

**KNOWLEDGE, ATTITUDES AND PRACTICES OF  
TEENAGERS REGARDING SAFER SEX IN ONANDJOKWE  
HEALTH DISTRICT: OSHIKOTO REGION, NAMIBIA**

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**MARCH 2005**

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TEENAGERS REGARDING SAFER SEX IN ONANDJOKWE  
HEALTH DISTRICT: OSHIKOTO REGION, NAMIBIA**

**A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE  
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**Abstract**

The impacts of teenage pregnancy, HIV/AIDS and other sexually transmitted infections among the youth such as dropout from school, long term effects and death is felt by most people worldwide. As a result of this, teenagers are in need of information regarding sexuality and safer sex to enable them to protect themselves against HIV/AIDS and other sexually transmitted infections and to prevent unintended pregnancies.

The purpose of this study was to explore and describe knowledge, attitudes and practices of safer sex by teenagers in Onandjokwe Health District; Oshikoto region with the aim of formulating appropriate recommendation which will help to improve the provision of information to teenagers.

A qualitative, exploratory, descriptive, contextual design was used to carry out the study. Focus group discussions were conducted. The population consisted of teenage learners in Grade 10 between the ages of 14-19 years. Stratified random sampling was used to select the participants from different schools which are within 10km radius from Onandjokwe Hospital which was the centre of the researcher. The same initial question was asked in each focus group to initiate the discussion. The main question was "How do you understand safer sex?" The data was analyzed according to Tesch's method.

The results indicated that teenagers have some knowledge on safer sex and other sexual health related aspects but such knowledge is limited. However they do have positive attitudes towards safer sex as they are not prepared to indulge in sex without preventive measures such as condoms/femidoms or to be forced into sexual activities when they are not ready.

Teenagers have also indicated that they practice safer sex by staying away from sex or by using condoms, masturbating and kissing or touching each other in order to satisfy their sexual needs. However they have problem with condom sizes as most of the condoms are too big for them and sometimes condoms are not available at all.

The results have also indicated that there are few or lack of educational programs which deals with the provision of information to teenagers regarding sexual health. Some people who were identified as source of information to teenagers do not really provide adequate information to teenagers regarding safer sex.

Recommendations to improve knowledge, attitudes and practices of teenagers regarding safer sex were formulated and described. This includes the following:

- There is a need to improve knowledge of teenagers regarding safer sex and other sexually health related issues through teaching young people sexual development from early age.
- Condoms need to be accessible and available to teenagers.
- Teachers need to be helped so that they can convey sexual health related information to teenagers in a more balanced manner.

- Parents need to be involved in educating their children on sexual health issues.
- There is a need to strengthen the existing educational programs and to develop other educational programs especially to those schools which do not have any educational programs.
- Similar research need to be conducted in other regions to determine knowledge, attitudes and practices of teenagers regarding safer sex.

**ABBREVIATIONS**

ABC	:	ABSTINENCE, BE FAITHFUL, USE CONDOM
AIDS	:	ACQUIRED IMMUNE DEFICIENCY SYNDROME
GRN	:	GOVERNMENT OF THE REPUBLIC OF NAMIBIA
HIV	:	HUMAN IMMUNODEFICIENCY VIRUS
MOHSS	:	MINISTRY OF HEALTH AND SOCIAL SERVICES
PHC	:	PRIMARY HEALTH CARE
STI	:	SEXUALLY TRANSMITTED INFECTIONS
UNAM	:	UNIVERSITY OF NAMIBIA
USAID	:	UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
WHO	:	WORLD HEALTH ORGANIZATION

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## **DEDICATION**

This study is dedicated to my adorable daughters Tuwilika and Ndakalako, let this be the sources of inspiration.

Special gratitude goes to my husband, Shikongo for his patience and support during this demanding time of studies.

**DECLARATION**

I declare that "KNOWLEDGE, ATTITUDES AND PRACTICES OF TEENAGERS REGARDING SAFER SEX IN ONANDJOKWE DISTRICT: OSHIKOTO REGION" is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of references.

  
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March 2005

# **CHAPTER 1**

## **ORIENTATION TO THE STUDY**

### **1.1 INTRODUCTION**

HIV/AIDS, sexually transmitted infections and teenage pregnancies are some of the major problems affecting young people worldwide and the impact is greater in the developing countries (Avert. Org, 2003:2; Arkutu, 1995:198). In this chapter background information of the study, analysis of the problem, problem statement, purpose and objectives, conceptual framework, research methods and design, are presented.

The aim of this study was to explore and describe knowledge, attitudes and practices of safer sex by teenagers in Onandjokwe Health District in Oshikoto region, with the purpose of making recommendations which will help in the improvement of their knowledge, attitudes and practices of safer sex.

## **1.2 BACKGROUND AND RATIONALE**

Namibia is a vast country covering 824,000 square kilometers. It has a population estimated at 1.8 million with the population growth rate of 2.6% per annum (Goamab, Keulder and Sherbourne, 2003:1). Ten percentage of the Namibian population are female teenagers and 11.2% are male teenagers between 15 -19 years of age (Government of the Republic of Namibia, 2000: 9).

At independence of Namibia the Ministry of Health and Social Services adopted a Primary Health Care approach as a foundation and cornerstone of health care delivery system in Namibia. Primary Health Care is an essential health care aimed at disease prevention and health promotion. This service is made universally accessible to individuals and families in the community (Searle, Brink & Grobelaar, 1993:126).

Within the framework of Primary Health Care, the Government of the Republic of Namibia has committed itself toward achieving health for all Namibians by the year 2000 and beyond. This can be achieved through the provision of health information so that people could realize that they themselves have power to shape their lives and to use better approach in preventing diseases (Searle et al, 1993:123).

The Government of the Republic of Namibia recognizes that in order to have a healthy nation, children and youth should be the main focus. Therefore, the Ministry of Health and Social Services has come up with programs aiming at promoting health and preventing diseases among children and youth such as immunization program and reproductive health program.

There is growing evidence that sexually transmitted infections (STI) such as gonorrhoea; syphilis, chlamydia, HIV/AIDS and unplanned pregnancies are increasing among teenagers in Namibia as well as in other countries. This is because teenagers are not practicing safer sex (Government of the Republic of Namibia, 1998:11; Arkutu, 1995: 197).

According to Amfar (2001: 1) between 40 000 and 50 000 Americans become infected with HIV every year. Half of them are between the ages of 13 - 24 years. According to Adebola (2003:2), the Centre for Disease Control reported that in 1998, teenage girls in the United State aged 15-19 years had the highest rate of chlamydia and gonorrhoea. It is also estimated that in 2002 there were about 3.2 million teens under the age of 15 years living with HIV globally (Avert.Org, 2003:1). In the industrial world about three million teenagers' contract sexually transmitted diseases each year and many will have a long-term health effect or defect. In New Zealand there were about 1245 live births to mothers aged under 18 years in 1998 (King, 2001:16).

According to Arkutu (1995:197) numerous health surveys and social studies have shown that in many African countries most teenagers between 60 – 70% are sexual active. As a result in some areas as many as 70% of girls have been pregnant at least once by the age of 18 years old.

In Namibia over half of the population is less than 25 years with one in three people aged between 10 – 24 years. More young women and men are becoming sexually active during their early teens and more than half have unprotected penetrative sex before the age of 16 years (Government of the Republic of Namibia, 1998: 11).

According to Maletsky (2000:1) close to, 50% of Namibian girls have children by the age of 19 years. Schwarz (2003:36) indicated that in the University of Namibia (UNAM) during 2003, 12.1% of girls and 4. 3% of boys between the ages of 15-19 years were already parents. At David Bezuidenhout Secondary School in Windhoek, 26 teenage learners have dropped out of school due to teenage pregnancy during the course of the year 2004 (Kakololo, 2004:1).

HIV/AIDS is also taking a heavy toll among Namibian youth. According to United Nations Children Emergency Fund progress report for 2000, HIV/AIDS infection rate among 15-24 years old in Namibia ranks the country as the fifth worst affected in the world.

One in five Namibian young women between the ages of 15-24 years is living with HIV/AIDS and 10% of young men between the ages of 15-24 years are living with HIV/AIDS. Other four countries in which young people between the age of 15-24 years are reported to be infected with HIV/AIDS are Botswana with highest infection rate of 34 percent (females) and 16 percent (males), Lesotho was ranked as the second while South Africa and Zimbabwe as the third and fourth respectively. It was also found that in 1999 about 11% of pregnant girls aged 15-19 who had attended prenatal clinics in Namibia were found to be HIV positive (Menges, 2000:1).

Otaala (2000:2) indicated that Namibia ranks as one of the third most affected by HIV/AIDS in the world with an overall prevalence of 20% among sexually active people. It is also estimated that 20% of the Namibians, who have HIV/AIDS, half of them are between 15-24 years of age. In the light of the above-mentioned problems some programs were developed and implemented.

### **1.2.1 Profile of the Ministry of Health and Social Services**

The Ministry of Health and Social Services has got 13 health regions. These regions are Omusati, Oshana, Ohangwena, Oshikoto, Okavango, Caprivi, Erongo, Omaheke, Khomas, Hardap, Kunene, Otjozondjupa and Karas (Government of the Republic of Namibia, 1995: 14). In each region there are district hospitals e.g. in Oshikoto region there are two district hospitals, Onandjokwe and Tsumeb.

Under those district hospitals there are clinics and health centres. Ministry of Health and Social Services has certain programs which are carried out by health workers in hospitals, health centres and clinics. Some of the programs are Family health program which includes Expanded Program on Immunization, antenatal and postnatal and family planning. There are also other programs such as HIV/AIDS and counselling and school health program.

#### **1.2.1.1 Onandjokwe school health program profile**

Onandjokwe Health District is a rural district in Oshikoto region, which is in the northern part of Namibia. There is a school health program, which falls under the Department of Primary Health Care (PHC). Onandjokwe school health program covers 4 circuits; these are Onyaanya circuit with 47 schools, Onathinghe circuit with 31 schools, Omuthiya circuit with 25 schools and Oshigambo circuit with 21 schools. The total number of schools included in Onandjokwe school health program is 124 schools. These schools are combined schools, junior secondary schools, senior secondary schools and primary schools. Most of the teenagers are found in combined schools, junior secondary and senior secondary schools.

### **1.3 ANALYSIS OF THE PROBLEM**

From the above discussion, it is clear that many teenagers worldwide are faced with problems such as teenage pregnancies which lead to drop out from schools, HIV/AIDS infection which leads to high death rate among future generation as well as infections due to other sexual transmitted diseases which may lead to long term effect or defects (Arkutu, 1995:197; Jackson, 2002:22). Namibia has not been excluded from such effects because there is high rate of teenage pregnancy, HIV/AIDS and other sexually transmitted infections.

The following are some of the tables which indicate the number of teenagers who attended antenatal clinic and treated for sexually transmitted diseases during 2001-2003 in Onandjokwe Health District in which the study is conducted which gives some evidence that teenagers are not practicing safer sex.

*Table 1.1*

**Number of teenagers treated for Sexual Transmitted Diseases 2001 – 2003 in Onandjokwe Health District, Oshikoto Region.**

<b>SEX</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>
Male	94	12	130
Female	188	107	235
<b>TOTAL</b>	<b>282</b>	<b>119</b>	<b>365</b>

*Table 1.2*

**Number of teenagers attended antenatal care during 2001 – 2003 in Onandjokwe Health District in Oshikoto Region.**

<b>AGE</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>
Under 15 years	10	11	13
15 – 19 years	625	578	567
<b>TOTAL</b>	<b>635</b>	<b>589</b>	<b>580</b>

According to the report of the National HIV Sentinel Survey, HIV prevalence among pregnant women between the ages of 13-19 years was 12% in 2000 and 11% in 2002 in the Onandjokwe district.

However, looking at the above tables, one can see that there are many teenagers being infected by sexually transmitted infections. It is also important to note that not all people present themselves to the health facilities when they are infected with sexually transmitted infections. Data of teenagers who have attended antenatal care are also alarming because this is an indication that many teenagers are dropping out of school due to teenage pregnancy. Therefore, there is an urgent need to enable young people to protect themselves against HIV/AIDS, other sexually transmitted infections and unplanned pregnancies.

According to studies done in Namibia factors which contribute to teenagers not to practice safer sex are:

(i) **Risk perception**

Many teenagers do not perceive themselves at risk of contracting HIV/AIDS and STI. For example according to the qualitative study done in Oshikoto region in 1999, teenagers were well aware of HIV/AIDS, but did not perceive the pandemic as a risk to their own lives (Schwarz, 2003:48).

In another study done in 2000 and 2002, the majority of young people between the ages of 12-18 years did not feel at personal risk of contracting HIV/STI (Schwarz, 2003:49).

**(ii) Poverty and unemployment**

Poverty and unemployment can contribute to unsafe sexual behaviours because young people need to be dressed nicely and to look good. They also want to eat nice food, but if these young people are poor and they do not have jobs, they will engage in prostitution to get money so that they can buy what they want (Government of the Republic of Namibia, 1998:11).

**(iii) Limited access to health services**

Many teenagers have limited or no access to health services e.g. when young people are infected with sexually transmitted infections, some of them are not aware that they are infected. This is because young people often have limited information about sex and sexual development and they have limited access to counseling services (Government of the Republic of Namibia, 1998:11).

**(iv) Lack of knowledge about sexual health**

Many teenagers have limited knowledge regarding sexual health. For example according to the study done in 1995 on sexual knowledge, attitudes and practices among Namibian youth, sexual knowledge was found to be shallow. This implies that young people do not have in-depth knowledge about sexual health (Tjiramba, 1995:1).

According to Arkutu (1995:197) the majority of sexual active teenagers are unaware of the risk involved in sexual activity at an early age or they are dangerously misinformed about the potential consequences of their behaviours.

