Sexuality, HIV/AIDS and Contraception. A Namibian Youth Perspective.

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Abstract

The current situation in Namibia suggests that there is need for concern about youth in an at-risk context. Education, unemployment and poverty have always been inter-related and Namibia has experienced an alarming increase in youth unemployment over the past few years. Poverty exacerbates the crises and also constraints individual's choices about issues relating to sexual behaviour, which makes especially the youth vulnerable to HIV/AIDS infection.

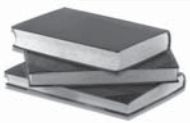
According to the Department of Health Services, 37% of Namibian women had experienced sexual intercourse by the age of 18, rising to 61% by the age of 20. Knowledge of modern contraceptive methods was high (more that 80%) among female adolescents, but practice was very low. Only 11% of sexually active females aged 15 to 19 reported using modern contraceptives.

The first of the study aim was to gain practical insight about perceptions amongst the youth about sexuality and HIV/AIDS and contraceptive use, which can assist in the formulation of a strategy towards HIV/AIDS education for Namibian youth in an at-risk context. The second aim was to gather descriptive data from Namibian youth about a number of personal issues, with special emphasis on those issues related to the creation of an "at-risk" environment.

The participants in this study were youth living in an at-risk context (Katutura and Khomasdal) in Namibia (N= 305). For the purpose of data collection, it was decided to use a quantitative approach, through the administration of a questionnaire.

The research evidence suggests that access to a full range of sexual and reproductive health education services is inadequate, despite the fact that many young Namibians are already sexually active and in need of information and healthcare. There is a need to empower marginalized youth, provide good leadership and establish support. All stakeholders have a responsibility to help the youth develop practical psychological and social skills to equip them for positive social behaviour and for coping with negative pressures. There is a need to create educational programmes that responds imaginatively to the crises. Skilled-based intervention strategies can also promote numerous positive attitudes and behaviours, including healthy decision-making, improved communication, and effective situational analysis.

Keywords: Contraceptives, Sexually Transmitted Infections, Abstinence, Monogamy, Faithfulness.



Introduction

Adolescence is the pivotal period between childhood and adulthood when youth need to acquire the attitudes, competencies, values, and social skills that will carry them forward to successful adulthood. Not only must parents, families and communities help, but also governmental institutions such as schools, must take an active part in supporting the positive development of children and youth.

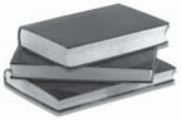
A number of social forces have changed both the landscape of family and community life and the expectations for young people. A combination of factors has weakened the informal community support once available to young people: high rates of family mobility; greater anonymity in neighbourhoods; extensive media exposure to themes of violence and heavy use and abuse of drugs and alcohol; and the deterioration and disorganization of neighbourhoods and schools as a result of crime, drugs, and poverty. At the same time, today's world has become increasingly complex, technical and multicultural, placing new and challenging demands on young people in terms of education, training and the social and emotional skills needed to function in a highly competitive environment (National Research Council and Institute of Medicine, 2002).

Children in Namibia are vulnerable to many stressful social and personal problems that can harm them and reduce the quality of their lives. Improving the current situation in Namibia will include tackling several inter-related issues pertaining to the youth and education (UNICEF, 1995). Namibia has a young population with 69.5% of the total population of 1.8million people under the age of 30 years. Around 50.3% of the total population is under the age of 19. There are 202 298 youth between the ages of 15-19, with approximately 72.4% of these youth live in rural areas (National Planning Commission, 2001).

Many of the social issues such as high rates of family mobility, heavy use and abuse of drugs and alcohol, crime etc. are directly related to poverty. As in most post-colonial societies, poverty is a reflection of the power relationships that have disadvantaged particular groups in a society. Even when these power relationships change in terms of the legal and political system, the process of changing the economic realities of daily living for the poorest of poor takes a very long time to rectify. Poverty and poor educational opportunities often reinforce one another. For example, living under conditions of poverty may often lead to certain learning difficulties. Learning needs may be neglected, which ultimately results in lower levels of qualification for work, thus promoting more poverty in a negative cycle of cause and effect (Donald, Lazarus & Lolwana, 2002). It is important to begin to turn the negative cycle into a positive one. Interventions need to be considered at all levels of the educational system, from the individual student, through to the classroom, to the whole-school development, to school-community collaboration, and ultimately to the wider issues of social transformation.

Health is a necessary condition for personal development and National development. HIV/AIDS, STI's, teenage pregnancies, alcohol and substance abuse and debilitating illnesses such as malaria, prevent the youth from fulfilling their personal development and therefore their potential to contribute to national development (National Planning Commission, 2000).

