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Exploring Gender, Reducing HIV/AIDS: A Training Design for Peer Facilitators of UNICEF Namibia's "My Future is My Choice" Program

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Exploring Gender, Reducing HIV/AIDS:
A Training Design For Peer Facilitators of UNICEF Namibia's "My Future is
My Choice" Program

A Master's Project
by

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Introduction

Namibia's current political state has been markedly influenced by its past history as a former German and South African colony. The years under repressive South African apartheid rule affected every aspect of black Namibians' lives politically, economically, and socially. With independence on March 21, 1990 came celebration and the birth of one of Africa's last independent countries. Black Namibians were jubilant and filled with hope for the future under a government that was progressive, democratic, and invested in cultivating the socio-economic and human capital of its people. In part due to a government led by the South West Africa People's Organization (SWAPO) political party, the party largely responsible for achieving independence, Namibia's economy is stable and secure, buoyed by strong GDP growth in the mining sector with diamonds, uranium, and zinc leading the way (Economist Intelligence Unit, 2004).

Although classified as a middle income country with a high per capita GDP relative to the region, Namibia still suffers from "enormous [socioeconomic] inequalities inherited at independence" (Government of the Republic of Namibia/United Nations Children's Fund, hereafter known as GRN/UNICEF, 2002, p. 6). According to the World Bank, Namibia has a Gini-coefficient of 0.7 and the 1998 Human Development Report indicates that "the richest 10 percent of the population receives 65 percent of the income. About half of the population survives on about 10 percent of the average income" (2004). Hence a major task for the government "continues to be the elimination of these disparities between the 13 different language/ethnic groups, between regions and between rural and urban areas" (GRN/UNICEF, 2002, p. 6). However, exacerbating these inequalities and threatening to

reverse many of the socioeconomic gains since the end of apartheid is the deadly specter of HIV/AIDS.

Like many of its Southern African neighbors, Namibia has been devastated by the HIV/AIDS pandemic, with infection rates hovering around 22.5% among sexually active adults and life expectancy averages plummeting from 58.8 years in 1995 to 43 years in 2000 [The Joint United Nations Programme on AIDS (UNAIDS), 2002 and the United Nations Development Programme (UNDP), 2000, as cited by the Ministry of Basic Education, Sport and Culture (MBESC) and the Ministry of Higher Education, Training and Employment Creation (MHETEC), 2003]. The government recognizes that HIV/AIDS is not simply a health issue, but one with larger socio-economic implications, as the country's development depends to a large extent on its human capital (MBESC & MHETEC, 2003). As the years have progressed, the pandemic has massively increased demands on social services such as health and welfare, in addition to "stretching coping capacity through its impact on income and costs, psychological effects of illness and deaths, and disruption of family structures" at the household, family, and community levels (Kinghorn, et al., 2002, p. ix).

The hardest hit demographic group are young people aged 10-24 who comprise 60% of new HIV infections (MBESC & MHETEC, 2003). Particularly vulnerable are young women and girls due to their low status in Namibian society, greater household burdens, pressures for early marriage, and vulnerability/risk of sexual abuse (Kinghorn, et al., 2002). However, the "proportion of teenagers who are *not* infected is likely to be higher than assumed by many young people. This is an important message of hope" (Kinghorn, et al., 2002, p. x). Keeping this in mind, Namibia has made young people a priority target group, as they can be more easily reached through HIV/AIDS information, prevention, care, and health

promotion programs in educational institutions (MBESC & MHETEC, 2003). Indeed, “more than any other sector, education has opportunities to influence levels of HIV infection among young people, through its direct contact with them in institutions and non-formal education” (Kingham, et al., 2002, p. xi). HIV/AIDS should therefore be considered “core business for every educational institution and professional” (MBESC & MHETEC, 2003, p. 1). It is against this backdrop that my own personal interest in this area has been forged, first as a U.S. Peace Corps volunteer (1999-2001) and then as a summer intern (2004) for UNICEF Namibia’s Adolescent HIV/AIDS Prevention Program (AHPP).

When I first arrived in Namibia in October 1999, I had only an inkling of the gravity of the HIV/AIDS situation. It was not until having spent time working alongside Namibians and living in a community where weekly funerals were a common occurrence that HIV/AIDS became something tangible and evident. As a secondary education teacher, I witnessed first-hand the ravages of HIV/AIDS in my school and larger community. Several of my students were HIV/AIDS-affected orphans and their pursuit of education encompassed a struggle for basic survival, as they had no support network to rely upon. Teachers were often on “sick leave” for weeks or months at a time, leaving students in teacher-less classrooms.

Due to the remoteness of my school (hence limited access to media messages) and the reluctance of other teachers in discussing issues related to HIV/AIDS, I felt that many students were completely unaware as to even the basics of HIV/AIDS, believing and perpetuating many myths about modes of transmission, origin of HIV, and espousing a certain fatalistic or even unfounded confident attitude (e.g. “I can’t/won’t catch HIV”) regarding their own mortality and invincibility. So although I was primarily an English

teacher, I choose to design a curriculum separate from that prescribed by Namibian national guidelines. My lesson plans incorporated HIV/AIDS education into standard listening comprehension, reading, writing, and speaking exercises (primarily dramas) which were ultimately designed to educate my grade 9 and 10 students about the basics of HIV and other STDs; modes of transmission; safer sex practices; explored the links between drugs, alcohol, and risky sexual behavior; and helped to create an open environment for discussion about issues related to HIV/AIDS, including the social stigma surrounding the disease.

While my work in the Peace Corps surrounding HIV/AIDS education was primarily in the classroom, as a UNICEF Namibia intern for the Adolescent HIV/AIDS Prevention Program (AHPP), I was involved in a mid-term assessment of the nationwide, peer-facilitated program, “**My Future is My Choice**,” (MFMC) a participatory life skills intervention for adolescents aged 15+ designed to provide information and training around reproductive health issues, HIV/AIDS education, decision making, and communication (United Nations, 2003b). Involvement in this non-formal education program provided insight into how UNICEF, the Namibian government, bilateral stakeholders, implementing partners, NGOs, and members of civil society are joining forces to respond to the HIV/AIDS crisis. In addition, working on the mid-term assessment was an opportunity to explore issues related to my personal academic and professional interests, specifically the impact of HIV/AIDS in Southern Africa (Namibia), non-formal education, youth development, and in particular, gender issues and the need for greater gender awareness in HIV/AIDS education and training. As such, this Master’s project is a reflection of my experiences, interests, research, recommendations, and conclusions about the importance and interconnectedness of these issues.

The following chapters—all set in the geographic context of Namibia—present a brief literature review on the following topics: Chapter One – *HIV/AIDS*; Chapter Two – *Youth*; Chapter Three – *Education*; and Chapter Four – *Gender*. The culmination of this Master’s project is a 5-day training meant to increase gender awareness amongst peer facilitators for the “My Future is My Choice” (MFMC) program, as I believe that greater gender sensitivity is crucial for the fight against HIV/AIDS, especially amongst young people.

Chapter One: HIV/AIDS

Overview: A Worldwide Pandemic

HIV/AIDS has emerged as a “highly complex and constantly evolving pandemic” that threatens the livelihoods of individuals, families, societies, and economies around the world (United Nations, 2003a, p. 11). Reports indicate that worldwide, over forty million people are currently HIV+ and that approximately twenty million have died from AIDS complications (Meier, 2003). Deaths due to HIV/AIDS are considered “premature deaths,” and many who die from AIDS-related causes were infected as teens and young adults (Summers, et al., 2002).

Developing countries have been affected most gravely, hosting more than 90% of all HIV infections to date, with the scourge of HIV/AIDS being felt more keenly in sub-Saharan Africa than anywhere else in the world (United Nations, 2003a). With only one tenth of the world’s population, Africa hosts over an estimated 60% of the global burden of HIV infection (De Cock, et al., 1994, as cited by Stanton, et al., 1999). Despite governmental and global efforts towards AIDS education, prevention, and treatment, the rates of new HIV/AIDS infections continue to grow on a daily basis and life expectancy continues to drop dramatically. UNAIDS estimates that “the survival time from HIV infection to death in sub-Saharan Africa is approximately eight to nine years” (2002, as cited by Summers, et al., 2002, p. 16). Overall, Africa alone has “experienced as many AIDS-related deaths in the last two decades of the twentieth century as Europe experienced during the period of the bubonic plague in the fourteenth century” (Kelly, 2000, p. 24).

Namibia's HIV/AIDS Situation

Namibia, with its small and widely dispersed population of approximately 1.8 million people, has a national prevalence rate around 22.5% amongst sexually active adults, thereby ranking it dubiously in the top five highest infected countries in the world (United Nations, 2003b). HIV infection levels vary widely between regions of the country, with more remote and less densely populated areas having lower levels of infection. While “[t]o some extent this may represent later development of the epidemic in some areas and communities, ... in all sites infection levels are high enough to be a huge public health challenge” (Kinghorn, et al., 2002, p. viii).

Since the first reported cases of HIV were reported in 1986, the pandemic has become the leading cause of death (47%) in hospitals (United Nations, 2003a; GRN/UNICEF, 2002). By the end of 1999, 160,000 people were living with HIV/AIDS in Namibia, of which 150,000 were 15-49 years old (United Nations, 2003a). To date, the pandemic has affected an estimated 243,000 Namibians, but the true impact of HIV/AIDS is yet to be seen, since given the long incubation period of the disease, “the recent growth in HIV prevalence has not yet resulted in the inevitable increase in AIDS morbidity and mortality” (United Nations, 2003a, p. 11). However, according to Namibia's Ministry of Health and Social Services (MOHSS), “evidence from the long term sentinel surveillance sites indicates that this situation is about to change,” as the rapid growth in HIV prevalence that occurred in the latter half of the 1990s will soon be reflected in greatly increased HIV/AIDS morbidity and mortality (United Nations, 2003a).

Overall, HIV/AIDS is the “single biggest threat to all development efforts in Namibia,” consuming up to 17% of the 2001 N\$1.2 billion health budget (United Nations,

2003a, p. 11) and impeding poverty reduction efforts across all sectors of society. This contributes to the already bleak situation, as poverty facilitates the spread of HIV and worsens its impact. In many contexts where poverty prevails, “responding to immediate short-term survival or satisfaction needs assumes greater importance than protecting long-term benefits” and in the case of HIV, this is the reality of the situation “where no immediate deleterious consequences are experienced and the infection appears to lie dormant for several years” (Kelly, 2000, p. 28). In addition, poverty creates situations of vulnerability to HIV infection in the following ways (Kelly, 2000):

- the lower nutritional status of poor people;
- their poorer state of general health;
- their lack of access to adequate health services;
- the smaller likelihood of treatment for STDs which they may have incurred;
- their lack of access to information and the means of protecting themselves in sexual encounters;
- the overcrowded conditions in which they live;
- the survival needs which cause poor women and girls to enter into sexual relationships and to protect their expected income by not insisting on condom use;
- the economic needs which propel young men from poor families to leave home and migrate from one high-risk locale to another in search of work; and
- the virtual absence of pleasurable experiences, other than sex, available to poor people.

It is important to keep in mind the vicious cycle of HIV/AIDS and poverty, because while poverty exacerbates vulnerability to HIV/AIDS, the reverse is also true in that HIV/AIDS aggravates poverty (Kelly, 2000). It does so by “thrusting households back on ever more limited resources as it removes wage-earners from employment, reduces the ability to engage in smallholding or agricultural work, deflects resources to medicines and health care, and draws down on savings or capital” (Kelly, 2000, p. 29).

On a larger scale, HIV/AIDS impacts a country's overall development in the following ways:

HIV/AIDS reduces life expectancy; increases child mortality; leaves large numbers of children without adult care; places intolerable strains on health-care systems; undermines economic development through increased labor costs and the decreased availability of skills human resources; and impoverishes households (Kelly, 2000, p. 27).

Because the majority of AIDS cases are found in adults between 20 and 50, with peak ages for women being 20-29 and 30-39 for men, the implications are that AIDS “strikes hardest at those who are in their most productive years,” wiping out years of education and training and depriving families, communities and society of experienced, skilled and active members (Kelly, 2000, p. 20). In addition to reducing worker productivity and diminishing human capital, HIV/AIDS impacts families the hardest, leaving children orphaned and without support (Kelly, 2000).

Currently, it is estimated that Namibia hosts over 84,000 orphans younger than 18 years, with projected estimates of 132,000 by 2010 (United Nations, 2003a; Kinghorn, et al., 2002). These children turn to siblings, extended families, and the community for support—the traditional African support network (Mberengwa & Johnson, 2003). As orphans, their position in life has forced them to depend on the goodwill of others who are struggling with their own sets of problems. These care networks are “being overwhelmed by the magnitude of the needs put upon them, leaving many children vulnerable to malnutrition, exploitation, and abandonment” (NIC/CIA, as cited by Summers, Kates, & Murphy, 2002, p. 21).

According to UNAIDS, orphans, especially females, living with extended families are more susceptible to discrimination and limited access to health, education, and social services; as such, many often end up maintaining their own households, with the concomitant economic

burdens, or turn to life on the streets where “without support systems and resources, they are at substantially increased risk of malnutrition, abuse, illness, and HIV infection” (Summers, Kates, & Murphy, 2002, p. 21).

What has been Namibia’s Response?

Namibia’s national response to HIV/AIDS started prior to independence with the 1987 establishment of an AIDS Advisory Committee and has since benefited from the commitment of political leadership at the highest levels (United Nations, 2003a; Kinghorn, et al., 2002). Given that political will is “internationally recognized as a distinguishing feature of all successful and sustainable efforts to combat the epidemic” (Kinghorn, et al., 2002, foreword), it was a prudent strategic move that following independence, Namibia’s new president, Dr. Sam Nujoma, launched the National AIDS Control Program (NACP) whose mandate was to coordinate and manage HIV patient-care and preventative activities (United Nations, 2003a). Shortly thereafter, the national response shifted its focus in order to “address the critical areas of containing the spread of HIV, as well as reducing the impact on the individual and the society” (United Nations, 2003a, p. 12), by establishing and implementing the initial Short-Term Plan (1990-1992) and the Medium-Term Plan I (MTP I, 1992-1998).

Following the MTP I, the pandemic had reached such grave proportions that a larger and more aggressive multi-sectoral approach was conceived and adopted, with many government sectors and non-governmental organizations (NGOs) working in conjunction with the NACP to implement HIV/AIDS prevention activities (United Nations, 2003a). Based on consultations at various levels of government and stakeholders, the Medium-Term Plan II (1999-2004) was developed. Subsequently, the National AIDS Committee (NAC)

was “elevated and restructured;” a National Multi-sectoral AIDS Coordinating Committee (NAMACOC) was established; the National AIDS Executive Committee (NAEC) was created and “charged with following-up and moving forward the implementation of the national multi sectoral response;” and the National AIDS Coordination Programme (NACOP), situated in the Ministry of Health and Social Services (MOHSS), replaced the original NACP (United Nations, 2003a, p. 12; Kinghorn, et al., 2002, p. ix). Currently, various sub-committees of NACOP exist to “cater for the specific needs of regions (RACOCs) and sectors (e.g. RACE’s in education regions)” while civil society groups and development partners “play key roles in the national HIV/AIDS response at all levels” (Kinghorn, *et al.*, 2002, p. ix).

In the words of the Ministers of Education, John Mutorwa (Minster of Basic Education, Sport and Culture) and Nahas Angula (Minister of Higher Education, Training and Employment Creation):

When at first the outbreak of HIV/AIDS became an issue affecting Namibia and Namibians, there was an initial tendency by people to view this as a matter only [related to] inflicted persons and the line Ministry of Health and Social Services. Everybody seemed to look at HIV/AIDS from a distance until the disease is now hitting mercilessly on the Namibian Nation. It has dawned on each individual/official that HIV/AIDS is ravaging and slowing down the strides that we are striving to make. There is now an increasing understanding amongst the people in Namibia, that this pandemic is a Namibian reality. (Kinghorn, *et al.*, 2002, foreword)

Many might ask, “So even with this recognition of the seriousness of HIV/AIDS and the multi-sectoral, national response to the epidemic, why are infection rates continuing to increase and why does the disease go on unabated?” One major obstacle yet to be surmounted is the stigma, shame, and silence associated with HIV/AIDS that is prevalent throughout Namibia.

Major Obstacles to Fighting HIV/AIDS

In many countries like Namibia, people living with HIV/AIDS frequently experience social stigma, scorn, or maltreatment because of the common belief that infected people “‘deserve’ their fate because of their drug-using habits or ‘promiscuous’ sexual behaviour” (Kelly, 2000, p. 29). People are afraid, not only of HIV’s “ready transmission and lethal outcome,” but also afraid that one’s HIV/AIDS status might be discovered by a spouse, boss, or community members (Kelly, 2000, p. 29). The fear of stigma and discrimination is fueled by “well-authenticated cases of individuals being denied medical care because of their HIV status, of employment being terminated or promotion denied on the same grounds, [and] of children being excluded from school because of HIV/AIDS in their families” (Kelly, 2000, p. 30).

What results is a private and public wall of silence, a reluctance to acknowledge HIV/AIDS’s presence, and instead, a referral to the disease “by innuendoes and half-suggestions. It is concealed as TB or malaria or meningitis or just as ‘a sickness’” (Kelly, 2000, p. 30). A vicious cycle develops where “false shame leads to silence, silence leads to stigma, stigma leads to a deeper sense of shame, and thereby to even greater silence and isolation” (Kelly, 2000, p. 30). This cycle can become so ingrained that families, communities, and larger society “may try to behave as if AIDS did not exist. But all the while, this whole atmosphere provides a dark, secretive breeding ground for the further spread of the virus” (Kelly, 2000 p. 30).

Who is Being Affected the Most?

Given this culture of silence, who is being affected the most? Considering that worldwide, “approximately half of the new HIV infections are among youth 15 to 24 years of

age” (UNAIDS, 1999, as cited by GRN/UNICEF, 2002, p. 48), it would be logical to conclude that youth, specifically those who are not receiving the information, access to means of protection (e.g. condoms), and the counseling they require in order to become educated as to how to stay HIV negative or how to live positively, are at the greatest risk of being affected by HIV/AIDS. Indeed, “lack of information on sexual development and sexual behavior, combined with unfriendly health services, create an environment which does little to help adolescents recognise and avoid risks as they become sexually active” (GRN/UNICEF, 2002, p. 8). These issues, and the consequent ramifications on Namibia’s bleak HIV/AIDS situation, will be discussed in greater detail in the next chapter.

Chapter Two: Youth

HIV/AIDS Prevalence and Incidence: The Global Impact on Youth

The HIV/AIDS epidemic is expected to have far-reaching worldwide demographic ramifications, impacting population structures, especially amongst teens and young adults (Summers, et al., 2002). The impact of HIV/AIDS on young people globally is dire, with facts and figures indicating the following:

- Of the estimated 40 million people living with HIV/AIDS worldwide, more than a third (38%) are under the age of 25 (UNAIDS, 2001, as cited by Summers, et al., 2002).
- Of the five million people newly infected with HIV in 2001, 58% were under the age of 25 (UNAIDS, 2002, as cited by Summers, et al., 2002).
- Worldwide, 6000 new infections occur daily among 15-to-24 year olds, or approximately one every 15 seconds; when infections among children under the age of 15 are factored in, “an estimated 8,000 young people become infected with HIV everyday worldwide” (UNAIDS, 2002, as cited by Summers, et al., 2002, p. 14).
- According to the U.S. Census Bureau, if current trends persist, “the global total of young people living with HIV/AIDS could rise from the current estimate of 12.4 million to 21.5 million in 2010, an increase of more than 70 percent” (2002, as cited by Summers, et al., 2002, pp. 15-16).
- Due to HIV/AIDS, the life-expectancy in many hard-hit countries “could drop below age 30...by the year 2010, reversing steady gains over the last century” (Summers, et al., 2002, p. 16).

The Impact of HIV/AIDS on sub-Saharan Youth

Geographically, sub-Saharan Africa has been particularly hard hit, with young people in this region representing 76% of the world’s HIV+ youth and 90% of the world’s AID orphans (approximately 12.1 million children) (UNICEF, 2000 and UNAIDS, 2000, as cited by Summers, et al., 2002). Within the region, Botswana and Lesotho host the highest proportion of infected youth, with up to 45% of young women and 19% of young men aged

15-to-24 estimated to be HIV+ in Botswana, and up to 51% of young women and 23% of young men estimated to be HIV+ in Lesotho (UNAIDS, 2002, as cited by Summers, et al., 2002).