**(v) Unclear messages from adults**

Most parents do not provide young people with accurate and clear information regarding sexuality; neither do they discuss sex and sexual relationships with their teenagers. Instead they give messages like “do not play with boys or girls” and such messages are not clear (Sanders, 2000:2).e.g. According to Blaauw, Farmer, Mameya, Mootseng and Venaani (1995:16), 61.8% of males and 34.4% of female teenagers did not discuss sexuality and consequences of teenage pregnancies with their parents.

**(vi) Unfriendly attitudes of health workers**

Some health services providers have unfriendly attitudes towards teenagers when it comes to reproductive health issues. They lack confidentiality and privacy when handling young people's problems (Government of the Republic of Namibia, 2002:2). As a result many teenagers are not free to visit health services as they are afraid of health workers.

#### **1.4 PROBLEM STATEMENT**

It's not clear whether teenagers have adequate knowledge and information regarding safer sex, because many teenagers are still becoming pregnant while in school and many are also becoming victims of HIV/AIDS and other sexually transmitted infections. Teenagers are also not free to discuss sex-related matters either with their parents, their teachers or with the health workers. This is mostly worsened by cultural factors, because discussing sex in most African cultures is taboo (Otaala, 2000:30).

In some parts of Namibia, if a teenager is diagnosed with sexually transmitted infections, or diagnosed as HIV positive, or falls pregnant it creates problem of rejection. Because people such as family members and other people in the community tend to turn their backs on such a teenager and she/ he has to cope with her/ his own stress and fears with little or no support either from parents, teachers or health workers.

Being rejected by important people in one's life is painful. Consequently, many teenagers end up committing suicide (Greathead, Devenish and Funnel, 1998: 3).

Due to such problem, the following research questions are investigated.

- What do teenagers in Onandjokwe Health District know about safer sex?
- Do teenagers in Onandjokwe Health District practice safer sex and how?
- What attitudes do teenagers in Onandjokwe Health District have towards safer sex?

- Are teenagers in Onandjokwe Health District aware of any educational programs in place which deal with the provision of information on reproductive health in their district?

## **1.5 PURPOSE OF THE STUDY**

The purpose of the study was to explore and describe knowledge, attitudes and practices of safer sex by teenagers in Onandjokwe Health District in Oshikoto Region.

## **1.6 OBJECTIVES OF THE STUDY**

*The specific objectives for the study are:*

- To determine the knowledge of teenagers on safer sex.
- To determine how teenagers practice safer sex.
- To determine the attitudes of teenagers toward safer sex.
- To determine whether teenagers are aware of any educational program in place which deals with the provision of information regarding safer sex in Onandjokwe health District.
- To make recommendations which will help teenagers to improve their knowledge, attitudes and practices regarding safer sex.

## **1.7 CONCEPTUAL FRAMEWORK**

According to Burns & Grove (1997:171) conceptual framework is the abstract, logical structure of the meaning that guides the development of the study and enables the researcher to link the findings to the nursing body of knowledge. Conceptual framework is an efficient mechanism for drawing together and summarizing accumulated facts, sometimes from separated and isolated investigations (Polit; Beck and Hungler, 2001:111). Framework deals with abstracts /concepts that are relevant to the study topic, thus providing a general understanding of the problem under investigation. The purpose of conceptual framework according to Rossouw (2003:99) is to identify the concepts and link these concepts to each other by means of literature study of existing framework such as models and theories.

Some aspects of Mischel and Bandura`s social cognitive theory formed the conceptual framework for this study. The reason is that the theory addresses both the psychosocial dynamics influencing the health behaviours (Baranowski, Perry and Parcel, 1996:156).

In this study the following constructs which were presented by Mischel and Bandura in their social cognitive theory will be applied. These are reciprocal determinism, observational learning, behavioral capability, expectancies and self efficacy (Baranowski et al, 1996:156).

According to Mischel and Bandura's social cognitive theory, the interaction of a person's characteristic, behaviour and the environment influence each other simultaneously. This continuous interaction is called reciprocal determinism. A change in one component has implications on the other (Baranowski et al., 1996:158). In this study the knowledge, attitude and the practice of teenagers regarding safer sex can be influenced by interaction of the teenager with his/her environment such as social environment .

Social environment include factors such as family members, friends and peers and this can influence the teenager to practice safer sex in such a way that if for example the teenager`s peer talk about safer sex and encourage each other to practice safer sex, then such a teenager can practice safer sex. .

The influence of social environment can be positive which will result in a teenager to practice safer sex or negative which may result in a teenager not practice safe sex.

On the other hand teenagers are in constant contact with other people such as family members, and friends, and they learn through observing the action of other people and the response such people receive. If a teenager considers such a response rewarding he/she will imitate the observed behaviour (Baranowski et al, 1996:159). For example if a teenager observed that his/her friend is having boyfriend/girlfriend she/he may also try to have a boyfriend so that she/he can fit in other's group.

Once a teenager enters into a relationship they may involve themselves in unprotected sexual activities and this may result in unplanned pregnancies, HIV/AIDS and other STIs.

Although people learn through observation, for the person to perform particular behaviours he/she must have knowledge of such behaviours and how to perform them (Baranowski et al, 1996:161). In this study for the teenager to practice safer sex, they must have knowledge of what safer sex is all about and how to practice it.

Expectancies and self efficacy will enable a teenager to obtain knowledge and to practice safer sex. Expectancies refer to values a person attaches to a particular outcome e.g. if a teenager place a positive value on safer sex she/he is likely to practice it unlike the one who attaches a negative value to safer sex. Self efficacy refers to the confidence the person has in order to take action (Baranowski et al., 1996:162). For example in case where a teenager has confidence he/she can discuss sex related subjects and ask his/her partners to practice safer sex, but if he/she lacks self confidence to talk openly to his/her partners, then this may result in unprotected sex.

## **1.8 DEFINITIONS OF CENTRAL CONCEPTS**

The following concepts will be defined as follow:

### **Safer sex**

Wehmeier (2000:1038) defined safer sex as sexual activities in which people try to protect themselves from HIV/AIDS, unplanned pregnancies and other sexually transmitted diseases.

Safer sex involve activities such as massage, masturbation, kissing, hugging, including, body to body rubbing, acting out fantasies, dancing sex movements and using sex toys or aids which are not shared (Berer, 1995:136).

### **Teenager**

"A person who is between the age of 11-20 years and such a person is undergoing extensive physical, psychological, emotional and personality development" (Kozier, Erb, Blais & Wilkinson, 1995:615).

### **Knowledge**

"The information, understanding and skills that one gains through education or experience" (Wehmeier, 2001:658).

**Attitudes**

The way one thinks and feels about something" (Wehmeier, 2000:62).

**Practice**

"A way of doing something that is the usual or expected way in a particular situation (Wehmeier, 2001: 912).

**1.9 RESEARCH DESIGN AND METHOD**

The research design chosen for this study is qualitative, exploratory, descriptive and contextual in nature. A detailed explanation of the design will be discussed in chapter 2.

The study population includes teenagers between the ages of 14-19 years who are still schooling in Grade 10 in Onandjokwe Health District. Schools targeted were combined schools and junior secondary schools within 10km radius from Onandjokwe Lutheran Hospital.

Five schools were chosen for this study, which are three combined schools and two junior secondary schools. Stratified random sampling was used to select the participants.

The researcher selected twelve teenagers from each school that is six female and six male teenagers. Data was collected by means of focus group discussions. Tape recordings were made during discussion and data was transcribed during data analysis.

Data from the focus group discussions was analyzed according to Tesch's method in Cresswell (1998:155). Ethical aspects were observed as explained in chapter 2.

### **1.10 SUMMARY**

This chapter has covered the general outline of the study, problem statement, conceptual framework and briefly research design and methods of the study. The research methods and design are fully explained in chapter 2 of the study.

## **CHAPTER 2**

### **RESEARCH DESIGN AND METHOD**

#### **2.1 Introduction**

In chapter one the overview of the study was given. In this chapter the research design and method, purpose and objectives will be discussed in details as well as trustworthiness and ethical considerations.

#### **2.2 Research design and method**

Qualitative research forms the basis of this research design and method. Qualitative research is a systematic, interactive, subjective approach used to describe life experiences and give them meaning. It is conducted to generate knowledge concerned with meaning and discovery (Burns and Grove, 1997:27). Qualitative approach was used in this study with the aim of seeking in depth understanding and insight into meaning of actions of teenagers (Ulin, Robinson, Tolley & McNeil, 2002:5). The researcher was involved in perceiving, interacting, reflecting, attaching meaning and recording information that was shared by participants.

The knowledge, attitudes and practices of teenagers regarding safer sex were the main focus for this qualitative study.

There was a need for the researcher to be open- minded and to interact harmoniously with the participants so that they can be free to express themselves (Burns and Grove, 1997:355).

The aim is to have access to unbiased information from the participants in order to explore, describe and analyze such information. Therefore the design for this study is qualitative, exploratory, descriptive, and contextual in nature.

Qualitative, exploratory, descriptive, contextual design requires the researcher to observe people in their context and interact with them using the most comfortable language. It can also be used to get information about how people think, feel and what they believe. Although generalization cannot be done to the whole population, it provides critical insight and understanding about a particular issue (Burns and Grove, 1997:29).

### **2.2.1 Exploratory**

The word “explore” implies examining something completely or carefully in order to find out more about it (Wehmeier, 2000:408). This study was exploratory because it was conducted to gain insight and understanding on knowledge, attitudes and practices of teenagers on safer sex.

The researcher thought that this study could enable her to formulate recommendations that will help in the improvement of knowledge, attitudes and practices of teenagers regarding safer sex.

### **2.2.2 Descriptive**

Descriptive involves the systematic collection of information with the aims of discovering and describing facts (Cormack, 1994:178). The study was descriptive because it was conducted to explore and describe the knowledge, attitudes and practices of safer sex by teenagers. The researcher sought to obtain subjective information from teenagers in order to be able to obtain complete and accurate information about a phenomenon through observation, description and classification (Brink, 1996:11)

The knowledge, attitudes and practices of teenagers on safer sex were explored and described. The emerging themes and categories provided guidance for the researcher to formulate recommendations which would help in the improvement of knowledge, attitudes and practices of teenagers regarding safer sex. This was important because in qualitative studies, reality is constructed by individuals involved in the study (Schaik, 1998:45).

### **2.2.3 Contextual**

A contextual study includes conducting the study within its setting which include, physical and social environment (Cresswell, 1998:62). Therefore in this study the data was collected through interacting with participants in their own setting with the purpose of collecting unique information. A contextual study was preferred because action related to description can only be given in a particular context. This study is contextual in nature as it was conducted in Onandjokwe Health District, Oshikoto Region.

## **2.3 Research Rationale**

Many teenagers are becoming pregnant while they are still schooling and many of them are becoming victims of HIV/AIDS and other sexually transmitted infections.

The effects of teenage pregnancies, sexually transmitted infections and HIV/AIDS are dropping out of school, long term effects or defects and death.

Teenagers are a vulnerable group and they need more information regarding sexual health which includes safer sex to enable them to protect themselves from HIV/AIDS, teenage pregnancies and other sexually transmitted diseases.

## **2.4 Research purpose and objectives**

### **2.4.1 Purpose of the study**

The purpose of this study was to explore and describe teenagers` knowledge, attitudes and practices on safer sex with the aim of formulating recommendations that will improve their knowledge, attitudes and practices regarding safer sex.

### **2.4.2 Objectives of the study**

The objectives of the study are as follow:

- To determine the knowledge of teenagers on safer sex.
- To determine the attitudes of teenagers towards safer sex.
- To determine whether teenagers practice safer sex.
- To determine whether teenagers are aware of any educational programs in place which deals with the provision of information regarding safer sex in Onandjokwe Health District.
- To make recommendations which will help teenagers to improve their knowledge, attitudes and practices regarding safer sex.

## **2.5 Research method**

The method used to conduct the study will be discussed in this section. This includes target population, sampling method, data collection, data analysis, methods of how the trustworthiness of the data was determined as well as the ethical consideration.

### **2.5.1 Target population**

According to Brink (1996:132) the target population is the entire group of persons or objects that is of interest to the researcher or meets the criteria the researcher is interested. In this study the target population was all teenagers between the ages of 14 - 19 years who are still schooling in Grade 10 in Onandjokwe Health District, Oshikoto Region.

### **2.5.2 Sampling method and sample size**

Sampling refers to the process of selecting the sample from the population in order to obtain the information regarding a phenomenon in a way that represents the population of interest (Brink, 1996:133). It is a process that involves selecting a group of people, events, behaviors or other elements with which to conduct a study (Burns and Grove, 1997:293).

In this study, stratified random sampling was used in selecting the sample. In stratified random sampling the population is divided into homogeneous subset from which the elements are selected using simple random sampling (Polit, Beck and Hungler, 2001: 241).

Teenage learners between the ages of 14-19 years in grade 10 from targeted schools were sub grouped according to their schools and according to their sex that is male learner in one group and female learner in another group. Their names for each group were put in the separate box for each school and the sample for each school was selected by using simple random sampling in which each element has an equal chance to be included in the sample that is the researcher pick out six names from each box. The following table indicates participants in the study:

*Table 2.1: Participant in the study.*

<b>Name of school</b>	<b>Sex</b>	<b>Total population</b>	<b>Sample taken</b>	<b>Withdrawn</b>
Hans Daniel Junior Secondary School	Females	46	6	0
	Males	52	6	0
Oneputa Combined School	Females	23	6	1
	Males	21	6	0
Onamulunga Combined School	Females	17	6	2
	Males	16	6	0
Olukonda Junior Secondary School	Females	18	6	0
	Males	9	6	0
Oshilulu Combined School	Females	34	6	1
	Males	22	6	1
<b>TOTAL</b>	<b>Females</b>	<b>158</b>	<b>30</b>	<b>4</b>
	<b>Males</b>	<b>120</b>	<b>30</b>	<b>1</b>

### **2.5.3 Sampling Criteria**

Sampling criteria are characteristics essential for membership in the target population which are developed from the research problem, purpose, conceptual and operational definition of the study variables and design (Burns and Grove, 1997:294).