HIV/AIDS seriously affects adolescents throughout the world. One-third of all currently infected individuals are youth, ages 15 to 24, and half of all ***new*** infections



occur in youth the same age. More than five young people acquire HIV infection every minute; over 7,000, each day; and more than 2.6 million each year (UNAIDS 1999).

About 1.7 million new adolescent HIV infections—over half of the world's total—occur in sub-Saharan Africa (UNAIDS 1999). In fact, nearly 70 percent of people living with HIV/AIDS live in sub-Saharan Africa, and over 80 percent of AIDS deaths have occurred there (Akukwe 1999). Although HIV/AIDS rates vary considerably throughout sub-Saharan Africa—generally lower in western Africa and higher in southern Africa—the epidemic has had a devastating effect on most African youth who often lack access to sexual health information and services. In particular, unmarried youth have great difficulty getting needed sexual health services. At the same time, cultural, social, and economic norms and pressures often put young African women at excess risk for HIV infection.

Leaders of some African nations, once unable to acknowledge the presence of HIV/AIDS, now publicly address HIV prevention and appoint task forces to mobilize and coordinate efforts against the epidemic (Caldwell 2000). In addition, business coalitions and non-governmental organizations (NGOs) often lead in utilizing peer education, advocacy, youth-friendly service delivery, and social marketing to battle HIV infection in sub-Saharan African nations (Population Reference Bureau 2000).

Young Women infected and affected by HIV/AIDS

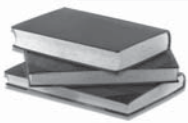
Half of all HIV infections worldwide occur in women in Africa (Akukwe 1999).
In seven of 11 studies in Africa, at least one woman in five, ages 20 to 25, was HIV infected; most HIV-infected young women will not live to age 30 (UNAIDS 2000).

In one city in South Africa, six out of 10 women, ages 20 to 25, were HIV infected; among youth in their early 20's, women's rates were three times higher than men's. In Malawi, HIV incidence in teenage women is six percent compared to less than one percent in women over age 35 (UNAIDS 2000).

Throughout sub-Saharan Africa, HIV infection rates among teenage women are over five times higher than rates for teenage males. In Kenya, nearly one teenage woman in four is living with HIV, compared to one teenage male in 25 (UNAIDS 1999).

The physical immaturity of younger women and women's lower status in society may contribute to disproportionate HIV infection rates. Women's lower status may prevent them from having control of their sexual relationships. For example, studies on women's first sexual experience show that over half of young women in Malawi and over 20 percent of young women in Nigeria experienced forced sexual intercourse (UNAIDS 2000, UNAIDS 1998).

According to the Department of Health Services, 37% of Namibian women had experienced sexual intercourse by the age of 18, rising to 61% by the age of 20. Knowledge of modern contraceptive methods was high (more that 80%) among female adolescents, but practice was very low. Only 11% of sexually active females aged 15 to 19 reported using modern contraceptives (Ministry of Health and Social Services, 1994).



Sexual Health Information and Access to Health Care

African adolescents cite lack of knowledge, inaccessibility, and safety concerns as primary reasons for not using contraception. For example, one study showed that less than 50 percent of youth in Madagascar and Nigeria know about contraception. Limited resources also make contraceptive use lower in Africa than in other world regions (Pathfinder International 1999).

Many African health services workers feel it is inappropriate to provide contraceptives to adolescents, often making it difficult or impossible for youth to obtain condoms and other contraception. For example, a study in Kenya found that three-fourths of family planning workers were unwilling to provide contraceptives to young women who had not given birth (Rosen & Conly 1998).

In sub-Saharan Africa, only half of the population has easy access to health care. Africa has one-third as many nurses per capita as the rest of the world. Moreover, the current ratio of doctors is lower than one per 10,000 population; the world average is one per 800 (Rosen & Conly 1998).

Limited budgets, problems imposed by the HIV epidemic, and few health care providers mean that improving reproductive health services is a challenge for most sub-Saharan African countries (Rosen & Conly 1998).

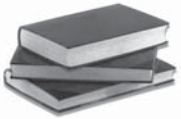
Sexual Attitudes and Behaviours of Namibian Youth

In sub-Saharan Africa, as in other regions of the world, a culture of silence surrounds most reproductive health issues. Many adults are uncomfortable talking about sexuality with their children. Others lack accurate sexual health knowledge (Pathfinder International 1999). Many Africans feel unable to discuss sexuality across perceived barriers of gender and age differences Many Africans are also reluctant to provide sexually active adolescents with condoms (Caldwell 2000).