Logically, high rates of HIV infection among young people are concentrated in countries with young populations and since over half of its population is estimated to be under the age of 18, sub-Saharan Africa is one of the youngest regions of the world (Summers, et al., 2002). The National Intelligence Council (NIC) has identified a number of countries with “youth bulges,” defined as “those in which the ratio of 15-to-29-year-olds to 30-to-54-year olds exceeds 1.27” (NIC, 2000, as cited by Summers, et al., 2002, p. 15). Of the 25 sub-Saharan countries with youth bulges, “over half have prevalence rates of HIV among young males and/or females higher than 10 percent” (UNAIDS, 2002, as cited by Summers, et al., 2002, p. 15). Most likely, the youth bulges will increase in such highly infected countries as Botswana, Burundi, Lesotho, and Mozambique as a result of the epidemic, “as those in slightly older cohorts die prematurely” (NIC, 2000 and UNAIDS, 2002, as cited by Summers, et al., 2002, p. 15).

The Impact of HIV/AIDS on Namibian Youth

In Namibia, new infections among young people aged 15-25 are “the main driving force in perpetuating the HIV/AIDS epidemic” (Kinghorn, et al., 2002, p. 5). Estimated prevalence is “close to zero among Namibians in the early teens, and then rises rapidly from the mid-teens to over 20% in individuals aged 20-24,” with higher levels of infection experienced in many communities (Kinghorn, et al., 2002, p. 5). Among Namibian women ages 15-19 and 20-24, rates have leveled since 1996 but remain too high (12% and 20%,

respectively), “to produce anything near an HIV/AIDS free generation” (Kinghorn, et al., 2002, p. 5).

A 2001 survey conducted by the Institute of Policy Research revealed important facts about high-risk sexual behavior among Namibian youth (Kinghorn, et al., 2002):

- Young Namibians become sexually active at an early age. The mean age for first sexual intercourse was estimated in 1997 to be 16 for males and 17 for females, “although 14.2 percent of males and 4.4 percent of females had started sexual activity before the age of 13 years” (GRN/UNICEF, 2002, p. 8).
- High-risk activity amongst the participants occurred more frequently around the ages of 16-18.
- There is a strong correlation between the age of first sexual intercourse and high risk sexual behavior (i.e. the younger people start having sex the more risky their sexual behavior tends to be).
- Being single is no indicator of one’s risk taking behavior.
- It appears that more males than females engage in high risk sex behavior.
- Few young Namibians are using any form of protection during intercourse.
- Well-educated individuals with greater access to information are basically at the same level of risk as less educated individuals with poor access to information. Though urban dwellers have more access to media, this does not appear to impact on their behavior.

Youth Vulnerability to HIV/AIDS Infection

What is causing young people to engage in such high-risk behaviors? Why are they such a vulnerable demographic group to HIV infection? Contributing factors often include youth’s biological and emotional development; financial dependence; peer pressure; family problems; and lack of parental guidance (Summers, et al., 2002; GRN/UNICEF, 2002).

High-risk behavior is also linked to “adolescents’ lack of sexual health information, limited perception of personal risk, their lack of the skills to act on the information, and their poor access to the services that can address many of these problems” (GRN/UNICEF, 2002, p. 51).

Socio-economic factors play a key role, as most young people at risk for HIV or already living with HIV/AIDS live in the world's poorest regions. Their vulnerability to HIV "operates within a broader context of poverty, which may include lack of access to education, economic opportunities, and health-related services....This is particularly true of girls and young women, who have less access to control over income, property, land, and credit" (Gupta, 2000, as cited by Summers, et al., 2002, p. 17).

Lack of health care access is significant, as "systematic disparities in access to health care for young people can heighten vulnerability to HIV," given that many of the countries hardest hit by HIV/AIDS "lack sufficient infrastructure and resources to deliver needed HIV-related services, including prevention and treatment services, HIV counseling and testing, and mental health care" (USAID, 2000 and NIC/CIA, 2002, as cited by Summers, et al., 2002, p. 18). Projections indicate that health care access will likely worsen "as the burden of caring for so many millions of people suffering from AIDS-related illnesses takes an increasing toll on health infrastructures" (USAID, 2000 and NIC/CIA, 2002, as cited by Summers, et al., 2002, p. 18).

For young people, additional barriers to health services include "lack of privacy and confidentiality, staff insensitivity to young people's special needs and perspectives, lack of affordable services, and lack of services geared toward adolescents ('teen friendly')" (USAID, 2000 and NIC/CIA, 2002, as cited by Summers, et al., 2002, p. 18). Stigma plays a key role in young people's (un)willingness to seek services, as young women and girls, for example, "may avoid health care services, including HIV testing and treatment for STDs, because of fear of stigmatization or even of violence—particularly if it becomes known that

they're sexually active (before or outside of marriage) or infected with HIV" (UNAIDS, 2002, and Gupta, 2000, as cited by Summers, et al., 2002, p. 18).

In Namibia, regional visits unearthed the following factors that negatively influence sexual behavior decision-making among youth (Kinghorn, et al., 2002):

- poverty and unemployment;
- peer pressure and community norms encouraging high risk sexual practices;
- cultural beliefs and activities which predispose to high risk sexual relationships;
- church beliefs which forbid talking about AIDS;
- ignorance and lack of AIDS education in the home;
- no parental or guardian control or guidance;
- abuse of drugs and alcohol;
- media exposure to sexual messages; and
- conflicting messages about prevention from various support groups (e.g. the use of condoms and safer sex vs. abstinence).

These factors “create a series of interconnected underlying causes,” including external socio-economic, educational and gender disparities, which when combined with “harmful traditional and cultural practices, limited political will, resources and operational policies,” create a dangerous reinforcing cycle leading to a situation “where adolescents’ rights to information, skills and services are being neglected and violated” (GRN/UNICEF, 2002, p. 51). As a result of this limited access to services and information, young people are “often unlikely or unable to protect themselves appropriately, as they demonstrate an inclination to sexual experimentation, often with multiple partners” and engage in other unsafe sexual behavior (Kiragu, 2001, as cited by Summers, et al., 2002, p. 16). So while more than 80% of young Namibian women are aware of modern contraceptives, practice is low, with “only 11 percent of sexually active females between the ages of 15-19 reporting contraceptive use and of these only 2.4 percent were using condoms” (UNAIDS/WHO, 1998,

as cited by GRN/UNICEF, 2002, p. 49). In another study among young women 18-24, 42% stated they used Depo-Provera, a contraceptive method that protects against pregnancy, but not against HIV transmission (SIAPAC, 1997, as cited by GRN/UNICEF, 2002).

Unfortunately, percentages for male use of condoms were not mentioned in the literature.

The manifestation of having inadequate skills and information on sexual and reproductive health often results in adolescent pregnancy, sexually transmitted diseases (including HIV/AIDS), and the facilitation of “violent behaviour, coercion and abusive gender and sexual relationships among adolescents,” behavior which is often reinforced by alcohol and/or drug abuse (GRN/UNICEF, 2002, p. 51). In many cases, adolescent girls experience HIV, STDs and pregnancy together, “a dangerous combination for their health and development” (GRN/UNICEF, 2002, p. 51).

Being infected with another STD increases the likelihood of both acquiring and transmitting HIV; unfortunately, the prevalence of STDs among youth is high (Summers, et al., 2002). A 1998 study in a Namibian northwest hospital found that 43% of young people had at least one reproductive tract infection, 24% had one recognizable STD, and 31% had multiple infections. The HIV rate among these STD patients was 13% (GRN/UNICEF, 2002).

In terms of teen pregnancy, the 1992 Demographic and Health Survey (DHS) found that 19% of young women had become pregnant or had a child by the age of 17, 36% by the age of 18, and 45% by the age of 19 (GRN/UNICEF, 2002). In addition to the socio-economic implications of being a teenage mother, adolescent girls “face problems of obstructed labor, anaemia, high blood pressure and other complications, which require

specialized antenatal care” which unfortunately, many teen girls do not seek out or receive due to the stigma associated with teen pregnancy (GRN/UNICEF, 2002, p. 49).

Also important to consider is that young people’s sense of invulnerability (e.g. “it can’t happen to me”), combined with lack of experience, “may leave them unaware of the consequences of their actions and therefore less likely to take precautions against risk of infection” (Population Reference Bureau, 2000, as cited by Summers, et al., 2002, p. 16).

Youth and their Relationship to Adults

As children progress into adolescence, they “become more and more responsible for their own actions, for what they choose to listen to and how they spend their time” (GRN/UNICEF, 2002, p. 50). Despite their growing self-reliance, however, many are still dependent on adults to meet their basic needs and rights for health and development. Young people have the right to expect protection from adults, but unfortunately, many often fall victim “to abuse, exploitation, denial, lack of access to information or services, and cultural and social traditions that directly or indirectly affect their health and development” (GRN/UNICEF, 2002, p. 50). Indeed, adults often exploit their power positions, either overtly as sexual predators or as “gatekeepers,” controlling young people’s access to information about sex, drugs, and health, thereby exerting major influence over young people’s choices, actions, and behaviors (GRN/UNICEF, 2002).

Parents and duty bearers may deny young people health information for moral, cultural and religious reasons (GRN/UNICEF, 2002). Many Namibian adults are uncomfortable discussing issues of sexuality with their children; others are uninformed about HIV/AIDS themselves; and still others fear that by talking about condom use or other safe sex practices, their children will engage in early sexual behavior (GRN/UNICEF, 2002).

However, despite their conservative attitudes, parents and adults in the community have a responsibility to provide information and guidance, as “lack of information on sexual development and sexual behaviour, combined with unfriendly health services, create an environment which does little to help adolescents recognise and avoid risks as they become sexually active” (GRN/UNICEF, 2002, p. 8). This lack of information can bring unintended and potentially dangerous results. For example, some heterosexual adolescent girls, “to avoid pregnancy and maintain virginity, may engage in alternatives to vaginal intercourse such as anal or oral sex, believing that these practices are not ‘having sex,’” and therefore carry no risk, which is false, as anal sex “is one of the most efficient ways to transmit HIV” and oral sex “though not as risky, is not entirely safe” (Gupta, 2000, as cited by Summers, et al., 2002, p. 17).

Compounding the situation are additional factors, such as peer attitudes and peer pressure to engage in early or unsafe sexual behavior, and adolescents being confused by the mixed messages they receive from their parents, community members, and the media (UNICEF, 2002b). Given the confusion regarding proper sexual health practices and attitudes, it is apparent that much still needs to be done to open up channels of communication and support between adults and adolescents, to ensure that they have accurate information and relevant skills, because “in an understanding environment, it is easier to make the right choices” (UNICEF, 2002b, p. 15).

Is HIV/AIDS Awareness Enough? What Else is Required for Prevention Efforts Amongst Youth?

Surveys indicate that while many young people around the world have now heard about the HIV/AIDS epidemic, awareness is unfortunately not universal. UNICEF reports

that in more than a dozen countries, over half of young people have never heard of AIDS (2000, as cited by Summers, et al., 2002). A significant percentage of at-risk-youth still harbor misconceptions about HIV transmission, as evidenced by surveys in 17 countries which revealed that 50% of adolescents “could not name a single method of protecting themselves from HIV infection (with girls knowing less than boys in all instances)” (UNAIDS, 2001 and Henry J. Kaiser Family Foundation, 2001, as cited by Summers, et al., 2002, pp. 16-17). Indeed, surprisingly, researchers in Mozambique found that 74% of young women and 62% of young men ages 15 to 19 were unaware of any way to protect themselves from HIV (UNAIDS, 2001 and Henry J. Kaiser Family Foundation, 2001, as cited by Summers, et al., 2002). In addition, a recent survey of young South Africans found high levels of concern about HIV/AIDS, but many still did not know important facts about the disease or how to prevent or treat HIV infection (UNAIDS, 2001 and Henry J. Kaiser Family Foundation, 2001, as cited by Summers, et al., 2002).

However, past experience has shown that information alone is not enough to convince young people to change their attitudes and sexual behavior, as awareness of HIV/AIDS among young people may not necessarily translate into a perception of personal risk, even among those in countries with very high prevalence rates. This phenomenon is due, in part, to “a lack of visibility of HIV-positive youth, with most young people living with HIV not even knowing they are infected” (Population Reference Bureau, 2001 and UNAIDS, 2001, as cited by Summers, et al., 2002, p. 17). Indeed, recent studies among Namibian youth have revealed that while the majority of young people know how to prevent HIV infection, they often lack the skills and support needed to make the right choices (UNICEF, 2002b). This dilemma will be further explored in the next chapter.

Ultimately, prevention interventions directed at youth will be critical to altering the future course of the pandemic (Kiragu, 2001 and Sittitrai, 1999, as cited by Summers, et al., 2002). While health experts note that the availability of “appropriate youth-targeted information varies widely across regions and within nations and communities” (UNAIDS, 2000, as cited by Summers, et al., 2002, p. 17), where and when they do exist, “such efforts have been shown to lead to increased knowledge about HIV/AIDS, delays in sexual activity, and increased condom use among those having sex for the first time” (Rosenfeld, et al., 2001, as cited by Summers, et al., 2002, p. 20). In fact, in Uganda and Thailand, where national prevention efforts have been among the most successful, young people were often the first to respond to prevention interventions. In Uganda, HIV prevalence declined significantly among pregnant women, with the greatest decline among those in the youngest age group (15 to 19 years old) and in Thailand, HIV prevalence rates declined among young military recruits (a proxy of national success for Thailand’s HIV prevention campaign) (Kiragu, 2001 and Sittitrai, 1999, as cited by Summers, et al., 2002). And in South Africa, “a new analysis of the potential impact of different prevention interventions, including increased condom use and a reduction in the number of sexual partners, among young people 15 to 19 years old...projects significant reductions in HIV incidence and prevalence over time” (Steinberg & Kramer, 2002, as cited by Summers, et al., 2002, p. 21). Indeed, such projection models reveal that “even modest changes in behavior—such as increased condom use and STD treatment—can significantly reduce HIV/AIDS prevalence” (Steinberg & Kramer, 2002, as cited by Summers, et al., 2002, p. 21).

The Importance of Focusing on Youth: Children are the Future

In fighting HIV/AIDS, there are several reasons for focusing on young people, including:

- **Numbers:** In 1995, primary and secondary school enrolments combined accounted for 18% of the world's population; sub-Saharan Africa's "school-age population of more than 230 million accounted for over 30 percent of its people" (Kelly, 2000, p. 34).
- **Vulnerability:** As discussed in our previous section, young people are at particular risk to HIV infection. UNAIDS estimated that in 1999 alone, "570,000 children under the age of 15 became infected, while by the end of that year one-third of the 33 million people in the world living with HIV were young people aged 15-24" (UNAIDS, as cited by Kelly, 2000, p. 34). Many are suffering acutely from the effects of HIV/AIDS, "some in their own persons, many in their families and among their friends, many as orphans" (Kelly, 2000, p. 34).
- **Human Development:** Young people are at a period of "sexual awakening, learning and experimentation, and need extensive help and support in making constructive use of their new-found powers" (Kelly, 2000, p. 35).

Indeed, for young people, the second decade of life "is a period of rapid growth and development for adolescents' bodies, minds and social relationships. It is a period of great opportunities, of new ways of thinking, of new influences, of changing roles and responsibilities. It is this period that will shape the future development of individuals, societies and countries" (GRN/UNICEF, 2002, p. 51). As such, investing in the health and development of young people is a key decision that will reduce the threats to the health, survival and well-being of adolescents while positively affecting Namibia's social and economic progress and stability (GRN/UNICEF, 2002).

- **Optimism and Idealism:** Young people "want to make a world for themselves and they want that world to be a better place than that which they have inherited from their predecessors" (Kelly, 2000, p. 35). This sentiment was expressed by a delegation of youth at the 1993 International Conference on STDS/AIDS in Africa: "We strongly believe that our energy, idealism and commitment can be used to stop the further spread of the AIDS epidemic that is devastating the social and economic fabric of our own countries" (UNAIDS, 1999, as cited by Kelly, 2000, p. 35).

Youth should be viewed as partners and allies in the fight against HIV/AIDS given their “untapped energy and ability to make behavioural choices, and because of the overwhelmingly positive response of adolescents as community mobilizers” (GRN/UNICEF, 2002, p. 51). As such, adolescents have a critical role to play in HIV prevention, peer education, the provision of adolescent friendly health services, and voluntary testing and counseling (GRN/UNICEF, 2002).

- **Hope:** Most importantly, young people represent the “window of hope” for the future, particularly given that “the proportion of teenagers who are *not* infected is likely to be higher than assumed by many” (Kinghorn, et al., 2002, p. 5).

In heavily infected countries, those most likely to be HIV-negative are those aged 5-14, that is, “those who should normally be in primary school. This is where hope for the future really lies” (Kelly, 2000, p. 35), hence the need for prevention efforts within the realm of **formal and non-formal education**. As such, the challenge that education faces is “to work with these disease-free children to enable them to remain so” (Kelly, 2000, p. 35). Chapter Three explores the role of education in reducing and preventing HIV/AIDS amongst adolescents more fully.

Chapter Three: Education

Overview: Namibia's Education Sector

During apartheid, black Namibians were subject to the “Bantu Education System,” essentially a racist and sub-standard quality of education used to dominate and oppress the black majority population. Following independence came the replacement of the colonial South African education system and the development of a new document entitled “Towards Education for All” (Nekhwevha, 1999). The new policy was meant to shift education from its “colonial moorings” and hence, the central goal was to “to promote equity and equality in classroom dialogue and participation, as well as to encourage democratic values and practices” (MEC 1993: 119-120, as cited by Nekhwevha, 1999, p. 497). Based on the scope of the changes and the new learner-centered framework, the program was “hailed as an educational breakthrough,” with the new policy containing “characteristics of what one might call a socially and culturally progressive education” (Nekhwevha, 1999, p. 497).

Namibia's dedication to education as a means of socio-economic development and as a human right has since continued, with education being a constitutional right of all citizens, widespread compulsory primary education, ratification of the UN Convention on the Rights of the Child, and the ratification of the African Charter on Human and People's Rights, all measures “which create obligations to ensure education and other support for children” (Kinghorn, et al., 2002, p. viii).

Today, the government is the nation's largest single employer, with the Ministry of Basic Education, Sport and Culture (MBESC) employing the largest number of people—20,000, including 18,000 teachers for approximately 1026 primary schools, 378 combined schools and 129 secondary schools (Kinghorn, et al., 2002). Together with “a variety of

other players including households, communities, development agencies, NGOs, local authorities, churches and other responsible authorities,” these teachers and the MBESC have made “remarkable strides” since independence towards Education For All, with its goals of “access, quality, equity, democracy, and efficiency” (Kinghorn, et al., 2002, p. viii). Other achievements have included primary school enrolment rates of 93%; outreach to ethnically marginalized San and Ovahimba children; an increase in the number of primary and secondary schools, especially in economically disadvantaged areas; an increase in the number of trained teachers and individuals in management positions; development of “in-country capacity for tertiary and vocational education” by the Ministry of Higher Education, Training and Employment Creation (MHETEC); and gender parity in enrolment levels for most regions (Kinghorn, et al., 2002, p. viii). However, despite Namibia’s successes and the post-apartheid emphasis on education, democracy, and equality, HIV/AIDS threatens to slow down or even reverse the strides the government has achieved.

The Impact of HIV/AIDS on the Education Sector

A complete discussion of how HIV/AIDS affects all aspects of the Namibian education system is beyond the scope of this chapter and, moreover, this Master’s project. It is clear that HIV/AIDS (a) affects educational demand and supply – pupils and school enrolments, potential clientele (i.e. the impact of orphans), and teachers and their training (i.e. quantity and quality); (b) influences the content, process, and organizational aspects of education; and (c) impacts the funding and planning aspects of education (Kelly, 2000).

While recognizing that the multitudes of these aspects are important, the following section focuses primarily on how HIV/AIDS has impacted the formation of Namibian policy for the education sector, as it is important to consider the following: as HIV/AIDS begins destroying

education systems, “education must undergo radical change if educational provision is to help in countering the spread of HIV/AIDS....The extent and magnitude of the epidemic’s potential impacts are such that policy-makers and planners must go beyond traditional approaches and solutions” (Kelly, 2000, p. 44).

