condom use with last higher risk sex partner.</li> </ul> <p><b>Young men:</b></p> <ul style="list-style-type: none"> <li>• 81.1% of young men reported using a condom at last higher risk sex.</li> <li>• 67.5% of young men reported consistent condom use with last higher risk sex partner.</li> </ul>	<ul style="list-style-type: none"> <li>• Sexually active young men reported taking more sexual risks than women and are two times more likely to have sex with someone they don't know well</li> <li>• Young women face the greatest risk by having multiple partners and by having sex with a male partner who is unfaithful.</li> <li>• 33.6% of sexually active youth had engaged in no sexually risky activity.</li> <li>• 32.2% of sexually active had more than one sexual partner in year.</li> </ul>

Indicators	KAPB 2006 15-19 year olds Non-participants	DHS 2006 15-24 year olds	MFMC 2008 15-19 year olds MFMC Participants
<b>Young people who engaged in transactional sex...</b>	<ul style="list-style-type: none"> <li>• 8% of sexually active young women reported receiving a gift for sex during their first sexual encounter.</li> <li>• 10.9% of sexually active young men reported receiving a gift for sex during their first sexual encounter.</li> </ul>	<ul style="list-style-type: none"> <li>• 1.5% of men (15-49) reported paying for sex in the past 12 months</li> </ul>	<ul style="list-style-type: none"> <li>• 1.8% of sexually active young women reported receiving money or a gift for having sex.</li> <li>• 3% of sexually active young men reported receiving money or a gift for having sex.</li> </ul>
<b>Young people and HIV testing...</b>	<ul style="list-style-type: none"> <li>• 14.3% of young people have been tested for HIV and 81% of those tested had received their results.</li> <li>• 70.7% of young people sampled knew where they could get tested for HIV.</li> </ul>	<p><b>Young women:</b></p> <ul style="list-style-type: none"> <li>• 36.8% of young women have been tested and received results.</li> </ul> <p><b>Young men:</b></p> <ul style="list-style-type: none"> <li>• 17% of young men have been tested and received results.</li> <li>• 82.9% of young men knew where they could get tested for HIV.</li> <li>• 86.6% of young people sampled knew where they could get tested for HIV.</li> </ul>	<ul style="list-style-type: none"> <li>• 28.7% of young people have been tested for HIV and 87.2% of those tested had received their results.</li> </ul> <p><b>Young women:</b></p> <ul style="list-style-type: none"> <li>• 30.1% of young women have been tested and received results.</li> </ul> <p><b>Young men:</b></p> <ul style="list-style-type: none"> <li>• 18.7% of young men have been tested and received results.</li> </ul>



APPENDIX D: RECOMMENDED REVISIONS OF MFMC CURRICULUM

Session	Content	Suggested Revisions
<b>Session 1: Getting Started</b>	<ul style="list-style-type: none"> <li>• Group rules</li> <li>• Building trust</li> <li>• Puberty and changes in our body</li> </ul>	<ul style="list-style-type: none"> <li>• No suggested revisions</li> </ul>
<b>Session 2: Reproductive Health</b>	<ul style="list-style-type: none"> <li>• Pregnancy and reproductive health</li> <li>• Consequences of teen pregnancy</li> <li>• Methods of contraception</li> </ul>	<ul style="list-style-type: none"> <li>• Revise the curriculum to identify better ways to help young people understand the implications of having a child in the teenage years and reinforce these messages through interactive follow-up activities.</li> <li>• Place greater emphasis on the fact that the only method of contraception that also prevents HIV is the consistent and correct use of a barrier method (condom or femidom).</li> </ul>
<b>Session 3: HIV &amp; STIS: The Facts</b>	<ul style="list-style-type: none"> <li>• HIV and STI transmission (including MTCT)</li> <li>• Identifying high danger, low danger, no danger sexual activities</li> <li>• Myths about HIV/AIDS (<b>Optional</b>)</li> <li>• Signs and symptoms of an STI</li> </ul>	<ul style="list-style-type: none"> <li>• Revise the curriculum to identify better ways of conveying the risk of passing the HI virus to the child (in utero, during birth, through breastfeeding) if the mother is HIV positive</li> <li>• Make the section on myths about HIV mandatory, rather than optional</li> <li>• Revise the curriculum to identify better ways to impart information about the increased risks for HIV infection associated with having an STI and the importance of being able to identify the signs of an STI.</li> </ul>