In several African countries, some people believe that men are biologically programmed to need sexual intercourse with more than one woman. Polygamy is a central, social institution that reinforces this belief. Moreover, some men believe that this "biologically programmed need" makes high-risk sex unavoidable (Caldwell 2000). In some impoverished communities, high HIV infection rates may be partly explained by early sexual initiation, consensual or coerced. For example, in a survey of 1,600 urban Zambian youth, over 25 percent of 10-year-old children and 60 percent of 14-year-old youth reported already having sexual intercourse (UNAIDS 2000).

One study of adolescents in 17 African countries showed that those with more education were far more likely to experience casual sex ***and*** to use condoms for casual sex when compared to less educated youth (UNAIDS 2000).

Pendleton (1994), reported that adolescent pregnancy in Namibia is common, due to early sexual activity combined with low contraceptive use. Statistics on Sexually Transmitted Diseases (STI's) (other than AIDS) are largely unavailable. However, earlier statistics collected at Independence revealed high STI rates among young adults. Since the incidence of AIDS has increased rapidly, compelled with the low rate of condom use is a virtual guarantee that STI transmission in Namibia will rise (United Nations Children's Fund, 1995).



There were 14 924 reported cases of HIV infection in Namibia during July 1994 – compared with 4 cases in 1986. A high percentage of cases have occurred among adolescents and young adults (12% of 15-25 year olds affected), and the rate of infection increases with age. Among adolescents, rates are higher for females than for males (United Nations Children's Fund, 1995).

HIV infection is increasing rapidly amongst Namibian adolescents, especially young women with one in five of the sexually active young people possibly infected with HIV (National Planning Commission 2001). From the 1998 sentinel surveillance on HIV sero-prevalence the age specific HIV prevalence in female STD patients under the age of 20 years was 24%, 42% in the age group 20 to 24 years and 39% for 25 to 29years (Ministry of Health and Social Services, 1994)

It is anticipated that the impact of HIV/AIDS on the Namibian school system will increase the number of children without caregivers at home, which will in turn reduce enrolment and increase learner and teacher absenteeism. Against this background, government policy has called for a campaign reduce the spread of HIV/AIDS infections amongst learners, teachers and other stakeholders, through education and making information available, which will be done in cooperation with other ministries and agencies. Not only the formal school curriculum, but also existing or new co-curricular activities at schools will be used as a vehicle for such awareness campaigns (National Planning Commission 2001).

Cultural, Social, and Economic Factors

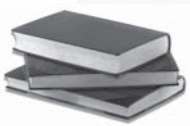
Some faith traditions in Africa teach that AIDS is a shameful disease and a punishment for those who have been sexually promiscuous, and many adults are reluctant to admit to a disease that seems to imply promiscuity (Caldwell 2000). One study showed three quarters of Nigerian Christian leaders believe that AIDS is a divine punishment (Caldwell 2000).

Poverty and HIV transmission are linked in a variety of ways. Poverty often leads to prostitution or to trading sexual favors for material goods. Young women may be especially vulnerable due to societal practices that deny them education and work opportunities. Poverty also leads to poor nutrition and a weakened immune system, making poor people more susceptible to tuberculosis and to STDs (Akukwe 1999, UNAIDS 1999, Rosen & Conly 1998).

The costs of providing treatment for people with AIDS drains resources from education, agriculture, and other domains important to gross national product. By 2005, AIDS treatment costs are expected to account for more than one third of Ethiopia's government health spending, more than half of Kenya's, and nearly two-thirds of Zimbabwe's (UNAIDS 1999).

In sub-Saharan Africa nearly eight million children, ages 14 and under, had been orphaned by AIDS by the end of 1997. Many of these youth must drop out of school (UNAIDS 2000).

Terms used to describe some HIV prevention strategies-such as "abstinence" or "faithfulness"-are not understood by a large majority of young adults in Namibia, a country where current HIV/AIDS prevalence is approximately 22 percent. The study of 100 Greater Windhoek youth, ages 15 to 25, revealed that common HIV/AIDS prevention terms are frequently misunderstood. Most young people believe that



"abstinence" means "to be absent" and "faithfulness" means faith in a religious sense, not being faithful to one sexual partner. The word "monogamy" was understood by only one-quarter, with 75 percent saying they had never heard the word (Johns Hopkins Bloomberg School of Public Health, 2003).