Incorporating the reality of HIV/AIDS necessitates mainstreaming the AIDS perspective in all aspects of policy formulation, planning and action. It demands the openness to consider new and hitherto untried solutions and modalities. It calls for vision, flexibility, and a courageous readiness to depart from the status quo. Ensuring the survival of a functioning education system necessitates responding dynamically and creatively to the educational impacts of the epidemic. The reason lies in the range, size and complexity of the numerous ways through which HIV/AIDS can undermine the education sector. (Kelly, 2000, p. 45)

Education and Information on HIV/AIDS: A Policy Focus Area for the Education Sector

Given the potential impact of HIV/AIDS for the education sector, the Namibian government issued a formal policy document in January 2003 which outlines roles for the Ministries of Education, education managers, principals, sector employees, students, and parents and caregivers, providing guidelines “to ensure that all in the education sector are fully informed about the disease, the way it is transmitted, the consequences and living positively with it” (MBESC & MHETEC, 2003, foreword). According to MBESC Minister John Mutorwa and MHETEC Minister Nahas Angula, the national HIV/AIDS policy “formalises the rights and responsibilities of every person involved, directly or indirectly, in the education sector with regard to HIV/AIDS: the learners, their parents and caretakers, teachers, administrators, ancillary staff, planners, in fact the whole of civil society” (MBESC & MHETEC, 2003, foreword). As such, Namibia’s official policy document contains several guiding principles, of which Principle 2.14 states:

The purpose of education about HIV/AIDS is to prevent the spread of HIV infection, to reduce excessive fears about the epidemic, to reduce the stigma and discrimination associated with HIV/AIDS, and to foster non-discriminatory attitudes towards persons with HIV/AIDS. Educators should ensure that learners and students acquire age and context-appropriate knowledge and skills in order that they may adopt and maintain behavior that will protect them from HIV infection. (MBESC & MHETEC, 2003, p. 2)

To achieve this principle, one of the sub-policies included in the national policy addresses

“Education and Information on HIV/AIDS.” This sub-policy specifically encompasses the following points (MBESC & MHETEC, 2003, p. 7):

1. A continuing life-skills, sexual health and HIV/AIDS education, prevention and care programme must be implemented at all educational institutions for all learners, students and education sector employees. Such programmes must also be implemented at hostels.
2. Age- and ability-appropriate education on HIV/AIDS must form part of the curriculum for all learners and students. Such education should be integrated into the life-skills and sexual health education programme and all other subjects for pre-primary, primary and secondary school learners.
3. Education and information regarding HIV/AIDS must be given in an accurate and scientific manner and in the language and terms that are understandable. Such education shall take the form of stand-alone sexual health, HIV prevention skills, and HIV/AIDS education programmes that are reinforced by including those topics into all aspects of the curriculum. Such education and information should specifically address and dispel myths concerning HIV/AIDS (for example, having sex with a young girl will cure HIV/AIDS). They should also inform learners and students about particular factors in the education institution’s local community that place learners and students at risk of HIV infection.
4. The Ministries shall appoint and train enough education sector employees as are needed to ensure that adequate attention is given to the teaching of life skills, sexual health and HIV/AIDS education at each educational institution.
5. Parents and caregivers of learners and students must be informed about all life skills, sexual health, HIV prevention skills, and HIV/AIDS education offered at the educational institution, including the learning content and methods to be used. Parents and caregivers should be invited to participate in parental guidance sessions and should be made aware of their role as sexuality and sexual health educators at home.

These five policy points can be separated into three groups. The first three points involve the impact of HIV/AIDS on the **content** of education, the fourth point addresses the impact of HIV/AIDS on the **delivery** of education, while the last point concerns the impact of HIV/AIDS on the **role** of education.

In addressing the first three points of the policy, one might consider Michael Kelly's assertion that the most obvious impact of AIDS on the **content of education** is "the incorporation of HIV/AIDS, reproductive health and life-skills education in the curriculum with... the intent of imparting the knowledge, attitudes, and skills that may help to promote safer sexual behavior" (2000, p. 70). Hence there is the need for the following: 1) development of life skills which equip pupils for positive social behavior and for coping with negative social pressures; 2) establishment of a human rights approach; 3) a shedding of the secrecy, shame, and stigma of HIV/AIDS by bringing the issues out in the open; 4) incorporation of work-related training and skills earlier in the curriculum in order to prepare those compelled to leave school early (because of orphanhood or other reasons) to care for themselves, their siblings, their families; and 5) an adjustment of educational content to cater for the skills society is losing through HIV/AIDS (Kelly, 2000).

In response to these needs, the Namibian government has implemented a number of initiatives, including incorporating HIV/AIDS education into the science curriculum, specifically the "inclusion of the study of sex education and sexually transmitted infections in the syllabus for Life Science (for junior secondary grades) and for IGCSE Biology (for senior secondary grades," and the introduction of a "Life Skills" course for all grades at the secondary school level (Campbell & Lubben, 2003, p. 530). In addition, the government has partnered with NGOs, bilaterals, and multilaterals on several HIV/AIDS extracurricular and

out-of-school education initiatives, such as UNICEF's "internationally recognized extracurricular 'My Future is My Choice' (MFMC) programme [which] targets 15 to 18 year olds in and out of school" (Kinghorn, et al., 2002, p. xi). These efforts have been complemented by "initiatives of other development partners, NGOs, communities and pre-service programmes in teacher training colleges" (Kinghorn, et al., 2002, p. xi).

In considering policy point four, it must be recognized that HIV/AIDS affects the **delivery of education** specifically regarding teachers as the central figures in presenting and teaching curriculum, including life-skills and reproductive health programs. As such, it is essential that teachers are trained properly in the HIV/AIDS subject matter and in pedagogical skills in order to convey the information correctly and effectively to their students. Kelly (2000, pp. 71-72) notes that the heavy dependence on teachers to deliver HIV/AIDS awareness curriculum "points to what tends to be a weak aspect of well-conceived programmes—their failure to take adequate account of the situation prevailing on the ground." By this, he is referring to the following common problems:

- the inadequacy of teacher knowledge and confidence;
- teacher embarrassment in treating of sexuality issues with the young and those of the opposite sex;
- teacher concern about lack of preparation to teach in the areas of HIV/AIDS, reproductive health and psycho-social life skills;
- the reluctance of teachers who are aware that they, or members of their families, are HIV-infected to teach something which is so painfully close to home;
- teacher feelings that this 'is not what education is about';
- teacher anxiety that in dealing with sexuality and sexual behavior they would break traditional taboos and offend parents; and
- the low credibility teachers may have because of their own high level of infection.

Given these problems, Namibian ministries of education and their planners need to respond accordingly with counseling support; pre-service and in-service training that will

enable teachers “to teach HIV/AIDS, reproductive health and psycho-social life skills correctly and in participative ways that have potential to impact on student attitudes and behavior;” and development of manuals that will improve “teacher knowledge and teaching competence in these areas” and materials suitable for use at different school levels (Kelly, 2000, p. 72). In addition, it is of utmost importance for the ministries to examine their own teachers’ complicity in spreading HIV vis-à-vis the increasingly more common phenomenon of male (or female) teachers using their positions of power to sexually exploit their female and male students. Namibia’s teachers are one of the highest infected demographic groups, with projections suggesting that approximately 1-in-7 educators are HIV+, with levels reaching 1-in-4 in Katima Mulilo, the region with the most advanced epidemic (Kinghorn, et al., 2002).

In addressing policy point five, one of the main ways HIV/AIDS affects the **role of education** is creating a paradigm shift in how people view the role of schools. Traditionally, schools have been seen as places where ideally, children would be educated “across the broad spectrum of the intellectual, social, moral, aesthetic, cultural, physical and spiritual domains” (Kelly, 2000, p. 84). Today HIV/AIDS has dramatically changed that role, as schools have begun to enter a new arena, “one which in the past was taboo for them (and which many parents and communities consider should still be taboo). Increasingly, the school is seen as having a major role to play in fostering sex-related attitudes and in inducing behavior patterns that will protect against HIV infection” (Kelly, 2000, p. 84). Kelly goes on to state that “in theory, this role belongs with parents, but in the majority of countries parents shun or do not adequately discharge their responsibilities in this domain” (2000, p. 84). As such, “with neither parents nor society’s structures addressing behavioral practices and

attitudes, the burden is gradually being transmitted to the school to do so” (Kelly, 2000, p. 84).

Regardless, mitigation of the impact of HIV/AIDS needs to involve the external community and family environments more effectively. Recommendations for doing so include the following (Kinghorn, et al., 2002):

- reinforce engagement of parents and communities;
- enhance skills and mandates of educators to deal with issues such as cultural or other obstacles to HIV/AIDS prevention;
- work with communities to build on traditional systems such as “*Shinyanga*” to change group norms;
- encourage the use of schools for community networking between parents, elders, NGOs, etc.
- ensure that schools actively address high-risk environments, e.g. trucking areas, *kuka* shops and bars, local construction projects and barracks; and
- develop national and local strategies to actively address risk of learners with absent parents—these include those boarding in the community and living in child-headed households.

It is clear that HIV/AIDS impacts education in wide-ranging, fundamentally significant positive and negative ways. Recommendations to policy makers and education planners would be to focus on the positive impacts as lessons or guidelines to offset the negative impacts. Rather than dwell on how the education sector is being devastated by the pandemic and lose hope for the future, it is just as important to recognize how education is being utilized to fight for the future, specifically for the future of Namibia—the youth.

The Role of Education in Preventing HIV/AIDS

Given that education played such a crucial role in bringing about Namibia’s social transformation in the post-apartheid context, the government must draw upon those lessons to utilize the education sector in fighting the advances of HIV/AIDS. Oxfam iterates that

“Education is the world’s single most powerful weapon against poverty. It saves lives. It gives people a chance to improve their lives” (Oxfam, 1999, as cited by Kelly, 2002, p. 38).

In this manner, education too can be “the world’s single most powerful weapon against HIV transmission,” particularly since education establishes conditions which render HIV transmission less likely vis-à-vis the following (Kelly, 2000):

- contributing to the promotion of national economic growth and personal poverty reduction;
- increasing individual propensity to access health services and to receive, understand, and act on public health messages;
- enabling improved health status through better nutritional knowledge and economic potential;
- reducing the gender inequality which is one of the fundamental driving forces of the HIV/AIDS epidemic;
- empowering people to claim and defend their rights, and to overcome stigma and discrimination;
- equipping people to insist upon accessible and good-quality health, education, and social safety-net services; and
- promoting better understanding and practice in the areas of individual rights, relationships, and responsibilities.

Given this backdrop, it is no surprise that over the years in Namibia, there has been “increasing recognition of, and response to, the critical role of the education sector in prevention, support of infected and affected people, and in maintaining service delivery despite AIDS impacts” (Kinghorn, et al., 2002, p. ix). Efforts include “various aspects of care, support, and mitigation of impacts on both employees and learners,” but the main impetus of the sector is **prevention** and **behavior-change** (Kinghorn, et al., 2002, p. ix). Indeed, current levels of HIV infection “fundamentally challenge the mission of the education sector” because unless prevention is more effective, “over one quarter of learners will become infected during or soon after their education. Most of these will die of AIDS before they reach the age of 40” (Kinghorn, et al., 2002, p. xi). So not only is HIV/AIDS a

“social and human disaster, it is a loss of investment in education that far exceeds most other system inefficiencies” (Kinghorn, et al., 2002, p. xi).

Since 75% of HIV transmission worldwide is through sexual intercourse, most countries have created, adopted, and adapted prevention and behavior-change programs meant to provide “relevant educational content, presented in a suitable way” such that young people develop “personally held value systems which...empower them to make correct and safe choices,” thereby reducing their likelihood of HIV contraction (Kelly, 2000, p. 33). Generally, such programs provide information and teach skills related to strengthening young people’s “capacity to prevent personal disaster, enhancing capacity to draw others back from the brink, and reducing the stigma, silence, shame, and discrimination so often associated with the disease” (Kelly, 2000, pp. 33-34). In Namibia, such education programs consist of both in-school curriculum measures and in particular, non-formal education initiatives, many of which are being sponsored by UN organizations like UNICEF with support from bilateral donors.

UNICEF in Namibia: Putting Youth First

HIV/AIDS has emerged as one of Namibia’s most critical challenges, and accordingly, is “central to the response being made by UNICEF’s Programme of Co-operation with the Government of Namibia for 2002-2005” (UNICEF, 2002b, p. 10).

Currently, UNICEF Namibia’s efforts extend to three programs:

- **Young Children’s Health Care and Development:** Program One addresses “the most critical problems of mothers and young children from 0-10 years old, including mother-to-child transmission of HIV and persistent problems of malnutrition and poor health” (UNICEF, 2002b, p. 10);

- **Adolescent HIV/AIDS Prevention:** Program Two targets 10-18 year olds and focuses on “the threat of HIV and AIDS among this sexually active group, accentuated by alcohol and substance abuse” (UNICEF, 2002b, p. 10); and
- **Special Protection and Disparity Reduction:** Program Three serves “to protect children of all ages from abuse and violence, and from a criminal justice system which is insensitive to the age of the perpetrator, and the new challenge of orphans and other children made vulnerable by HIV/AIDS” (UNICEF, 2002b, p. 10).

Each program contains projects and sub-projects which focus on specific problem areas and “build on what is already in place, bringing together different sectors to work in unison” (UNICEF, 2002b, p. 11). However, central to our discussion is UNICEF’s work in Program Two: Adolescent HIV/AIDS Prevention and its second project, Capacity Development Through Life Skills (including “My Future is My Choice”).

Program 2: Adolescent HIV/AIDS Prevention Program (AHPP)

Overall AHPP objectives include (GRN/UNICEF, 2002):

- contributing to at least 70% of parents, teachers and youth/health facility service providers encouraging risk reduction behaviors of adolescents, and at least 90% of adolescents having correct sexual health information;
- ensuring that at least 90% of adolescents have the appropriate skills required for HIV prevention;
- ensuring that at least 70% of health facilities and 100% of youth facilities in 18 districts (in 11 regions) involve adolescents in the provision of adolescent friendly health services and that at least 90% of adolescents in these districts have access to “one star” adolescent friendly health services;
- striving towards supporting the national goal of a 25% reduction in new HIV infection among young people.

AHPP is further divided into three projects:

- Project 1: Communication for an Enabling Environment
- Project 2: Capacity Development Through Life Skills
- Project 3: Adolescent Participation in Youth Friendly Health Services

Combined, these projects function towards developing “the capacity of adolescents and duty bearers to reduce risk behaviors that contribute to HIV infection, sexually

transmitted diseases, teenage pregnancy, substance abuse and adolescent violence”

(GRN/UNICEF, 2002, p. 16). In addition, these projects specifically involve young people themselves to “[meet] adolescents’ rights to information, life skills and services; play a critical role in the planning, development and testing of programme activities; be the main implementers and also, be responsible for monitoring the impact of the activities”

(GRN/UNICEF, 2002, p. 16). Pertinent to our discussion is Project 2, which houses the “My Future is My Choice” program.

Project 2: Capacity Development Through Life Skills

The main objective of this project is to “ensure that at least 90 percent of adolescents have the appropriate skills required for HIV prevention. This objective will be met through three sub-project objectives” (GRN/UNICEF, 2002, p. 60):

- reaching a minimum of 100,000 15 to 18 year olds cumulative over 4 years, and 25% of out-of-school youth between the ages of 15 to 25 each year, with “My Future is My Choice” life skills education;
- making life skills training for 10 to 14 year olds operational in schools (e.g. the “Window of Hope” program); and
- providing opportunities for on-going skills development through peer education activities.

In addition, the project emphasizes empowering girls and the expansion of school and community-based peer education activities across the country (GRN/UNICEF, 2002).

My Future is My Choice: A Non-Formal, Peer Education Model for HIV/AIDS Education

My Future is My Choice (hereafter known as “MFMC”) was developed by the Ministry of Basic Education Sport & Culture (MBESC) and the Ministry of Higher Education Training and Employment Creation (MHETEC), in partnership with UNICEF and

the University of Maryland School of Medicine. As a “life skills intervention,” MFMC’s primary purpose is to equip young people aged 15 to 18 with information surrounding issues of reproductive health, STDs and HIV/AIDS, and skills for decision making, resisting peer pressure, and communicating more effectively. As such, youth participants learn about their sexuality; learn how to protect themselves against STDs and HIV; and practice assertiveness skills, independent decision-making, and improving interpersonal communication skills “between boys and girls, between friends, between young people, their parents and their community” (UNICEF, 2004, p. 1; GRN/UNICEF, 2003, p. 3). Some of the best information about MFMC comes directly from the program manual which answers the question, “What is special about My Future is My Choice?” (GRN/UNICEF, 2003).

My Future is My Choice...

- focuses on developing life skills;
- develops and strengthens problem solving skills and builds up the self esteem of young people;
- is aimed at promoting positive behaviour change and social skills empowerment;
- is a participatory activity;
- is based on extensive research and has been shown to be effective;
- encourages avoidance and protection from HIV/AIDS, STDs and unwanted pregnancy;
- gives information about values and provides young people with the negotiation skills to delay sexual intercourse;
- provides young people with the communication skills they need to be able to say no to unsafe and/or unwanted sexual relationships;
- gives information about how to avoid substance abuse (drugs and alcohol);
- gives information about relationships and gender issues; and
- has varied and interesting topics i.e.: information on “how does my body work” and skills for “planning for my future.”

MFMC utilizes a **peer education model** with secondary school graduates as youth facilitators who are assigned to one or two secondary schools in their community. In order to

become facilitators, unemployed secondary school graduates are invited to apply annually and those selected by Regional Youth Health Development Committees (RYHDCs) receive two weeks of training, usually conducted by UNICEF and Ministry of Education trainers. During this training, new facilitators are introduced to the logistics of monitoring, are introduced to each of the ten lessons (each lasting 2 hours long) included in a typical MFMC course, and most importantly, are given the opportunity to practice a “participatory” style of facilitation with trainers and peers who are available for critical feedback. Facilitators are encouraged to use this style when conducting their own MFMC courses because “People learn best by doing things. They learn even better when what they are doing is fun. *My Future is My Choice* should be fun for the participants and the facilitator. It is an interactive programme that requires the participation of all the people attending the training”

(GRN/UNICEF, 2003, p. 5). As such, sessions are divided into different activities:

- **Let’s Play:** A game to teach skills in a fun way or to make people relax
- **Let’s Do:** Activities to practice what they have learned and/or small group work. When participants are asked [to perform] role plays, “they need to be given the opportunity to do so in their first language. Practicing new skills, such as negotiating safer sex, can be easier in one’s home language than in English!”
- **Let’s Talk:** Information sharing and discussion time. Discussing and asking questions is very important for young people as this helps them to think critically.
- **Closing Circle:** A relaxing exercise and/or closing discussion for each session (GRN/UNICEF, 2003, p. 6)

It is also envisaged that new facilitators will learn that effective facilitation involves not “telling” youth participants what to do, but rather encouraging young people to analyze their own behaviors (UNICEF, 2004). Indeed, as described in the MFMC facilitator’s manual:

Young people need to be able to think for themselves and take responsibility for their future. They need to be responsible for their own development. Young people have the courage and confidence, and with the skills and a supportive environment, they will be able to protect their future. (GRN/UNICEF, 2003, p. 3)

Each youth participant receives a MFMC workbook containing relevant and supplemental information for each session. Young people who attend all ten sessions receive a certificate of completion and a t-shirt. In addition, before these participants “graduate” from the course, they commit themselves to reaching their friends with the skills and information they have learnt during MFMC (e.g. join or start an AIDS Awareness Club, talk to friends, get together with others to do HIV/AIDS awareness dramas, etc). MFMC facilitators are expected to provide support to such follow-up activities.

Is “My Future is My Choice” an Effective Life Skills Program?

Since its nationwide implementation in 1999, MFMC has reached over 160,000 young people aged 15 to 18, providing 20 hours of peer facilitated life skills training. The program has also trained 118 young people as “master trainers” and 1238 young people as MFMC facilitators (GRN/UNICEF, 2002). In 2000, MFMC was documented by UNAIDS as a “best practice” and in 2001, it was awarded one of the Commonwealth HIV prevention prizes. Other organizations, such as UNICEF Mozambique, have successfully adapted the intervention to combat their own HIV/AIDS problems (UNICEF, 2004). In 2003, Namibia’s Ministry of Basic Education, Sport and Culture declared MFMC an official extra-curricular activity that should be offered at all secondary schools. These accolades and official recognition are based on the fact that “the acquisition of life skills by adolescents, which is the development of cognitive and psychosocial skills, through a participatory training process, has been shown to have a substantial impact on sexual health information, knowledge, practice and behaviour” (GRN/UNICEF, 2002, p. 60).

Following MFMC’s 1996 pilot, “longitudinal research comparing control and intervention groups of 150 adolescents each showed that those young people who attended

MFMC delayed sex longer and were more likely to use condoms once they initiated sexual intercourse” (UNICEF, 2004, p. 1). Other researchers have come to similar conclusions. Fitzgerald, et al. report that the Namibian intervention “considerably improved participants’ knowledge and attitude with respect to HIV/AIDS and their intended condom use compared to a control group” (1999, as cited by Campbell & Lubben, 2003, p. 530). Stanton, et al.’s research revealed that for the sub-sample of “sexually inexperienced youth, significantly more of the intervention group were still virgin 1 year after the intervention. Initial sexual activity with the use of a condom was also significantly higher in the intervention group than the control group” (1998, as cited by Campbell & Lubben, 2003, p. 530).

Ndjoze-Ojo reports on the positive outcomes of MFMC in her study of the impact of HIV/AIDS education programs in Namibia. Based on her survey of 500 learners and 61 HIV/AIDS education program implementers, she reports that “the MFMC programme not only reduced adolescent sexual risk behaviour but also created a demand for similar training programmes for young learners” (2001, as cited by Campbell & Lubben, 2003, p. 530). Significantly, Ndjoze-Ojo discusses that “while the Life Skills curriculum was seen to be well tailored to prepare learners with positive attitudes to deal with HIV/AIDS problems, ...it was the MFMC programme that had greatest impact on behaviour” (2001, as cited by Campbell & Lubben, 2003, p. 530). Therefore, according to Campbell & Lubben, “there is thus some evidence of the effectiveness of this major extra-curricular HIV/AIDS education project” (2003, p. 530).