<b>Session 4: HIV &amp; AIDS: Reducing the Risks</b>	<ul style="list-style-type: none"> <li>• Self-assessment of risk</li> <li>• ABC model of prevention and its limits</li> <li>• Strategies for abstaining or delaying sex</li> <li>• How to use a condom</li> <li>• Negotiating the use of a condom (Optional)</li> </ul>	<ul style="list-style-type: none"> <li>• Emphasise the dangers of the “Be Faithful” strategy for HIV prevention, especially for young people.</li> <li>• Emphasise that unless you see test results, it is not possible to know with certainty that a person is not HIV positive.</li> <li>• Expand and develop the condom demonstration activities such that all participants complete the course knowing how to correctly and comfortably demonstrate the use of both a male condom and femidom. Condom demonstrations should be conducted a minimum of two times with any given group of participants.</li> <li>• Make the activity on negotiating condom usage required.</li> <li>• Include role plays of obstacles to consistent condom use.</li> <li>• Update the session to include information about the risks associated with transactional, concurrent sex, and intergenerational sex as well as the protective effects of male circumcision.</li> </ul>
<b>Session 5: Facing HIV and AIDS</b>	<ul style="list-style-type: none"> <li>• Stigma and discrimination against PLWHA</li> <li>• Voluntary Counselling and Testing</li> <li>• Treatment and ARVs</li> </ul>	<ul style="list-style-type: none"> <li>• Address the fears associated with testing more directly and include more interactive activities.</li> <li>• Formalise a link between the programme and local VCT centres, both in terms of providing additional information as well as offering VCT services at school.</li> </ul>
<b>Session 6: Decisions, Choices and Consequences</b>	<ul style="list-style-type: none"> <li>• Decision making</li> <li>• Decision-making &amp; risk-taking</li> <li>• Understanding who/what influence our decisions</li> </ul>	<ul style="list-style-type: none"> <li>• No suggested revisions</li> </ul>

<b>Session 7: Communication</b>	<ul style="list-style-type: none"> <li>• Different ways of communicating</li> <li>• Practicing Assertiveness</li> <li>• Saying no</li> <li>• Negotiating no (<b>Optional</b>)</li> </ul>	<ul style="list-style-type: none"> <li>• Anchor communication activities into specific prevention strategies (i.e. delaying sex, or consistent condom usage)</li> <li>• Make the 'Negotiating No' Activity mandatory</li> </ul>
<b>Session 8: Values and Relationships</b>	<ul style="list-style-type: none"> <li>• Identifying values</li> <li>• Understanding gender roles in relationships</li> <li>• Difference between a good and bad relationship</li> </ul>	<ul style="list-style-type: none"> <li>• Consider mainstreaming and integrating values into various components of the curriculum rather than having as a separate session.</li> <li>• Begin programme with discussion of values</li> </ul>
<b>Session 9: Alcohol and Drugs</b>	<ul style="list-style-type: none"> <li>• Health and social risks of alcohol and drug abuse</li> <li>• Attitudes towards drinking and drugs</li> <li>• Saying no to alcohol and drugs under peer pressure</li> </ul>	<ul style="list-style-type: none"> <li>• Revise content on alcohol and drugs to identify how to better promote healthier attitudes towards alcohol and drug use as well as responsible drinking</li> <li>• Include activities related to navigating the social contexts of substance use</li> </ul>
<b>Session 10: Our Future</b>	<ul style="list-style-type: none"> <li>• Commitment for behaviour change (pledges)</li> <li>• Plan graduation ceremony and ongoing peer activities (w/contact teacher)</li> </ul>	<ul style="list-style-type: none"> <li>• No suggested revisions</li> </ul>

## APPENDIX E: COST ESTIMATES FOR EXPANSION OF MFMC PROGRAMME: TWO MODELS

Based on the recommendations offered in Chapter 5, a model of service delivery based on the employment of full-time facilitators who offer the MFMC programme to all Grade 8 learners was developed and its associated costs estimated. The main aim of the proposed model is to attract and, most importantly, retain highly skilled facilitators in whom significant investments – in the form of training – are made. The primary manner in which this will be achieved is by offering of competitive market-related salary packages to facilitators, who up until now have been paid as volunteers on a piecemeal basis based on the number of courses run per year. While more details on the setting of the salary package is provided in the body of the text, the following paragraphs describe the cost estimates drawn up on the basis of this model.

In order to put these figures into perspective, costs incurred with the expansion of services according to the current model of having volunteer peer facilitators deliver the programme (see Model 1) have been compared with the new proposed model of having a permanent cadre of MFMC facilitators deliver the programme (see Model 2). In both estimates, it is assumed that the programme will be expanded and offered to all Grade 8 learners.