"These findings are important as we develop an HIV/AIDS prevention strategy for Namibian youth," said C. Kirk Lazell, USAID Health Officer in Namibia. "We know we have to craft a program and messages that are sensitive to the issue of language, testing messages in local languages, to ensure young people have a clear understanding of HIV transmission and prevention" (Johns Hopkins Bloomberg School of Public Health, 2003).

Because of mass media programs, young adults know about using condoms to prevent HIV/AIDS, but some are afraid or unwilling to discuss condoms and are perhaps not using them properly or consistently. For example, one male respondent reported abstinence as his preference and was unwilling to talk about condoms because it is against his Christian faith to have sex before marriage. The study further showed that most young adults were profoundly influenced by the mass media and that the church is a major social and support organization for them (Johns Hopkins Bloomberg School of Public Health, 2003).

Statement of the Problem

The problems confronting youth in Namibia today can be perceived to be overwhelming. They are facing staggering issues, such as fear of dropping out of school, low self-esteem, crime and delinquent behaviour, poverty, violence and high-risk sexual behaviour that increases the odds of contracting HIV/AIDS (Mufune, 2002).

If the youth are to be helped, then there must be programmes to help them. But what kinds of programmes would assist Namibian Youth? Such programmes would need to address selected risk factors. This study focused on exploring the current perceptions of Namibian youth and obtaining specific information about the risk factors that impact their lives. Through this it is hoped to assist programmes to address sexuality and HIV/AIDS as a selected risk factor, for Namibian youth.

Methodology

A descriptive research approach was employed for gathering information about lifestyle and at-risk behaviours relating to sexuality, HIV/AIDS and contraceptive use amongst Namibian youth.

Population and Sample

The participants in this study were youth living in an at-risk context in two low-income suburbs namely Katutura and Khomasdal in Windhoek, Capital of Namibia. The population was all grade 10 learners enrolled in Government schools. A sample of three hundred and five learners was taken (N= 305).

Research Instrument

For the purpose of data collection, it was decided to use a quantitative approach, through the administration of a structured questionnaire, which focused the following areas:

- Sources of sex education
- Their knowledge about certain methods of birth control

- Satisfaction with sex education
- Information needed on sexually transmitted diseases
- Pressure to having sex
- Age of first sexual intercourse
- Reasons for having sexual intercourse
- Frequency of using birth control
- Reasons for not using birth control
- Opinions on levels of protection of certain contraceptives
- Who they can talk to about contraceptives and sexually transmitted infections

Data Analysis

Data was prepared, entered and processed using the SPSS. Descriptive statistics were used (frequencies and percentages to analyze the participants' responses. Various two-way contingency table analysis were used to evaluate whether a statistical relationship exist between two variables.

Discussion of Results

The participants were asked to identify from a list of sources, those that provided them with sex education (see Figure 1). The most frequently mentioned sources were schools, followed by TV, books and then friends/partners. Other sources mentioned included parents, Internet, health units, pharmacy, and doctors/ nurses.

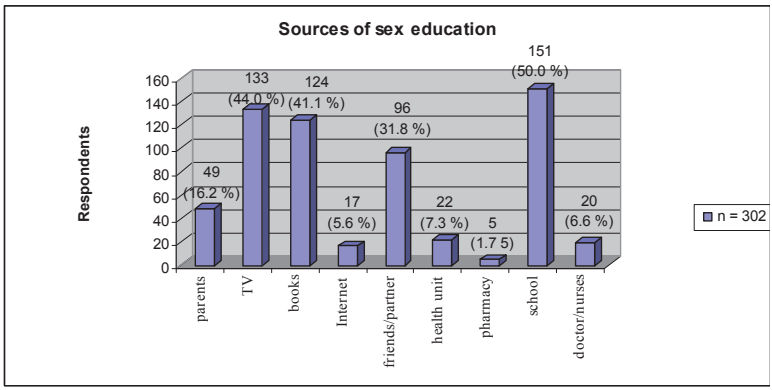


Figure 1

Sources where participants gained information about sex education

The participants were then asked how familiar they were with methods on a list of given methods of contraceptives (see Table 1). The type they were the least knowledgeable about was norplant, followed by foam, sponge, rhythm method temperature. Other methods they were not that familiar with included the IUD, condom with foam, the calendar method and depo provera injection. The ones they were the most knowledgeable about were condoms, abstinence and "the pill."