So What’s the Problem? Challenges for MFMC and the Education Sector

Given the number of positive studies regarding the effectiveness of MFMC in bringing about behavior change amongst youth, why are the rates of HIV continuing to

increase in this age group? Many would argue that HIV/AIDS education programs “as applied in Namibian schools seem not to have fully adapted its content and focus to ensure that it provides young people with the skills required to empower them to protect themselves against HIV/AIDS and cope with its consequences” (Kinghorn, et al., 2002, p. xi).

Unfortunately, many schools and learners have not been reached in any substantial way, as evidenced by 69% of Grade 10 learners in a school survey answering at least one of three questions incorrectly on basic facts about HIV/AIDS (Kinghorn, et al., 2002, p. xi).

Learners, particularly those in the poorer, rural north, had considerable misconceptions, as “almost half stated that some people are immune to AIDS and that HIV infected people always look unhealthy” (Zimba & Mostert, 1993, as cited by Campbell & Lubben, 2003, p. 530). In addition, these same learners also reported that many “anticipated that their peers would reject them if they objected to premarital sex and that the use of condoms suggests distrust in your partner” (Zimba & Mostert, 1993, as cited by Campbell & Lubben, 2003, p. 530). In these rural areas, programs are “hampered by lack of equipped teachers in Guidance and Counselling and Science, or other systems to support peer and other HIV education. Generally HIV/AIDS activities are not prioritized in reality even if they are time-labeled” (Kinghorn, et al., 2002, p. 6).

Even in schools which support extracurricular programs like MFMC, enrolment for courses is limited to 22 students at a time, and many schools “do not sustain programmes after initial activities [and] large numbers of learners seem to know very little about the programme content apart from the fact that it distributes condoms” (Kinghorn, et al., 2002, p. 6). Hence there is skepticism as to whether risk behavior of young people is actually changing.

Given these gaps in knowledge and common misconceptions about safe sex practices, UNICEF Namibia invited me as an intern to conduct a mid-year assessment of MFMC, specifically focusing on re-evaluating the program's content and methodology. The following section briefly describes my experience, observations, findings, and suggestions.

Summer Internship Insights

Purpose of Research:

In lieu of an annual MFMC mid-year meeting, it was decided by the UNICEF Namibia Adolescent HIV/AIDS Prevention Program Officers that a mid-year assessment might prove to be more useful for evaluating the current state of the program, particularly from the grassroots viewpoint of graduates (youth), facilitators, master trainers (MTs), and senior master trainers (SMTs) working in various regions. The research tools for the mid-year assessment, namely focus group discussion questionnaires developed by myself, AHPP program officers, and my counterpart, a UN Volunteer, were meant to evaluate the program's content and methodology with the hope of reviewing MFMC's effectiveness in delivery, and the content's relevance to adolescent HIV/AIDS prevention.

Research Methodology:

The mid-year assessment of MFMC was conducted over three months, from June to August 2004 by Ms. Usia Nakaambo, national UNV with UNICEF, and by myself as the Adolescent HIV/AIDS Prevention Program (AHPP) summer intern. Research methodology included the following:

- In-office desk research
 - Relevant background information on MFMC, young Namibians and HIV/AIDS, life skills education, etc.
 - previous reports and MFMC assessments

- content analysis of the MFMC facilitator's manual
- Session observations of current MFMC courses (see *Appendix 1*)
- Development of focus group discussion (FGD) questionnaire guidelines (see *Appendices 2-4*)
 - participants (youth graduates)
 - facilitators
 - master trainers (MTs)/senior master trainers (SMTs)
- Three weeks of field research /FGD interviews were conducted with each of the aforementioned groups in the following regions (see *Appendix 5* for FGD Site Selection Criterion and *Appendix 6* for Travel Schedule,):
 - Khomas (pilot)
 - Oshana
 - Omusati
 - Kunene
 - Erongo (east and west)
 - Omaheke
 - Hardap
- Meetings with Youth Health and Development Program (YHDP) and/or Monitoring and Evaluation (M&E) chairpersons throughout the research regions

Sampling:

The FGD groups ranged in size from one individual (Hardap MT/acting SMT) to fourteen interviewees (Oshana participants). The graduates and facilitator groups were a non-random sample, as MTs and SMTs were requested to select the participating graduate and facilitators using their own discretion. The only research specifications provided were that, if possible, participating facilitators should be recently-trained (2004) and that the graduate groups should be mixed gender and have completed MFMC within the last year. The only regional exception to the latter two stipulations was in the Hardap region, where all the graduates interviewed were girls and only one of them had actually completed all ten MFMC sessions. Please see *Appendix 7* for a summary of the sampling groups.

Focus Group Discussion Format:

Each FGD interview lasted anywhere between 30 minutes to two hours, depending on the level of interviewee engagement, input, and feedback. Some groups were quite talkative, while others were more reluctant to contribute commentary. The FGD interviews were held on school grounds, in Ministry buildings, or in YHDP offices. All interviews were conducted in an informal manner. Confidentiality was promised upfront and interviewees were encouraged to be honest with their answers and opinions of the program. Given my counterpart Usia's language capability in *Oshiwambo* and *Afrikaans*, it was decided that she should be the primary interviewer (and translator) in the case that interviewees could not fully understand the questions in English nor express themselves comfortably outside of their mother-tongue. I took on the role of secondary interviewer and primary recorder. During the Omaheke and Hardap segment of the mid-year assessment, we were accompanied by Mr. Immanuel Kavejandja, a national UNV working within the HIV/AIDS Management Unit (HAMU) of the Ministry of Basic Education, Sport, and Culture (MBESC).

Research Findings and Outcomes:

The FGD questionnaires focused on four main areas: 1) content analysis, 2) the role of the peer facilitators, 3) gender dimensions, and 4) whether or not overall administrative support was sufficient (these questions were only directed towards the MTs and SMTs).

Pertinent to our discussion are the first three focus areas.

Based on the responses received during the FGDs, **content analysis** was conducted on each of the MFMC sessions:

- Session 1: Getting to Know Each Other
- Session 2: How Does My Body Work

- Session 3: HIV/AIDS, STDs, and Young People
- Session 4: Decision Making: Choices and Consequences
- Session 5: Interpersonal Communication
- Session 6: Our Values
- Session 7: Relationships and Emotions
- Session 8: Saying No
- Session 9: Alcohol, Drugs, and Young People
- Session 10: Our Future

Overall, the participants interviewed enjoyed the sessions and information provided by the MFMC training. However, many graduates, facilitators, MTs, and SMTs felt that some of the sessions could be combined, especially if the topics were redundant. As each session stands, theoretically, the content should be sufficient to last for the full two hours, but in practice, most sessions, with the exception of sessions 2, 3, and 9, rarely expanded to fill the allotted time period. This may be due to the facilitator's ineptitude to conduct the session properly, a lack of engagement or interest on the part of the participants, or may be the result of schools placing restrictions on the amount of time facilitators are allotted to conduct sessions due to sports, afternoon study, etc.

Based on the responses of the interviewees, it is clear that some sessions are better liked than others and it would appear that sessions such as 2, 3, 7, and 9 are enjoyed because they are particularly pertinent to participants' lives. These sessions provide the information that young people feel they need in order to understand the dangers of engaging in high risk behavior. The other sessions act as supports for proper decision making. In this sense, many are complementary content-wise (e.g. sessions 4, 5, 6, and 8) and could be combined in order to free up a few sessions to incorporate some of the new topics that graduates, facilitators, MTs, and SMTs suggested as being pertinent to MFMC, such as mother to child transmission

(MTCT), voluntary counseling and testing, updated HIV/AIDS statistics, the physiological effects of HIV/AIDS, home-based care, etc.

In terms of the **role of the peer facilitators**, involving young people as facilitators has been a focus of MFMC from the beginning. The peer education model was implemented in order to reach adolescents most effectively, with the rationale that young people would be more open to discussing issues of sexual health, alcohol and drugs, peer pressure, negotiating condom use, and so forth with facilitators who were closer in age. Indeed, the results of the FGD confirmed this to be true, as MFMC graduates in all the regions preferred having peers as facilitators rather than having teachers or other adults conduct the sessions. This preference for peer facilitation was based on graduates' appreciation and desire for anonymity and a more non-formal learning environment.

Anonymity—Being Able to Share Openly:

Graduates throughout the regions commented that they felt more comfortable talking about the MFMC content material with peer facilitators who were not authority figures, especially teachers. With a peer facilitator who was not affiliated with the school, graduates felt more honest and open about sharing personal information and asking questions which might have been embarrassing otherwise. Teachers were described as being less friendly, easily angered, inexperienced with the subject matter, “old fashioned,” more strict, and more shy about sharing information about sexual reproductive health. In the Khomas region, graduates were adamant against having teachers as facilitators because teachers are authority figures who are in contact with parents and adults; graduates commented that teachers may use the information that graduates share during the sessions “against them” as a potential

threat. The only exception was in the Kunene region, where graduates stated that they would not necessarily feel shy about talking to their teachers about the MFMC topics.

Non-formal Learning Environment:

While some graduates commented that their facilitators occasionally utilized a “traditional” teacher style of presenting the material (i.e. using the chalkboard, “open your workbooks to page...”, etc.), most graduates noted that facilitators were fun, friendly, personable, open about sharing personal experience, willing to answer questions, were less strict, had better attitudes, were more knowledgeable about the MFMC subject matter, utilized a colloquial style of speech, and were “teen friendly.” So, although many courses were held on school grounds in classrooms, facilitators were still able to establish a non-formal learning atmosphere which was conducive to sharing and learning

In terms of **gender dimensions**, the mid-year assessment FGDs included many questions surrounding gender-related topics, such as participant enrollment, participation rates of girls and boys in sessions, the effect of having mixed gender participant groups, and the impact of a facilitator’s gender on the effectiveness of their facilitation. This research focus and many of the questions were developed as a result of my own interest in the topic, since I believe a gender-based approach to dealing with HIV/AIDS amongst young people in Namibia is crucial, as women and girls are at particular risk given the uneven power dynamics between women and men in this patriarchal culture. Many concepts of masculinity and femininity undermine young girls’ rights and abilities to make decisions surrounding when to have sex, and with whom, and restrict their access to the information and skills to

protect themselves against STDs, including HIV/AIDS. The research findings and their larger societal implications will be discussed in the next chapter, *Gender*.

Chapter Four: Gender

As mentioned in Chapter Two (“Youth”), there are certain sub-populations which have been identified as “bearing a disproportionate share of HIV’s proliferation and/or are at increasing risk,” namely young women and girls (Summers, et al., 2002, p. 18). Around the world, women comprise an increasing proportion of adults living with HIV/AIDS, increasing from 41 percent in 1997 to 50 percent in 2001 (UNAIDS 2001 & 2002, as cited by Summers, et al., 2002). In sub-Saharan Africa, women represent more than half of all people living with HIV/AIDS (55%), as compared to men (45%), translating to over 12.2 million women infected and 10.1 million men infected (UNAIDS 2001 & 2002, as cited by Summers, et al., 2002; Kelly, 2000; and UNICEF, 2002a).

Globally, among women, peak HIV prevalence occurs around age 25, while in men it occurs 10 to 15 years later and at generally lower levels (Summers, et al., 2002). In many countries, however, HIV prevalence occurs amongst an even younger population. For example, among South African girls, infections peak between ages 15-19, while among South African boys, infections peak between 20 and 24 (Stanecki and Kaiser Foundation, 2000, as cited by Summers, et al., 2002). In some of the most affected countries, the rates of new HIV infections among girls are as much as five to six times higher than those among boys (Summers, et al., 2002). In Botswana, for example, “up to 45 percent of women age 15 to 24 are estimated to be HIV positive, about twice the proportion of HIV-positive men in the same age group” (Piot, 2001 and UNAIDS, 2002, as cited by Summers, et al., 2002, p. 18).

Taking a Gender Conscious Approach to HIV/AIDS Education

Given the above numbers, facts, and statistics, it is clear that there is a critical need for educators to acknowledge and understand gender's role in HIV/AIDS education issues (note: see *Appendix 8* for gender definitions). Biologically and culturally, being a girl or a boy, a woman or man, influences the level of risk for contracting HIV/AIDS and dictates how a person experiences the infection and disease (UNICEF, 2002a). Indeed, the common condition of women and girls' social and economic powerlessness and low status relative to that of men/boys "is the root cause of women's and girls' greater vulnerability to HIV infection, their disadvantaged position in coping with it and the greater suffering from its effects" (UNICEF, 2002a, p. 4). Leading global institutions working in HIV/AIDS prevention concur that HIV/AIDS education and awareness programs must address these unequal social, economic and political factors, with gender as the "recommended tool of analysis" (UNICEF, 2002a, p. 4), if these programs are to be successful. Let us explore some of these factors further in understanding why we must take a gender conscious approach to HIV/AIDS education.

Why Are Women and Girls Most Vulnerable to HIV/AIDS?

Biological Factors:

Biologically, the risk of becoming infected with STDs, including HIV, during unprotected vaginal intercourse is greater for women than men due to the "physiology of the female genital tract, specifically because the vagina is the receptive organ during sex and the mucosa of the vagina and cervix is permeable and so allows body fluids to pass through" (UNICEF, 2002a, p. 6). In addition, the vagina, with its comparatively larger surface area, is exposed to greater contact with STDs during intercourse (Kelly, 2000). The risks are greatest

in menopausal women and particularly amongst young women, as the “immaturity of young women’s reproductive organs makes them even more vulnerable than mature women to HIV infection by providing enhanced opportunity for exposure and infection” (UNAIDS, 2000 and Kiragu, 2001, as cited by Summers, et al., 2002, p. 18).

Additionally, the presence of a sexually transmitted infection (STI) increases the risk of HIV transmission, so early detection is critical to HIV/AIDS prevention. However, for women and girls, STDs/STIs often go undetected because of an absence of symptoms, lack of access to health facilities, an unawareness of being at risk, an inability to prevent being put at risk, and for many, fear of how their partners or their own families may react to the issue (UNICEF, 2002a). Another biological dimension is the transmission of HIV from parent to child during pregnancy, birth, and breastfeeding. As such, clinics and hospitals should strive towards increasing the availability of voluntary and confidential counseling and testing to parents (UNICEF, 2002a).

These and other factors result in girls aged 15-19 being four to six times more likely to be HIV-positive than their male peers (Kelly, 2000). And the younger one is when infected, the longer the time between HIV-infection and death; hence “women who are infected at a young age can expect to survive longer than their male peers who become infected at a later age” (Kelly, 2000, p. 28), thus resulting in varied social, political, and economic ramifications for women and men.

Social Factors:

Cultural practices and attitudes play a pivotal role in increasing female vulnerability to HIV infection (Kelly, 2000). In many societies, “female ignorance of sexuality is associated with the feminine norms of virginity and the notion of ‘saving oneself’ for one

man” (UNICEF, 2002a, p. 6). However, this emphasis on sexual innocence is detrimental in protecting adolescent girls from HIV/AIDS as they are limited from “talking openly about their bodies, sex and reproduction” and do not seek information or services related to their sexual health (UNICEF, 2002a; GRN/UNICEF, 2002). And those girls and young women who are sexually active are discouraged from openly discussing sexual issues with their partners, since community norms dictate that women should be sexually ignorant and inexperienced (GRN/UNICEF, 2002).

These cultural attitudes translate to real, and negative, impacts. A longitudinal study reported that in 1995, 46% of urban females (18-24) were able to identify sexual intercourse as a risk factor for HIV infection; this declined to 36% in 1997. In the same study, in 1995 only 43% of urban females identified consistent condom use as a prevention method; this declined to 38% in 1997 with only 2.7% of urban females talking about condom use with their regular partners (SIAPAC, 1997, as cited by GRN/UNICEF, 2002).

In contrast, while gender norms dictate that women should remain poorly informed about sex, young men and boys are expected to be knowledgeable and sexually experienced in order to conform to common standards of masculinity. However, in many cases, adolescent boys are also poorly informed about sex, but because of societal norms, they are reluctant to acknowledge their lack of knowledge (GRN/UNICEF, 2002). So ironically, while young women and girls risk their sexual health “because they must appear to be ignorant and cannot openly seek information,” young men risk their sexual health because “they must appear to be knowledgeable and, therefore, cannot openly seek information either” (GRN/UNICEF, 2002, p. 50).

In all cultures, the manner in which girls and boys are brought up is the result of gender norms relating to their “emotional and sexual needs” (UNICEF, 2002a, p. 6). Hence, girls are taught to be passive and dutiful to the men in their lives and that to be “real women,” they must be attractive to men. This often renders them susceptible to pressure from men to have early sex in order to be accepted, protected, and loved. Young boys and men, in contrast, are encouraged to “seek and conquer” by exerting pressure on girls (UNICEF, 2002a). The combined cultural pressure for women to be sexually ignorant, yet dutiful and submissive, and for men to be dominant, sexual predators can have deleterious results when dealing with the issue of HIV/AIDS transmission.

It is acceptable for men and boys in many societies to have multiple sex partners, whether they are single, in steady relationships, or married (UNICEF, 2002a). This lack of male fidelity puts women at risk, as being faithful to their partner does not necessarily protect women from contracting HIV/AIDS (UNICEF, 2002a). Compounding this issue is that in the majority of societies, women “lack complete control over their lives and are socialized from an early age to be subordinate and submissive to men, particularly men who command power such as father, uncle, husband, or male guardian” (Kelly, 2000, p. 28). Indeed, “socially promoted male dominance and lack of self-assertiveness on the part of women make it very difficult for [women] to refuse sex or to insist on the use of condoms with a partner who may be HIV-infected” (Kelly, 2000, p. 28). This latter point is important in that after abstinence, when used correctly, condoms are the most effective form of protection against the transmission of HIV. However, studies show that men and boys are less likely to use them, especially in steady relationships (UNICEF, 2002a). And for women, insisting that a partner or husband wear a condom “might be interpreted as a challenge to long-accepted

rules, and could raise questions about [her] loyalty, fidelity, and trust” (Gupta, 2001, as cited by Summers, et al., 2002, p. 19). This lack of bargaining power with regard to regular condom use “leads to many women being infected by their sole-sex partner—their husband, and increases the likelihood that the wife of a man who has died of AIDS will herself soon succumb to the disease” (Kelly, 2000, p. 28).

Adolescent girls have even less control over how and when sex takes place, given their age and gender (GRN/UNICEF, 2002). In some societies, the vulnerability of young women is aggravated by older men targeting young girls who are considered to be less likely to be infected (Kelly, 2000), or by a misguided belief that having sex with a virgin will cure or prevent AIDS (UNAIDS, 2000 and Human Rights Watch, 2001, as cited by Summers, et al., 2002). Other traditional cultural practices, such as early marriages and female circumcision, also expose girls to increased risks (UNICEF, 2002a). Important to note is that young women who have sex with older partners are at greater risk for infection because “these older partners are more likely to be infected than age-equivalent partners would be” (UNAIDS, 2000 and Human Rights Watch, 2001, as cited by Summers, et al., 2002, p. 18). Indeed, growing evidence suggests that sexual relationships between older men and younger women “are responsible for much of the gender disparity between young women’s and men’s infection rates and for the increasing numbers of infections among younger girls” (Gregson, et al. and UNAIDS, as cited by Summers, et al., 2002, p. 18).

Economic and Political Factors:

Women and girls are the majority of the world’s poorest people. Globally, women labor the longest hours for the least economic returns, “routinely performing multiple roles—even while pregnant—at the workplace (low paid productive work), in the home (unpaid

productive/reproductive work) and in the community (voluntary work)” (UNICEF, 2002a, p. 7). Women are consistently denied equal participation in policymaking and equal access to resources, thus resulting in “institutionalized discrimination in employment, housing, education and health” (UNICEF, 2002a, p. 7). As such, their needs are often disregarded and unaddressed, thereby increasing their dependency and vulnerability on men, and limiting their ability to change or influence the conditions of their lives (UNICEF, 2002a).

This lack of economic opportunity and political power among women contributes to the spread of HIV, especially since many women and girls, given their lack of economic autonomy, partner with older men for protection and support (i.e. “sugar daddies”) (Gregson, et al., and UNAIDS, as cited by Summers, et al., 2002), and must often provide sexual services in return with little power to insist on condom use (UNICEF, 2002a). This is the case particularly amongst girls and young women “who have less access to and control over income, property, land, and credit... Without options, young women may exchange sex for money, shelter, or safety—often under the threat of violence” (Gupta, 2001, as cited by Summers, et al., 2002, p. 17). Studies of unmarried adolescents in several sub-Saharan countries have found that 13-18% of girls have received or been given money or gifts in exchange for sex (Summers, et al., 2002). Because many adolescent girls, including HIV-affected orphans, have no other means to support themselves, they may be forced to remain in relationships with violent partners or with those believed or known to be HIV+ (Summers, et al., 2002)

Additionally, given the low societal status of women and girls and the widespread violation of their rights, “many are trafficked or sold into prostitution, even by their own families” (UNICEF, 2002a, p. 7). In armed conflicts, women and girls “suffer the most

harmful consequences of migration, trafficking, and displacement..., including rape and other forms of sexual violence” (UNICEF, 2002a, p. 7). All of these economic and political factors place women and girls at high risk for contracting HIV/AIDS.