Before presenting cost estimates for these two models, some key assumptions that were used to generate the estimates for each model are briefly described below.

### **Key Assumptions:**

#### *Programme structure*

As per current guidelines, the programme consists of 10 two hour sessions of participatory training. In the new model, this contact time will be divided into 20 one hour sessions over 10 weeks. As described above, with expansion of the programme participation will no longer be voluntary. Rather courses will be offered to all pupils during lesson time (i.e. Life Skills) rather than only pupils who participate in the programme as an after school activity.

#### *Participants per session*

The programme currently prescribes that courses be offered to a maximum of 22 learners per session. As the average number of Grade 8 pupils per school is estimated to be 84, this would mean that roughly four courses would need to be offered per school to ensure that all learners received the programme.<sup>1</sup>

EMIS (2007) data indicates however that average class sizes in junior secondary are larger than this, at approximately 32 (31.7) learners per class with a range of between 31 and 35 across regions. Taken together, these pieces of information imply that there are roughly three Grade 8 classes per school.

Given the working assumption that the programme will be integrated into the Grade 8 school curriculum in the future and the impracticality of splitting classes, it was decided to base the number of courses offered per school on the average number of classes per school rather than the target number of learners (22) to which the course was designed to be delivered. As a result of this assumption, fewer courses are necessary per school.

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<sup>1</sup> All education statistics have been derived from EMIS (2007).

Because the institutionalisation of the MFMC programme involves delivering the MFMC curriculum, in part, through Life Skills classes and with Life Skills teachers being trained in the programme, it is assumed that there will be an in-built method of quality assurance when delivering the course to greater numbers of learners than for which the MFMC programme was originally intended.

### *Coverage*

Cost estimates were based on 100% coverage. Estimates for both models are based on the goal of providing the MFMC programme to all learners in all 608 secondary and combined schools that offered Grade 8 nationally. Where facilitator attrition threatened the achievement of this goal, appropriate assumptions were made about the costs that are likely to be incurred in sourcing and training suitable facilitators to replace those who withdraw from the programme.

### *Attrition*

Under Model 1 (expansion according to current model with volunteer facilitators), it was assumed that half (50%) of the facilitators who were trained at the beginning of the year would withdraw from the programme by the end of the year. Under Model 2, no explicit assumption was made about staff retention rates other than assuming that what attrition did occur would not warrant the training of additional facilitators. It is assumed that there will be sufficient capacity available amongst remaining facilitators to undertake the tasks of those who leave.

### *Training*

Facilitator training remains in its current format and consist of two courses; an initial training session of 10 days followed by one day of refresher training later in the year. Costs of training were taken from current records of training expenses.

An additional component, however, that involves training Life Skills teachers has been added. Life Skills teachers are now offered two training courses, an initial two day training course on the MFMC curriculum as well as a one-day follow-up training. In the absence of any information on exactly how much such courses would cost, the current costs of standard training programmes were used to estimate these training costs.

### *Required numbers of facilitators*

In Model 1, the total number of facilitators required nationally was based on the total number of courses that would be needed to cover all 50 575 Grade 8 pupils in the 608 schools nationally, after making allowance for the distribution of learners within schools and the distribution of schools within regions. For this exercise, it was assumed that, in line with current practice, each facilitator would be responsible for visiting one school.

In Model 2, the total number of facilitators was based on the assumption that courses were to be offered in three of the four school terms, that each facilitator was to spend two days per week offering courses at any given school and that one day each week would be dedicated to meetings, administrative duties and outreach activities such as setting up school AIDS clubs and administering the programme to out-of-school youth.

Given these assumptions, it was calculated that each facilitator could offer the programme to learners in six schools each per year. This figure and information on the regional distribution of schools was then used to estimate the total number of facilitators required to administer the programme nationally.

### *Salaries*

In Model 1, remuneration is based on the number of courses an individual facilitator conducts and is set at 500 Namibian dollars per course. Facilitators are also eligible for a transport allowance of 10 US dollars per course.

In Model 2, however, facilitators are salaried. Salaries consist of a cash component of 2 500 Namibian dollars, an additional 10% (\$250) of the value of cash package for benefits; such as a funeral plan and group life assurance; and yet another 10% of cash value (\$250) as a transport allowance i.e. a total monthly package of 3 000 Namibian dollars.