Table 1: How knowledgeable participants were about certain methods of contraception

Methods of Birth Control	Frequency	No knowledge	Basic knowledge	Know how to	No response
Abstinence	282	46	127	109	24
Foam	273	237	23	13	33
Diaphragm	279	169	81	29	27
Condom	286	39	84	163	20
IUD	278	212	45	21	28
Female condom	282	108	109	65	24
Norplant	275	242	20	13	31
Calendar method	279	189	65	25	27
Temperature	274	218	40	16	32
Rhythm	275	221	43	11	31
Sponge	274	233	28	13	32
Pill	279	86	127	66	27
Withdrawal	278	108	117	53	28
Depo Provera	280	166	77	37	26
Condom with foam	285	225	34	26	21

When asked how satisfied they were with the sex education that was available to them, from the 299 youth who responded to this question, 73.6% were satisfied or very satisfied, 12.7% somewhat satisfied and 3.8% either somewhat dissatisfied or very dissatisfied (see Figure 2).

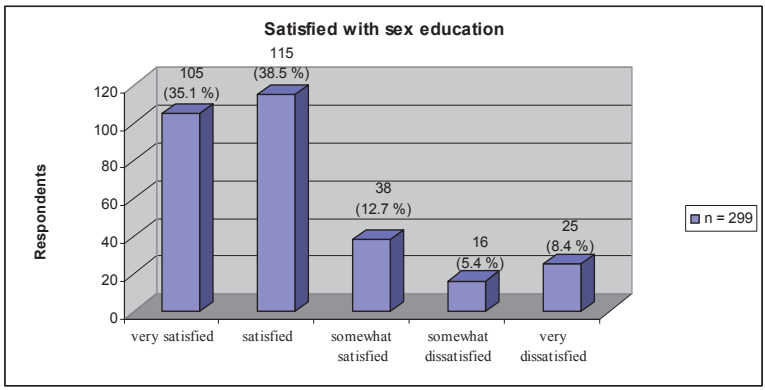


Figure 2 - How satisfied participants were with sex education

Two hundred and ten (70.2%) of the participants were worried about getting sexually transmitted infections (STI's). They were asked out of a list of given diseases, which ones they would like more information about (see Figure 3). Most participants were interested in AIDS information, followed by Clarnydia and Veneral Warts. However, of the 299 participants who answered this question, 30 (10%) reported having no interest in information on any of the infections.

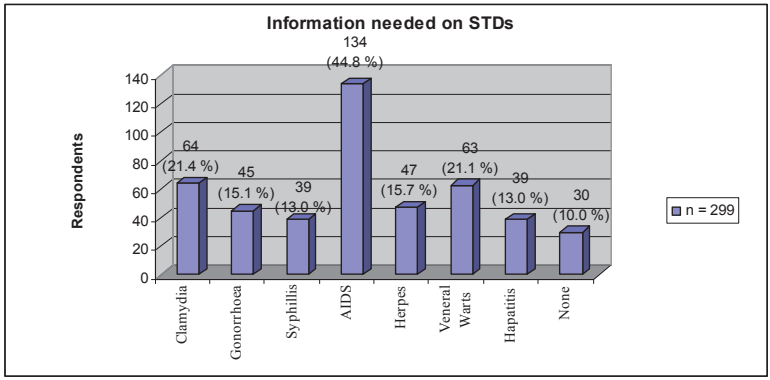


Figure 3 - Sexually transmitted infections about which participants would like more information

The participants were asked if they ever felt pressure from their partner or friends to have sex (see Figure 4). Of the 296 adolescents who responded to this question, 64.5% almost never or never felt pressured to have sex, but a few did feel pressured

as indicated by the 28.7% who answered always or sometimes.

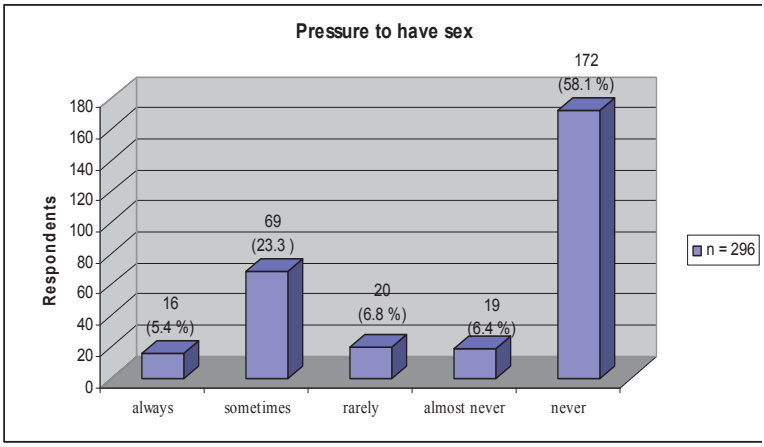


Figure 4 - How often participants felt pressured to have sex

A difference was noted between ages in terms of first sexual intercourse (see Figure 5), with the age range 11 to 16 appearing as the critical period.