Sexual Abuse and Violence:

Sexual exploitation, abuse, and violence are crimes that cross cultural and class lines and are exacerbated by poverty, violence, and various kinds of discrimination (UNICEF, 2002a). Violence and abuse against women, adolescent girls, and young children is a widespread problem, especially when “coupled with a high level of alcohol use and abuse” (GRN/UNICEF, 2002, p. 9). UNAIDS reports that many new cases of HIV infection among women are the result of gender-based violence in their homes, schools, work places, and social spheres (UNAIDS, 2000 and AP, 1998, as cited by Summers, et al., 2002). Physical and sexual abuse significant contributing factors for STDs and HIV infection among young adolescent girls, given that women and girls “are the main subjects of abusive male behaviours that spread HIV/AIDS, such as sexual violence, rape and incest” (GRN/UNICEF, 2002; UNICEF, 2002a, pp. 6-7). Violence is also a co-factor in unwanted pregnancy, pregnancy complications, and miscarriages (GRN/UNICEF, 2002).

Central to the issue of sexual abuse and violence are unequal gender relations. As mentioned in the previous sections, women and girls are “in a subordinate position to men, often economically dependent, and with little bargaining or negotiating power, particularly on sexual matters” (GRN/UNICEF, 2002, p. 9). Adolescent girls and young women are likely to have their first sexual experience at the insistence of an older, male partner, a partner who has likely been exposed to HIV through multiple partners (UNICEF, 2002a).

With such high HIV infection rates, “it is critical that women should be able to take charge of their sexual relations” (GRN/UNICEF, 2002, p. 9).

Gender-based sexual violence is a significant problem in Namibia. Data from the Women and Child Protection Unit in Windhoek for 1999 indicate that 40% of abuse victims are under 18. National police statistics reveal that 33% of reported rape cases are girls under the age of 16. In one study, 50% of adolescent males indicted, “sometimes a boyfriend has to hit a girlfriend to get what he wants” (GRN/UNICEF, 2002, p. 49).

The threat of sexual violence and coercion may also keep those already HIV-positive from seeking available care due to fear for their physical safety or fear of stigma. Many women have heard horror stories, such as an incident in South Africa where “a woman who made her HIV infection public was stoned to death by neighbors who felt she had brought shame upon their community” (UNAIDS, 2000 and AP, 1998, as cited by Summers, et al., 2002, p. 19). Fear of reactions such as this prevents women from finding out or speaking out about their sexual health.

The Links Between Gender, HIV/AIDS, and Education

Because of the low value placed on girls and women, when demand for education falters, the first ones to be negatively affected are girls, especially those in rural settings. Indeed, worldwide, nearly two-thirds of the 120 million children without access to schools are girls (UNICEF, 2002a). Typically, when there are problems meeting the costs of education, families will favor their sons, withdrawing their daughters from school (Kelly, 2000). Families’ unwillingness to spend scarce resources on girls’ education or medical care ultimately limits adolescent girls’ access to the information, skills, and means to protect themselves against HIV/AIDS (UNICEF, 2002a).

In addition, because many societies consider that a girl's place is in the home, in an AIDS-stricken household, adolescent girls, perpetuating their traditional care giving and nurturing roles, will be the first ones taken from school when sick parents need help or families need income (UNICEF, 2000 and UNAIDS, 2001, as cited by Summers, et al., 2002). They will be deprived of educational opportunities and as morbidity and mortality rates rise, young girls will bear a disproportionate share of caring for HIV/AIDS infected family members, providing care and support for younger siblings while facing the "emotional burden of having to support older siblings and parents while they die" (Kelly, 2000; UNICEF, 2002a; GRN/UNICEF, 2002, p. 50).

Another reason that girls may be withdrawn from school before boys may have to do with how each is socialized to handle the psycho-social impact of HIV/AIDS. Michael Kelly asserts that since almost every culture socializes boys to emulate masculinity as dominance and emotional self-possession, adolescent boys who have been traumatized by AIDS "may seek to repress their emotional disturbance (very likely, to their eventual damage) and continue to attend school" (2000, p. 53). Girls, in contrast, are socialized to be "submissive, yielding, dependent and emotionally more demonstrative, and hence are more likely to remain or be kept away from school because of AIDS trauma" (Kelly, 2000, p. 53).

Some parents withdraw their girls from school because they fear that their children's live will be cut short because of HIV/AIDS, so they want to see their daughters married early to bear as many children as possible and thereby ensure the continuity of the family (Kelly, 2000). Other parents may choose to keep their daughters out of school for fear of sexual predators like "sugar daddies" who prey on young girls. Aware of the dangers and risks, some parents do not allow their daughters to attend school or other education programs,

particularly those that are far from the girls' home or school (Kelly, 2000). An additional dimension to this issue is the high prevalence of teachers and male students as perpetrators of rape and sexual abuse on school grounds and in the hostels. This is the case in Namibia and will be discussed later in this chapter.

Michael Kelly succinctly and correctly summarizes the overall situation: “The somber conclusion is that HIV/AIDS further complicates the full and rightful participation of girls in educational programmes, making it more difficult to achieve this objective than it would have been in a world without AIDS” (2000, p. 54). As such, HIV/AIDS prevention requires concerted action from all sectors, particularly from education, as educators are strategically placed in educational institutions which “reach further into communities around the world than any others” (UNICEF, 2002a, p. 3). Importantly, educators need to “set the pace in addressing the fundamental element of gender inequalities” (UNICEF, 2002a, p. 3).

Currently, there is an urgent need to improve the content of HIV/AIDS education materials while also strengthening teaching and learning methodologies in relation to gender issues (UNICEF, 2002a). Beyond this for HIV/AIDS educators, however, the challenge is to understand gender differences and discrimination (i.e. biological, social, political, and economic) and “to address this vulnerability and direct HIV/AIDS related risk in their work” (UNICEF, 2002a, p. 5). In particular, there needs to be the realization that women and girls are more vulnerable to HIV infection due to poverty, economic dependence, and especially, “skewed power relations and [cultural] concepts of masculinity that undermine their right, and ability, to make their own decisions in the family and in society in general” (UNICEF, 2002a, p. 3). These decisions include when to have sex (and with whom), and about means of protecting themselves against sexually transmitted diseases, including HIV/AIDS

(UNICEF, 2002a, p. 3). Indeed, one of the central issue from a gender perspective is the “redistribution of resources and power towards women and therefore towards more equal distribution of power and resources for all. For this to happen, the roles of men and boys must be considered” (UNICEF, 2002a, p. 5). This is particularly true for a country like Namibia, with its deeply entrenched patriarchy.

Namibian Patriarchy and the (Not-So Hidden) Gender Curriculum

Despite Namibia’s successes and the post-apartheid emphasis on democracy and equality, disparities still exist in relation to class, race/ethnicity, and especially gender. These disparities exist as vestiges from apartheid, inter-ethnic discrimination, and cultural norms regarding gender roles and the worth of women in Namibian society. With independence came the end of racist and segregationist policies of white South African oppression. However, the new black Namibian ruling party, composed of the culturally dominant Owambo group, continued with many of the same oppressive practices, much in the same way that “newly freed” peoples of oppression (e.g. first wave immigrants who have assimilated or acculturated) scapegoat other groups (e.g. second wave, newly-arrived immigrants) to ensure their newly achieved societal status.

In Namibia, the new targets of discrimination were non-Owambo ethnic minority groups (e.g. the Herero, Nama, San, etc.) and women. Namibian women of all ethnic groups were also subject to an African patriarchal system that was in existence far earlier than the apartheid years. Indeed, Namibian women bore the brunt of both oppressive white South African rule and the oppression by Namibian men who due to discrimination and humiliation in the workforce, and overall society emasculation, responded with “avoidance, anger, turning to alcohol and violence, or internalizing racism and transferring it to other ethnic

groups....To reassert their worth, men unleashed their frustrations on the women, becoming more aggressive, authoritarian, and sexually unaccountable” (Kandirikirira, 2000, para. 3).

While Namibia’s constitution protects children’s rights, in reality, discrimination in the treatment of girls and boys is standard practice in most communities. In this patriarchal society, female and male roles are separate in the domestic and public spheres, with men and boys doing the more highly regarded and respected duties, such as herding the cattle, which, in Namibian society, are valued more than money (bills). This unequal treatment is particularly prevalent in rural areas where a girl is “expected to do ‘double day’ work, helping with domestic work in the home after working in the fields a half or full day.” A young girl’s duties include cleaning the house, caring for younger siblings, fetching firewood and water, pounding millet, and preparing evening meals. By age 10, a girl is “considered the ‘second mother’ of the house” (Hailonga & Rogge, 1994, para. 7). Namibian girls, despite their contribution, are regarded as inferior to male children and are socialized to be submissive and obedient (Hailonga & Rogge, 1994). Ester Namene Phillemon (1994, para. 2) recalls:

I still remember how my brothers used to have the final say during arguments and I had to shut my mouth and be obedient to them....I was a bit stubborn when I was young. I always had to argue with my male relatives when it came to doing dishes and some house duties. Some of my favorite questions were: “What will happen if they do girls’ work?”; or simply, “Why can’t boys do this or that?” You can guess what the answers were.

These social requirements of “femininity” and the “male notion of perfect womanhood are imposed throughout the life of girls and women, from before birth to old age” (Hailonga & Rogge, 1994, para. 8). These cultural ideas are perpetuated by negative stereotypes in the media and in textbooks and are thereby manifested in socially influential settings such as educational institutions.

In every school around the country, regional ethnic minorities, girls, and especially minority girls are subject to harassment, discrimination, and are denied many of the privileges of their ethnic majority, male counterparts. It is clear that in aiming for equal access to education, the government believes that once the girls get into school, all will be well. The fallacy in this argument is the assumption that Namibian schools operate in a gender neutral context. This is far from the truth, as any teacher and any learner (both male and female) will tell you. In Namibian schools, girls are relegated to the margins of the classroom. They are overlooked, pushed to pursue the less academic track of “home science” as an elective, and are regularly told they will fail out of school regardless of how hard they work. This is a self-fulfilling prophecy in that many girls, without strong female role models, encouragement, or academic support, do indeed end up dropping out of school.

Sister Namibia (1991) interviewed 20 teachers and 40 learners of various ages to react to questions surrounding sexism in schools. These were some of the questions posed and the answers received:

Who talks most in the classroom? Both teachers and learners confirmed that boys took active part in the classroom by asking questions and discussing topics. Some boys said that they knew girls who did not say a single word during the entire school year. Surprising? Not necessarily if one examines the societal restrictions on female contributions. In Namibia, “feminine” girls are expected to be “quiet and docile.” Hence asking questions is regarded as masculine, active behavior. “It is acceptable and good when boys ask questions, but once the girls dare do it, it is seen as inappropriate. When this happens, there will be staffroom discussions about ‘problem’ schoolgirls, because they dare to challenge accepted female behaviour” (para. 4). In this sense, learners are being socialized to believe that

“female experience is seen as uninteresting, insufficient and inappropriate” (para. 5). Girls keep quiet because they believe what they know and experience is not valid.

Who takes up time and attention? While teachers responded that they allocate equal time to both sexes, more than 75% of the students said that teachers spend more time with boys. So, “although the teachers themselves are unaware of this fact, the students know the truth” (para. 6). Reasons? Since boys are the ones asking the questions and doing most of the talking, the teachers spend most of their time answering them. Also, many stated that “boys are demanding and want immediate attention while the girls who want attention have to wait or can be ignored” (para. 8). Feedback, praise, and encouragement going towards the boys “boost their confidence and then they are able to demand even more attention” (para. 9). Again, girls keep quiet and do not attract attention to themselves “because they have nothing to offer that is considered valuable” (para. 9).

Who takes up space? Both teachers and students said boys take up more space through they way “they sit with their legs spread out,” their disorderly desks, and their free and regular movement throughout the classrooms (para. 10). Girls, in contrast, “are confined to their seats neatly, legs closed, hands on their desks, in the expected and appropriate way” (para. 10). This control and domination over space are “expressions of the masculinity, authority and freedom which come from the knowledge of their importance as males and the whole history of male experience. They believe that what they have to offer is important, appropriate, valued and that they themselves are very important anyway” (para. 11). Namibian girls are made to feel small and hence take up a corresponding amount of classroom space.

Who sets the topics for classroom discussions? Again, both teachers and students said that boys usually initiate classroom discussion topics. In addition, Namibian boys “usually oppose the discussions of female experience because that is not interesting [to them]. So they react very negatively and disruptive” (para. 13). Teachers, in many cases, will direct their lessons to the boys because they want the “the co-operation and interest of boys (in order to control them)” (para. 13). Again, the implication is that “women’s knowledge is invisible, is not on record, is not valued, so they do not have anything valuable to say, so they keep quiet” (para. 13).

Who is usually the teacher's pet? Many teachers denied having pets, but some (female teachers) said that they prefer boys because “they are tidy, work hard, eager, clever, etc.” (para. 14). As such, in most schools, boys are considered model students and often receive prizes. They are recognized as having individual identities (i.e. “John, will you explain the problem?”), whereas girls are usually addressed as a homogenous group (i.e. “Girls, can one of you explain the problem?”) (para. 14). Girls are unknown and unnamed, a sign of rejection and inferiority.

So indeed, the government can give girls access to education, but what kind of education will they truly be receiving? In this sense, Namibia has much larger social issues to deal with that extend beyond the classroom walls.

Body Politics: Violence in the Classroom and in Namibian Society

Beyond the classroom inequalities exist body politics. Girls who become pregnant are coerced out of school, although this is constitutionally illegal. The boys (and often male teachers) who get them pregnant are allowed to stay in school and are not punished in any way whatsoever. School administrators blame the girls for not being on birth control, yet do

not encourage the boys to use condoms for supposed “cultural reasons.” This is also a larger societal problem in the context of a country with such a high HIV/AIDS rate. The government does not take such gendered double standards into consideration in any of their ministry documents.

In addition, girls who live in the hostels (most rural primary and secondary schools are boarding schools) are subject to sexual abuse from male students, teachers, and community members. Based on my experience, this sexual coercion is condoned in the schools; when girls report the abuse to teachers or to the hostel supervisors, their pleas are ignored or only barely acknowledged. The government makes no mention of these serious societal problems in discussing “access” to education. Indeed, so while 15 years ago, Namibia was “born of a violent struggle for independence from the Apartheid South African Regime, which was based on the power of one race over another,” for the girls and women of today, “the liberation struggle is far from over. In fact we can speak of a war being waged on a daily basis by men against women and children” (Khaxas, 2000, para. 2). Studies have shown that negative self-images picked up from their parents, “have lead to exploitative and abusive relations between boys and girls and self-destructive behaviour” (Kandirikirira, 2000, para. 3). It would seem as though violence against women and children has become “an integral feature of the so-called peaceful post-colonial Namibia” with women and children being attacked, abused, and violated, not “by some foreign army invading their homes, but by the very men they love and live with: their husbands, boy friends, friends, fathers, step fathers, uncles and brothers” (Khaxas, 2000, para. 4).

According to Elizabeth Khaxas, “we need research to find out how masculinities are constructed in our various Namibian communities, and how violence becomes an integral

part of manhood in so many of our boys and men” (2000, para. 7). In addition, Namibians need “far more serious efforts by our leaders in government and traditional authorities to transform the oppressive gender regime. Peaceful conflict resolution must be aimed at for at all levels of society, from the household and the local community level to interstate relations” (2000, para. 8).

Masculinity – the Other Half of the Gender Equation

In discussing masculinity, it is important to keep in mind that there are reasons why men and boys have not been a focus of work guided by a gender analysis, beginning with the acknowledgment that there is much male opposition to gender equality “either for ideological reasons, because of their unquestioned assumptions, or simply to preserve entrenched privileges” (Kaufman, 2003, p. 3). Gender and development work and approaches have primarily been led by women and it is understandable that their focus has been on those most critically affected by gender discrimination, as resources are scarce and there has been “justifiable concern about siphoning them away from women and girls” (Kaufman, 2003, p. 3). In addition, there is the pervasive equation of women with gender (e.g. women = gender), “an equation still largely true not only in development work, but also in academia, politics, and the popular mind” (Kaufman, 2003, p. 3), which only serves to put the emphasis on women and girls, thereby overlooking men and boys’ roles in the gender equation. This limited perspective on gender and development “is a recipe for disaster” (Kaufman, 2003, p. 3).

The assumption that programs meant to improve the lives of women and girls can be pursued without addressing and involving men “fails to acknowledge men’s role as gatekeepers of current gender orders and as potential resisters of change” (Kaufman, 2003, p.

3). By leaving out men and boys, only the symptoms of the underlying gender system are addressed, rather than getting to the heart of the problem of patriarchy (Kaufman, 2003).

This is because, ultimately, gender is about “relations of power between the sexes and among different groups of women and men” (Kaufman, 2003, p. 4). Programs to empower women are only one part of redressing these relations of power—“there also needs to be systematic and systemic efforts to change the lives of men and boys if we are to redress power relations at their root” (Kaufman, 2003, p. 4).

The Challenges of Addressing and Involving Men and Boys

A man’s masculinity “is a bond, a glue, to the patriarchal world....Through the incorporation of a dominant form of masculinity particular to his class, race, nationality, era, sexual orientation, and religion, he gains real benefits *and* an individual sense of self-worth” (Kaufman, 2003, p. 8). In particular, a common feature of many definitions of manhood is the equation of manhood with power (e.g. manhood = power) (Kaufman, 2003). For women, this power “may be experienced physically or financially, emotionally or intellectually, politically or through brute force” (Kaufman, 2003, p. 11). This equation of masculinity with power “is one internalized by boys into their developing personalities....Consciously and unconsciously, they individually reproduce gender privilege in all facets of their lives” (Kaufman, 2003, p. 11 & 15).

Perhaps a boy embraces this power because it gives him privileges and advantages that girls do not usually enjoy or, perhaps it is simply a means that allows him to feel strong, capable, and grown up. Whatever it is, the source of this power is in his surrounding society, although he quickly learns to exercise it as his own. And so, the collective power of men is perpetuated only in part through social and cultural institutions and structures. (Kaufman, 2003, p. 11).

Michael Kaufman is adamant that “we must never underestimate the huge individual investment that men can make in maintaining their masculinity and maintaining power and control” (2003, p. 17).

Men and boys resist change not only because of their learned ideologies and assumptions or even because of their privileges as men; they *also* do so because their whole experiences of themselves and the surrounding world often leads to a struggle to hold onto their ephemeral purchase on power and control. Since power is equated with manhood, loss of power equals a loss of manhood. One practical consequence is this: challenging men and boys can create an irrational reaction based on fear. (Kaufman, 2003, pp. 17-18).

Strategies for Addressing and Involving Men and Boys

The abovementioned issues point to the need to address men and boys because they participate in the gender equation, their lives are shaped by gender, and since they control social discourse and resources, “we must address men and boys if we want to ensure success at changing our gender order and ending discrimination against women and girls” (Kaufman, 2003, p. 15). Indeed, if gender is about power, “as actual relations of power between men and women, and between different groups of men, start to shift, then our experiences of gender and our gender definitions must also begin to change” (Kaufman, 2003, p. 13). The process of gender work is ongoing and this includes “the process of reformulation and upheaval” (Kaufman, 2003, p. 13).

Many would argue that a head-on challenge to men’s power is necessary, but this will inevitably provoke fear and backlash (Kaufman, 2003). Rather, a more effective strategy may be to challenge men’s power through “hooking into men’s own contradictory experiences” as this may lead to an understanding of their links to the issues and problems being confronted, but also, about how they will benefit from the changes despite the “privileges they stand to lose” (Kaufman, 2003, p. 18). Strategies to promote gender equality

and human rights for women will be most effective if and when we are able “to neutralize men’s fears and find ways for them to embrace change” (Kaufman, 2003, p. 18).

But strategies must go beyond simply addressing men because “in a sense, women have long addressed men, but with only partial success.” Men must also be involved in struggles for gender equality and they must help “define the nature of that participation” (Kaufman, 2003, p. 15). Indeed, while not all men commit individual acts of violence against women, “*all men must take responsibility for helping end the problem*” (Kaufman, 2003, p. 19; author’s emphasis). This is because manhood “is constructed in the eyes of men and because men have long controlled the instruments of opinion-making, law-making and administration of justice” (Kaufman, 2003, p. 19). Hence gender-based violence will continue “so long as some men encourage displays of violence and so long as other men do not challenge these versions of manhood or challenge the individual or social acts of violence, or challenge society’s permission of the violence” (Kaufman, 2003, p. 19).