The sample for this study was selected from population which meets the following criteria:

- The teenager must be between the ages of 14 -19 years.
- She/he must be still in school in Grade 10.
- Schools included in the study should be within 10 km radius from Onandjokwe Lutheran Hospital which was the centre of the researcher.

### **2.5.4 Data Collection:**

According to Granger and Chulay (1999:116), data collection is the process of collecting the data from the chosen participants. In this study data was collected using focus group discussions.

Focus group discussion is the discussion in which the respondents are grouped to address questions on a given topic usually in a conversational unstructured format (Babbie and Moun-ton, 2001). Focus group discussion was selected as this will allow participants to interact and produce data and insight that would not be produced without group interaction (Ulin, Robinson, Tolley & McNeil, 2002:92).

All ten focus group discussions were conducted in English as this was the language referred by teenage learners. All ten focus group discussions were audio taped. Participants were divided into two groups at each school according to sex so that they can express their views freely because females may not be able to talk freely in the presence of men and vice versa (Ulin et al, 2002:92).

Two focus group discussions were conducted at each school. All respondents were encouraged to talk on what they know about safer sex.

#### *2.5.4.1 Preparation*

Participants were briefed on the purpose of the research and their consent was obtained verbally prior group discussion. Participants were notified of the venues where the focus group discussions were to be conducted. Venues were non- threatening and seats were arranged in a semi-circle to allow face to face interaction.

The researcher used a tape recorder with cassettes with the permission of participants to tape record the discussions. The researcher facilitated the discussions while the assistant researcher did the tape recording. Information was collected till the data was saturated as this was demonstrated by repetition of information (Polit et al, 2001:44).

#### 2.5.4.2 *The Role of the Researcher*

Burns and Grove (1997:355) emphasized that the facilitator in the focus group discussion should take a non-directive role. The facilitator should just participate to start the conversation and to prevent the discussion from wandering too far from the questions of the study. The emphasis is on group interaction and on the significance of what is being said. The facilitator's attitude has to be permissive and she should show interest in what is being said.

One of the central question that was asked during the discussions was "Tell me, how you understand safer sex?" This question was used in all ten focus group discussions. Each discussion lasted for at least one hour.

#### 2.5.4.3 *Communication Techniques used during the discussions*

- In order for the participants to express their views freely the researcher has to utilize non-directive communication techniques. In this study the following communication techniques were used:
- *Reflection* which involves restating the respondent's comment either in the exact same terminology or by repeating part of his/her comments (Roger, 2004:2). In this study the researcher restated what the respondent has explained when necessary in order to understand the essential message.
- *Exploring* which encourages the respondent to expand upon their remarks as this will help him/her to see the problem more (Steve, 2004:1). In this study the researcher explored by asking the respondents to elaborate more on certain issues.
- *Clarifying* which involves stating or voicing what the respondents seems to imply rather than what was said. This was done to verify impressions which will help the respondents to become more aware of their feelings (Steve, 2004:1). In this study questions were asked to clarify unclear statements.
- *Probing* which involves repeating of questions to help the respondent to understand the question and for the researcher to obtain more information (Burns and Grove, 1997:355).
- *Summarizing*, this involves the reviewing of what has been discussed and it helps to organize the discussion and to bring together important points (Roger, 2004:2).

- *Minimal response*, this is the ability of the researcher to do more listening than responding to avoid biased information. The aim was to get more information from the respondents.

#### 2.5.4.4 *Field Notes*

The researcher kept the written records of all observations as observed and noticed from each group. These records were necessary to capture important events and non verbal communication which could not be tape recorded but could be of importance in understanding certain phenomenon (Streubert and Carpenter, 1998:98).

#### 2.5.4.4 *Transcribing of tapes*

The tape recorded data were transcribed verbatim. The aim was to have meaningful information during discussion and to start with data analysis (Krueger, 1994:6).

### **2.5.5 Data Analysis**

Data analysis is the systematic organization and synthesis of the research data (Polit et al, 2001:460). It is conducted to reduce, organize and give meaning to the data (Burns & Grove, 1997:53).

Data from the focus group discussions was analyzed according to Tesch`s method in (Cresswell, 1998:155). After the discussions were completed the researcher did the following:

- Listen to the taped information on the cassettes and get sense of the information, transcribe all the taped discussion, read through the transcriptions and write down some ideas as they came to mind.
- Read through the field notes and transcriptions, pick up the most interesting information/points, thought the underlying meaning, list all topics and cluster similar topics together to form themes.
- Take the list of topics, go back to the data, abbreviate the topics as codes, write the codes next to the appropriate segments of the text, organize the scheme and see whether new categories and codes could come up.
- Find the most descriptive wording for the topic and turn them into categories, reduce the categories by grouping the topics together that are related to each other and draw lines to show interrelationship between the categories.
- Make a final decision regarding each category.
- Assemble the data which belongs to each category in one place for preliminary analysis.

Supervisors who are knowledgeable in qualitative data analysis were engaged in coding and supervising the data analysis. The researcher and the supervisors met to discuss the results and consensus was reached on the major theme categories and subcategories.

## **2.6 Literature Control**

The results of the study were discussed in relation with relevant literature. The reason being no study exists in isolation and literature control can help the researcher to compare prior studies on the topic under investigation (Bourner, 1996:2).

## **2.7 Measures to ensure trustworthiness**

Trustworthiness is the method of evaluating the qualitative data by assessing criteria of credibility, dependability, transferability and conformability (Polit et al, 2001:471). In this study credibility (truth value), dependability and confirmability were used as measures to ensure trustworthiness.

### *Credibility*

Credibility refers to confidence in the truth of the data (Polit et al, 2001:312).

Credibility was demonstrated through various techniques such as prolonged engagements, persistent observation, and member checks.

Prolonged engagement refers to the investment of sufficient time in data collection process (Polit et al, 2001:313). In this study the researcher spent some time with the participants and builds some trusting relationship. The researcher conducted meetings with the participants to inform them about the study proceedings. Participants were informed that their interest will be respected and anonymity will be maintained.

Persistent observation refers to the researcher's focus on the aspects of the situation that is relevant to phenomenon being studied (Polit et al, 2001:313). In this study the researcher tried to identify and explore crucial factors expressed by the participants through rephrasing and repeating questions on the issues of interest.

The researcher used tape record to record discussions with the purpose of validating the data. Field notes were taken to record gestures/non verbal communication of participants. Member checks refer to providing feedback to the participants regarding preliminary findings (Polit et al, 2001:314).

In this study the discussions which were tape recorded were played back to the group for their comments immediately after the discussions. This was done because participants wanted to listen on what they have said how they were talking.

### *Dependability*

Dependability was demonstrated through external audit. This was done by sending focus group discussion transcriptions to supervisors to assist with data analysis and coding of data by supervisors. Consensus discussion between the researcher and supervisors on the category theme was done.

### *Confirmability*

Confirmability refers to the objectivity or neutrality of the data (Polit et al, 2001:315). In this study confirmability was demonstrated by explaining research methodology fully including literature control to maintain clarity. Dense description of the results with direct quotation from participants was used.

## **2.8 Ethical Consideration**

The following ethical measures were adhered to during this study:

### *2.8.1 Researcher – Participants' relationship*

The researcher orientated the participants before the study was conducted. The researcher visited the participants before data collection in order to build a trusting relationship. Participants were given information on how they can contact the researcher if they wish to do so.

### 2.8.2 *Informed Consent*

Informed consent means that participants have adequate information regarding the research study, comprehend the information and have power of free choice enabling them to consent voluntarily to participate in the research or decline participation (Polit et al, 2001:78). In this study the title, purpose, method and objectives of the study were explained to the participants and their consent was obtained verbally.

### 2.8.3 *Gaining Access*

Formal letters requesting for permission were written to the Director of the Ministry of Basic Education, Sports and Culture, Ondangwa East and to the principals of targeted schools and such permission was granted.

### 2.8.4 *Free and voluntary participation*

Participants were informed that they had the freedom to participate in the study or to withdraw from the study after all the information was given to them.

### *2.8.5 Confidentiality and anonymity*

Participants were assured that the information collected would be handled with confidentiality. Data is not linked to individuals but reported in aggregate. Letters of alphabet were used to identify the participants. This was done with the purpose of not mentioning any participant's name in order to ensure anonymity. Permission was obtained from the participants to audiotape the discussions.

### *2.8.6 Statements of the research purpose*

The participants were informed about the purpose of the research and the expected benefits to both the researcher and the participants.

## **2.9 Summary**

This chapter has discussed the research rationale, objectives of the study, research design and method. In chapter 3 the findings of the study will be discussed.

## **CHAPTER 3**

### **FINDINGS AND DISCUSSION**

#### **3.1 Introduction**

In the previous chapter, the methodology used to conduct the study was discussed. In this chapter data analysis will be discussed according to the findings and in relation to literature control.

The sample in this study consisted of sixty teenage learners between the ages of 14 – 19 years both males and females in Grade 10 in Onandjokwe Health District, Oshikoto region. Five participants withdrawn from the study and reasons for withdrawal were not indicated. Participants were divided in groups according to gender, because sometimes females may not feel comfortable to share their views with males and vice versa. The schools included were combined schools and junior secondary schools within 10km radius from Onandjokwe Lutheran Hospital.

### 3.2 Findings

The raw data were coded and four categories of data were identified and further divided into various themes as displayed in the following table.

Table 3.1: **Major themes categories and subcategories.**

Knowledge	HIV/AIDS Sexually transmitted infections Safer sex
Practice	Self protection and HIV/AIDS prevention Self satisfaction Talking about safer sex
Attitudes	Safer sex Decision making
Information	Source of information Educational programs

### **3.3 Discussion of findings**

Knowledge, attitudes and practice of teenagers regarding safer sex are the major focus of this study and they will be discussed as follow.

#### **3.3.1 Knowledge of teenagers on HIV/AIDS and other sexually transmitted infections.**

HIV/AIDS and other sexually transmitted infections such as syphilis, gonorrhoea; chlamydia, genital ulcer, trichomonas vaginalis etc. are some of the major problems infecting people of all age group including teenagers in Namibia (WHO, 2001:9).

Therefore teenagers who are future generation need to have knowledge on HIV/AIDS, STI including the causes, the mode of transmission as well as the preventive measures.

During the discussion, it came out that although there are some teenagers who know something about HIV/AIDS and STI their knowledge is so limited. This was evident as per following quotes:

*“AIDS stands for Acquired Immune System”.*

*“AIDS stands for Acquired Immune disease Syndrome.”*

*“AIDS stands for Acquired Immune deficiency disease.”*

According to Nzimande (2003:36) AIDS stands for Acquired Immune Deficiency Syndrome which is caused by HIV and it impairs the body to fight infections with the result that the body becomes extremely susceptible to life threatening diseases. Other quotes which serve as evidence that teenagers have limited knowledge on sexually transmitted infections are as follow:

*“I only know of other sexually transmitted diseases such as syphilis and gonorrhoea and that is all”.*

*“The only sexually transmitted disease which I know is syphilis.”*

*“Chicken pox is also a sexually transmitted disease.”*

*“There is a sexually transmitted disease which causes a person to have sores around the genitals, but I do not know the name of such disease”.*

According to Avraham (2001:42) there are many sexually transmitted infections such as chlamydia, trichomoniasis, gonorrhoea, non gonococcal urethritis and cervicitis, genital warts, genital herpes, syphilis etc. which can infect a person if she/he does not practice safer sex.

The findings correlate with the information from literature. Government of the Republic of Namibia (1998:11) indicated that when young people are infected with a sexually transmitted infection, some of them they are not aware that they are infected.

This is because young people often have limited information about sex and sexual development and they have limited access to sexually transmitted diseases services.

According to the study done by Tjiramba (1995:3) on sexual knowledge, attitudes and practices among the Namibian youth, it was identified that young people displayed basic knowledge of sexual issues but the depth of knowledge was quite shallow. Such limited knowledge will lead to teenagers not to seek for professional help when they are infected with STI because they do not know that they have an infection.

Greathead, Devenish and Funnel (1998:2) indicated that teenagers are left to discover their sexuality through their peers and are thus left to absorb and perpetuate the myths, misconception and incorrect information of the past generation.

Due to the lack of knowledge and understanding about sexual health related problems they find themselves in situation they have not expected.

Besides limited knowledge on sexual health related problems teenagers know that they are at risk becoming infected by HIV/AIDS/STI. The following statements are evidence for this:

*“Any one is at risk of being infected by HIV/AIDS/STI if she/he does not practice safer sex”.*

*“Young people between the ages of 15-25 years who involve themselves in sexual intercourse are at risk of becoming infected by HIV/AIDS/STI”.*

*“Those who sleep around and those who have many boyfriends or girlfriends are at risk of being infected by HIV/AIDS/STI”.*

*“Any one is at risk because even a new born baby can be infected by HIV/AIDS through breast milk from the mother if the mother is HIV positive”.*

*“Any one is at risk of being infected by HIV/AIDS but more specifically people between the ages of 18-20 years because these are the people who are interested in having boyfriends and girlfriends but they do not protect themselves”.*

The findings correlate with some information from the literature. Advocates (2004:1) indicates that everyone is at risk of HIV/AIDS/STI because is not who you are but is what you do that put a person at risk.

According to Gorin and Arnold (1998:225) sexually active teenagers are also at risk of sexually transmitted infections because the cervical squamocoluminar junction emerges in adolescence makes teenage girls more vulnerable to chlamydial and gonorrheal infections.