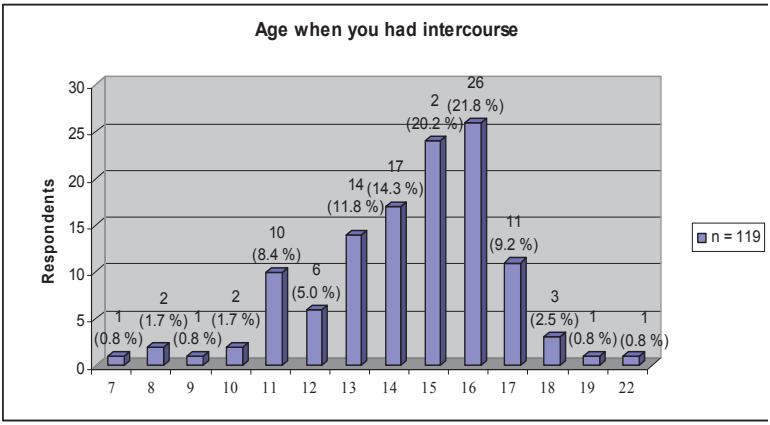


Figure 5 - Age of first sexual intercourse

When the participants who had had sexual intercourse were asked to choose out of a list given, the reasons why they had sexual intercourse (see Table 2), the two most frequently mentioned reasons were, "moment of passion" and "love for partner". The two reasons that were mentioned the least were "did not want to lose partner" and "loneliness."

Table 2: Reasons for having sexual intercourse (multiple responses possible)

Reasons for Having Intercourse	Frequency (n= 126)	Percentage
Love of partner	35	27.8%
Pressure of partner	13	10.3%
Under influence of substances	11	8.7%
Wanted to start a family	6	4.8%
Curiosity	7	5.6%
Forced physically	5	4.0%
Moment of passion	39	31.0%
Loss of self-control	11	8.7%
Pressure from friends	6	4.8%
Loneliness	2	1.6%
Did not want to lose partner	1	0.8%
Felt ready	21	16.7%
TOTAL	126	100.0%

They were then asked the method of birth control that they had used. The most frequently mentioned method was condoms, followed by abstinence and IUD.

The participants were also asked how often they of their partner(s) used birth control (see Table 3). Only a third (33. 1%) of the participants always used contraceptives. Alarming however is the fact that 43% never of almost never used birth control.

Table 3: Frequency of using contraceptives

How Often Do You Use Contraceptives?	Frequency (n= 142)	Percentage
Always	47	33.3%
Sometimes	19	13.4%
Rarely	15	10.6%
Almost never	12	8.5%
Never	49	34.5%
TOTAL	142	100.0%

These participants were then asked which, in a series of given reasons, explained why they did not use birth control in the past (see Table 4). However, no significant statistically difference was observed between males and females with regard to regularity of contraceptive use ($p=0.37>0.05$)

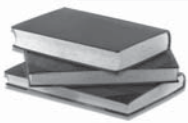


Table 4: Reasons why participants didn't use contraceptives (multiple responses possible)

Reasons why not using birth control	Frequency (n= 92)	Percentage
Thought I did not have sex often enough to become pregnant	13	14.1%
Wanted to become pregnant	5	5.4%
Using birth control is against my personal values	10	10.9%
Afraid parents would find out	16	17.4%
Afraid of being questioned or examined by a doctor	6	6.5%
Did not know where to get birth control	8	8.7%
Too embarrassed or shy to get birth control	8	8.7%
No convenient clinics where one can get birth control	7	7.6%
Birth control cost too much	13	14.1%
Did not get around to getting birth control	8	8.7%
Believe birth control is harmful	14	15.2%
It just happened	14	15.2%
Thought it would not happen to me	11	12.0%
Did not fit	2	2.2%
I am male	2	2.2%
TOTAL	92	100.0%

The participants were asked if they had ever had a child. Of the 165 adolescents who answered this question, 13 (7.9%) had.

Table 5 shows the participant's opinions regarding the protection level of different methods of contraceptives against sexually transmitted infections. Abstinence was by far the birth control method that the participant's thought would give them the best protection against sexually transmitted infections. However, it is important to note that 38.1% thought that the pill was a good means to prevent them from getting sexually transmitted infections.