Therefore effective approaches must “find ways to appeal to some of the very values we are ultimately challenging” (Kaufman, 2003, p. 18). This translates to reaching men and boys based on the notion that they have the power to end violence against women in their community—“We are appealing to men’s notion that they are powerful, but we are here subverting the notion of power, from one of domination to the power to care and nurture” (Kaufman, 2003, p. 18). In addition, male involvement and participation will lead to men and boys feeling a sense of “ownership” which will allow them to “feel they have a personal relationship to the issues and a stake in the process of change” (Kaufman, 2003, p. 16).

Another strategy is to acknowledge the reality of sexism and the “privileging of the male voice” (Kaufman, 2003, p. 20). Since men “gauge their manhood in the eyes of men

[and] boys gauge their manhood in the eyes of other boys and men,” it is essential that the voices of men are mobilized and utilized to speak to other men and boys (Kaufman, 2003). Indeed, “it may seem a sexist decision to say we need to use men’s voices to reach men with the goal of listening to women’s voices and concerns, but it actually is a practical choice thrust on us by a sexist reality” (Kaufman, 2003, p. 20).

The key entry point in addressing and involving men and boys is to emphasize building healthy relationships with women and girls because the focus on communication in relationships, respect, sexual responsibility, sexual violence, and emotional and verbal abuse encourages young men, in particular, to “really understand the immediate relevancy of the issue of violence against women” (Kaufman, 2003, p. 21). As men and boys develop an awareness of the problems and their personal relationship to the issues, hopefully this means that “increasing numbers of men will develop a commitment to redirecting resources towards measures [that] promote gender equality” (Kaufman, 2003, pp. 15-16).

Overall, the work towards addressing gender inequalities “suggests there is an active process that creates and recreates gender. It suggests that this process can be an ongoing one...It suggests that gender is not a static thing that we become, but is a form of ongoing interaction with the structures of the surrounding world” (Kaufman, 2003, p. 8).

Potential Positive Outcomes of Addressing and Involving Men and Boys

- creating a large-scale and broad social consensus on a range of issues that previously have been marginalized as issues only of importance to women when in fact they are often also issues for men;
- mobilizing resources and the social and economic institutions controlled by men, as such efforts could result in a net gain in resources available to meet the needs of women and girls;
- developing effective partnerships between women and men, and between a range of institutions and organizations;

- increasingly and patiently isolating and marginalizing those men working to preserve men's power and privilege;
- raising the next generation of boys and girls in a framework of gender equity and equality;
- by changing the attitudes and behaviour of men and boys, improving the lives of women and girls in the home, workplace, and community;
- gaining unexpected insights into current gender relations and the complex forces that promote discrimination against women and prevent gender equality; and
- gaining unexpected insights into other social, cultural, political issues (Kaufman, 2003).

So What Does This All Mean for UNICEF's "My Future is My Choice" Program?

A gender-based approach to dealing with HIV/AIDS amongst young people in Namibia is crucial, as women and girls are at particular risk given the uneven power dynamics between women and men in this patriarchal culture. Many concepts of masculinity and femininity undermine young girls' rights and abilities to make decisions surrounding when to have sex, and with whom, and having the information and skills to protect themselves against STDs, including HIV/AIDS. As such, the mid-year assessment focus group discussions included many questions surrounding gender-related topics, such as participant enrollment, participation rates of girls and boys in sessions, the effect of having mixed gender participant groups, and the impact of a facilitator's gender on the effectiveness of their facilitation.

Participant Enrollment:

Most facilitators, MTs/SMTs, and graduates revealed that girls comprise the great majority of participants enrolled in MFMC courses. This was the case in all the regions (with the exception of Kunene where there was more male enrolment), although officially, course enrollment should be comprised of an even number of girls (11) and boys (11). Many

contact teachers attempt to adhere to this quota system, but if there are not enough boys, the contact teachers or facilitators will sign up additional girls and proceed with conducting the course. In some instances, the courses will have only female participants, such as in all girls' schools or, as in the case of the graduates interviewed at Mariental High School (Hardap region), the sole boy initially enrolled in their cohort opted to drop out as the sessions progressed. One of the graduates interviewed from Swakopmund Senior Secondary School (Erongo region) was the sole boy in his cohort, but he was reluctant to contribute much input about MFMC during the FGD. In most of our session observations, girls were the majority gender, although there were exceptions in Okahao (Omusati region), Gibeon (Hardap region), and a few sessions in Windhoek (Komas region) where there seemed to be an even number of girls and boys.

When asked why the participant enrollment was so gender-skewed, many facilitators, MTs/SMTs, and graduates stated that boys often feel as if they “know everything” about HIV/AIDS and that participating in MFMC would be a waste of their time. Other reasons for low male enrolment include other after school commitments, especially sports, intimidation because of the high number of girls in the course, and general disinterest with MFMC's HIV/AIDS education content.

Participant Engagement:

Given that there is a much higher enrollment of girls in MFMC, it would seem obvious that they would be more engaged during the sessions. In most of the regions, this holds true, although in Opuwo (Kunene region), the MT and SMT commented that the boys are more active during the sessions. Otherwise, in most regions, the girls are more vocal and participatory, dominating over the boys. It is the responsibility of the facilitators, however,

to encourage all participants, both girls and boys, to participate actively during the sessions. In this sense, gender sensitivity and awareness also needs to be stressed during facilitator training. This will be further explored in the “Conclusions and Recommendations” section.

Mixed Gender Participant Groups:

One of the MFMC mid-year assessment areas for exploration was the possibility of switching to single-sex participant groups to create a safe forum for girls and boys to learn about life skills without the stigma or awkwardness of discussing potentially culturally inappropriate material with each other. However, during the course of the FGDs, the majority of both girls and boys in all the regions expressed a preference for the existing mixed gender groups asserting that they were comfortable discussing the MFMC content material with each other. In the case of Khomas, graduates said that it was more “exciting” having a mixed gender group, especially for role plays, and girls joked that having boys in the course would attract more girls to sign up. In addition, in some regions, such as Erongo (Swakopmund), Kunene, Omaheke, and Oshana, graduates commented on the importance of learning from and with each other. However, most of the FGD groups were female-dominated. Girls may have felt differently about having mixed gender groups had they been in the minority throughout their MFMC course.

Indeed, important to note is that some learners also expressed a preference for single gender groups. In the Erongo region (Omaruru), graduates commented that many girls are shy and afraid that boys will tease them or spread rumors; this sentiment was echoed in Swakopmund where graduates discussed how sometimes boys can be immature and tease the girls. Other learners in the Omusati and Erongo (Swakopmund) regions felt that while

having a mixed gender group was fine overall, perhaps having single gender groups for certain sessions or topics might be more comfortable.

Gender of the Facilitator:

In addition to exploring the option of having single gender participant groups, some of the FGD questions required graduates to discuss their preference for having a facilitator of the same or opposite gender. Responses varied from region to region with graduates in Erongo (Swakopmund), Hardap, Kunene, Omaheke, Omusati, and Oshana regions commenting that a facilitator's gender was irrelevant as long as she or he is qualified and open about sharing the MFMC material. Other graduates in Erongo (Swakopmund and Omaruru) expressed a preference for having a facilitator of the same gender for when discussing gender-specific topics or sensitive issues. In contrast, some graduates stated that they would prefer a facilitator of the opposite gender. This was the case in Omusati; Khomas, where the female graduates stated that having a male facilitator would attract more girls to sign up for MFMC; and Erongo (Omaruru), where the boys expressed preference for a female facilitator because they were afraid male facilitators would "get angry at them."

However, above all, despite their facilitator's gender, graduates in all regions unequivocally expressed a preference for having a peer educator conducting the MFMC courses rather than having an adult teacher.

Conclusion and Recommendations:

While it is positive that so many girls are signing up for MFMC and learning the information and developing important skills, a gender-based response to HIV/AIDS also needs to include boys learning the same information and developing similar skills. Education

of one gender at the exclusion of the other is detrimental to the fight against HIV/AIDS as life skills involves negotiation between the sexes. Given the nature of female-male relationships in Namibia, MFMC teaches adolescents, especially girls, interpersonal communication skills, self-esteem, and assertive behavior in learning how to say no in the face of peer and male pressure. Even some male graduates commented on the importance of MFMC for girls because of societal pressures young girls face from boys and men. Such comments indicate the possibility of teaching boys to become aware of how their male privilege is oppressive to girls and how they can be better allies to their female classmates, girlfriends, sisters, mothers, etc. So while MFMC can help girls develop the skills to survive and empower themselves in a patriarchal setting, MFMC can also help boys recognize how they are complicit in perpetuating patriarchal practices and behaviors. As such, gender awareness is crucial for developing Namibian society, as girls and boys consider and reconsider their ascribed gender roles, privileges or non-privileges, and work towards contributing positively to a more gender-balanced future. And the peer facilitators play a pivotal role in ensuring that such awareness is happening amongst their participants. The following are my main gender recommendations for MFMC:

- **Increase male enrolment.**

Again, as mentioned above, while it is positive that so many girls are signing up for MFMC courses and gaining communication skills, learning how to negotiate peer pressure, and learning the basics of HIV/AIDS, sexual functions, and how to protect themselves against STDs, the effectiveness of the program is diminished if boys are not gaining this knowledge and these skills. Gender is about power relations and about how women and men interact. If boys are not exposed to the same sort of information and training, they will continue to

perpetuate the same gender inequalities that exist in Namibian society. Indeed, the key entry point in addressing and involving men and boys is to emphasize building healthy relationships with women and girls because the focus on communication in relationships, respect, sexual responsibility, sexual violence, and emotional and verbal abuse encourages young men, in particular, to “really understand the immediate relevancy of the issue of violence against women” (Kaufman, 2003, p. 21). Like Michael Kaufman asserts, we must be able to bring men and boys into the fold by “hooking into their experience” and involving them as key partners and allies. The more male enrolment, the greater the chances that these boys will spread the gender awareness to their male peers and will grow up desiring a more gender balanced in society where the emphasis is on mutual care and not power.

Suggestions from facilitators, MTs/SMTs, and graduates for increasing male enrolment ranged from enforcing gender quotas to recruitment in the boys’ hostel to getting in contact with sports coaches and having them assist with sign ups. Importantly, male graduates should be recruited to help encourage their male peers to participate in the program.

- **Maintain the mixed-gender participant groups.**

This is important in that girls and boys can learn from each other and practice negotiating “life skills” with the opposite gender. Again, gender is about “relations of power between the sexes and among different groups of women and men” (Kaufman, 2003, p. 4). Learning how to interact in a positive manner is one step in creating a healthier, gender balanced society. A mixed gender group is also important in that positive dialogue between girls and boys can be fostered by a facilitator who has enough awareness of gender-related issues (see my next recommendation). During MFMC session; misconceptions can be

cleared up, topics can be explored from both perspectives; and a safe, trusting environment for learning from each other can be established. However, depending on the subject matter, consider setting aside some sessions to be single sex only.

- **Improve facilitator training by incorporating more gender-awareness training.**

Given that facilitators play such a key role in presenting the MFMC materials and topics to participants, more attention needs to be given to increasing their understanding of gender-related issues, specifically those regarding the relationship between gender and HIV/AIDS. By increasing facilitators' awareness, this helps them to be more effective advocates and allies in fostering a more positive, gender-balanced society.

This training should be an important supplement to the current MFMC facilitator training which covers the administrative/logistic aspects of running courses and the content of the individual sessions. Facilitators should undergo this gender awareness training with the goal of being able to increase gender awareness amongst their own MFMC students. As such, the training should focus on the gendered nature of HIV/AIDS and should include the following topics: differences in biological, social, political, and economic effects of HIV/AIDS for women and men; societal causes and implications of gender-based violence, sugar daddies/mommies, teen pregnancy, etc.; stereotypical expectations of girls and boys in society and in relationships; and ways in which girls and boys can work to contribute and create a more gender-balanced future.

The final section of this Master's project is a possible model for increasing gender awareness amongst the current and new peer facilitators of UNICEF Namibia's MFMC.

Introduction: Training

The following training should take place over five days, with each day building upon the ideas of the previous day, starting from low-risk topics to high-risk topics. The topics are as follows: Day 1 – *Gender Groundwork*; Day 2 – *Where Do We Get Our Ideas About Gender?*; Day 3 – *Gender and HIV/AIDS Risk*; Day 4 – *Let's Talk About Sex...*; and Day 5 – *Revisiting Gender Roles*. Each day is scheduled from 8AM – 5PM, with break and lunch times set aside.

Since this is a training for UNICEF, there are material requirements, especially flip chart paper, koki pens (i.e. markers), tape, glue, and other art supplies. The types of activities (*) are far-ranging: ice-breakers, dyad/triad work, small and large group discussions, movement activities, games, drawing, skits/role plays, debates, group stretch, creation of educational materials, action plans, etc. They are meant to be a model for fun, alternative ways of conducting training activities for young people. Indeed, many of the activities involve writing, acting, movement, and discussion—all modeling the types of activities meant to be incorporated and utilized during official MFMC sessions.

It is important to acknowledge that the activities and times outlined in this training are just a suggested framework. The facilitator(s) of the gender training can select the most appropriate activities and change the time limits to meet the needs of the group, depending on the participants' previous knowledge and understanding of gender issues, the size of the group, and other constraints (i.e. logistical, budgetary, time, etc.). However, it is important that by the end of the training period, MFMC peer facilitators should be able to make the connection between the inverse relationship between gender awareness and HIV/AIDS rates,

that is, when gender awareness increases, HIV/AIDS rates decrease, and that as peer facilitators, it is their responsibility to help spread this knowledge to their MFMC participant groups, Namibia's "Window of Hope."

* Note: many of these activities have been adapted from the following: Commonwealth Secretariat (2001). *Gender and Relationships: A Practical Action Kit for Young People*. London: Commonwealth Secretariat.

Day 1: Gender Groundwork

8:00 – 8:05: **Welcoming Remarks**

8:05 – 8:10: **Overview of Today's Agenda**

8:10 – 8:25: **Ground Rules**

- * *objective*: establishing a respectful, open, and trusting learning environment
- * *materials*: flip chart paper, koki pen, tape
- introduce some basics (e.g. be respectful of differing opinions, share airspace, don't judge others, no name calling, etc.)
- allow participants to contribute to the list and record their rules
- post up flip charts and keep them visible for the remainder of the training week

8:25 – 8:45: **Opening Go-Around/Ice Breaker**

- * *objective*: meet and greet -- learning each other's names
- * *materials*: name tags or sturdy paper to make cards; koki pens
- have participants design their own name tags/cards and move into a circle
- one by one, have them introduce themselves to the group, naming something unique about themselves
- go around again, but take off the name tags or remove the name cards and have participants introduce the person sitting on their right
- do a few more rounds in this fashion until people are more comfortable with each other's names

8:45 – 9:00: **Let's Talk...**

- * *objective*: to explore some of the hopes, expectations, and concerns participants have for the week
- * *materials*: flip chart paper, koki pen, tape
- group brainstorming session
- record their ideas into different categories: 1) hopes, 2) expectations, 3) concerns, and 4) other; tape up next to ground rules

9:00 – 10:00: **Thinking About Ourselves**

- * *objective*: encourage participants to examine their own views, assumptions, and belief system
- * *materials*: paper and pencils
- (5 min) – have group count off into pairs and disperse about the room; pass out paper and pencils to each pair

- (30 min) – let participants know that you will be reading off a series of questions and they will have a few minutes to think, jot down their ideas, and then share with their partners
 - *What are my own beliefs and assumptions about women and men?*
 - *How well do I understand the impact of gender and the way women and men interact?*
 - *What do I think is proper behavior for adolescent girls? For adolescent boys?*
 - *How do I feel about young people who have different beliefs to my own, for example about sex before marriage or abortion?*
 - *How would I feel if a person in the group revealed that they were homosexual?*
- (25 min) – large group debrief
 - have each pair share their answers to one of the questions
 - ask for reactions to this activity
 - Did people feel comfortable sharing with their partner?
 - Were people honest with themselves?
 - Were people surprised or not surprised by their feelings and/or beliefs?

10:00 – 10:20: **Break #1**

10:20 – 11:00: **Build a Tower**

- * *objective:* team-building exercise
- * *materials:* packs of notecards; tape, scissors, paper clips
- divide the participants into small teams of four or five
- place the materials in the center of the room
- (20 min) – give them this much time to build a “tower” at least four feet high; tell them that they have all the information and the materials they need and otherwise must be creative
- (20 min) – have the groups quickly describe their tower and the building process; follow up with some of the following questions:
 - Did people see this activity as a competition? Why or why not?
 - Was access to “resources” a problem?
 - What kind of planning went into the construction? Was there much discussion before construction started? Did group members contribute input equally? Were different voices respected?
 - Were there any roles that women and men fell into? Who did more of the leading? The building? The watching?

11:00 – 12:00: **“Gender” vs. “Sex”**

* *objective*: to understand the difference between gender and sex

* *materials*: flip chart paper, koki pen

- prior to the start of this activity, write following statements on a flip chart (without the answers that are in the brackets); add local examples too
 - *Women give birth to babies, men do not.* [S]
 - *Little girls are gentle, boys are aggressive.* [G]
 - *Men’s voices break at puberty. Women’s do not.* [S]
 - *Women can breastfeed babies, men cannot.* [S]
 - *Most farmers and herders are men.* [G]
 - *Men work and earn the money. Women stay at home and cook and clean.* [G]
- (10 min) – have a short discussion about the biological roots of “sex” and the social constructions of “gender”
- (15 min) – post up flip chart and ask individuals to distinguish which statements are related to “gender” and which are related to “sex”
 - participants can discuss their answers with their neighbors
 - after buzz dies down, indicate the correct answers on the flip chart
- (15 min) – find out if participants still have questions about the difference between “gender” and “sex”
 - have group members respond to these questions
- (20 min) – post up two different flip charts: “gender” and “sex”
 - have a large group brainstorm all the different examples of the two concepts
 - invite a participant to record the group’s thoughts

12:00 – 1:00: **Lunch**

1:00 – 1:45: **Being a Woman, Being a Man**

* *objective*: to explore the positives and negatives about being a woman or a man

* *materials*: flip chart paper, koki pen

- (15 min) – go-around #1
 - women: “I’m happy that I’m a woman because...”
 - men: “I’m happy that I’m a man because...”
- (15 min) – go-around #2
 - women: “I wish that I was a man so that I could...”
 - men: “I wish that I was a woman so that I could...”

- have the participants answer the above questions in two different rounds; remind them about the ground rules if necessary
- have another participant record the groups' answers onto four different flip charts (each corresponding to the go-around questions)
- (15 min) – brief group discussion about participants' comments and wishes

1:45 – 2:45: **Thinking About Gender Roles**

- * *objectives:* 1) to explore the benefits and drawbacks about gender roles, 2) to explore societal attitudes and expectations for girls and boys
- * *materials:* paper, pencils, flip chart papers, koki pen

- (15 min) – read aloud the following statements and have participants complete them individually; give enough time in between statements for participants to think and jot down their answers

- *The best thing about being a woman is...*
- *A man would never let a woman see...*
- *A girl would be praised by her parents if...*
- *The parents of a boy let him...*
- *A boy would be praised by his friends if...*
- *Men get embarrassed when...*
- *Parents expect girls to...*
- *Boys are allowed to...*
- *Women really want to...*
- *A girl would get teased if she...*

- (20 min) – divide participants into teams of two or three and have them share answers
- (25 min) – large group debrief questions
 - When you shared with others, were there any surprising answers? Any similar answers?
 - Are there different answers for boys/men and girls/women?
 - Are women and men expected to behave in different ways?
 - Who has these expectations of your behavior? Parents? Other adults? Friends?
 - Are there some attitudes towards women that you didn't feel comfortable with?
 - Are there some attitudes towards men that you didn't feel comfortable with?
- have a volunteer record the key learnings/points from the discussion on flip chart paper

2:45 – 3:00: **Break #2**

3:00 – 3:05: **Group Stretch**

3:05 – 3:50: **Gender Assumptions: Part I**

- * *objective*: to think about the assumptions that we make about girls and boys
- * *materials*: copies of Worksheets 1 and 2 (use a local, gender neutral name); paper and pencils

- split the larger group into two single-gender groups
- for the first round, hand out Worksheet 1 to the men and Worksheet 2 to the women

- (5 min) – let the group discuss their answers in small groups (do not tell them that the worksheets are different)

- (5 min) – hand each group the other set of worksheets (gender reversed); let the groups work on these worksheets

* **Worksheet 1: Chomi**

Chomi is 10 years old. He lives with his mom and dad. He likes playing sports and listening to music. His best friend lives nearby.

1. Which sports do you think Chomi likes playing?
2. Who do you think is his favorite band?
3. What do you think his best friend is called?
4. What do you think he does when he comes home from school?
5. What do you think his favorite color is?
6. What do you think his favorite food is?
7. What job do you think he wants to do when he grows up?