Hopkins (2002:3) indicated that female teenagers are biological more susceptible to HIV acquisition than older women, they tend to have highest age specific rates of both gonorrhoea and chlamydia infections that cause cervical inflammation and increase the risk of acquiring HIV. However the findings also contradict some information from the literature. According to Schwarz (2003:48) the majority of young people between the age of 12-18 years did not feel at personal risk of contracting HIV/STI.

### **3.3.2 Knowledge of teenagers on safer sex**

Safer sex reduces the risk of becoming infected with HIV/AIDS, other STI and unplanned pregnancy (Terrace, 2004:1). Teenagers need to have knowledge on what safer sex is all about in order to be able to practice it.

During the discussion it again came out that some teenagers do have limited or no knowledge on safer sex. The following statements are evidence for this.

*“Safer sex is when you keep yourself not touched by disease such as AIDS and Syphilis”.*

*“Safer sex means protected sex when one is using condoms.*

*“I have no idea what safer sex means”*

Berer (1995:130) explained that safer sex involves some strategies such as being faithful to one partner, saying no to sex and delaying sexual intercourse until one is ready to get married, reducing the number of sexual partners or avoid having multiple sexual partners, selecting partners carefully, excluding people at risk and using condoms if involved in sexual intercourse.

According to Brian (2004:2) safer sex does not entail just wearing a condom, but it also includes knowing what to avoid and making right decisions.

Nova (2004:1) stated, abstinence or choosing not to have sex is the only way that truly protects the person and her/his partner from sexually transmitted infections and unplanned pregnancy. If one decides to have sex there is no 100% guaranteed method of protection against pregnancy and sexually transmitted infections.

Besides those who have limited knowledge regarding safer sex there are some teenagers who have some knowledge on safer sex. This was expressed by the following statement:

*“Safer sex means not to do sex at all”.*

*“Safer sex is when one taking care of himself by sticking to one partner or stay away from sex”.*

*“Safer sex means you do sex with somebody you know well”.*

These three statements correlates with Berer's strategies of safer sex that's abstinence and selecting partners carefully, excluding people at risk or being faithful to one partner (Berer 1995:130).

Most teenagers do have knowledge on the importance of practicing safer sex. This was expressed by the following statements:

*"It is important to practice safer sex, so that the HIV virus cannot spread from one person to another"*.

*"It is important to practice safer sex, so that you prevent yourself from sexually transmitted diseases such as gonorrhoea."*

*"It is important to practice safer sex so that one can prevent your girlfriend from getting pregnant"*.

*"It's important to practice safer sex to reduce embarrassment because if your country is rated high in HIV/AIDS infection this will cause embarrassment"*.

*"It's important to practice safer sex for many reasons such as to protect your body from infectious diseases e.g. syphilis"*.

*"It's important to practice safer sex because one can not get pregnant while schooling"*.

These findings correlate with what the literature has stated. According to Terrace (2004:1), practicing safer sex reduce the risk of passing any sexually transmitted infections and unwanted pregnancy to your partner.

According to USAID Namibia (2003:2), prevention campaign that focuses on comprehensive abstinence, be faithful or use condoms (ABC) approach with particular emphasis on delay of sexual debut, limiting partners, increase availability and use of condoms with non-regular partners and testing and counseling can reduce HIV/AIDS prevalence.

These findings also indicated that most teenagers know the risks involved in practicing unprotected sex. This was expressed as follow:

*“If you do unprotected sex you may get infected by sexually transmitted diseases.”*

*“If you do unprotected sex you can give pregnant to a girl while you have no money to support the baby.”*

*“If you do unprotected sex you may get diseases such as HIV and once you get tested and you are positive you may end up killing yourself”.*

*“You may get unwanted pregnancy while you are young and you will leave school. If you get HIV you may die and if you are not educated you will not get job because nobody will employ uneducated person”.*

*“Unprotected sex will result in unwanted pregnancy and sometimes you go and deliver and you may die due to pregnancy complications. If you are lucky you can go back to school but many schools do not want to admit mothers so you may go and look for work and the work you will get is like selling “kapana” and “tombo” and life will not be good at all”.*

The findings correlate with the information from the literature. Arkutu (1995:197) and Jackson (2002:22) indicated that unprotected sex will lead to teenage pregnancy and HIV/AIDS with its effects which include dropout from schools and death.

### **3.3.3 Practice of safer sex by teenagers**

The word “practice” was defined by Wehmeir (2001:912) as a way of doing something that is the usual or expected way in a particular situation.

According to Baranowski et al (1996:158) for the person to practice something he/she must have knowledge of it in order to be able to do it.

#### **3.3.3.1 Self protection and HIV/AIDS prevention**

According to this study teenagers have indicated that they do practice safer sex. This was expressed by the following descriptions:

*“I protect myself from HIV and other sexually transmitted diseases by staying away from sexual activities”.*

*“I protect myself from HIV and other sexually transmitted diseases by using condoms”.*

*“I protect myself from HIV/AIDS by being tested and asking my partner to be tested before involved in sex”.*

*“I protect myself by abstaining from sex and not to have a girlfriend until I complete my education”.*

*“I protect myself from HIV/AIDS and other sexually transmitted diseases by staying with one partner”.*

Although teenagers indicated ways of how they practice safer sex, from the discussion it came out that they do have problem with sizes of condoms as well as access to condoms. This was expressed by the following statements.

*“Sometimes you want to use condom, but the condom sizes available are too big and they cannot fit you. There is a need for small size condoms”.*

*“Nurses should provide us with condoms, because sometimes you want to have sex, but there are no condoms and this will lead you to involve yourself in unprotected sex which will lead to unwanted pregnancy”.*

*“It is better if condoms can be put at cucashops and nearby markets and schools, because at hospital and clinics where condoms are found they are far and sometimes they are not available”.*

*“Sometimes if you go to hospital asking for condoms, nurses will ask you many questions, because they think you are too young to get involved in sex”.*

Some of these findings correlate with the information from the literature. According to Rivers and Aggleton (2001:2) young people often have less access to information, services and resources.

Health services are rarely designed specifically to meet their needs and health care workers only occasionally receive specialized training in issues related to adolescent's sexual health. Therefore young people in a variety of context reported difficulty accessing condoms.

Authors further argued that one of the most important reasons why young people are denied adequate access to information, sexual health services and protective resources such as condoms derive from the stereotypical and often contradictory ways which they are viewed. It is popularly believed that all young people are risk taking pleasure seekers who live only for the present (Rivers and Aggleton, 2001:2).

According to the Government of the Republic of Namibia (1998:11) many teenagers have no access or little access to health services. Government of the Republic of Namibia (2002:2) indicated that health services providers have unfriendly attitudes towards teenagers when it comes to reproductive health issues. They lack confidentiality and privacy when handling young people's problems. Such attitudes result in teenagers being afraid of visiting health services.

Consequently big condom sizes, lack of access to health information and resources and unfriendly attitudes towards teenagers will lead to teenagers not to practice safer sex and this will result in HIV/AIDS infection, other STI and unplanned pregnancy.

### 3.3.3.2 How teenagers satisfy their sexual needs

According to Greathead et al (1998:95) the most dramatic of all developmental events in teenage is increased sexual desire, highlighted by new and mysterious feeling and thought associated with it. Due to such an increased sexual desire teenagers need to satisfy such desire.

During the discussion teenagers indicated that they satisfy their sexual desire through practicing safer sex. This was expressed as follows:

*“If you have a girlfriend you can satisfy your sexual need by just kissing each other but not having sex “.*

*“If you have a girlfriend you can touch each other so that you can satisfy your sexual desire”.*

*“If you do not have a boyfriend you can just touch your self on your clitoris until you are satisfied”.*

*“I can satisfy my sexual desire through masturbation”.*

*“I can satisfy my sexual desire by doing sex but using condoms”.*

This correlate with the literature because according to Berer (1995:136) practicing safer sex involves activities such as massaging, masturbation, kissing, hugging, cuddling, body to body rubbing or using sex toys or aids which are not shared.

### 3.3.3.3 How the youth talk about safer sex

For the teenagers to practice safer sex they also need to talk about it amongst themselves. This is because when children are growing up, they start to loosen ties with families and form new ties with peers which may influence them positively or negatively (Searle et al, 1993:415).

During the discussion it emerged that although there are some teenagers who discuss about safer sex, some of them never talk about it. This was demonstrated by the following expression:

*“We talk about safer sex by encouraging others not to involve themselves in sex as they are still young”.*

*“We talk about safer by encouraging using condoms when involved in sexual intercourse”.*

*“We tell others that getting involved in sex while still young is very dangerous so they must stay away”.*

*“We do not really discuss issues related to safer sex”*

*“We never discuss safer sex issues”*

According to Baranowski et al, (1996:158) social environment which include peers at school or in the class is one of the factors which influence the teenagers to practice or not to practice safer sex. For example if his/her peers encourage him/her to stay away from sex or to use condom when involved in sexual activity than such a teenager is likely to follow his/her peers.

Stanhope and Lancaster (1996:666) identified that discussing reproductive health related topics such as sexuality is a sensitive matter. Teenagers have difficulties in expressing themselves because of the limited sexual vocabulary and embarrassment due to lack of knowledge. According to Otaala (2000:31) discussing sex in many African cultures is taboo. Consequently this leads to many teenagers not to discuss sexually related issues. Schoelberlein (2001:5) indicated that teenagers commonly mask their concerns and questions regarding sexual related issues because of fear and embarrassment.

### **3.3.4 Attitudes towards safer sex**

According to Wehmeier (2001:62) attitudes is the way one thinks and feels about something. Udjombala (2001:14) indicated that attitude is a complex psychological concept that cannot be observed easily as a person's physical characteristics. It serves as a convenient summary of a wide variety of beliefs about health and illness.

Therefore an attitude is simply a tendency to evaluate an object or construct in positive or negative terms.

#### **3.3.4.1 Attitudes of teenagers regarding safer sex.**

In this study attitude of teenagers regarding safer sex was determined by asking questions such as “what can you tell your boyfriend or girlfriend if he/she asks you to have sex with him/her? And other questions like “How can you convince your boyfriend or girlfriend to practice safer sex?

During the discussion it appears that teenagers have positive attitudes toward safer sex. This was shown by the following expressions.

*“If my girlfriend asks me to have sex with her I will tell her that we have to use a condom”.*

*“I will tell my girlfriend that I do not want to have sex because it is my choice and if she insists I will leave her”.*

*“I will tell my boyfriend that I am not going to have sex with you as I am still young and I am not ready, so we have to wait until we get married so that we can take care of our children”.*

*“I will tell her to wait until the age of 25 years so that I can finish school as I do not want to spoil my future”.*

*“I can say yes if we are using condoms, but if he does not want condom, I will leave him and move on with my life.*

*“I will convince my boyfriend to practice safer sex by telling him to carry condoms always and to get tested if he wants to have sex with me.*

Sometimes teenagers want to say no to sex but peer pressure and lack of assertiveness prevents them to do so. Sellers (1993:1720) indicated that teenagers need to be reassured that it's alright to say no to sex. According to Terrace (2004:4) starting a conversation with a partner about safer sex is not easy for both male and female teenagers. It is often difficult to be assertive when negotiating safer sex because usually teenager may worry about the partner's reaction and they may also worry if they do not know how to use a condom.

Rivers and Aggleton (2001:4) indicated that sexually active young women are discouraged from discussing sex openly with their own partners since women are encouraged to be ignorant and inexperienced. Consequently young women are unlikely to communicate their need for safer sex with their partners.

#### **3.3.4.2 Opinion of teenagers on sex at an early age**

Sometimes teenagers start to have sex at an early age. According to Onandjokwe Health information system there were about 10 pregnant women under the age of 15 years in 2001 and 11 and 13 pregnant women under 15 years in 2002 and 2003 respectively who attended antenatal care.

There are many contributing factors for teenagers to start sex at an early age and some of these contributing factors are lack of knowledge on the risks involved in sex at an early age, lack of knowledge on how to practice safer sex, poverty, unclear messages from parents and peer pressure etc. (Tjiramba, 1995:1; Sanderson, 2000:2).

According to teenagers who participated in this study they think that it is not good to start having sex at an early age. The following statements expressed by teenagers demonstrated such evidence.

*“It is not good to have sex at an early age, because you may end up pregnant while still young and if your baby got sick you don’t know how to take care of that baby”.*

*“It is not good to have sex at an early age, because you may become infected with HIV/AIDS and you may die soon”.*

*“I don’t think that sex is for the small children so it is not allowed, it is for the people who are 25-45 years”.*

*“One does not need to think about sex at the age of 15 years, because he/she is still young”.*

From the literature reviewed it correlates with the above findings, because it indicates that teenagers are vulnerable group at risk of unwanted pregnancy as well as HIV/AIDS if they do not practice safer sex due to their development stage.

According to Kozier, Erb, Blass & Wilkinson (1995:616) teenage is a period of development where the secondary characteristics are appearing and during this period teens start to attract opposite sex. The author further argued that teenagers begin Piaget`s formal operation stage of cognitive development at the age of 15 years. A main feature of this stage is that teenagers think beyond the world of reality, they are highly imaginative and idealistic. They may consider things that do not exist and ways things could be or ought to be. Consequently teenagers may end up being involved in sexual activity while they are still young (Kozier et al, 1995:617)

One of the major characteristics of teenagers is the awakening of awareness of social relationships and status within personal group context. A strong desire develops for acceptances by parents, friends and peers. Consequently teenagers begin to expand their horizons and take interest in the society at large.

They start to develop strong relationship with their peers and the influence of peers could be positive or negative and may outweigh that of parents. Negative influence may lead to deviant behavior which includes unprotected sex (Searle et al, 1993:415).