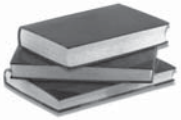


Table 5: Participants' opinions of the level or protection types of contraceptives have against sexually transmitted infections

Type of protection	Good		Fair		Poor		Don't know		Total
	n	%	n	%	N	%	n	%	
Abstinence	225	79.5	16	5.7	9	3.2	33	11.7	283
Foam	6	2.2	39	14.4	25	9.3	200	74.1	270
Diaphragm	31	11.7	35	13.3	49	18.5	150	56.6	265
Condom	144	51.1	69	24.5	29	10.3	40	14.2	282
IUD	30	11.3	27	10.2	30	11.3	178	67.2	265
Female condom	93	34.2	50	18.4	31	11.4	98	36.0	272
Norplant	12	4.6	17	6.5	29	11.2	202	77.7	260
Calendar method	22	8.1	24	8.9	40	14.8	184	68.1	270
Sympto thermal	6	2.2	16	6.0	32	11.9	214	79.9	268
Rhythm	6	2.2	19	7.1	34	12.6	210	78.1	269
Sponge	12	4.5	12	4.5	30	11.4	210	79.5	264
Pill	54	19.8	50	18.3	80	29.3	89	32.6	273
Withdrawal	19	7.0	28	10.3	108	39.7	117	43.0	272
Depo Provera	14	5.2	31	11.6	75	28.0	148	55.2	268
Condom with foam	21	7.9	23	8.6	28	10.5	195	73.0	267

Table 6 identifies the individuals who the participants reported that they would want to talk to if they needed someone to talk to about contraceptive methods or sexually transmitted infections. Their first choice mentioned by more then one-third (36.0%) was a doctor and the second choice (20.1%) was their mother.

Table 6: Individuals and/or agencies that participants would talk to about methods of birth control and sexually transmitted infections (open ended question)

Would Want to Talk to…	Frequency (n= 239)	Percentage
Doctor	86	36.0%
Stranger	9	3.8%
Anyone	33	13.8%
Friends	25	10.5%
Mother	48	20.1%
Sister/brother	7	2.9%
Teacher	25	10.5%
Cousin	2	0.8%
Partner	4	1.7%
TOTAL	239	100.0%

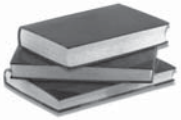
They were then asked how comfortable they would feel talking to this person or agency about contraceptive methods or sexually transmitted infections. More than three quarters (78.7%) felt they would be very comfortable or comfortable talking with these individuals or agencies.

Finally the participants were asked if they had ever experienced or witnessed violence or sexual assault. Of the 291 participants, only 53 (18.2%) reported that they had experienced or witnessed violence or sexual assault. It is important to note that of the individuals whom had either personally experienced or witnessed violence or sexual assault, almost half (43.9%) sought out help or support.

Conclusion

The impact of HIV/AIDS on the Namibian school system is seen as likely to increase the number of children without caregivers at home, to reduce enrolment, to increase learner and teacher absenteeism, and lead to situations where the school cannot function effectively. Against this background heightened efforts must be made to reduce the spread of HIV/AIDS infections amongst learners, teachers and other stakeholders, through education and making information available, which will be done in cooperation with other government ministries and agencies. Not only the formal school curriculum, but also existing or new co-curricular activities at schools must be used as a vehicle for such awareness campaigns.

The effects of pregnancy can be devastating to the academic success of teenagers. Experts have suggested that prevention of pregnancy requires teens to have life options that will motivate them to prevent pregnancy, and also to be educated about sexuality and birth control. Sexuality education classes in schools and after-school programmes are crucial for the prevention of teen pregnancy, as previous



research has demonstrated that certain programmes increase abstinence and birth control use. Family planning and counselling services are also important for participants who are at-risk for pregnancy. The teen birth rate has fallen in the past few years, and some researchers believe that sexuality education programmes are partly responsible for this improvement. However, as can be seen from results of this research, there are still a number of participants that are sexually active and that are engaged in unprotected sex.

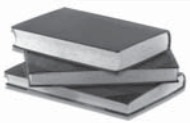
After 20 years people are still making resources and plans on how to address the epidemic when there is no need anymore. People have been dying for the past two decades and there are innumerable resources available already. Some forms of HIV/AIDS education have been shown to be more effective than others, but what is essentially important is that the population is informed about the dangers and information to protect themselves and other people.

The problems and issues facing youth in an at-risk context in terms of sex education are interdisciplinary. Therefore the problem-solving approach should also be. The whole community must be involved. There is a need for better communications among the different disciplines, parents, academics the church and government about what each is doing in this area, and what does and does not work. There is much research being done, but it is often "unpublished" or remains part of internal government research, resulting in conflicting and confusing messages going out towards the youth.