* **Worksheet 2: Chomi**

Chomi is 10 years old. She lives with her mom and dad. She likes playing sports and listening to music. Her best friend lives nearby.

1. Which sports do you think Chomi likes playing?
2. Who do you think is her favorite band?
3. What do you think her best friend is called?
4. What do you think she does when she comes home from school?
5. What do you think her favorite color is?
6. What do you think her favorite food is?
7. What job do you think she wants to do when she grows up?

- (10 min) – using the worksheet activity as a foundation, introduce the next activity by posting up a flipchart with the following statements

- *HIV positive women should not have children.*
- *There's something wrong with girls/women who are not married by a certain age.*

- *Girls/women should not enjoy sex.*
 - *Girls/women who dress in skimpy clothing are asking for trouble.*
 - *Boys/men just can't help themselves when it comes to sex.*
 - *Marriage between a much older woman and younger man is acceptable.*
 - *Sex is a duty of girls/women to satisfy their male partner/husband.*
 - *Girls/women should always be faithful to their partner/husband.*
 - *Boys/men need to have sex outside of a steady relationship.*
- (10 min) – have the participants individually read over the statements and record T/F on a separate piece of paper
 - next, cross out the genders on the flip chart and replace them with the opposite gender; have participants record T/F in a different column for these statements
 - (15 min) – large group discussion questions
 - In both exercises, how did your opinions/answers change when the gender was changed?
 - In the second activity, how did changing the gender impact how HIV/AIDS is spread?

3:50 – 4:35: **Gender Assumptions: Part II**

- * *objective:* to continue exploring gender assumptions and attitudes; to get participants up and moving
- * *materials:* sheets of paper, koki pen, tape
- post the following signs in different areas around the room: “agree,” “disagree,” “not sure”
- (25 min) – explain to participants that you will read the following series of statements and that they must move to the area of the room that matches their answer
 - *Boys are stronger than girls.*
 - *The way you look is more important than the way you behave.*
 - *Girls are more emotional than boys.*
 - *Looking after children is not a man's job.*
 - *Girls want to get married more than boys.*
 - *A girl should always do what her boyfriend tells her.*
 - *Sport is more important for boys than girls.*
 - *Girls need to find a good husband, boys need to find a good job.*
 - *A boy who likes cooking and looking after children is not a real boy.*
 - *Boys are less good at showing sympathy than girls.*
- after each statement, ask for one person from each group to explain their answer
- tell participants that they can move to other groups after hearing other people's reasons

- (20 min) – large group discussion; regroup and ask the following questions
 - Did men choose different answers/areas than women?
 - Did anyone change their mind after hearing others' opinions? Why?
 - Did people feel obligated by peer pressure to go to certain areas for certain questions? Why or why not?

4:35 – 5:00: Closing Go Around

- * *objective*: to bring closure to the day and elicit feedback from the group
- * *materials*: flip chart paper, koki pen

- post up the following sentences:
 - “One thing I learned is...”
 - “The best thing about today is...”
 - “Next time I would like it if...”

- go around and have each participant answer each question
 - record participants' feedback on a separate flip chart
 - keep participants' suggestions in mind throughout the week

Day 2: Where Do We Get Our Ideas About Gender?

8:00 – 8:15: Ice-breaker -- Inner Circle, Outer Circle

- * *objective*: to continue getting to know others in the group
- * *materials*: topic questions, some sort of timer (e.g. watch or clock)
- evenly divide the group into an “inner circle” which faces the “outer circle”
- the group is given a question and each facing “pair” has 30 seconds each to respond to the question; clap to let people know when to switch
- for the next round, have either the outer or inner circle move one or two spaces to the right
- a new question/topic is posed and the pairs discuss in the same manner as round 1
- rounds continue this way until time runs out
- possible questions:
 - Where were you born and where did you grow up?
 - If you could travel anywhere in the world, where would it be and why?
 - What’s your best quality/skill and why?
 - Do you have a cultural heroine/hero?
 - What’s the most important value in your culture?

8:15 – 8:20: Agenda Overview

8:20 – 9:40: Where Do We Get Our Ideas About Gender?

- * *objective*: to think about sources of information and attitudes about gender
- * *materials*: flip chart paper, koki pens
- (10 min) – group brainstorm of all the sources of information and attitudes about gender, sex, and sexual behavior they can think of
 - examples: friends, parents, grandparents, siblings, TV, films, teachers, health workers, churches, politicians, advertising, pop music, magazines, books, traditional proverbs, etc.
- (30 min) – divide group into two smaller groups
 - hand out flip chart paper and koki pens to each group
 - have each group draw **images** depicting the roles of women and men in society
 - after about 25 minutes, have each group present their ideas/pictures to the other group
- (20 min) – group discussion of images
 - Which images are similar or dissimilar?
 - What was easier to draw—women’s role or men’s roles? Why?

- (20 min) – discuss the roles that society expects women and men to play
 - What are some of the common stereotypes? (e.g. men are strong, women are weak; men are the breadwinners, women stay at home, etc.)
 - make a list of the stereotypes on a separate flip chart sheet

9:40 – 10:00: **Break #1**

10:00 – 12:00: **Family Expectations**

- * *objective:* to think about the way girls and boys are treated in families
- have the participants count off and divide into different groups
- (20 min) – have each group think about the first time that they became aware that girls and boys are treated differently
 - encourage participants to explore early childhood/family memories
- (35 min) – ask each group to prepare short **role plays** to explain their ideas about differential gender treatment
 - have women play male roles and men play female roles
 - give groups until lunchtime to prepare

12:00 – 1:00: **Lunch**

1:00 – 2:10: **Fishbowl**

- * *objective:* anonymous writing exercise about community views on gender
- * *materials:* flip chart paper, bag/box, paper, and pencils
- on a flip chart paper, post the follow questions:
 - *How does your community view women?*
 - *How does your community view men?*
 - *How do you see yourself?*
 - *Are your views different from those of your community?*
 - *What ideas of women would you like to change?*
 - *What ideas of men would you like to change?*
- (20 min) – give participants time to write down their answers, individually and anonymously
- (30 min) – collect responses into the bag/box
 - mix up the responses and pass the bag/box around the circle
 - have each person randomly pull out a response and read it aloud to the group
- (20 min) – group discussion
 - What are people's reactions to others' thoughts and feelings?

2:10 – 2:50: **The Value of Girls and Boys**

* *objective*: to continue exploring societal gender attitudes and values

* *materials*: flip chart paper, koki pen

- (20 min) – ask participants to imagine that they are expecting a child
 - What sex/gender would they choose for this child and why?
 - go around and ask participants to reveal their answers
 - tally up the answers/reasons on two separate flip charts (women’s answers vs. men’s answers)

- (20 min) – group discussion
 - What were some of the differences between women’s and men’s answers?
 - What are some of the larger cultural/societal implications of wanting a certain sex/gender for your child?

2:50 – 3:10: **Break #2**

3:10 – 3:15: **Group Stretch**

3:15 – 4:30: **Gender Bender Pictionary**

* *objective*: to have fun while exploring the gendered nature of occupations

* *materials*: cards with types of local occupations (e.g. farmer, cook, nurse, engineer, bicycle repair person, vegetable seller, food stall vender, business person, teacher, etc.), flip chart paper, koki pens

- (45 min) – divide the group into two teams and explain the rules:
 - taking turns, each team will send a person to the board as the “drawer”
 - you will show them a card (but not their team), and the “drawer” must silently draw pictures (but not words) so that her/his team can guess the occupation; decide on the time limit (approximately five minutes)
 - whether or not the team guesses correctly, they must decide whether or not a woman can do this job (record the answers on a separate flip chart)
 - let the next team play a round; continue in this manner until the end of 45 minutes

- (30 min) – group discussion
 - Why are some occupations only for women or men?
 - Is this based on “gender” or “sex”? Why?
 - What do participants hope to pursue as future occupations? Do they feel limited by their gender or sex?

4:30 – 5:00: **Closing Go-Around**

- *Plus*: What was enjoyable and/or informative about today?
- *Delta*: What could be changed for future sessions?

Day 3: Gender and HIV/AIDS Risk

8:00 – 8:20: **Ice-breaker – Count to Ten**

- * *objectives:* 1) to energize participants and have them get to know each other by working towards a common goal; 2) to have participants figure out ways to strategize without direct communication
- participants form a silent circle, shoulder to shoulder, standing up
- the goal of the activity is to count from one to ten in consecutive order, but counting from one person to the next or head nods to prompt the next “counter” are not allowed
- participants must figure out how to count from one to ten without two or more people yelling out the same number; if this happens, the group must start again
- once the group reaches ten successfully, the activity is complete
- *hint: the best strategy is to go as fast as possible, as this reduces the chances of people saying the same number at the same time!

8:20 – 8:25: **Agenda Overview**

8:25 – 8:45: **Reproductive Organs**

- * *objective:* to review female and male reproductive organs
- * *materials:* handouts (or flipcharts) of female and male reproductive organs
- (20 min) – refresher course on the different parts and functions of the female and male reproductive organs

8:45 – 9:45: **Biological Factors**

- * *objective:* to explore the biological factors related to HIV/AIDS risk
- * *materials:* biological factors – Q & A sheets
- divide groups into two teams and explain rules of game:
 - one person from each team will be sent to answer a question
 - after hearing the question, they can answer the question individually or consult with their team
 - reveal the correct answer and tally up points
- (40 min) – Questions
 - 1) *Biologically, the risk of becoming infected with STDS, including HIV, during unprotected vaginal intercourse is greater for women? True or False.*
 - A: True. The vagina is the receptive organ and there is a much larger surface area for exposure to STDs.

- 2) *The risks of contracting HIV are greater for young women because of the immaturity of their reproductive organs? True or false.*
 - A: True. Young girls' immature reproductive organs provide enhanced opportunities for exposure and infection.
- 3) *The presence of a STI **decreases** the risk of HIV transmission. True or False.*
 - A: False. STIs increase the risk of HIV infection.
- 4) *For women and girls, STIs often go undetected. True or False.*
 - A: True. STIs go undetected in women and girls for many reasons, including 1) absence of symptoms, 2) lack of access to healthcare, and 3) unawareness of being at risk.
- 5) *Among young people aged 15-19, are boys or girls 4-6 times more likely to be HIV positive?*
 - A: Girls.
- 6) *Men infected at a young age can expect to survive longer than their female peers who become infected at a later age. True or false?*
 - A: False. Women infected at a young age can expect to survive longer than their male peers who become infected at a later age.
- (20 min) – wrap up
 - at the end of the game, hand out game Q&A's and open things up for discussion
 - did participants learn anything new or surprising?

9:45 – 10:05: **Break #1**

10:05 – 12:00: **Political/Economic Factors**

- * *objective:* to explore the political/economic factors related to HIV/AIDS risk
- * *materials:* flip chart paper, koki pens
- (10 min) – split the participants into all female and male groups and have each brainstorm a list of how they spend their time as either women or men into the following categories: daily, weekly, and occasionally (e.g. spending time with friends, domestic chores, going to the clubs/bars/discos, etc.)
- (25 min) – using these brainstormed lists, have each team create “**activity clocks**” depicting a typical “day in the life of...”
 - use pictures and short descriptions
- (25 min) – have each group create an “activity clock” for the opposite gender

- (15 min) – bring groups back together and have them present both their “clocks” to the other group
- (40 min) – discussion points
 - Are there differences in the things that women and men do daily, weekly, and occasionally?
 - Are there differences in work, responsibilities, leisure time and activities? Are there some differences that you’d like to change?
 - Do you think a woman and man who are married (and/or live together) and have a family share the workload and responsibilities equally or do you think one of them does more work?
 - Do you think a woman and man who are married (and/or live together) and have a family have equal power in their relationship or do you think one of them has more power?
 - Who makes the money? Who’s poorer?
 - How can women earn money? Do some turn to “sugar daddies” and prostitution?
 - Who makes the political decisions for your country? How does this affect who makes money?

12:00 – 1:00: **Lunch**

1:00 – 1:45: **Social Factors – Part I**

- * *objective*: to explore the social factors related to HIV/AIDS risk
- * *materials*: flip chart paper, koki pens, handouts

- draw five of the following tables on a flip chart:

	Women	Men
Agree		
Not Sure		
Disagree		

- (10 min) – give each participant a copy of the following statements and ask them to answer “agree,” “not sure,” or “disagree” according to their beliefs. Ask them to indicate their gender at the top of the sheet, but otherwise, their answers are anonymous.
 - *Women should have the same sexual freedom as men.*
 - *It is the man’s role to initiate and discuss sex.*
 - *Sexual faithfulness is important in a relationship.*
 - *Women have the main responsibility for contraception.*
 - *People should only have sex if they are in love.*

- *If a woman gets pregnant, it is mostly her fault.*
 - *Women should fulfill men's sexual needs.*
 - *Men show their masculinity by having many partners.*
 - *Women have weaker sexual desires than men.*
 - *Young men should know more about sex than young women.*
 - *It's okay for a young woman to get angry.*
 - *Everyone should be sexually faithful.*
 - *Women are emotionally stronger than men.*
 - *It's okay for a young man to not want sex.*
 - *It's okay for a young woman to not want sex.*
 - *Young women should ask young men out.*
 - *Sex is more important to young men than young women.*
 - *For young women, love and romance are more important than sex.*
 - *Young women who carry condoms are "easy."*
- (15 min) – collect the sheets and randomly choose five questions to tally up
 - tell participants the question being tallied and show them the completed chart with the differences in responses from women and men
 - do this for each of the five questions
 - (20 min) – group discussion points
 - Are there differences between the opinions of women and men in the group?
 - Are there attitudes/behaviors unacceptable for young men to do in a sexual relationship? For young women?
 - Are certain emotions usually more associated with young men than young women? Vice-versa?

1:45 – 2:50: Social Factors – Part II (Socratic Seminar)

* *objective:* to encourage cross-gender discussion about female and male attitudes

* *materials:* blank note cards, pencils

- (5 min): pass out cards to participants and have them anonymously write two questions they'd like to ask the opposite sex as a result of the previous activity (i.e. about things that puzzled or confused them, things that made them upset or angry, etc.)
 - collect the cards and have the men form an inner circle and the women form an outer circle
- (20 min): explain that the men will answer the women's questions and the women will listen without commenting and that the groups will switch during the next round
 - read aloud the women's questions and allow the men to answer and comment

- (20 min): switch groups (women on the inside, men on the outside)
 - read aloud the men's questions and allow the women to answer and comment while the men listen

- (20 min): bring the participants back together for a large group discussion
 - Did any of the answers surprise people?
 - Have women changed any their ideas about men? Vice-versa?
 - Have the men changed their ideas about men?
 - Have the women changed their ideas about women?

2:50 – 3:05: **Break #2**

3:05 – 3:10: **Group Stretch**

3:10 – 4:30: **Gender Attitudes & Roles: Relationships**

- * *objective*: to explore gender differences in terms of relationship expectations
- * *materials*: flip chart paper, koki pen

- post the following questions on flip chart:
 - *How do we expect women to behave in a sexual relationship?*
 - *How do we expect men to behave in a sexual relationship?*
 - *What problems do women have in a sexual relationship?*
 - *What problems do men have in a sexual relationship?*

- (20 min) – let participants address the questions and discuss the answers
 - What are the differences between expectations and problems for women and men?
 - What are the differences between the men in the group's answers and the women's?
 - have a volunteer record key learnings/points on a separate flip chart (one for each question)

- (40 min) – next split the participants into two groups: “*acceptable*” and “*unacceptable*” for a **debate** activity during which each team will send a representative to “debate” the following statements that you will present:
 - *A woman asking a man for sex*
 - *To do things to please your partner*
 - *To have sex without being in love*
 - *To hit each other*
 - *To be sexually faithful to one's partner*
 - *To have sex with lots of different people*
 - *To tell lies to your partner if you think the truth will hurt them*
 - *A woman saying no to sex*

- (20 min) – post-debate discussion
 - What do participants think about the statements?
 - Was it difficult to argue for a statement if they didn't personally agree with it?
 - Did people change their original opinions after listening to other people's opinions?
 - Who has control in relationships? How does this affect how HIV/AIDS is spread?
 - How can women negotiate their position in a relationship more effectively?
 - How can men help women in creating more equality in a relationship?

4:30 – 5:00: **Closing Go-Around**

- *Plus*: What was enjoyable and/or informative about today?
- *Delta*: What could be changed for future sessions?

Day 4: Let's Talk About Sex...

8:00 – 8:15: **Opening Go-Around**

- * *objective*: mid-week check in to see how participants are feeling

8:15 – 8:20: **Agenda Overview**

8:20 – 8:50: **Fishbowl**

- * *objective*: anonymous writing activity to gauge participants' thoughts on dealing with sexual issues
- * *materials*: bag/box, paper, and pencils
- (10 min) – give participants time to write down their thoughts anonymously about discussing sexual issues with their peers, parent/other adults, young people, others in the group, etc.
- (20 min) – collect responses into the bag/box
 - mix up the responses and pass the bag/box around the circle
 - have each person randomly pull out a response and read it aloud to the group
 - Do people have comments or questions?

8:50 – 9:15: **Ideas About Sex**

- * *objective*: to explore ideas about sex in an open and comfortable environment
- * *materials*: flip chart paper, koki pen, tape
- (10 min) – post up the following statements to the group
 - read each aloud and have each participant truthfully raise their hands if they agree or disagree with the statement; remind everyone of the “ground rules”
 - keep a tally next to the statements
 - *When someone says no to sex, it means they do not like the other person.*
 - *It is more important to educate boys about condom use than girls.*
 - *A real man is one who has sex with a woman.*
 - *Someone who dresses in a sexy way wants to have sex.*
 - *If a girl or a boy accepts an invitation to go to someone's house alone, she or he would be expected to have sex.*
 - *It is the woman's responsibility to decide how sexual a relationship is.*
 - *It's okay for girls and young women to carry condoms.*
 - *People should only have one sexual partner in a lifetime.*

- (15 min) – large group discussion
 - Was it difficult to be honest in front of others, especially members of the opposite sex?
 - Did you answer truthfully?
 - Are there differences between women’s and men’s answers? Why do you think this is the case?

9:15 – 10:00: **Reasons For Having Sex**

- * *objective*: to explore the reasons young people have sex
- * *materials*: flip chart paper, koki pen
- (5 min) – have the group brainstorm all the reasons why people have sex
 - e.g. to prove they love each other; for money and presents; it feels good; etc.
 - have volunteer write down all their answers on a flip chart
- (15 min) – split the group into small groups—women and men
 - have each small group which reasons apply to women and which apply to men
 - Which reasons are positive or negative for having sex?
- (5 min) – bring the groups back together and have a representative from each group share their group’s answers
- (20 min) – large group discussion
 - In terms of reasons for having sex, what do women and men have in common?
 - Are there reasons that women have sex that are different from men and vice-versa? Why?
 - How can we make sure that women and men only have sex for positive reasons, especially adolescents?

10:00 – 10:15: **Break #1**

10:15 – 11:15: **Gender and Attitudes to Safer Sex**

- * *objective*: to explore differences in how women and men feel about safer sex
- * *materials*: flip chart paper, koki pen
- (10 min) – group brainstorm: “What does safer sex mean?”
 - e.g. using a condom, non-penetrative sex, etc.
 - have a volunteer write down all their answers on a flip chart
- (20 min) – split up into women/men groups
 - have each group discuss the ideas on the list
 - women should decide whether or not each is easy or difficult for women to initiate, request, demand, etc. and why

- men should decide whether or not each is easy or difficult for men to initiate, request, demand, etc. and why
- (10 min) – have one or two people report back to the group
 - have a volunteer record women’s thoughts on one flip chart and men’s thoughts on another
- (20 min) – large group discussion
 - What are some of the similarities between what women and men are saying?
 - What are some of the differences between what women and men are saying?
 - If a man wants to have sex and a woman does not, should he take her feelings into account or go ahead?
 - Why do you think women have sex when they do not want to? Can a woman say not to sex? Why or why not?
 - What can we do as women and men to make sure to practice safer, consensual sex?