The author further argued that many teenage problems are self identification and confusion concerning role expectation which include heightened sexuality. As a result, teenagers found themselves in a sexual relationship where they involve themselves in sexual intercourse (Searle et al, 1993: 415).

Participants have given different opinion regarding the age of starting sex and it was expressed as follow:

*“I think that the person can start having sex at the age of 18 years, because at that age at least a person have finished school and has job and money and a house and might be married and if you happen to have disease such as HIV/AIDS you can buy your medicines and take care of the baby”.*

*“One can start having sex at the age of 25 years, because you are no longer young, and you know what you are doing”.*

*“I think one can start having sex after marriage, because after marriage people are allowed by culture to have sex and to have children”.*

Although there are those who think that sex can be started from the age of 18 years and above, some of them think that even at the age of 15 years one can do sex. This was expressed as follow:

*“Even at the age of 15 years one can do sex, because sex is a natural thing as long as one is using a protection”.*

Greathead et al (1998:95) indicated that the question to have or not to have sex start at puberty and this is more difficult due to factors such as imbalance of hormones and lack of decision making skills. According to Lothian (2003:1) teenage is a difficult time because teens are faced with very complicated and important decisions to make. One of such decisions is whether to have sex or not. Many teenagers want to say no but lack of assertiveness and peer pressure prevent them from doing so.

Terrace (2004:2) indicated that young people feel a lot of pressure to have sex.

Friends may tell them that they are all doing it and they may feel pressured by a particular person such as boyfriends or girlfriends. According to Sellers (1993:1720) teenagers must not involve themselves in sexual activities while they are young they have to wait until they are mature physically and psychologically so that they can make wise decisions.

### **3.3.5 Source of information regarding sexual health**

Provision of information to teenagers regarding sexuality will help them to realize that they have power to shape their lives and it will also help them to use better approaches in preventing sexually transmitted diseases and unwanted pregnancies.

During the discussion with participants, health facilities were identified as the most important source of information regarding sexual health. This was demonstrated by the following expressions.

*“I get information regarding sexual health from clinics and hospitals, especially if I visit the hospital or clinics nurses teach us how to use condoms and contraceptives”.*

*“I get information from clinic for example when I visit the clinic nurses gave us some books to read “*

*“I get information on sexual health from hospital, like when I went for treatment; nurses gave us pamphlets to read”.*

Such findings correlate with the evidence from literature. According to the Government of the Republic of Namibia (2002:2), health facilities are the most important source of health information, therefore health workers need to be up- to-date with health information in order to provide it to other people.

According to Rivers and Aggleton (2001:7) sexual health services need to be user friendly and training in adolescent health issues should be provided to health care workers.

Other sources of information identified by participants are “My future is my choice program which is found at some school but at some schools it does not exist.

Media such as radio, television and newspapers were also identified as source of sexual health information as well as life science and life skills teachers and regional councilors.

This was expressed as follow:

*“I get the information by reading from magazines such as Choose Life and from newspapers”.*

*“I get information from school e.g. from life skill teachers”.*

*“I get information from radio and television”.*

*“I was a member of a group called”My future is my choice” when I was at another school in Ohangwena region and I got some information on sexual health from such a group”.*

*“You can also get some information from Regional Councilors e.g. if you have some questions you can go to their offices and ask them”.*

According to Greathead et al (1998:1) teenagers are being bombarded with sexual messages by mass media which often include sexual aggression due to their limited knowledge on sexual health related matters they find themselves in situations which they had not intended.

Although there are many sources of information on sexual health related matters, it emerged from the discussion that most of the information focused more on HIV and AIDS. This was expressed as follow:

*“Most of the information we got focused on HIV/AIDS such as causes and prevention, because some people who visited us showed us some videos cassette on HIV/AIDS”.*

*“The information focuses on the prevention of HIV/AIDS and how to live and care for HIV infected people”.*

*“The information includes how the body can be attacked by HIV virus and how the virus spread to other people”.*

Sexual health is a very broad concept which includes other aspects such as the development of reproductive system, the causes and prevention of other sexually transmitted diseases and teenage pregnancy (King, 2001:2).

#### **3.3.5.1 Persons most comfortable to discuss sexual issues.**

Because of the adverse effects of teenage pregnancy, HIV/AIDS and other sexually transmitted diseases among the youth, teenagers need to be made aware of such effects.

Raising awareness among the youth need to become everybody's business, because health for all people cannot be achieved by making use of health workers alone. Other sectors such as education, community's own resources such as parents and traditional leaders have to be involved so that optimum standard of health among the youth can be achieved (Vlok, 1996:26).

During the discussion, it came out that teenagers feel more comfortable to discuss sexual health related matters with health workers and teachers. This was expressed by the following statements.

*"I feel more comfortable to discuss sex and sexual relationship with nurses, because they know more about how to prevent diseases and they have knowledge and skills on such issues".*

*"I feel more comfortable with the doctors, because they have more knowledge when it comes to sexual health matters".*

*"I prefer to discuss sex and relationship with nurses, because they have more knowledge about health related matters and they will offer different opinions".*

*"I feel comfortable to discuss sexual health related matters with my teacher, because I will not be shameful to talk to my teacher".*

*"I prefer to discuss sexual health related matters with a female teacher, because she knows more on women's problems".*

Although teachers were identified as sources of information, it also emerged from the discussion that not all teachers are equipped with more information on sexual health. This was expressed as follow:

*“Teachers need to be trained in issues related to sexual health so that they can give learners adequate information”.*

*“Like the information we get from teachers, they only give us the information they know and think that young people need but we need to know more about sexual health, so I think teachers need to consult doctors and nurses for more information”.*

*“I do not think the information we get is enough especially from teachers they only explain few things about sexual activities”.*

Such findings correlate with findings in literature. According to Boler & Corroll (2003:4) it appears that teachers choose which message to give to learners often relying on an overly scientific approach and avoiding any discussion about sex.

According to the study done in the schools of state of Tamil Nadu in India, from 92% of students who claimed that they had received HIV education, about one-third reported never having been taught about sex.

Schoeberlein (2001:5) indicated that teachers must be clear that they are presenting health information not their own personal beliefs, religious views or values.

During discussions teachers must listen and respond professionally to direct statements or questions of teenagers. According to Greathead et al (1998:95) educators need not to limit their teaching to what they believe is right as this will prevent teenagers from establishing their own value systems.

The author further argued that presenting sexual information in a more balanced manner highlighting the positive and negative effects is not only more honest but will help teenagers to make reasonable decisions. Rivers and Aggleton (2001:6) indicated that teachers also require training in delivering sex education and developing confidence in talking to young people about sex.

Other people identified by teenagers as whom they feel comfortable to discuss sexual health related matters are friends, brothers, sisters and parents. Although parents were also identified as source of information some respondents indicated that parents are not free to discuss sex and relationship with their teenagers. This was expressed as follow:

*“I feel more comfortable to discuss sex and relationship with my friends, because they talk more freely than my parents”.*

*“But some parents are not free to discuss sex related issues especially fathers”.*

*“Not all parents discuss sex-related matters with their children and the reason for this is that they think their teenagers are still kids, but at the end teenagers end up being pregnant or infected with HIV/AIDS and other sexually transmitted diseases”.*

The findings correlated with findings from literature. Gorin and Arnold (1998:215) identified most parents are not able to talk seriously about sexuality and do not feel comfortable to respond to their children's questions. They find it hard to have open and constructive discussion about sexual matters.

According to Greathead et al (1998:1) most parents are not equipped to provide the necessary information as many are not adequately informed or are too embarrassed to discuss sexuality. The author further argued that parents generally agree that teen sex is not advisable because of the devastating effects it have. This caused many parents to use fear to discourage sexual activity among teenagers by highlighting the negative consequences. This was done in hope that curiosity and natural desire to experiment will stop. Unfortunately using fear has shown to encourage teenagers to have sex.

According to Otaala (2003:31) discussing sex in many African cultures is taboo, but parents and community leaders must understand that the world in which young people live today is different from the world of twenty or thirty years ago.

Rivers and Aggleton (2003:3) indicated that in countries such as India and Nicaragua parents and children reported that they do not talk to each other about sex. Often parents and family members do this with the belief that they are protecting young people from the information they believe may lead to sexual experimentation.

However evidence has shown that young people who communicate openly about sexual matters with their parents are less likely to be sexually active or in case of girls to become pregnant before marriage.

### **3.3.6 Educational programs.**

In order to provide the necessary information to teenagers regarding safer sex and to address their needs, educational programs need to be developed in schools and health facilities. Such health programs will help young people to maintain healthy behaviors and change or avoid behaviors that can put themselves or other at risk (WHO 1992:4).

Large numbers of young people throughout the world attend school, therefore information, values and skills conveyed in schools can have a considerable impact on young people's lives (WHO, 1992:2).

During the discussion, it came out that there are only limited educational programs for teenagers, whether in schools or health facilities. This was expressed as follow:

*“I can only remember that we were visited by some HIV positive people who came to warn us about the danger of HIV/AIDS, but beside that there are no other educational programs which provide us with information regarding sexual health”.*

*“There are no other educational programs which provide us with information regarding sexual health beside “My future is my choice”.*

*“There are no educational programs which provide us with information regarding safer sex; we only get some information from newspaper like super Strike and Youth talk”.*

*“There is one educational program called My future is my choice but we do not have it at our school, some people under such program visited our school but we do not know where they came from”*

*“There are no educational programs which provide us with information regarding safer sex”.*

This correlates with the findings from literature. According to Schenker (2003:1) we are still far from meeting the challenge for providing young people with accurate, reliable, practical, non discriminatory and comprehensive knowledge, information and skills that will help them not to be infected with HIV/AIDS and other sexually transmitted infections.

Katz and Finger (2002:1) identified that there is an understandable fear that teaching teenagers about sexuality might encourage them to experiment sexual activity.

However in countries that have instituted comprehensive programs on sex education, the rates of teenage pregnancies and birth are substantially lower than in countries that did not make such provision.

Gorin and Arnold (1998:226) argued that the World Health Organization has spoken strongly that sex education in school will not encourage early or increased sexual activity in young people but it will lead to the postponement of sexual activity or increase responsible sexual behaviors and help to protect teenagers not only from unwanted pregnancies but also from potential fatal disease.

During discussion, it also came out there are some schools that have educational programs such as “My future is my choice” and AIDS awareness clubs, but there are some schools which do not have any educational program.

Even though some schools have educational programs, not all learners are members of such programs. This can be validated by the following statement.

*“We have AIDS awareness club at our school, but not all learners are members, but there are not criteria which restrict them from becoming members it is only that they are ignorant”.*

This can be interpreted that there is ignorant on the side of the learners, but other contributing factors could be that the learners do not really understand the importance of such clubs. According to WHO (1992:4) educational programs should be developed within the context of beliefs and values as well as behavioral norms of the society. It needs to address the needs and concerns of young people.

Participants in the study also indicated that the information they get either from existing educational programs and other sources are not adequate. This was expressed as follow:

*“The information we get about sexual health is not enough, because in our country there are some people who do not know how to protect themselves against sexually transmitted diseases”.*

*“I don’t think the information we get about sexual health is enough, because most teenagers do not know how to use femidoms or condoms”.*

*“I think the information that we get is not enough, because if you compare a person from urban area to the person from rural area, some people in rural areas do not believe that HIV/AIDS do exist”.*

*“I don’t think the information we get is enough because we still need more information on sexual health matters”.*

*“The information we get is not enough because there lot of changes taking place so we need some programs so that we will be able to take care of ourselves so that we can improve our health”.*

According to WHO (1992:2) educational programs should fully inform young people about HIV/STI transmission and means of prevention and help them to develop skills to act on their knowledge and communicating it to others. Educators should develop program activities in which they assess what teenagers want to know and what they already do. Educators need to promote positive attitudes towards teenagers and build life skills such as assertiveness, self esteem and confidence.

Greathead et al (1998:1) indicated that education about sexuality should provide information and guide young people towards healthy attitudes and to develop concern and respect for others.

Rivers and Aggleton (2001:6) stated that formal programs on sex education and HIV-related education are most successful when they include messages about safer sex as well as abstinence. The authors further argued that program designers and others concerned with HIV infections must promote a greater awareness of structural issues affecting young people and improve access to education and health services

Participants have also given their views on how the information should be improved in order to reduce the risk of HIV/AIDS/STI transmission and unwanted pregnancy. These views were expressed as follow:

*“Nurses need to organize meetings in the villages so that they can give information, because the information given in the village can be received better than the one given in the hospital”.*

*“Learners from rural areas need to be shown pictures of people who are already infected with HIV or suffering from AIDS e.g. the face of the patient can be covered than the picture can be taken”.*

*“Nurses need to organize meetings in the community and to talk in churches and at schools in order to provide the youth with information on sexual health related matters”.*

*“There is a need for some programs in villagers for people who do not attend schools so that they can be taught on how to prevent sexually transmitted diseases and such programs need to be organized by health care team”.*

*“Hospital staff needs to visit schools and give booklets in which learners will get some information on sexual health matters”.*

Such findings correlates with the findings from the literature as health workers are viewed by community members as good source of information. According to WHO (2001:1) health workers are viewed as vital to the health sectors and through their respective expertise they contribute directly to the betterment of the general health of the human being and they support and create health and well being. Therefore health workers need to be equipped with knowledge and skills so that they can make a major contribution to the health of the whole community including teenagers.

### **3.4 Summary**

In this chapter, the data was analyzed and discussed in light of the literature control. In the final analysis teenagers have limited knowledge on safer sex and other sexual health related matters. Some of the factors which lead to teenagers to have limited knowledge are that teenagers are not provided with adequate information regarding safer sex whether by parents or teachers. They have limited access to health services, because health services are rarely designed specifically to meet their needs. There are only few educational programs which provide teenagers with information on safer sex and other sexual health related matters. On the other hand teenagers know the risks involved in practicing unprotected sex which include HIV/AIDS and other STI as well as unwanted pregnancy.