### *Learner Materials*

In line with the current programme, in both models every learner is provided with a material pack which costs US \$2.73.

### *Cost Estimates*

Based on the foregoing model parameters, the total costs of providing services under the two different models have been estimated to be:

#### **Model 1:** Expansion to all schools with volunteer peer facilitators

<b>Item Description</b>	<b>Cost</b>	
A) Training Costs		4 469 610
Facilitator Training	3 504 262	
Teacher Training	965 348	
B) Operational Costs		2 537 351
Facilitator Salaries	912 000	
Transport Allowances	189 832	
Learner Materials	1 435 519	
<b>Total</b>		<b>7 006 960</b>

#### **Model 2:** Expansion to all schools with permanent peer facilitators

<b>Item Description</b>	<b>Cost</b>	
A) Training Costs		1 911 479
Facilitator Training	946 131	
Teacher Training	965 348	

B) Operational Costs		5 323 519
Facilitator Salaries	3 888 000	
Learner Materials	1 435 519	
<b>Total</b>		<b>7 234 998</b>

All figures are presented in Namibian dollars and are based on the exchange rate of roughly 10 US cents per one Namibian dollar that held on 3 December 2008.

The first and most obvious difference to note is that providing the MFMC programme according to the second model is marginally more expensive than the first, at 228 thousand Namibian dollars more. In percentage terms, this difference represents just over 3% in the cost of service provision under Model 1 compared to Model 2.

This is overwhelming driven by the increase in facilitator salaries associated with the provision of the programme under the Model 2. Another key difference between the two models is that training costs are so much larger under Model 1.

Differences in the relative weightings of different cost items in models' cost estimates reflect the rationale that informed the development of the proposed model. To reiterate, the emphasis under the proposed model is now squarely on the formalisation of facilitators' job functions and the retention of these staff members.

This change in focus is reflected in the composition of total costs, where now over half (54%) of total costs are spent on Facilitator salaries. This figure is in sharp contrast to the previous model, which is based on scaling-up the current programme. Under this model, merely 13% of Total Costs will be spent on Facilitator salaries, with this figure rising to 16% if transport allowances are taken into account. By far the bulk of expenses will be spent on Training Costs (64%). As highlighted in the main text and borne out by administrative records, this is driven largely by the high dropout rate and the resulting need to train large numbers of facilitators. In our cost estimation exercise the dropout rate has been set at 50% per year. Although this rate might seem high at first, it should be noted that this figure is much lower than that implied in UNICEF Namibia administrative records on numbers trained and schools reached in any given year.

Furthermore, it is argued that looking at the cost estimates for Year One statically without consideration of the low retention rate and associated recurrent nature of high training costs under the existing mode of programme delivery necessarily biases the proposed new model of programme delivery. Under the latter model, with its higher staff retention rate, training costs would peak in Year One and thereafter fall as fewer new entrants would need to be trained in subsequent years. Under the current model, however, with its high staff turnover rate it is more than likely that few participants from the previous year would return at the beginning of the next year.

Thus, one would expect that a significant proportion of current facilitators would not return at the beginning of the next year. Therefore, the need to train large numbers of facilitators would arise. Note that training costs are apt to rise even further after taking this into account as the need for re-

training has not been taken into account. Arguably, there may exist an acute need for this sort of training, especially given the relatively few courses which individual facilitators may actually give per year.

To illustrate these effects, assume that 50% of the facilitators who remain at the end of the year drop out at the beginning of the next year i.e. 75% of those at the beginning of year 1 are there at the beginning of year 2 and that 20% of teachers need to be retrained. Using this assumption and holding all others related to attrition the same, training costs would still be inordinately high at 3 036 726 Namibian dollars in year 2 (in current prices) and would still represent over half (54%) of Total Costs. On the other hand, if retention rates for Facilitators and Teachers in Model 2 were set relatively low at 80%, the comparative amount spent on training would be 382 296 Namibian dollars. Incidentally, the cost differential would then be reduced to just 131 738 Namibian dollars (5 574 071 for Model 1 versus 5 705 815 for Model 2).

Staff retention is doubly important as it enables facilitators to accumulate experience in their area of expertise. These learning-by-doing effects, or the lack thereof, are an important factor in the success of any programme as they are direct determinants of the quality of service that can be offered. Clearly, this important aspect of service delivery is ignored in our current static estimates of the start-up costs of the programme in its inception year. As this analysis was restricted to a costing analysis and only for the first year, one can only speculate on the larger positive effects that this change in programme structure would have on service delivery.