11:15 – 12:00: **Negotiating the Power Dynamic: Condoms and Safer Sex**

* *objective*: to encourage people to think about what barriers young people, especially women, face when negotiating condom use

* *materials*: flip chart paper, koki pen, tape

- around the room, post up various “lines” that men use to pressure girls into have sex without a condom
 - *I’ll be very careful.*
 - *Everyone else does it without condoms.*
 - *I’ll buy you something nice if we have sex without a condom.*
 - *Don’t you know I’m a clean person? I won’t give you a disease.*
 - *We don’t need to worry about AIDS. I haven’t got it.*
 - *If we don’t do it now, it’ll damage my health.*
 - *Don’t you trust me?*
 - *If you loved me, you’d do it.*
- ask participants if they’ve ever used these lines or heard them before
- are there other lines that need to be added?
- (20 min) – have participants pair up (with the opposite gender if possible) and *move* around the room to each of the “lines” to discuss how a women might respond in each scenario
- (15 min) – bring the pairs back together and discuss the *strategies* suggested for use
- (10 min) – have one or two pairs **act** out a short, positive scenario

12:00 – 1:00: **Lunch**

1:00 – 2:20: **Danger Zones – Part I: Community Mapping**

* *objective:* to help young people identify places and times when they might be at risk of unsafe sexual behavior

* *materials:* flip chart paper, koki pens

- divide participants into women/men small groups
- (30 min) – hand out flip chart paper and koki pens and have each team **draw** a “map” of their community with the main features (e.g. rivers, stores, churches, schools, bars, truck stops, etc.).
 - also have them mark the places where potentially risky sexual behavior could take place
- (15 min) – bring the two groups together and have the teams present their maps to each other, focusing on the high risk places
- (15 min) – brief discussion
 - Are there differences between women’s and men’s maps of their “danger zones”? Do men have many “danger zones”?
 - Why do these differences exist? What or who causes these problems?
- (20 min) – regroup and strategizing
 - bring the participants back together and count off into mixed gender groups
 - have each new team go back to one of the maps and strategize solutions to the problems
 - Do women’s and men’s suggestions/ideas differ? Why or why not?

2:20 – 2:55: **Danger Zones – Part II: Role Reversal Play**

* *objective:* role playing as part of increasing gender awareness of unsafe sexual situations

* *materials:* materials for participants to create props, if necessary

- (35 min) – based on the previous exercise, have the mixed-gender groups create **role plays** relating to the “danger zones,” with women playing male roles and men playing female roles
 - allow groups to prepare up until the break and tell them they should be prepared to present their role plays after Group Stretch

2:55 – 3:15: **Break #2**

3:15– 3:20: **Group Stretch**

3:20 – 4:30: **Danger Zones – Part II: Role Reversal Play (cont.)**

* *objective:* to allow groups to present their “Danger Zones” role plays

* *materials:* depends on each group’s needs

- (50 min) – each group has 25 minutes to present their role plays
- (20 min) – large group discussion
 - What were people’s reactions to the performances?
 - How did it feel to play the opposite sex/gender?
 - How did this activity increase your awareness of the “danger zones” in your community for women and men?

4:30 – 5:00: Closing Go-Around

- *Plus*: What was enjoyable and/or informative about today?
- *Delta*: What could be changed for future sessions?

Day 5: Rethinking Gender Roles

8:00 – 8:20: **Ice-breaker – Where the Wind Blows**

- * *objective*: to energize the group and get people up and moving
- * *materials*: a large space
- the group forms a circle and one person (the “caller”) stands in the middle
- she or he says, “the wind blows for people _____ (fill in the statement with something that is true for the caller)
 - e.g. “the wind blows for people wearing striped socks;” “the wind blows for people who are the eldest sibling;” “the wind blows for people who were born in another country;” etc.
- after the caller makes a statement (let’s say “the wind blows for people wearing striped socks”), all those wearing striped socks must run and claim an emptied spot by another participant wearing striped socks; the caller also tries to claim a spot
- the object of the game is to find a new spot so one doesn’t have to be the caller
- in the next round, the new caller must make another “the wind blows for people _____” statement
- the activity can continue endlessly, but is meant to be a brief energizer to get the group up and moving for the final day of training!

8:20 – 8:25: **Agenda Overview**

8:25 – 9:25: **Fishbowl**

- * *objective*: anonymous writing activity to gauge how people’s impressions, thoughts, feelings, etc. on gender have changed during the week
- * *materials*: bag/box, paper, and pencils
- (15 min) – *Round 1*: How have the activities and discussions this week changed your views on femininity, masculinity, and gender roles?
- (15 min) – *Round 2*: Are there any topics or ideas which have surprised, embarrassed, angered, or frustrated you?
- give participants time to answer both questions and while anonymous, the participants should number their responses according to the round and indicate their gender
- (20 min) – collect responses into the bag/box
 - mix up the responses and pass the bag/box around the circle
 - have each person randomly pull out a response and read it aloud to the group
- (10 min) – brief discussion on comments

9:25 – 9:55: **Revisiting Gender Roles – Masculinity (Part I)**

* *objective*: to discuss participants' views on masculinity

* *materials*: flip chart paper, koki pen

- split the group in their small women/men groups
- present the following statements to the groups:

- *In general, men:*

- *hide certain feelings*
- *are independent and don't ask for help*
- *avoid talking about personal matters*
- *compete with each other*
- *are brave, strong, and take risks*
- *have a need to prove their manhood*
- *measure their value by their ability to earn money and support their family*

- *Regarding sex, men:*

- *pretend they know it all*
- *feel that sex keeps them healthy*
- *feel the need to perform*
- *find it difficult to talk about sexual issues*

- (30 min) – give each group time to discuss the statements
 - Which ones do they think are true or false? Why?
 - Which ones do they agree or disagree with? Why?
 - Have participants' feelings about masculinity changed based on anything they've learned this past week?

9:55 – 10:15: **Break #1**

10:15 – 10:45: **Revisiting Gender Roles – Masculinity (Part II)**

* *objective*: to have a cross gender discussion on masculinity

* *materials*: flip chart paper, koki pen

- (30 min) – bring groups back and have a large group discussion about some of the comments, thoughts, and questions the two different groups may have had about masculinity
 - let the participants guide the discussion and respond to each other
 - have a volunteer note the main ideas/points

10:45 – 11:15: **Revisiting Gender Roles – Femininity (Part I)**

* *objective*: to discuss participants' views on femininity

* *materials*: flip chart paper, koki pen

- split the group in their small women/men groups
- present the following statements to the groups:
 - *In general, women:*
 - *are open with their feelings*
 - *are dependent and always in need of help*
 - *constantly talk about personal matters*
 - *never compete with each other unless it's over a man*
 - *are weak and afraid to take risks*
 - *are rarely required to prove their womanhood*
 - *measure their value by their ability to please their men and raise their families*
 - *Regarding sex, women:*
 - *know nothing at all*
 - *feel that they must have sex to satisfy their partner's needs only*
 - *do not enjoy sex*
 - *find it difficult to talk about sexual issues*
- (30 min) – give each group time to discuss the statements
 - Which ones do they think are true or false? Why?
 - Which ones do they agree or disagree with? Why?
 - Have participants' feelings about femininity changed based on anything they've learned this past week?

11:15 – 11:45: Revisiting Gender Roles – Femininity (Part II)

- * *objective:* to have a cross gender discussion on femininity
- * *materials:* flip chart paper, koki pen

- (30 min) – bring groups back and have a large group discussion about some of the comments, thoughts, and questions the two different groups may have had about femininity
 - let the participants guide the discussion and respond to each other
 - have a volunteer note the main ideas/points

11:45 – 12:00: Additional Thoughts?

- (15 min) – open time for participants to discuss any unanswered or unaddressed issues

12:00 – 1:00: Lunch

1:00 – 2:50: The World Would be a Better Place if Men and Women Respected Each Other

- * *objective:* to explore the possibility of changing existing gender relations
- * *materials:* flip chart paper, koki pen

- (15 min) – group brainstorm
 - “Who are the people in your life whom you respect?”
 - have a volunteer copy down participants’ answers, keeping female participants’ and male participants’ answers separate

- (20 min) – discuss gender differentials
 - E.g. Why do boys respect their fathers more than their mothers? Or vice-versa? Why do girls respect their mothers more than their fathers? Or vice-versa? Why are all the country’s leaders men? Who are our heroines?

- (15 min) – “In this society, do women and men respect each other?” Why or why not?
 - have another volunteer copy down participants’ answers, separating the “yes’s” from the “no’s”

- (30 min) – “How can we work towards creating a society where women and men respected each other more? Is this important to you?”
 - have another volunteer note the strategies for a more gender-equal society

- (30 min) – “What is the connection between increasing respect between women and men and decreasing HIV/AIDS?”
 - help participants make the connections of the previous four days of training
 - have another volunteer note the connections
 - make sure that participants truly understand that respect and HIV/AIDS rates is an inversely proportional relationship; when respect increases, HIV/AIDS decreases
 - illustrate with a diagram if necessary

2:50 – 3:05: **Break #2**

3:05– 3:10: **Group Stretch**

3:10 – 4:10: **Teaching Our Community/Spreading the Word**

- * *objective:* to take the lessons and learnings from the training and educate the local community about increased gender awareness
- * *materials:* art supplies (construction paper, koki pens, glue, tape, scissors, etc.)

- (30 min) – divide the participants into mixed gender groups
 - give people time to create *educational materials/tools* to teach their peers/community about how to increase respect among women and men as a means to decrease HIV/AIDS rates
 - e.g. posters, picture/comic books, poetry, skits, songs, etc.

- (30 min) – present materials to other groups
 - other groups can give feedback and suggestions for improvement and implementation of these educational materials/tools

4:10 – 4:30: Action Plans!

* *objective:* to give participants the opportunity to think about their “next steps”

* *materials:* paper, pencils

- (20 min) – give participants some time to create their own action plans regarding how they will integrate gender awareness into their facilitation of upcoming “My Future is My Choice” sessions
 - participants can work independently or in pairs to share ideas

4:30 – 5:00: Closing Go-Around

- *Plus:* What was enjoyable and/or informative about today? About the whole week?
- *Delta:* What could be changed for future sessions?

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Appendix 1: MFMC Session Observation Schedule

Region	Date of Visit	School (Location)
Khomas	June 8, 2004	Concordia High School (Windhoek)
Khomas	June 9, 2004	Eros High School (Windhoek)
Omusati	July 8, 2004	Oshikulufitu Combined School (Ombalantu)
Erongo (East)	July 12, 2004	Ubasen Primary School (Omaruru)
Erongo (West)	July 15, 2004	Kuisebmond Secondary School (Walvis Bay)
Hardap	August 5, 2004	AME Secondary School (Gibeon)

* Note: Session observations should have occurred in the Oshana, Kunene, and Omaheke regions as well, but there were no current MFMC sessions being conducted during our field research dates in those regions.

Appendix 2: FGD Interview Guideline -- Participants

MFMC Assessment

Interview Guideline FGD – Participants

Date: _____

Region: _____

Number of Participants: girls: _____ boys: _____

Introduction:

- Who encouraged you to join MFMC?
- How many sessions of MFMC did you attend? Where/which school?
- Did some participants in your course drop out? If so, why did they drop out?

Content:

- What did you enjoy most about the MFMC training?
- What did you not like about it?
- Was there anything in MFMC that you did not know before? (if yes, what – probe for new knowledge gained)
- Can you remember the topic of a session that you thought was good?
- What about topics which were not good?
- MFMC has different types of activities, such as information sharing, games, review of previous session, group work, role plays, closing circle.
 - During which type of activities did you learn most?
- Were you comfortable talking about certain issues with boys and girls in your group?
 - If not, would you rather have all boy and all girls groups?
- Would you recommend your friends to attend MFMC? (Why/why not?)
- If there was a MFMC course 2 with more topics/more skills, would you attend? (Why/why not?)
 - If yes, can you think of any HIV/AIDS topics that your friends/yourself might like more information which is currently not covered?

Facilitator effectiveness:

- Was your facilitator always on time?
- Did s/he have enough information/knowledge on the session content?
- Would you rather have a peer facilitator of your same gender? Why or why not?
- Did your facilitator use a question box? – If yes, did you make use of it?
- Please describe your facilitator's style of presenting information.
- How did you like her/his facilitation style? Was it different from what teachers do, or quite similar?
- Did the sessions run too slow/too fast? Where there opportunities to ask questions and receive feedback from the facilitators?

Post-activities:

- What did you plan to do in your graduate's action plan?
- Which of those activities did you carry out? (If they didn't carry them out, probe for reasons?)
- Did you talk about MFMC and what you learned in the course with your parents or other adults with whom you stay? (If yes, what did you talk about, and what was their reaction?)
- Did you talk about MFMC with your friends? Your siblings? (If yes, what did you talk about, and what was their reaction?)

Additional comments:

Appendix 3: FGD Interview Guideline -- Facilitators

MFMC Assessment Interview Guideline FGD – Facilitators

Date: _____

Region: _____

Number of Facilitators: _____

Facilitator since (year): F1: F2: F3: F4:

 F5: F6: F7: F8

- Which of the MFMC sessions do you consider most important? Why?
- Which of the sessions do you think is not so important? Why?

Go through all sessions to get reactions on how important they are/how well they work, whether participants engage well or not, which are 'difficult' or 'boring' to facilitate.

Session 1: Getting to Know You

Session 2: How Does My Body Work?

Session 3: HIV/AIDS, STDs, and Risk Reduction

Session 4: Decision Making—Choices and Consequences

Session 5: Inter-personal Communication

Session 6: Our Values

Session 7: Relationships and Emotions

Session 8: Saying No

Session 9: Alcohol, Drugs, and Young People

Session 10: Our Future

- How do you find the balance of different types of activities? Is there enough/too much games/sharing/role play/group work etc?
- Do you sometimes find that you need to change the instructions in the manual to make the activities run better? (examples?)
- What differences do you notice between the old (grey/green) and new (yellow) manual?
- Do you find girls and boys are equally engaged? Are boys and girls both active in the sessions, or boys/girls more?
- Do you think young people would sign up for MFMC if there were no T-Shirts at the end?
- Do participants make use of the question box to ask questions? (If not, why not)
- What type of questions do you get from participants which go beyond the information currently contained in MFMC?
- What type of post-activities do the graduates actually carry out? (Would you say that most carry out their action plan, or parts thereof? How do you know?)
- Did you ever attend a refresher training? (What did you learn? How useful was it?)
- What support do you receive from:
 - Your MT:
 - Your SMT:
 - Contact teacher:
- Do you have any overall suggestions on how to improve the current MFMC course (content, format, organization etc)?
- Do you think a MFMC 2 with more advanced knowledge would be popular? (If yes – what topics?)

Appendix 4: FGD Interview Guideline -- MTs & SMTs

MFMC Assessment

Interview Guideline FGD – MTs & SMTs

Date: _____

Region: _____

Number of MTs: _____ **Since which year?** **MT1:** **MT2:**

MT3:

Number of SMTs: _____ **Since which year?**

- Which of the MFMC sessions do you consider most important? Why?
- Which of the sessions do you think is not so important? Why?

Go through all sessions to get reactions on how important they are/how well they work, whether participants engage well or not, which are 'difficult' or 'boring' to facilitate.

Session 1: Getting to Know You

Session 2: How Does My Body Work?

Session 3: HIV/AIDS, STDs, and Risk Reduction

Session 4: Decision Making—Choices and Consequences

Session 5: Inter-personal Communication

Session 6: Our Values

Session 7: Relationships and Emotions

Session 8: Saying No

Session 9: Alcohol, Drugs, and Young People

Session 10: Our Future

- How do find the balance of different types of activities? Is there enough/too much games/sharing/role play/group work etc?

- What types of activities do facilitators have difficulties with?
- What differences do you notice between the old (grey/green) and new (yellow) manual?
- Do you find girls and boys are equally engaged? Are boys and girls both active in the sessions, or boys/girls more?
- How do facilitators currently support participants' post-activities? How do you support the facilitators' efforts?
- What support do you give to your facilitators during monitoring?
- What support do you give to your facilitators during other times?
- Do you have any overall suggestions on how to improve the current MFMC course (content, format, organization etc)?
- Do you think a MFMC 2 with more advanced knowledge would be popular? (If yes – what topics?)
- Additional Comments:

Appendix 5: FGD Site Selection Criterion

Region	Urban/Rural	Functioning/ Non-Functioning	Established/ Newly-established
Khomas (pilot)	Urban	Functioning	Established
Oshana	Urban	Functioning	Established
Omusati	Urban/Rural	Functioning	Established
Kunene (North)	Rural	Non-functioning	Newly-established
Erongo (East)	Urban/Rural	Functioning	Established
Erongo (West)	Urban	Functioning	Established
Omaheke	Urban/Rural	Non-functioning	Newly-established
Hardap	Rural	Non-functioning	Newly-established

* Note: Given the constraints of available transport, time, and human resources, certain regions had to be excluded from the mid-year assessment.

Appendix 6: Travel Schedule

Regions	Date	Graduates	MTs/ SMTs	Facilitators	YHDC/M&E Chairpersons	Session Observation
Oshana	Mon, July 5	14:30	-----	10:30	9:00	-----
Oshana	Tue, July 6	-----	9:00	-----	-----	14:30
Omusati	Wed, July 7	14:30	-----	10:30	9:00	-----
Omusati	Thur, July 8	-----	9:00	-----	-----	14:30
Kunene	Fri, July 9	-----	14:30	-----	-----	-----
Kunene	Sat, July 10	9:00	-----	14:30	-----	-----
Erongo (East)	Mon, July 12	-----	9:00	-----	-----	14:30
Erongo (East)	Tue, July 13	14:30	-----	-----	9:00	-----
Erongo (West)	Wed, July 14	14:30	-----	-----	-----	-----
Erongo (West)	Thur, July 15	-----	-----	9:00	-----	14:30
Erongo (West)	Fri, July 16	-----	9:00	-----	-----	-----
Omaheke	Mon, Aug 2	14:30	-----	9:20	9:00	-----
Omaheke	Tues, Aug 3	-----	9:00	-----	-----	14:30
Hardap	Wed, Aug 4	14:30	-----	-----	-----	-----
Hardap	Thur, Aug 5	-----	-----	9:20	9:00	14:30
Hardap	Fri, Aug 6	-----	9:00	-----	-----	-----

Appendix 7: FGD Sampling

Region	Graduates: M/F	Facilitators: M/F	MTs: M/F	SMTs: M/F
Khomas (pilot)	Female: 6 Male: 3 (Total: 9)	Female: 4 Male: 2: (Total: 6)	Female: 1 Male: 1 (Total: 2)	Female: 0 Male: 1 (Total: 1)
Oshana	Female: 5 Male: 9 (Total: 14)	Female: 3 Male: 2 (Total: 5)	Female: 4 Male: 2 (Total: 6)	Female: 1 Male: 1 (Total: 2)
Omusati	Female: 5 Male: 3 (Total: 8)	Female: 3 Male: 2 (Total: 5)	Female: 2 Male: 2 (Total: 4)	Female: 0 Male: 1 (Total: 1)
Kunene	Female: 8 Male: 3 (Total: 11)	Female: 2 Male: 1 (Total: 3)	Female: 1 Male: 0 (Total: 1)	Female: 0 Male: 1 (Total: 1)
Erongo (East)	Female: 4 Male: 4 (Total: 8)	Female: 1 Male: 0 (Total: 1)	Female: 0 Male: 1 (Total: 1)	Female: 0 Male: 1 (Total: 1)
Erongo (West)	Female: 4 Male: 2 (Total: 6)	Female: 2 Male: 0 (Total: 2)	Female: 1 Male: 0 (Total: 1)	Female: 1 Male: 0 (Total: 1)
Omaheke	Female: 6 Male: 3 (Total: 9)	Female: 1 Male: 1 (Total: 2)	Female: 1 Male: 1 (Total: 2)	Female: 0 Male: 1 (Total: 1)
Hardap	Female: 5 Male: 0 (Total: 5)	Female: 1 Male: 1 (Total: 2)	Female: 0 Male: 1 (Total: 1)	Female: 0 Male: 1 * (Total: 1) *
Summary	Female: 43 Male: 27 (Total: 70)	Female: 17 Male: 9 (Total: 26)	Female: 10 Male: 8 (Total: 18)	Female: 2 Male: 7 (Total: 9)

*Note: The Hardap MT was also the “Acting SMT” for the region at the time of our visit.

Appendix 8: Gender Definitions

Gender: “describes the roles of women and men that are determined by political, economic, social and cultural factors rather than by biology....We are taught ‘appropriate’ behaviour and attitudes, roles and activities, expectations and desires. It is this learned behaviour that forms gender identity and determines gender roles” (UNICEF, 2002a, p. 4).

Gender roles: “not necessarily the same all over the world, or even within a country or region. Many social, religious and cultural factors modify and regulate the roles of men and women in communities. But even though gender norms vary according to cultures and communities, women are subject to the dominant influence of men at every level of society. This imbalance of power in gender relations has negative consequences for women in all areas of their lives including sexuality, sexual relations and reproductive health” (UNICEF, 2002a, pp. 4-5).

Gender perspective: “examines female and male roles, responsibilities, opportunities and resources within the context of the distribution of power between women and men....But it is not a neutral instrument nor does it seek to exchange the places of dominance and subordination. Rather, it promotes equality, and comprehensive human development. Women’s empowerment is a key objective of any gender-oriented development process and, moreover, of any development process aimed at achieving equity and sustainability” (UNICEF, 2002a, p. 5).

Gender rights: “Emphasizing economic, cultural, and social rights in overcoming women’s subordination and affirming the human rights of women, girls as integral to a framework of human rights for all” (UNICEF, 2002a, p. 5).

Gender and HIV: “How being female or male influences personal experience, risks and responses in relation to HIV/AIDS” (UNICEF, 2002a, p. 5).