However teenagers have positive attitude towards safer sex as they have indicated that they may rather abstain from sex or use protective measures such as condoms if they are involved in sexual activities. Therefore in the next chapter, conclusions, recommendations, and limitations will be presented.

## CHAPTER 4

### CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

#### 4.1 Introduction

In the previous chapter the findings of the study were presented and discussed in detail by integrating the findings into existing literature. In this chapter, conclusions, recommendations and limitations are described.

The purpose of the study was:

- To explore and describe knowledge, attitudes and practices of safer sex by teenagers.
- To make appropriate recommendations which will help teenagers to improve their knowledge, attitudes and practices on safer sex. To achieve these objectives the researcher conducted focus group discussions consisting of teenagers from different schools.

The central questions in the study were:

- What do teenagers know about safer sex?
- Do teenagers practice safer sex and how?
- What attitudes do teenagers have toward safer sex?

- Are the teenagers aware of any educational program in place which deals with the provision of information regarding safer sex?

A qualitative, exploratory, descriptive and contextual research design was used to answer these questions. Focus group discussions consisting of teenagers were conducted at different schools. Relevant observations were recorded in the field notes and they were utilized during data analysis.

During data collection and data analysis certain strategies were used to ensure trustworthiness of the data and this includes criteria such as credibility, dependability, and confirmability.

## **4.2 Conclusions and recommendations as per objectives**

Conclusions from the findings are presented in relation to the objectives of the study and relevant recommendations are made.

### **4.2.1 Objective one: To determine the knowledge of teenagers on safer sex**

#### **Conclusion**

Teenagers have some knowledge on safer sex and other issues related to sexual health, however such knowledge is limited.

Contributing factors to teenagers to have limited knowledge may be attributed to limited access to information and few or lack of educational programs at schools and in the community. Health services are rarely designed specifically for teenagers and there is fear that teaching teenagers about sexuality might encourage them to experiment sexual activities (Rivers and Aggleton, 2001:2; Katz and Finger, 2002:1).

### **Recommendations**

There is a need to improve the knowledge of teenagers on safer sex and other sexual health related issues. This can be done through teaching young people sexual development from early age, especially when they are entering puberty so that they can understand better other aspects such as how a person become pregnant or can be infected by HIV/AIDS and STI. This will enable teenagers to understand what safer sex is all about and the importance of practicing it.

Due to limited access to information and health services, there is a need to establish health services specifically designed for young people e.g. in health facility there is a need to have a room for young people and health workers who are specifically trained to deal with adolescent reproductive health issues. Such health care workers should provide information to young people and attend their problems and counsel them. This will encourage teenagers to go to health facilities and look for information since they consider health workers as best sources of information.

#### **4.2.2 Objective two:** To determine how teenagers practice safer sex.

### **Conclusions**

It was stated by teenagers that they do practice safer sex by staying away from sexual activities, using condoms, getting tested before involving in sex and also by masturbating and kissing or touching each other in order to satisfy their sexual needs. Although teenagers do practice safer sex, they identified some of the problems which may sometimes lead them not to practice safer sex such as unavailability of condoms and big sizes condoms that they do not fit and also that sometimes they do not have access to condoms since hospitals and clinics are sometimes far. The attitude of health workers make teenagers shy to ask for condoms as health workers might say that they are too young to get involved in sexual activities.

### **Recommendations**

It is better to place condoms at cucasshops and market places because these are the places where most people meet their friends. Where this strategy is already practiced it needs to be strengthened. However community members should be made aware of condom distribution strategy and improve access to them. At health facilities, it is better to put condoms in toilets so that teenagers do not need to ask for them but just to pick from toilets.

**4.2.3 Objective three:** To determine the attitudes of teenagers toward safer sex

### **Conclusion**

The researcher concluded that teenagers have positive attitudes toward safer sex as they are not prepared to indulge in sex without preventive measures such as condoms/femidoms or to be forced into sexual activities when they are not ready to do so.

### **Recommendations**

Such practice needs to be strengthened and these teenagers can be used in other schools to motivate others to adopt same attitudes.

**4.2.4 Objective four:** To determine whether teenagers are aware of any educational programs in place which deals with the provision of information to teenagers regarding safer sex.

### **Conclusion**

Most teenagers are aware of only few educational programs which provide them with information regarding sexual health and safer sex mainly “My Future is my Choice”.

This educational programs is only at some schools, while there are no educational programs which deal with the provision of information to teenagers regarding sexual health related matters and safer sex at some schools.

It was also found that although teenagers are provided with some information regarding sexual health, the information is so limited, because it is mostly focused on HIV/AIDS and only little emphasize was put on other sexually transmitted diseases and teenage pregnancy.

### **Recommendations**

Since large numbers of teenagers are found in schools, it is recommended that there is a need to increase and improve the educational programs which provide teenagers with information regarding safer sex and other sexual health related issues. This can be done by establishing educational programs at schools especially those school which do not have any program like “My future is my choice” so that all school can have uniformity and all learners especially teenagers need to be members of such programs and clubs. The subject life science offered at school need to be reviewed to include issues related to sexual and reproductive health.

There is also a need to introduce peer group education sessions at schools where teenagers can share information and discuss issues related to sexual health because teaching a certain topic in the class only few learners will get something but some of them might not listen. However if learners are discussing a topic among themselves, they might get a lot of ideas as they will be free to talk to each other, but this need to be discussed under guidance of a knowledgeable facilitator.

### **4.3 Other relevant Recommendations**

#### **4.3.1 Helping teachers to convey knowledge related to sexual health to teenagers**

Literature and this study revealed that teachers do not really convey adequate information to teenagers regarding sexual health. Literature has indicated that teachers choose which messages to give to learner and avoid any discussion about sex, therefore they require training in delivering sex education and developing confidence in talking to young people about sex (Boler and Carroll, 2003:4; Rivers and Aggleton, 2001:6).

In order to help teachers to convey knowledge related to sexual health, there is a need to do collaborative workshops between health workers and teachers, so that teachers can be helped on how to convey or teach issues related to sexual health.

Where possible sexual health related matters need to be taught by health workers e.g. as guest teachers, because sometimes teachers find it difficult to teach sexual health issues due to limited sexual vocabulary.

#### **4.3.2 Involving parents in educating their children on sexual health issues.**

This study also revealed that there is a need to involve parents in educating their children about sexual health, because parents are not free to discuss sexual health issues with their children, instead they give unclear messages to their teenagers like “do not play with girls or boys” (Sanderson, 2000:2).

In order to involve them in educating their children, parents themselves need to understand sexual health issues and this can be done through meetings and programs in media such as radio and television. Parents need to be made aware that it is their responsibility to talk to their children and to understand that teaching sexuality to children will not encourage them to experiment sexual activity as most parents think. However it will help teenagers to take more responsibility of their own lives.

### **4.3.3 Conducting similar research in other regions**

There is a need to conduct similar research in other regions to determine knowledge, attitudes and practices of other teenagers regarding safer sex as this will enable health programs to be improved or developed to address the needs of teenagers.

## **4.4 Limitations of the study**

The following were the limitations to this study:

- Although it was accepted that participants would answer honestly to the questions posed to them, the presence of researcher might have influenced them that they answered in a manner in which they thought it is expected and this is commonly referred to as the Hawthorne effect (*Cormack, 1994:143*).
- Although the participants preferred to respond in English and they tried their best to communicate, this was a set back, because they were limited to express themselves because of the language.
- This study results are contextual and cannot be generalized to other regions.
- The study could have covered many schools in Onandjokwe Health District but due to time limit and unavailability of funds this was not possible.
- Although the sample size for each school was suppose to be six learners some participants have withdrawn from the study and this was a setback because the researcher did not get their views.

#### **4.5 Summary of the study**

The study focused on the knowledge, attitudes and practices of safer sex by teenagers. Literature search on safer sex and teenagers were conducted. Information was collected which enabled the researcher to explore and describe the knowledge, attitudes and practices of teenagers regarding safer sex.

The study revealed that teenagers have limited knowledge on safer sex and positive attitudes toward safer sex and they do practice safer sex beside other problems of unavailability and lack of access to condoms

Recommendations were formulated based on the results of the study. There is a need to improve the knowledge of teenagers on sexual health and teachers and health workers to work in collaboration with each others. There is also a need to improve educational programs especially at schools. This would help the teenagers to take responsibilities of their own lives and to prevent HIV/AIDS and other sexually transmitted infections as well as unwanted pregnancies.

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## ANNEXURE 1

# APPLICATION FOR PERMISSIONS TO CONDUCT RESEARCH

Date: 06 April 2004

P. O. Box 870  
Ondangwa  
9000

Enquiries: Mrs. E. Mulenga  
Onandjokwe Health Training Centre  
Tel: (065) 240111 (W)  
(065) 242256 (H)  
Cell: 081 2900 135  
Fax: (065) 248202

The Acting Director of Education  
Ministry of Basic Education, Sport and Culture  
ONDANGWA EAST  
P/BAG 2027

**RE: APPLICATION FOR PERMISSION TO CONDUCT THE RESEARCH STUDY IN THE FOLLOWING SCHOOLS: Hans Daniel Junior Secondary School, Combined School, Oneputa Combined School, Onamulunga Combined School, Olukonda Combined School and Oshilulu Combined School,**

I am Ester Mulenga, a Master in Public Health Degree student at the University of Namibia. One of my requirements is to conduct a research study for my dissertation and I am hereby applying for a permission to conduct my research study in the above-mentioned schools, which fall under your directorate from June - August 2004. The study title is: **Knowledge, Attitudes and Practices of teenagers regarding safer sex in Onandjokwe District, Oshikoto Region.**

The study population includes teenagers between the ages of 14 - 19 who are still schooling in Grade 10 in the six above-mentioned schools. The information to be collected will be handled with confidentiality and used for study purpose only.

Therefore, I am humbly requesting your good office to grant me a permission to conduct my research study in those schools.

Attached please find the copy of approval letter from the University of Namibia, the copy of my research proposal and some of the questions to be included in the research study.

I will appreciate it if my application receives your favourable consideration.

Thank you,

Yours faithfully

  
\_\_\_\_\_  
Mrs. E. Mulenga

P. O. Box 870  
Ondangwa  
9000  
22 April 2004

**Enquiries:** Mrs. E. Mulenga  
**ONANDJOKWE HEALTH TRAINING CENTRE**

**Tel:** 065 - 240111 - 2297 (w)

065 - 242256 (h)

**Cell:** 081 2900 135

**Fax:** 065 - 248202

The Principal  
**Hans Daniel Junior Secondary School**  
Ondangwa

**RE: APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH STUDY AT HANS DANIEL JUNIOR SECONDARY SCHOOL.**

I am Ester Mulenga, a Master in Public Health Degree student at the University of Namibia. One of my requirements is to conduct a research study for my thesis and I am hereby applying for a permission to conduct my research study at your school, from June - August 2004. The study title is, **Knowledge, attitudes and practices of teenagers regarding safer sex in Onandjokwe Health District, Oshikoto region.**

The study population includes teenagers between the age of 14 - 19 years who are still schooling in Grade 10 in five schools, which include Hans Daniel Junior Secondary School. The information to be collected will be treated with confidentiality and used for study purpose only.

Therefore, I am humbly requesting your good office to grant me a permission to conduct my research study in your school. Once permission is granted I will contact you in person and arrange with you.

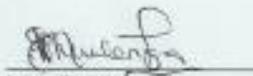
Together with my application I am enclosing the following:

- ❖ Copy of permission letter from the Regional Director of Oshikoto Region, Ministry of Basic Education, Sport and Culture.
- ❖ Copy of approval letter from the University of Namibia.

I will appreciate it if my application receive your favorable consideration.

Thank you,

Yours faithfully

  
Mrs. E. Mulenga

P. O. Box 870  
Ondangwa  
9000  
22 April 2004

**Enquiries:** Mrs. E. Mulenga  
**ONANDJOKWE HEALTH TRAINING CENTRE**

**Tel:** 065 - 240111 - 2297 (w)  
065 - 242256 (h)  
**Cell:** 081 2900 135  
**Fax:** 065 - 248202

The Principal  
**Olukonda Junior Secondary School**  
Ondangwa

**RE: APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH STUDY AT  
OLUKONDA JUNIOR SECONDARY SCHOOL.**

I am Ester Mulenga, a Master in Public Health Degree student at the University of Namibia. One of my requirements is to conduct a research study for my thesis and I am hereby applying for a permission to conduct my research study at your school, from June - August 2004. The study title is, **Knowledge, attitudes and practices of teenagers regarding safer sex in Onandjokwe Health District, Oshikoto region.**

The study population includes teenagers between the age of 14 - 19 years who are still schooling in Grade 10 in five schools, which include Olukonda Junior Secondary School. The information to be collected will be treated with confidentiality and used for study purpose only.

Therefore, I am humbly requesting your good office to grant me a permission to conduct my research study in your school. Once permission is granted I will contact you in person and arrange with you.

Together with my application I am enclosing the following:

- ❖ Copy of permission letter from the Regional Director of Oshikoto Region, Ministry of Basic Education, Sport and Culture.
- ❖ Copy of approval letter from the University of Namibia.

I will appreciate it if my application receive your favorable consideration.