There are also a growing number of uncoordinated efforts from a variety of institutions to reverse the impacts of HIV/AIDS in Namibia. The ultimate success of these efforts will only be realized if the following are given priority:

- Stronger political will and better coordinated institutional leadership at all levels
- Establishing better coordinated and dedicated HIV/AIDS programmes in a supportive environment in all schools
- Broadening the response to include all stakeholders from civil society, churches, NGO's and the private sector
- Reducing stigma and discrimination faced by those infected and affected with HIV/AIDS
- Better protection of vulnerable young Namibians through positive reinforcement, constructive criticism and appropriate feedback.

Finally, whichever agency plays the primary role in the implementation of skilled-based HIV/AIDS and sex education; it is imperative for programme providers to collaborate with other stakeholders and community members in all stages of planning and delivery.



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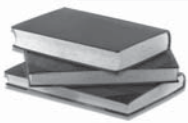


GENERAL INFORMATION

Editorial Policy

NERA Journal, a professional, refereed journal, encourages submission of previously unpublished articles on topics of significance to individuals concerned with education in Namibia. As a publication that represents a variety of cross-disciplinary interests, the Journal invites manuscripts on a wide range of topics, especially in the following areas:

- Psychology and sociology of learning and teaching
- Issues in research and research methodology
- Curriculum design and development
- Testing and evaluation
- Professional preparation and professional standards

Because the journal is committed to publishing manuscripts dealing with educational research in Namibia, all submissions drawing on relevant research and its implications and applications are welcome. All practical, teaching related issues should be submitted to the REFORM FORUM, however.

GUIDELINES FOR ARTICLES
Submission Categories

Full-length Articles

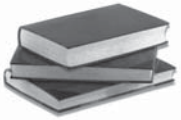
- Manuscripts of not more than 10 – 25 double spaced pages OR 6000 – 10 000 words (including references, notes, tables).
- Content must:
- Appeal to general interests
- Strengthen the relationship between theory and practice
- Be accessible to the broad readership, not only specialists
- Offer new, original insights or interpretations and not just restatement of other's ideas and views
- Make significant contributions to the field
- Arouse readers' interest
- Reflect sound scholarship and research design with appropriate, correctly interpreted references to other authors' works
- Be well written and organized
- Practical articles must be anchored in theory
- Theoretical articles and reports of research must contain a discussion of implications or applications of practice.

Review Articles

- Submission should be no longer than 1500 words
- Any occasional review article, that is, comparative discussions of several publications that fall into a topical category.
- Articles should provide a description and evaluation comparison of the materials and discuss the relative significance of the works in context of the current theory and practice.

Brief Reports and Summaries

- Submissions should be 5-6 double-spaced pages (approximately 3000 words)



- Any short report on any aspect of the theory and practice in the teaching profession.
- Reports can present either preliminary findings or focus on some aspect of a larger study.
- All discussions of issues should be supported by empirical evidence, collected through qualitative or quantitative investigations.
- Key concepts and results must be presented in a manner that will make the research accessible to our diverse readership.

The Forum

- Submissions should be no longer than 7-10 double-spaced pages or 3000 – 4000 words.
- Reactions regarding specific aspects or practices of the teaching profession
- Brief discussions of qualitative and quantitative research issues and of teaching issues
- Responses to published articles and reviews are welcome.

Review of Books, Textbooks and Software

- Submission should be no longer than 500 words.
- Any succinct, evaluative review of professional books, classroom texts, and other instructional resources.
- Reviews should provide a descriptive and evaluative summary of the significance of the work in the context of current theory and practice.

Requirements

- The article should have a Namibian character to apply to similarities in Namibian Education
- Two hard copies, as well as a disc, must be submitted which will be kept for some time.
- Double spacing throughout
- Indicate number of words at the end of the article
- Author's name should appear only on cover sheet, not on the title page (for screening purposes).
- Documents should be submitted to the Editor with a covering letter that indicates a full mailing address and both home and work telephone numbers. Where available include an electronic mail address and fax number.
- The author should include a brief statement that the article has not been published before.
- If an article is not accepted for the NERA Journal, the author should indicate whether the Editor may submit it to the Reform Forum of NIED.
- A brief biographical statement of the author (in sentence form, maximum 50 words), plus any special notations or acknowledgements that should be included.
- All submissions should conform to the requirements of the Publications Manual of the American Psychological Association (APA Manual).
- The Editor reserves the right to make editorial changes in any submissions accepted for publication to enhance clarity of style.
- The views of the contributors do not necessarily reflect those of the Editor, the Editorial Advisory Board, or NERA Journal.