Thank you,

Yours faithfully

  
Mrs. E. Mulenga

P. O. Box 870  
Ondangwa  
9000  
22 April 2004

**Enquiries:** Mrs. E. Mulenga  
**ONANDJOKWE HEALTH TRAINING CENTRE**

**Tel:** 065 - 240111 - 2297 (w)  
065 - 242256 (h)  
**Cell:** 081 2900 135  
**Fax:** 065 - 248202

The Principal  
**Onamulunga Combined School**  
Ondangwa

**RE: APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH STUDY AT ONAMULUNGA COMBINED SCHOOL.**

I am Ester Mulenga, a Master in Public Health Degree student at the University of Namibia. One of my requirements is to conduct a research study for my thesis and I am hereby applying for a permission to conduct my research study at your school, from June - August 2004. The study title is, **Knowledge, attitudes and practices of teenagers regarding safer sex in Onandjokwe Health District, Oshikoto region.**

The study population includes teenagers between the age of 14 - 19 years who are still schooling in Grade 10 in five schools, which include Onamulunga Combined School. The information to be collected will be treated with confidentiality and used for study purpose only.

Therefore, I am humbly requesting your good office to grant me a permission to conduct my research study in your school. Once permission is granted I will contact you in person and arrange with you.

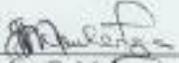
Together with my application I am enclosing the following:

- ❖ Copy of permission letter from the Regional Director of Oshikoto Region, Ministry of Basic Education, Sport and Culture.
- ❖ Copy of approval letter from the University of Namibia.

I will appreciate it if my application receive your favorable consideration.

Thank you,

Yours faithfully

  
Mrs. E. Mulenga

P. O. Box 870  
Ondangwa  
9000  
22 April 2004

**Enquiries:** Mrs. E. Mulenga  
**ONANDJOKWE HEALTH TRAINING CENTRE**

**Tel:** 065 - 240111 - 2297 (w)  
065 - 242256 (h)  
**Cell:** 081 2900 135  
**Fax:** 065 - 248202

The Principal  
**Oneputa Combined School**  
Ondangwa

**RE: APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH STUDY AT ONEPUTA COMBINED SCHOOL.**

I am Ester Mulenga, a Master in Public Health Degree student at the University of Namibia. One of my requirements is to conduct a research study for my thesis and I am hereby applying for a permission to conduct my research study at your school, from June - August 2004. The study title is, **Knowledge, attitudes and practices of teenagers regarding safer sex in Onandjokwe Health District, Oshikoto region.**

The study population includes teenagers between the age of 14 - 19 years who are still schooling in Grade 10 in five schools, which include Oneputa Combined School. The information to be collected will be treated with confidentiality and used for study purpose only.

Therefore, I am humbly requesting your good office to grant me a permission to conduct my research study in your school. Once permission is granted I will contact you in person and arrange with you.

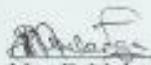
Together with my application I am enclosing the following:

- ❖ Copy of permission letter from the Regional Director of Oshikoto Region, Ministry of Basic Education, Sport and Culture.
- ❖ Copy of approval letter from the University of Namibia.

I will appreciate it if my application receive your favorable consideration.

Thank you,

Yours faithfully

  
Mrs. E. Mulenga

P. O. Box 870  
Ondangwa  
9000  
22 April 2004

**Enquiries:** Mrs. E. Mulenga  
**ONANDJOKWE HEALTH TRAINING CENTRE**

**Tel:** 065 - 240111 - 2297 (w)  
065 - 242256 (h)

**Cell:** 081 2900 135

**Fax:** 065 - 248202

The Principal  
**Oshilulu Combined School**  
Ondangwa

**RE: APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH STUDY AT OSHILULU COMBINED SCHOOL.**

I am Ester Mulenga, a Master in Public Health Degree student at the University of Namibia. One of my requirements is to conduct a research study for my thesis and I am hereby applying for a permission to conduct my research study at your school, from June - August 2004. The study title is, **Knowledge, attitudes and practices of teenagers regarding safer sex in Onandjokwe Health District, Oshikoto region.**

The study population includes teenagers between the age of 14 - 19 years who are still schooling in Grade 10 in five schools, which include Oshilulu Combined School. The information to be collected will be treated with confidentiality and used for study purpose only.

Therefore, I am humbly requesting your good office to grant me a permission to conduct my research study in your school. Once permission is granted I will contact you in person and arrange with you.

Together with my application I am enclosing the following:

- ❖ Copy of permission letter from the Regional Director of Oshikoto Region, Ministry of Basic Education, Sport and Culture.
- ❖ Copy of approval letter from the University of Namibia.

I will appreciate it if my application receive your favorable consideration.

Thank you,

Yours faithfully

  
Mrs. E. Mulenga

## **ANNEXURE 2**

**PERMISSION LETTERS FROM MINISTRY OF  
HEALTH AND SOCIAL SERVICES,  
DIRECTOR OF EDUCATION ONDANGWA  
EAST AND PRINCIPALS OF DIFFERENT  
SCHOOLS**



REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198  
Windhoek  
Namibia

Ministerial Building  
Harvey Street  
Windhoek

Tel: (061) 2032507  
Fax: (061) 227607  
E-mail: [sowoses@mhss.gov.na](mailto:sowoses@mhss.gov.na)

Enquiries: Ms. S. Owoses

Ref.: 17/3/3/AP

Date: 11 May 2004

**OFFICE OF THE PERMANENT SECRETARY**

Ms. E. Mulenga  
P. O. Box 870  
Ondangwa

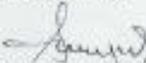
Dear Ms. Mulenga,

**KNOWLEDGE, ATTITUDE AND PARCTICES OF TEENAGERS REGARDING SAFE SEX IN ONANDJOKWE DISTRICT, OSHIKOTO REGION, NAMIBIA**

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit. However, some issues in the proposal need to be revisited. Please find attached comments/recommendations for consideration.
3. Kindly be informed that approval has been granted under the following conditions:
  - 3.1. The data collected is only to be used for your Masters degree;
  - 3.2. A quarterly progress report is to be submitted to the Ministry's Research Unit;
  - 3.3. Preliminary findings are to be submitted to the Ministry before the final report;
  - 3.4. Final report to be submitted upon completion of the study;
  - 3.5. Separate permission to be sought from the Ministry for the publication of the findings.

Wishing you success with your project.

Yours sincerely,

  
DR. K. SHANGULA  
PERMANENT SECRETARY



Directorate: Policy, Planning and HRD

Subdivision: Management Information and Research

*Forward with Health for all Namibians by the Year 2000 and Beyond!*



REPUBLIC OF NAMIBIA

MINISTRY OF BASIC EDUCATION SPORT AND CULTURE: OSHIKOTO REGION

Tel: (065) 240024  
Fax: (065) 240315

Private Bag 2028  
ONDANGWA  
NAMIBIA  
20/04/2004

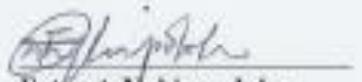
Enq: Timoteus H Ndakunda

Mrs E Mulenga  
P.O Box 870  
Ondangwa 9000

Dear Madam

**RE: REQUEST FOR PERMISSION TO DO RESEARCH.**

1. Your letter date 06/04/04 bears the reference.
2. Per mission to do research at Hans Daniel JSS, Onampadhi PS, Oneputa CS, Onamulunga CS Olukonda JSS, and Oshilulu CS is granted provided that:
  - 2.1 The school programme is not interfered with.
  - 2.2 Arrangement is made with the concerned principals.
3. Wishing you the best in your study.

  
Ester A Nghipondoka  
Regional Director Oshikoto



REPUBLIC OF NAMIBIA

MINISTRY OF BASIC EDUCATION, SPORT & CULTURE  
OSHIKOTO REGION  
OSHIGAMBO CIRCUIT

**HANS DANIEL NAMUHUJA JSS**

Enq: E. Shipena  
Tel: 065-248152

TO: Mrs E. Mulenga  
Onandjokwe Health Training Centre  
Oshikoto Region

DATE: 29.04.2004

Dear Mrs Mulenga

Re: Permission to Conduct a Research Study at H.D. Namuhuja JSS

Be informed that your permission has been granted to conduct your research at our school. See the school principal with your time-table.

Yours in Education

A handwritten signature in black ink, appearing to be 'E. Shipena'.

E.SHIPENA  
School Principal



Olukonda J.S.S  
Private Bag 2028  
Oshigambo Circuit  
Oshigambo Region

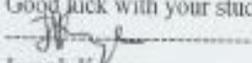
Enq: Ms Gabriel

Dear Mrs. Mulenga

Re: **REQUEST FOR PERMISSION TO DO RESEARCH.**

1. Your letter date 22 April 2004 bears the reference.
2. The permission to do research at Olukonda Junior Senior Secondary School is granted provided:
  - 2.1 The school program is not interfered with.
  - 2.2 Prior arrangement is made in advance.

Good luck with your study.

  
Joseph Kamenyé  
PrincipalA



MINISTRY OF BASIC EDUCATION, SPORT AND CULTURE  
OSHIKOTO REGION  
OSHIGAMBO CIRCUIT  
**ONAMULUNGA COMBINED SCHOOL**

Dear Sir/Madam (MULUNGA E)

RE: PERMISSION TO CONDUCT RESEARCH AT SCHOOL.

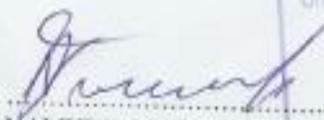
This letter serves to respond to your letter asking permission to come and conduct your research at our school in this year of 2004.

1. You are authorized to come and carry out your investigation at our school, provided that no interruption of school programmes can take place because of your presence.
2. Your programmes and time table should be available at school on time so that we can make the necessary arrangement in terms of accommodation and informing the class groups that you would like to meet at school.
3. Note that the permission from school authority may change any day if the needs arises. That means you may need to have permission from our Regional Director of Education in Ondangwa as well.

I hope this information will be useful to you.

Thanks for choosing our school for your research purposes.

Yours faithfully

  
.....  
NAMUPOLO I.K  
PRINCIPAL





## ONEPUTA COMBINED SCHOOL

MINISTRY OF EDUCATION, SPORT AND CULTURE: OSHIKOTO REGION, OSHIGAMBO CIRCUIT

P.O. Box 874, ONDANGWA

Tel: (065) 248228

28 May 2004

### Permission granted to conduct a research

Your application to conduct a research study at Oneputa Combined school is approved. You are welcome to visit the school to carry out your research study.

Thanks

Yours truly,



Oshilulu Comb. School  
Oshigambo Circuit  
Oshikoto Region

30 April 2004

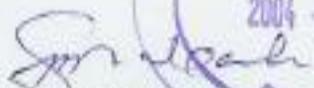
Dear Madam,

**RE: APPLICATION FOR PERMISSION TO CONDUCT RESEARCH.**

You are hereby informed that your application for permission to conduct research at the above-mentioned school has been approved on condition that it does not interfere with the school programme.

Thanks in anticipation.

Faithfully Yours,



S. Nambambi  
**ACTING PRINCIPAL**



## ANNEXURE 3

Transcription of focus group discussion 3

**TRANSCRIPTION OF FOCUS GROUP DISCUSSION 3**

**KEY:           R: Researcher**

**Knowledge, Attitudes, and practices of teenagers regarding safer sex, Onandjokwe District, Oshikoto Region.**

Date:           5 August 2004

Venue:         Onamulunga Combined School

Participants:   Grade 10 learners aged 15-19 years (6 male learners)

The researcher introduced herself and the topic as well as the purpose of study.

Participants were asked to introduce themselves by their first names.

The discussion was held in the library of the school, seats were arranged in a semi circle and the researcher seated in front of the semi circle. The atmosphere was a relaxed one.

The researcher briefed the participants on what will happen during the discussion as follow:

First of all I would like to thank you all for making yourself available to come and attend this discussion in which we will discuss matters related to safer sex. This session was chosen because of high rate of teenage pregnancy, sexual transmitted infections and also due to the problem of HIV/AIDS infection.

Firstly I would like to brief you on what is going to happen during this discussion:

- The discussion will be recorded with a tape recorder.
- You will be identified by letters of alphabet i.e. A,B,C,D,E and F so that no name will be mentioned to ensure anonymity.
- Everyone in this group is expected to participate in the discussion.
- The information to be collected will be handled with confidentiality, so it will not be given to any other person rather than myself and my supervisors.
- Participation in this study is voluntary; no one will be forced to participate. If you feel like withdrawing from the study you are free to do so.

*R:* First I would like to start asking general question which have to do with HIV/AIDS and other sexually transmitted infections as these are some of the problems facing the youth. What does HIV stands for?

*Learner A:* HIV stands for Human Immune Virus

*R:* What does AIDS stands for?

*Learner F:* AIDS stands for Acquired Immune Deficiency Syndrome.

*R:* Who is at risk of being infected by HIV/AIDS?

*Learner D:* Anyone

*R:* Why are you saying anyone is at risk of being infected by HIV/AIDS?

*Learner D:* I say anyone is at risk, because even a small baby/newborn baby can be infected.

*R:* How a newborn baby can be infected by HIV/AIDS?

*Learner A:* A newborn baby can be infected through breast milk from the mother if the mother is infected by his man she can pass the virus to the baby.

*Learner D:* Woman can also infect a man if she has a virus not only man can infect a woman.

*R:* How can a man and a woman infect each other with the virus?

*Learner B:* They can infect each other through sexual intercourse

*R:* Beside HIV/AIDS which can be transmitted through sexual contact, do you know any other disease which can be transmitted through sex?

*Learner F:* Other sexually transmitted diseases are like syphilis and gonorrhoea.

*R:* Any other disease that you know?

*Learner C:* That is all

*R:* How do you understand safer sex?

*Learner A:* Safer sex is the sex that is protected.

*R:* Protected how?

*Learner A:* Protected when using condom.

*Learner B:* I agree with A

*Learner C:* I also agree with A and B

*Learner D:* Safer sex is when one keeps himself safe by not doing sex.

*Learner F:* Safer sex is when one is taking care of himself by sticking to one partner or staying away from sex.

*R:* Why do you think it is important to practice safer sex?

*Learner A:* It is important so that one can prevent his girlfriend from getting pregnant.

*R:* How can you prevent your girlfriend from getting pregnant through safe sex?

*Learner A:* By using a condom.

*Learner D:* It is important to practice safe sex, so that one can prevent himself from diseases such as HIV/AIDS.

*Learner C:* I think safer sex can also be a mean of family planning.

*R:* How can safer sex be viewed as a means of family planning.

*Learner C:* Because if people are using condoms, then they will not give birth to many children.

*R:* How do you as young one talk about safer sex amongst yourself?

*Learner D:* We talk about safer sex by advising each others to be careful on what we are doing.

*R:* Any other opinion?

***No response from the group.***

*R:* What is your opinion of having sex at an early age e.g. from 10 years?

*Learner B:* Having sex at an early age is not good, because at that age you do not even know how to use a condom.

*Learner C:* I do not think that sex is for the young ones, but it is for the married couple.

*Learner F:* I don't think it is good to start having sex at an early age, because you can be infected by diseases like HIV/AIDS and you can die soon.

*R:* At what age do you think a person can start having sex?

*Learner B:* One can start having sex after marriage because that is culturally acceptable.

*Learner C:* I think at the age of 25 years one can start having sex, because you are no longer young, you know what you are doing

*Learner E:* At the age of 35 years, because by that age one is already married.

*Learner D:* I also agree with E.

*R:* As you are growing up and your body is developing, sometimes there is that desire or demand, from your body to have sex. How do you satisfy your sexual needs?

*Learner A:* I read from one book that one can touch yourself to satisfy that need.

*R:* Is that you actually do?

***No response.***

*Learner F:* I can satisfy that desire by masturbating.

*Learner B:* I agree with F

*R:* What is your opinion on having unprotected sex?

- Learner D:* If you do unprotected sex, you will give pregnant to a girl.
- Learner F:* You can also get diseases such as HIV/AIDS and other sexually transmitted diseases.
- R:* What can you tell your girlfriend if she asks you to have sex with her?
- Learner A:* I will tell her to use a condom.
- R:* What if she does not want to use a condom?
- Learner A:* Then I will not have sex with her.
- Learner E:* I do agree with A.
- Learner B:* I will tell her I do not want to have sex, but I do not have a reason.
- Learner D:* I will tell her to wait until the age of 25 years as by that time we may be married, because if we have sex I am afraid to be attached by diseases such as HIV/AIDS.
- R:* Let's say you have a girlfriend, but you cannot always trust anybody, because sometimes she may meet some other man, how will you convince your girlfriend to practice safer sex?
- Learner F:* I will tell her that if you find another man you must make use of condom.
- Learner A:* If I do not trust her I will just leave her.
- R:* How do you get information about sexual health?
- Learner A:* We get information by attending programs from my future is my choice.
- R:* Do you have such program at your school?
- Learner A:* Yes, we have it at our school, but it specifically focus on young people between the age of 15 years and above.

*R:* What exactly is included in the information you get?

*Learner A:* It focuses on the use of condom, how to say no to sex and how to protect yourself from other sexually transmitted diseases.

*Learner C:* I get some information during church sessions when some visitors visit our church for from councilors.

*Learner D:* I also get some information from regional councilors as sometimes they do organize meetings.

*Learner E:* We got some information from Life Science and Life Skills teachers.

*Learner F:* I get if from hospital notice boards whenever I visit the hospital.

*R:* With whom do you feel comfortable to discuss sex and sexual relationship?

*Learner A:* With my friends.

*R:* Why do you feel comfortable to discuss it with your friends?

*Learner A:* Because I will not be afraid of my friends so I will be free to discuss with them.

*Learner D:* I feel comfortable to discuss it with teachers, because I will not be shameful to talk to my teachers.

*Learner E:* I also agree with D.

*Learner F:* I feel comfortable to discuss sexual relationship with my life science and life skills teachers as well as those teachers who are responsible for the program “My future is my choice”, because they have more information.

*R:* Which other educational programs provides you with information regarding sexual health?

*Learner A:* There is other information in youth papers such as super strike.

*Learner E:* You can also get some information from open talk newspaper.

*Learner F:* Other information can also be found from posters at cucashops and schools.

*R:* Give your opinion on the information you receive about sexual health?

*Learner C:* I think such information is adequate, because one can learn how to use condom and to protect yourself.

*Learner E:* I also agree with C.

*Learner F:* I don't think that such information is enough, because like the one in the newspaper not all people do buy a newspaper and not all people read the newspaper.

*R:* What do you think should be done to improve on such information and to reduce the risk of STI/HIV?

*Learner A:* There is a need to be some condoms to be for the small size, because most of condoms are of big size. Family planning pills should be stopped, because they are contributing to STIs as many girls are not using condoms once they are making use of family planning pills.

*Learner E:* Condoms need to be placed at schools because hospitals are far and sometimes if you go to the hospital to get condoms the health workers ask you many questions, because they think you are young to get involved in sex.

*Learner F:* Hospitals need to bring condoms to the cecashop to reduce STI/HIV, because hospitals are far and some people do not have money to go to health facilities. But at the cecashop it where most people meet their friends.

*R:* We have come to the end of our discussion. Thanks once again for your time. I wish you all the best.

## ANNEXURE 4

### Summary of focus group discussion

**SUMMARY OF TRANSCRIPTION OF FOCUS GROUP DISCUSSION:5 and 6**

**VENUE:** Olukonda Junior Secondary School

**PARTICIPANTS:** Grade 10 learners 6 males and 16 females between 15 - 19 years.

**Introduction**

The researcher welcomed everyone and introduced the topic and the purpose of the study and briefed the participants on what will happen during the discussion. First the researcher started asking general questions to test general knowledge. The following are questions asked and answers given during the discussion.

**Q: What does HIV stands for?**

**A:** Human Immune Virus?

**Q: What does AIDS stands for?**

*There was a silence*

**A:** Acquired Immune Deficiency Syndrome

**Q: Who is at risk of becoming infected by HIV/AIDS?**

**A:** Those who sleep around, those who have many boyfriends, or girlfriends

- Young people between the ages of 15 - 25 years who involve themselves in sexual intercourse.
- Everybody involved in sexual intercourse if not protected is at risk
- Everybody involved in sex with infected person

**Q: Which other diseases do you know which are called Sexually Transmitted Disease?**

A: There is another disease called syphilis and also gonorrhea.  
That is all we know

**Q: How do you understand safer sex?**

A: Safer sex means if you have a partner you have to use condom or femidom.

- It means to do sex with somebody you know well, safer sex is when you keep yourself not touched by diseases such as AIDS and Syphilis.
- Safer sex is the method such as using condom or femidom to protect yourself from becoming infected by HIV.

**Q: Why do you think is important to practice safer sex?**

A: So that one can be health, because you cannot get Sexually Transmitted Diseases.

- It is important to prevent unwanted pregnancies and other Sexually Transmitted Disease e.g. HIV/AIDS.

- It is important so that the virus cannot spread from one person to another.
- It is important for many different reasons such as to protect your body from infectious disease e.g. syphilis.

**Q: How do you young ones talk about safer sex?**

A: We talk about safer sex by encouraging others not to do sex because they are still young.

- We talk about how young people can avoid diseases and unwanted pregnancies.
- We talk about safer sex by encouraging others to use condoms when involved in sexual activity.

**Q: What is your opinion of having sex at an early age e.g. at the age of 10, 11, 12 years?**

A: It is not good, because you may end up pregnant while you are still young.

- If you are young and you become pregnant you will not be able to support the baby and if your baby gets sick you don't know how to take care of that baby.
- I do not think that sex is for small children so it is not allowed; it is for the people who are 25-45 years.

**Q: At what age do you think a person should start to have sex?**

A: At the age of 25-45 years, because at that age the person is allowed to marry and can have sex.

- A person can start having sex at the age of 30 years, because at that age a person is grown up enough and know what you are doing.
- At the age of 18 years, because at that age a person have finished school and may have a job, and money and might be married and if one happen to have a disease you can buy your medicines and take care of the baby.
- At the age of 20 years, because if you are very young you cannot cope with the baby.
- At the age of 15 years, because sex is a natural thing, but one should use protection.
- At the age of 35-45 years a person can start having sex because he/she know the advantages and disadvantages of having a baby.

**Q: As you are growing up and your reproductive organs are developing, sometimes you may have a sexual desire. How do you satisfy your sexual need?**

- A: If you have a girlfriend you can satisfy your sexual need by just kissing and touching each other but not having sex.
- If you do not have a girlfriend you can just touch yourself until you are satisfied.
  - You can touch your clitoris until you are satisfied
  - You can just ignore it, because it cannot kill you.

**Q: What is your opinion on having unprotected sex?**

A: If you do unprotected sex you may get infected by Sexually Transmitted Diseases.

- You can give pregnant to a girl while you have no money to support the baby.
- You may get diseases such as HIV and once you get tested and you are positive you may end up killing yourself.
- You may get unwanted pregnancy while you are young and you will leave school. If you get HIV you may die and if you are not educated you will not get a job because nobody will employ uneducated person.
- Unprotected sex result in unwanted pregnancy, sometimes you go to deliver and you may die due to pregnancy complications, but if your are lucky you come back to school, but many schools do not want to admit mothers so you may go and look for work and your work will be making "kapana" and telling "tombo" and life will not be good at all.

**Q: What can you tell your girlfriend or boyfriend if she/he asks you to have sex with her/him?**

A: I will say I do not love her because of sex

- I will tell her to wait until the age of 25 years so that I can finish school as I do not want to spoil my life.
- I will tell her that I do not want to have sex, because it is my choice and if she insist I can leave her.

- I will tell her to wait until the age of 25 years as we are still young and there are no condom size I can fit.
- I will tell her to wait until we get married so that we cannot spoil our future, because after marriage we can be able to have children and support them.
- I can tell him that I don't want, because I am afraid of teenage pregnancy while I am still in school.
- I can say yes, if we are using condom but if he/does not want condom I will move on with my life.

**Q: How can you convince your girlfriend/boyfriend to practice safer sex?**

A: By encouraging her/him to stay away from sex with other partners.

- By telling her to choose only one boyfriend
- By telling her/him to use condoms if involved in sexual activity

**Q: How do you protect yourself from HIV and other STI?**

A: I protect myself by staying away from sexual activities.

- I protect myself by using condoms.
- I can protect myself by not involving in unprotected sex.

**Q: How do you get information about sexual health?**

A: We get information from school e.g. from Life Skill subject

- I get information from clinics e.g. if you visit clinic, nurses can give you some books.
- We also get some information from regional councilor's offices e.g. if you have question you can go and ask them.
- I get the information from friends and from parents and teachers.
- I get the information from nearest nurses.

**Q: What exactly is included in such information?**

A: The information includes how the body can be attacked by the virus

- Some information is on how to take care of HIV infected people.
- Some information also include encouraging the youth not to have sex while at school as they are still young.
- The information also includes the advantages of safer sex and disadvantages of unprotected sex.

**Q: With whom do you feel comfortable to discuss sex and sexual relationship?**

A: I feel comfortable with other youths as I am free to talk to them and they can give me enough information.

- I feel comfortable with nurses; because they know our body properly and if there is any problem they may be able to identify it.
- I feel more comfortable with teachers and nurses, because they can give me more information on how to protect yourself against diseases and unwanted pregnancy.

- I feel comfortable with my parents because they are the one who can give me permission to enter into a relationship.
- I feel comfortable with my own older sister, because she has passed through the process and know how to protect herself so she can tell me to do the same.

**Q: Which other educational programmes provide you with information regarding sexual health?**

A: We have AIDS awareness club at our school, but not learners are members but there are no criteria which restrict them from becoming members it is only that they are ignorant.

- There is no other educational program, but we read the information from newspaper which the principal gave to us such as open talk and choose life.

**Q: Give your opinion on the information you get on sexual health related matters**

A: I do not think the information we get is enough, because like the one from teachers they only give us the information they know and they think that young people need not to know more about sexual issues. I think teachers need to consult nurses and doctors for more information.

- I do not think the information we get is enough especially from teachers they only explain few things about sexual activities.

- It is good to read and get information as sometimes you may get new information, but it is not enough, because we do not get in depth information. We need more information such as to see an HIV infected person.
- I think we still need more information from nurses, because they have more information and they need to encourage learners to stay away from unprotected sex.
- The information we get is not enough, because there are a lot of changes takes place. We need some programs so that we will able to take care of ourselves so that we can improve our health

**Q: What can be done to improve such information?**

- A: I think there is a need to call doctors and nurses from different hospitals to come and talk to the learners and give us more information.
- I think young people need to form up organizations in the village which will encourage young people to play safer sex.
  - Nurses need to come and give us more information so that we can give it to other community members and our young sisters.
  - Nurses need to do meetings in the community to provide youth with information.
  - Nurses need to be encouraged to talk in schools and community and to bring along condoms, because hospitals where condoms are found they are very far and sometimes at the clinics condoms are not available.

## **ANNEXURE 5**

### **Letter from the editor**

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**NAMIBIA LODGE 2000**

Our place to lodge in style

**FAX MESSAGE**

To	For Ms. E. Mulenga	From	Chief Ankama
Fax		pages	1
Tel		Date	20 January 2005
Re;		Cc;	
	urgent	review	comment   reply

To whom it may concern

RE: Language review of Ms. E. Mulenga's dissertation

I Chief Ankama lecturer at the UNAM Northern Campus Language Center would like to inform you that I have indeed done language review on Ms. E. Mulenga's dissertation titled "Knowledge, attitudes and practices of teenagers regarding safer sex in Onandjokwe health district: Oshikoto region, Namibia." This language review was wide ranging including structures, tenses, plurals, consistency, spelling and more. The review was penciled on a hard copy (printed) and she is expected to accept or reject these corrections/suggestions as necessary.

Seasonal greetings from

Chief Ankama  
